June 16, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Request for Information; Health Technology Ecosystem

Dear Administrator Oz:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to offer ideas to build on past interoperability efforts and shape the future of the health technology ecosystem. ACHP strongly supports CMS' vision of leveraging the appropriate use of technology to empower consumers to make informed decisions about their health care. We commend CMS for its continued leadership in advancing data exchange, consumer transparency and patient-centered innovation. ACHP is committed to ensuring that technology enhances care delivery and coverage while also promoting accessibility, trust and simplification across the health system.

ACHP is the only national organization advancing a unique payer-provider aligned model of health care that fosters true competition, delivering high-quality coverage and care. As local insurers, ACHP member companies provide affordable coverage options to tens of millions of Americans in nearly 40 states and D.C., remaining in their markets even when other carriers exit. Operating on margins of one to three percent, ACHP members excel at identifying administrative and programmatic efficiencies. They are essential to maintaining an innovative and competitive health industry for consumers.

ACHP supports ongoing efforts to improve health data exchange to streamline processes and equip patients with their personal information to make better decisions. ACHP member plans rely on this data to collaborate with their provider partners to effectively manage their member population's health. A robust health data and technology ecosystem is critical to improve consumer access and use of data and improve operational excellence and efficiencies at our member companies. ACHP offers the following principals and recommendations to advance the Administration's goals:

Health Data and Technology Principles:

1. **Ensure provider connection and reciprocity.** There are no real incentives to guarantee that providers will use the APIs that payers are developing to comply with the Provider Access and Prior Authorization interoperability rules. CMS and ASTP/ONC should streamline payer-provider endpoint connections and create standards for providers' workflows to ensure that payers' APIs will connect. They should also establish incentives for providers to use these APIs, so payers, providers and patients can all benefit from increased data exchange.

2. **Educate patients on the power of data.** Opportunities to increase patients' access to their own data are only helpful if there are easy-to-use tools and patients actually use them. CMS should lead a patient education initiative to increase patient awareness of the Patient Access API, how they can use it and the privacy risks associated with downloading their data to third-party apps.

3. **Invest in innovation.** Interoperability networks are only as valuable as the participants they include. Small organizations like independent providers and non-profit, local plans struggle to invest the necessary resources to realize the level of coordination and interoperability needed to participate in these networks. CMS should consider ways to offer support and resources to these organizations so that they can contribute meaningful data in this process.

ACHP Recommendations and Technical Responses

Accelerate API Implementation and Utilization for Patients, Providers and Other Payers

ACHP is supportive of interoperability efforts to improve the health care system. To maximize the success of these policies, ACHP encourages CMS and ASTP/ONC to promote three strategies:

1. **Provider connectivity and reciprocity –** Health plans can only succeed in sharing and processing health information if their provider partners are able to connect to their APIs and actively participate in the exchange of data. CMS and ASTP/ONC should:

   - ***Create both a digital endpoint directory and workflow standards to ensure providers' EHRs can connect to payers' Prior Authorization and Provider Access APIs.*** Without this health plans will have to create custom pathways for each provider connection, a burdensome and resource-intensive process. Mechanisms that streamline payers' connection to providers' EHR systems will contribute to the success of these APIs.

   - ***Require providers to use the APIs.*** Shifting prior authorization processes to an API will require significant changes in culture and administrative processes within provider organizations. The current incentive mechanism – the MIPS measure – does not go far enough to do this, as it only requires impacted providers to submit one prior authorization request through the API per year. Additionally, this incentive mechanism only applies to Medicare-participating providers. Without better incentives, health plans risk building and connecting resource-intensive APIs that will not be used.

   - ***Align APIs with performance measures and risk adjustment calculations and/or HEDIS quality measures.*** This would demonstrate a return on investment for both payers and providers, helping justify the resource allocation that often serves as a significant barrier.

2. **Patient education –** In 2018, health plans invested significant resources to develop the Patient Access APIs. Now, in 2025, there is still little uptake of these APIs, largely due to lack of awareness. Accordingly, CMS and ASTP/ONC should:

- ***Develop a patient education initiative in coordination with payers and providers.*** By initiating a large-scale patient education initiative, CMS and ASTP/ONC can play a primary role in disseminating information to patients and help them understand what they can do with their data. This type of education initiative could also address concerns with the Patient Access APIs, such as privacy risks associated with downloading data to third-party apps.

3. **Resource or regulatory support –** Smaller healthcare organizations may struggle to find the resources or IT talent to integrate the technology needed to fully advance interoperability. This includes both local, non-profit health plans like ACHP members, but also the smaller, rural and independent providers they contract with. CMS and ASTP/ONC should:

   - ***Invest in resources that advance innovation, through standardized reference implementations and offer shared service platforms or grants for plans under a certain size.*** API adoption remains low due to high implementation costs, unclear business value and inconsistent provider and payer readiness and participation. Additionally, ACHP members report that significant portions of their provider networks still submit prior authorization requests via fax, despite efforts to transition to electronic methods. CMS and ASTP/ONC should be concerned that smaller providers, including independent and rural practices, do not have the capital to invest in infrastructure that will connect to payers' APIs, limiting their ability to benefit from increased interoperability.

