NCQA Detailed Comments to HHS Health Technology Ecosystem RFI

Patients & Caregivers

PC-5. What can CMS and its partners do to encourage patient and caregiver interest in these digital health products?

NCQA recommends that CMS take a leadership role building trust, transparency and usability in the digital health ecosystem by promoting independent, third-party evaluation of digital health products. As digital tools become more central to how patients manage their health—particularly outside traditional clinical encounters—patients, caregivers and providers will need to be able to identify the tools that improve health outcomes and drive down health care costs.

To meet this need, NCQA is developing a program that defines and evaluates high-quality digital condition management. Digital health products are often asynchronous, app-based and patient-directed, designed to support chronic condition management, behavioral health and preventive care. But the current ecosystem lacks consistent standards for evaluating their clinical rigor, usability and data exchange capabilities.

By anchoring digital health innovation in trusted, independent evaluation, CMS can accelerate adoption, reduce risk and help ensure that digital tools deliver meaningful value to patients and the health care system.

NCQA Recommends

- Leverage trusted third-party evaluators to assess digital health tools using transparent, evidence-based criteria.
- Promote a national signal of trust—such as a CMS-endorsed directory of evaluated tools—to guide provider and patient decision making.
- Align incentives across value-based care and quality improvement programs to encourage the use of independently evaluated tools.
- Encourage integration of certified tools into EHRs and care workflows to help ensure digital health complements clinical care, rather than creating parallel systems.

PC-7. If CMS were to collect real-world data on digital health products' impact on health outcomes and related costs once they are released into the market, what would be the best means of doing so?

As the steward of HEDIS®, NCQA brings decades of experience in defining, validating and evolving performance measures that assess health outcomes, utilization and patient experience across the health care system. HEDIS is used by more than 90% of health plans, making it one of the most widely adopted and trusted measurement frameworks in the country. This broad adoption provides a scalable and credible foundation for evaluating the performance of digital health tools in real-world settings.

NCQA's leadership in digital quality measurement, and its ongoing transition to FHIR®-based standards, further position it to support integration of digital health products into value-based care.

NCQA is creating a quality framework to standardize engagement metrics and outcomes for digital condition management products. This will help evaluate the impact of programs on member health, giving purchasers confidence and setting quality targets for digital health products.

PC-8. In your experience, what health data is readily available and valuable to patients or their caregivers or both?

Patients and caregivers increasingly benefit from access to structured clinical data such as lab results, medication lists and visit summaries. Although these data types are foundational for managing chronic conditions and coordinating care, the next frontier in meaningful data access is expanding the types of information available and integrating them in ways that reflect the "whole picture" of a person's health.

One promising opportunity is the patient-generated health data. Data from wearables, home monitoring devices and health apps—such as glucose monitors, step counters and sleep trackers—offer continuous, real-world insights that can enhance chronic disease management and support more personalized care. These data streams, when validated and integrated into clinical workflows, can help detect early signs of deterioration, support shared decision making and reduce unnecessary utilization.

Pharmacy and prescription data also present a valuable opportunity. Information from pharmacy benefit managers and retail pharmacies can support medication reconciliation, adherence monitoring and safety surveillance. Although these data are critical for understanding treatment effectiveness and avoiding adverse drug events, they are often separated from clinical records.

Behavioral and mental health data are also often separated from general medical records due to privacy concerns, but are essential for whole-person care. Integrating these data into broader health records can improve care coordination, especially for individuals with co-occurring physical and mental health conditions.

Non-medical drivers of health—such as housing stability, food access, transportation and financial strain—are acknowledged as critical to health outcomes. These data may be sourced from community-based organizations, public health agencies or patient-reported assessments. When integrated into care planning and quality measurement, they can help identify barriers to care, inform risk stratification and support the most vulnerable populations.

Additional opportunities include lab and diagnostic imaging data stored outside EHR systems, such as those from regional lab networks or independent imaging centers. Integrating these sources would improve continuity of care and reduce duplicative testing.

Patient-reported outcomes, collected through surveys or digital tools, offer a direct window into a patient's experience with symptoms, functioning and quality of life—dimensions that are often invisible in traditional clinical or claims data.

Together, these data sources offer a more complete, person-centered view of health. NCQA sees significant potential in leveraging standards like FHIR, expanding the use of digital quality measures and supporting third-party validation to ensure data are usable, trusted and actionable.

PC-12. What are the most valuable operational health data use cases for patients and caregivers that, if addressed, would create more efficient care navigation or eliminate barriers to competition among providers or both?

One of the most valuable, and underleveraged, operational health data use cases is access to patient-facing quality measures: clear, timely and actionable information that helps patients and caregivers compare provider performance and make informed care decisions.

Patients often lack visibility into how providers perform on measures that matter to them, such as chronic condition management, preventive care or patient experience. Making these metrics accessible through digital tools—such as provider directories, care navigation apps or personal health records—would empower patients to choose high-performing providers and foster healthy competition in the marketplace.

Providers

PR-2. What are obstacles that prevent development, deployment or effective utilization of the most useful and innovative applications for physician workflows, such as quality measurement reporting, clinical documentation and billing tasks? How could these obstacles be mitigated?

A significant obstacle to innovation in physician workflows—particularly for quality measurement—is the reliance on outdated data standards such as the Quality Data Model (QDM) and Quality Reporting Document Architecture (QRDA). These standards were developed for electronic clinical measures (eCQM), but are not widely used outside quality reporting, which limits interoperability and increases implementation burden.

QRDA, in particular, requires complex mapping of EHR data into rigid XML formats, often necessitating custom development and manual validation. This process demands substantial resources and does not align with current clinical workflows. QDM, while useful for defining clinical concepts, lacks the flexibility and real-world alignment of newer standards like HL7 FHIR.

NCQA Recommends:

- Accelerate the transition to FHIR-based digital quality measures, which use interoperable, standards-based APIs and align with the broader health IT infrastructure.
- Sunset QDM and QRDA in favor of US Core and QI-Core profiles, which are more widely supported and better integrated into clinical systems.
- Invest in tooling, technical assistance and community support to help providers and vendors adopt FHIR-based reporting and Clinical Quality Language (CQL)-based logic.
- Align quality measurement with clinical documentation workflows so data used for care delivery can also support reporting without duplication.

By modernizing the data infrastructure for quality measurement, CMS can reduce provider burden, improve data quality and enable more timely, actionable insights for care improvement.

PR-6. What strategies can CMS implement to support providers in making high-quality, timely and comprehensive healthcare data available for interoperability in the digital product ecosystem? How can the burden of increasing data availability and sharing be

mitigated for providers? Are there ways that workflows or metrics that providers are already motivated to optimize for that could be reused for or combined with, efforts needed to support interoperability.

NCQA recommends that CMS adopt a dual strategy: 1.) Incentivize the use of digital quality infrastructure that aligns with provider workflows and 2.) reduce administrative burden by leveraging existing data sources and standards.

NCQA is developing Advanced Primary Care (APC) offering as a comprehensive, standards-based program that integrates digital quality measurement, care coordination and interoperability into a single, scalable solution. It draws on NCQA's deep experience with the Patient-Centered Medical Home (PCMH) Recognition program and digital HEDIS, and is designed to align with HL7 FHIR standards and the US Core Implementation Guide—ensuring compatibility with modern health IT infrastructure and enabling real-time, patient-centered performance measurement.

NCQA Recommends

- Promote digital-first incentives like APC that embed interoperability and data-sharing expectations into care delivery.
- Leverage existing provider incentives (e.g., quality reporting, value-based care contracts) to align with interoperability goals, reducing duplication and streamlining compliance.
- Support FHIR-based APIs and Bulk FHIR exports to enable real-time, scalable data exchange for quality measurement and care coordination.
- Invest in shared infrastructure (e.g., registries, directories and identity services) that providers can use across programs to reduce fragmentation.

By aligning interoperability requirements with programs providers already value—such as NCQA Accreditation and CMS quality reporting—CMS can accelerate adoption while minimizing burden.

PR-8. What are ways CMS or partners can help with simplifying clinical quality data responsibilities of providers?

To simplify clinical quality data responsibilities for providers, CMS and its partners can play a pivotal role by accelerating the transition to digital quality measurement. NCQA has developed an initial version of digital measures that are standardized, computable and aligned with HL7 FHIR standards. These measures are fully specified (thereby reducing the interpretation and coding burden), configurable for multiple use cases, including quality at point of care, and reduce variability across programs and EHR vendors, making it easier for providers to report once and use the data across multiple programs.