     Similarly, ACHP member plans are limited in financial resources and technical expertise. By offering resources like technical expertise and financial assistance, CMS and ASTP/ONC could help get the "last mile" of healthcare organizations connected to essential health IT infrastructure. Ensuring the viability of smaller, nonprofit health organizations is essential to maintaining a diverse and competitive healthcare marketplace. These organizations often serve as critical access points for underserved, rural and high-risk populations; groups that may otherwise face significant barriers to care. Their continued participation drives down costs through competition and supports the broader goals of health system improvement. Without targeted support, these organizations risk being left behind in the digital transformation, which could amplify disparities and reduce consumer choice in the long term.

<u>A Nationwide Provider Directory</u>

CMS should establish a National Provider Directory to alleviate regulatory burdens for payers and providers, improve data quality and advance other innovations such as integrating pricing and quality data. This "single source of truth" could increase accountability for both payers and providers – with providers being held responsible and accountable for the accuracy of their own information and health plans being held responsible for pulling that information into their systems in a timely manner.

A National Provider Directory would create further opportunities for innovation and transparency, as it could integrate pricing information and real-time quality data, making it an actionable source of

information. Patients can only take ownership of their health if they are able to find and schedule an appointment with a provider – a National Directory could significantly improve that experience.

ACHP has documented several problems health plans face in keeping provider directories up to date, which highlights why a National Directory is necessary:

- *Health plan provider directories are only as good as the information they receive from providers.* Many ACHP member companies have found that the quality of the data provided from a physician's office or group depends on who answers the request. One ACHP member company noted that it can receive different information depending on whether they speak with a general administrative staffer, the credentialing department or the billing department. Depending on who responds, knowledge of the practice or their interpretation of health plans' data requests varies. This variation in responses makes it exceedingly difficult to verify information and correct inaccurate data.

- *There are no enforcement mechanisms to ensure providers update health plans when they change their information, even when required or contractually obligated to do so.* Providers are required, by the No Surprises Act and/or their contractual agreements with payers, to update their information in a timely manner. There is little oversight or enforcement, however.

- *There is no standard across public and private payers about how providers report a change in their information.* Providers receive directory update requests from each health plan they contract with and these requests can come in various formats. It is a time-intensive and burdensome task for an already overburdened workforce. This lack of standardization can lead to misunderstandings.

- *Comparing provider-submitted information with claims data is not a silver bullet:* Comparing provider information between the directories and claims data can offer health plans some insights into the accuracy of the provider's information. Claim comparisons offer mixed value, though, when it comes to whether a provider is accepting new patients or if a provider has retired or is deceased. An abundance of claims or lack thereof is not sufficient information for a health plan to change a provider's information or status, but it may indicate the need for follow-up processes.

Until a National Provider Directory is established, ACHP recommends the following policies to improve provider directories:

1. ***Streamline and standardize provider directory requirements for payers across lines of business.*** This would include standardizing the reporting format and information for providers. This type of standardization would reduce providers' burden of navigating multiple different forms and formats. It would also improve data quality by creating a common understanding that the information providers should submit for directories should only focus on the data that helps a patient's ability to schedule an appointment with in-network providers.

2. ***Hold health plans harmless for directory inaccuracies if they can verify use of a multi-layered provider directory accuracy and verification process.*** ACHP member companies invest significant resources to keep their provider directories up to date. If health plans can verify that they are using several approaches to keep provider directory information up to date, they should not be penalized for problems caused by external factors outside of their control.

3. ***Do not penalize health plans for inaccurate provider directories and do not implement requirements to remove providers from directories.*** Financial penalties for health plans with inaccurate provider directories will do little to improve the information. A penalty would only add administrative dollars to health plan efforts. Additionally, forcing health plans to remove providers from their directories altogether can be burdensome if a provider later submits correct information or renegotiates the contract with the plan. ACHP supports policies that allow plans to suppress that provider's information until it can be updated.

CMS should establish a CMS-managed FHIR endpoint directory that includes NPI, organization, supported data types, and credentialing status would greatly simplify connections between stakeholders. Similar to a National Provider Directory, this could serve as a foundational infrastructure asset for payers and providers, dramatically reducing burden. Routing data to the right endpoint is difficult without reliable directories and creates inefficiencies that reduce and slow adoption. This, in turn, slows care coordination, quality reporting, and patient data access.