As one of the first organizations to invest in digital quality measures aligned with CMS' Digital Quality Measurement Strategic Roadmap, NCQA has gained valuable insights from both the development and early implementation of these measures. We believe it is critical that others building digital measures align with a shared architecture and implementation approach. NCQA is well-positioned to share our knowledge, as well as real-life implementation learnings from

technology vendors, health plans, and care delivery organizations, to support alignment and broader adoption across CMS, states, and other measure developers.

Aligning reporting requirements across CMS programs would further reduce redundancy and administrative burden. Additionally, CMS could offer centralized dashboards that give providers real-time visibility into their performance.

NCQA urges CMS to reduce provider burden by using Bulk FHIR APIs, CARIN Blue Button FHIR APIs, and other standards for exchanging digital engagement, wellness, treatment, and patient data. This approach would eliminate the need for providers to build and maintain complex measure logic locally and would help ensure consistent measure interpretation and application. Providing real-time (or near real-time) feedback based on these calculations would empower providers to make timely improvements in care delivery and close care gaps more effectively.

The success of digital quality measurement depends on the quality, completeness and interoperability of the underlying data, however. To support this, NCQA is already developing content, approaches, and data quality programs designed to assess and improve the readiness of clinical data for quality improvement and measurement. NCQA offerings focus on key dimensions such as conformance to standards, completeness of required data, consistency across sources, stability of data inputs, plausibility of values (at the patient and population level) and overall fit for digital measure usage. They are designed using FHIR standards to support both data collectors and data aggregators in validating and improving the data they submit for quality reporting.

NCQA is also piloting two delivery models: a certified application model that allows third-party developers (ex. HIEs, care delivery or analytics platforms) to implement NCQA-defined data quality evaluation content and earn certification, and a data quality-as-a-service model that offers centralized, scalable tools for assessing data quality across systems using FHIR APIs.

To consolidate interoperability and quality reporting responsibilities, CMS should promote multi-purpose data infrastructure. NCQA supports the use of FHIR APIs not only for quality reporting, but also for care coordination and public health reporting. Encouraging EHR vendors to design documentation workflows that serve clinical, operational and quality needs simultaneously would maximize the return on IT investments. To that end, CMS and ASTP/ONC should better align certification and quality reporting programs.

For data registries to support digital quality measurement more efficiently, CMS should establish clear technical and operational requirements. Registries capable of ingesting and transmitting structured data in real time should be built on FHIR architecture. NCQA recommends that registries also support transparent governance, data provenance tracking and certification for digital readiness to ensure trust and accountability in measure calculations.

Finally, to support real-time clinical decision making, registries must go beyond passive data collection. They should enable bidirectional exchange, pushing insights or alerts back to providers at the point of care. NCQA encourages development of registries that offer intuitive dashboards, performance feedback and APIs that integrate directly into clinical workflows.

Payers

PA-1. What policy or technical limitations do you see in TEFCA? What changes would you suggest to address those limitations? To what degree do you expect these limitations to hinder participation in TEFCA?

One of the most pressing concerns is the lack of clarity about data exchange fees. While TEFCA doesn't explicitly prohibit fees for health care operations use cases, it doesn't provide clear guidance. This ambiguity creates hesitation among payers, which are unsure whether they will be charged for data access or expected to subsidize exchange costs.

TEFCA's current technical framework does not sufficiently address data quality, limiting its utility for organizations that rely on high-integrity data for digital quality measures.

NCQA Recommends

- Issue definitive guidance on allowable data exchange fees, especially for health care operations, to reduce payer uncertainty.
- Align TEFCA participation with CMS programs or offer financial/regulatory incentives to encourage provider engagement.
- Integrate data quality validation and certification into TEFCA's technical framework.
- Expand TEFCA's technical capabilities to include Bulk FHIR and other scalable mechanisms for quality measurement and reporting.
- Establish agile governance with regular stakeholder input and the ability to pilot alternative exchange models under TEFCA.

PA-2: How can CMS encourage payers to accelerate the implementation and utilization of APIs for patients, providers and other payers, similar to the Blue Button 2.0 and Data at the Point of Care APIs released by CMS?

CMS should introduce one or more Medicare Advantage (MA) Star Ratings metrics that explicitly reward standardized, bidirectional data exchange between MA plans, their provider networks and patients. This would build on the interoperability momentum initiated under the first Trump administration, and align with CMS's broader goals of advancing digital health and reducing administrative burden. A Star Ratings measure focused on API-enabled data exchange would not only incentivize adoption, but would also create a consistent benchmark for evaluating progress across plans.

CMS should establish a voluntary "early adopters" program that recognizes and supports payers and providers that implement APIs ahead of regulatory timelines. Participants could receive public recognition, technical assistance and potential bonus points in future Star Ratings or Innovation Center models. This would create a positive feedback loop and surface best practices that can inform national implementation.

PA-5. What are ways payers can help with simplifying clinical quality data responsibilities of providers?

Payers can help simplify clinical quality data responsibilities by adopting digital-first strategies that reduce manual reporting and promote interoperability. One of the most effective approaches is leveraging NCQA's Electronic Clinical Data Systems (ECDS) reporting method. ECDS

enables the use of structured electronic clinical data from EHRs, registries, and other digital sources—eliminating the need for manual chart abstraction and allowing for more timely, accurate, and scalable quality measurement. It also supports alignment across programs by applying consistent measure logic, which is especially valuable for organizations participating in both CMS and commercial value-based care arrangements.

ECDS is already in use across several CMS programs, including the Medicaid Adult and Child Core Sets, the Marketplace Quality Rating System, and the Medicare Advantage Star Ratings program. Its adoption in these programs demonstrates its scalability, policy relevance, and alignment with national standards like HL7 FHIR and USCDI.

Technology Vendors, Data Providers and Networks

TD-1. What short term (in the next 2 years) and longer-term steps can CMS take to stimulate developer interest in building digital health products for Medicare beneficiaries and caregivers?

To stimulate developer interest in building digital health products for Medicare beneficiaries and caregivers, CMS should focus on enabling a modern, standards-based infrastructure that developers can build on—one that supports real-time data exchange, scalable quality measurement, and seamless integration into clinical workflows. In the short term, CMS can accelerate this by promoting the use of HL7 FHIR APIs and supporting Bulk FHIR data extraction capabilities. These technologies allow developers to access and use clinical data more efficiently, enabling the creation of tools that are responsive, interoperable, and aligned with provider workflows. NCQA's Bulk FHIR Quality Coalition has already demonstrated the feasibility of this model, but broader adoption will require CMS to address gaps in certification and vendor readiness.

CMS should also invest in shared infrastructure and services that developers can leverage to build scalable, standards-aligned solutions. NCQA's Digital Content Services (DCS) and the contained HEDIS digital quality measures, is a prime example: it provides a centralized, certified source of digital quality measure logic that vendors—such as EHR developers, analytics platforms, and care coordination tools—can integrate directly into their workflows, products and solutions. This allows developers to deliver real-time, actionable quality insights at the point of care without having to recreate complex logic or maintain separate reporting engines. Looking ahead, digital quality measures, along with AI-assisted data mapping and coding language translation, and scalable CQL engines, will further reduce implementation burdens and enable more intelligent, adaptive applications. By aligning certification, payment incentives, and technical standards around digital quality measures, CMS can create a developer-friendly ecosystem that encourages innovation while advancing its goals for digital transformation and value-based care.

TD-6. What unique interoperability functions does TEFCA perform? What existing alternatives should be considered? Are there redundant standards, protocols or channels or both that should be consolidated?

To support both regional data exchange and TEFCA's national framework, a hybrid strategy is essential—one that builds on the strengths of each, rather than forcing a one-size-fits-all model. Regional HIEs and state-based networks have long-standing trust, governance and data quality

practices that are deeply embedded in local care delivery. TEFCA offers a standardized, scalable infrastructure for national-level exchange. These models can coexist, with TEFCA serving as a national “overlay” that extends the reach of regional networks.

A dual participation model would allow organizations to engage in both TEFCA and regional exchanges, with harmonized policies for consent, data quality and governance. This approach would help ensure continuity for local stakeholders while enabling broader interoperability. CMS and ASTP/ONC can further support this by funding state-based infrastructure as a TEFCA on-ramp—helping Medicaid agencies and HIEs modernize their systems without abandoning their regional strengths.

TD-9. What are the benefits of redefining certification to prioritize API-enabled capabilities over software functionality? What would be the drawbacks?

Redefining certification to prioritize API-enabled capabilities offers CMS and ASTP a unique opportunity to align quality reporting expectations with real-world data exchange. By embedding performance benchmarks and validating the completeness of quality-relevant data elements through API certification, CMS/ASTP can help ensure that APIs are not just technically compliant, but also functionally impactful, and that they support the broader goals of value-based care and digital transformation.