Price Transparency Implementation

CMS should explore solutions that identify how best to integrate quality information alongside prices to allow consumers to evaluate the services that best respond to their individual needs. Consumers are able to make more informed health care choices when they have access to both price and quality information. ACHP also encourages this Administration to prioritize commonsense, consumer-centric price transparency policies that allow for the selection of more affordable, high-quality care. Previous efforts around personalized pricing tools through insurers should be favored over more burdensome and less informative machine-readable files that have limited usefulness from a consumer's perspective.

TEFCA

CMS should provide implementation guidance and incentivized adoption models focusing on quality measures and/or reporting supporting broader population health initiatives. TEFCA lacks tangible benefits or clear implementation pathways. There is little incentive for health plans to participate with TEFCA as many of its goals are also accomplished on the payer side via the several API requirements. In addition, without highly functioning state HIEs – a reality in several states where ACHP members operate – or pre-existing QHIN infrastructure in regional markets, the cost and complexity of onboarding into TEFCA feels disconnected from day-to-day data needs. ACHP member company health plan IT departments have several competing high-priorities and voluntary participation is not one of them when the others are critical to efforts such as, quality improvement initiatives, administrative system modernization, price transparency and, most notably, interoperability. To address the limited resources community plans are

able to allocate to voluntary opportunities, CMS could provide funding support via government grants or public-private partnerships to assist with QHIN onboarding and testing environments, incentivizing and increasing participation.

Digital Identity

CMS should establish a certification framework for digital identity credentials for patients. Maintaining proprietary login systems is costly and creates friction for members, especially those navigating across multiple health systems or insurers. Patient identification is fragmented across payers and providers, leading to delays in care coordination, duplicate records and fragmented care planning. The lack of guidance on the technical and legal aspects of integrating third-party identity solutions creates resistance towards adopting these types of innovations in the market. A CMS pilot or demonstration that included robust technical guidance on integration and enables these credentials to satisfy compliance requirements would demonstrate efficacy, applicability in value-based care arrangements and user value.

Information Blocking

CMS and ONC should anonymize payer-submitted complaints. Payers hesitate to report information blocking due to unclear definitions and case examples of what constitutes blocking behavior, fear of harming provider relationships and uncertainty about CMS's enforcement process. Educating payers and simplifying the submission process would increase payer engagement and EHR vendors and provider systems accountability.

Quality Reporting Burden

CMS should streamline measure sets and encourage payer-provider collaboration via shared data hubs and open APIs. Further, by mandating aligned electronic Clinical Quality Measures (eCQMs) and standard data formats (FHIR-based quality submissions) CMS would significantly reduce friction. CMS has the opportunity to reduce burden and improve payer provider collaboration associated with quality measures and improvement initiatives. Providers face duplicative, often conflicting quality reporting requirements across CMS programs, commercial payers, and state agencies. In addition, limitations within EHRs and lack of data integration compound the burden.

Value-Based Care

CMS should require and subsidize core digital infrastructure for APMs. APMs vary in structure, making one-size-fits-all tech requirements unworkable. However, lack of standardization creates inefficiencies and complexity for participants. A defined set of modular, standards-based components (SMART on FHIR APIs, digital quality reporting, identity verification) that APMs must support would address this issue while still allowing variability in how providers and plans implement them. In addition, without an industry-wide standard or best practices, ACHP member companies often find that providers are reluctant to enter into APMs because of the technical and reporting requirements that are unique from payer to payer. Defining a

minimum digital toolkit (risk engines, registries, engagement platforms) and offering federal technical assistance would help level the playing field and increase adoption of APMs.

CMS should prioritize and refocus standards on patient-centered outcomes and data sharing via basic interoperability standards. Success in value-based models requires access to timely clinical, behavioral, and social determinant data, yet provider EHR/EMR systems and interoperability gaps limit the ability to capture and share these data elements. Claims data alone is not sufficient for proactive care management. In addition, current criteria often prioritize documentation and audit requirements over usability and clinical relevance (most meaningful and impactful measures to care for populations), which frustrates providers and drains resources. Often the partner, builder or implementor of payer interoperability initiatives, vendors likewise (EHRs/EMRs, population health platforms, and care/case management systems) need incentives to build features that reduce manual entry and allow third-party applications to plug into clinical workflows through open APIs. Clinical data sharing is inconsistent. EHR/EMRs vary in their support for standardized APIs, and providers are often unaware or unable to participate in data exchange without significant cost or technical effort. CMS should ensure EHR vendors expose necessary clinical data and support data integration for SDOH leveraging standardized data standards. Funding for shared community demonstration projects which emphasize health data exchange and funding for platforms could accelerate readiness.

Thank you for your consideration of ACHP's feedback and recommendations. We look forward to partnering with the Administration to create a robust health technology ecosystem across the payer landscape. Please contact Ginny Whitman, Associate Director of Public Policy, at vwhitman@achp.org with any questions or to discuss our recommendations further.

Regards,

Dan Jones

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ACHP