There are drawbacks, however: Prioritizing APIs without addressing real-world usability risks repeating past mistakes, where certified capabilities existed in name only. Certification must therefore go beyond technical conformance, and include performance, completeness and usability metrics. Certification should also include test decks that simulate real-world data exchange scenarios, including quality reporting use cases.

CMS can reinforce this by aligning payment incentives with API responsiveness. For example, CMS could require providers to respond to API-based data requests as a condition of participation in value-based programs, or include API responsiveness in Promoting Interoperability scoring. CMS could also fund provider-side tooling that simplifies API configuration and response workflows.

ASTP and CMS need to establish a clear, enforceable pathway for integrating USCDI+ into certification that will be vital to ensuring API-enabled systems not only exchange data, but do so in ways that support measurable improvements in care quality. While the USCDI provides a foundational dataset for interoperability, its current structure—and even the addition of standalone modules like USCDI+ Quality—does not fully meet the needs of chronic condition management or digital quality measurement. These modules are a step forward, but they remain disconnected from certification and regulatory enforcement.

TD-12. Should CMS endorse non-CMS data sources and networks and if so, what criteria or metrics should CMS consider?

CMS should endorse non-CMS data sources and networks, but with clear, rigorous criteria to ensure trust, consistency and value. NCQA recommends that CMS adopt a framework that prioritizes data integrity, auditability and alignment with national standards, while leveraging proven private-sector infrastructure like HEDIS and NCQA’s Data Aggregator Validation program.

Endorsing non-CMS data sources can expand access to high-quality, real-world data, and reduce duplication of effort across programs. However, to ensure that data are fit for regulatory and payment purposes, CMS should require endorsed sources to undergo a formal validation process. For example, Data Aggregator Validation evaluates the quality and integrity of clinical data from ingestion to endpoint, helping ensure that data meet standards required for HEDIS reporting. This process parallels the traditional HEDIS audit, and provides a trusted mechanism for certifying data quality.

By endorsing validated, standards-based data sources—whether public or private—CMS can reduce provider burden, improve data quality and accelerate the shift to digital measurement. This approach also allows CMS to focus its resources on oversight and policy alignment, while leveraging the innovation and infrastructure already developed by organizations like NCQA.

Value-Based Care Organizations

VB-3. What are essential health IT capabilities for value-based care arrangements?

First and foremost, systems must support interoperable data exchange using HL7 FHIR standards and CQL, the industry standard for expressing digital measure logic clearly, computably and consistently. It enables automated quality measurement and clinical decision support by allowing systems to interpret and apply measure logic directly to patient data.

This capability is foundational for value-based care, where timely, accurate and standardized data are essential for evaluating performance and improving outcomes. By using CQL, health IT systems can be assured that quality measures are applied uniformly across different platforms and care settings, reducing variation and administrative burden. NCQA uses CQL to define its digital HEDIS measures so the logic behind each measure is transparent, testable and aligned with national standards. CMS is also prioritizing the transition from QRDA to FHIR-based CQL measures as part of its broader digital quality strategy, reinforcing the importance of this capability across the health care ecosystem.

VB-4. What are the essential data types needed for successful participation in value-based care arrangements?

To successfully participate in value-based care arrangements organizations must have access to a comprehensive set of high-quality data types—and just as important, data must be validated and trusted. NCQA strongly emphasizes the importance of using audited HEDIS results as the foundation for value-based care because they represent the gold standard in performance measurement: standardized, independently verified, widely adopted across the health care system.

Essential data types include clinical data from EHRs, administrative claims, pharmacy data, lab results and patient-reported outcomes. The value of these data types depends on their integrity—which is why NCQA's HEDIS audit process is so critical to helping ensure that data used to calculate performance measures are complete, accurate and conform to rigorous specifications. The HEDIS audit process evaluates the technical systems and the data flows used by health plans.

Audited HEDIS data are already used across American health care, including CMS Stars, Medicaid managed care and commercial value-based contracts. Data are not only trusted by

regulators and payers, they also provide a consistent benchmark for comparing performance across plans and populations. As value-based care models evolve, the ability to rely on audited, standardized data will be essential for aligning incentives, reducing administrative burden and safeguarding fairness in performance evaluation. The essential data types for value-based care are not only clinically rich, but also validated through processes like the HEDIS audit, so stakeholders can trust decisions about payment, improvement and accountability.