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U.S. Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-0042-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Thank you for the opportunity to provide feedback on the CMS Health Technology Ecosystem Request for Information (RFI). CAQH shares CMS's commitment to advancing a digital infrastructure that improves access to care, reduces administrative burden, and promotes innovation. We welcome the opportunity to serve as a partner and resource to CMS—offering insights, experience, and infrastructure that supports provider data accuracy and interoperability efforts across the healthcare system.

CAQH is deeply integrated across both the provider and health plan communities. For over 25 years, we have worked side-by-side with stakeholders to make healthcare work better through collaborative governance and trusted relationships. Our governing bodies include national and regional health plans, and our federally designated CORE initiative brings together more than 100 participating organizations—representing payers, providers, vendors, and standards development entities. We recently expanded our convening efforts to include a Provider Advisory Council, reinforcing our commitment to balanced, multi-stakeholder input. Across all our efforts, the ultimate goal is to support a healthcare system that works better for everyone, including the patients it serves.

This strong foundation enables CAQH to operate centralized platforms that reduce redundancy, support compliance, and improve the efficiency of provider data collection, credentialing, directory maintenance, and coordination of benefits—directly contributing to better data, lower costs, and improved patient access to care.

Provider Data Infrastructure

CAQH's provider data platform is an open, front door for all US providers to enter, update, and attest to their information for multiple uses across the industry—including health plan enrollment, primary source verification, credentialing, and provider directories – end to end provider data management. By enabling validated, single-point data submission to more than one thousand participating health plans and other organizations, the solution significantly reduces redundancy and improves data accuracy across the healthcare system.

Member Data and Coordination of Benefits

CAQH also maintains a continuously updated registry of health plan eligibility and contact information for more than 235 million health plan members—representing approximately 75% of all insured lives in the U.S., including over 23.5 million Medicaid and 21 million Medicare members. US health plans share their member eligibility data with CAQH and trust our Coordination of Benefits (COB) solution to identify overlapping coverage, manage claims, and improve third-party liability management.

Interoperability and Industry Insights

In addition to our data platforms, CAQH advances interoperability through the Committee on Operating Rules for Information Exchange (CORE), designated by HHS as the national authoring entity for operating rules. The

federally mandated and voluntary CORE Operating Rules are widely adopted across the industry and contribute to an estimated $46 billion in annual savings. The CAQH Index, informed by data from providers and health plans, underscores the value of automation and standards-based exchange in reducing cost and complexity. Now in its twelfth year, the 2024 report identified a $20 billion opportunity to simplify healthcare by shifting from manual processes to automated ones.

CAQH has a proven track record of convening healthcare stakeholders, reducing administrative burden, and improving data quality across the healthcare system through scalable, standards-based solutions.

Advancing Shared Goals

CAQH shares CMS's belief—and enthusiasm—that the responsible adoption of technology can empower patients, improve care delivery, and strengthen healthcare operations. We are encouraged by the leadership of CMS and ASTP/ONC in advancing a modern digital infrastructure to support these important objectives. To support this effort:

- Leverage existing infrastructure to reduce duplication and accelerate progress.
- Promote consistent, high-quality data to support seamless, real-world interoperability.
- Advance certification and business rules to build trust and ensure effective implementation.

As this work continues, aligning with open standards, certification pathways, and interoperable technologies will be essential to driving meaningful progress while minimizing burden.

CAQH welcomes the opportunity to collaborate and share how our trusted, national provider data platform—already used by millions of providers and thousands of organizations—can support efforts to improve data accuracy and accessibility at scale. Our detailed RFI response follows, divided into two sections:

- Section I: National Provider Directory Related Questions
- Section II: Interoperability, Data & Security Related RFI Questions

Backed by long-standing industry partnerships and technical expertise, CAQH stands ready to contribute to this important effort. Please contact Erin Weber, Chief Policy & Research Officer, at 202-517-0435 or eweber@caqh.org with any questions or requests for further information.

Sincerely,

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Section I: National Provider Directory Related Questions

Advance Provider Directory Accuracy Through Collaboration and Existing Infrastructure

Patients depend on providers, health plans, and regulators working together to ensure provider directories are accessible and accurate. Achieving and sustaining success in improving the accuracy of provider directory information requires alignment with existing regulatory and business frameworks, meaningful coordination, and broad stakeholder participation. CAQH fully aligns with CMS's commitment to enhancing the usability and accuracy of provider directories.

The healthcare ecosystem is governed by multiple regulatory frameworks and encompasses diverse use cases for provider data. CAQH simplifies the complexity of provider data management by serving as a centralized, open platform where providers can update and attest to their information for multiple administrative needs, including credentialing and provider directory maintenance. Millions of providers across the country use CAQH to submit the data required for credentialing and directory purposes and are prompted every quarter to verify its accuracy. CAQH's platform is used by individual providers — at no cost —in all fifty states and the District of Columbia, either through mandates, codification, contracts, or voluntary usage. The solution is used by hundreds of provider types, including doctors, mental health providers, advanced practice providers, dentists and other specialists.

With provider consent, CAQH securely shares their submitted information with health plans based on the networks they want to join. Over 1,000 organizations participate, including all major national and regional health plans, as well as other public and private stakeholders. This streamlined approach significantly reduces redundant data submissions for providers, enables timely credentialing processes, and supports continuous updates to provider data, all of which directly contribute to maintaining accurate and up-to-date provider directory information.

CAQH has a nationwide footprint and deep experience maintaining accurate provider data at scale—expertise CMS can leverage to strengthen its directory initiative. Achieving and sustaining high-quality provider data requires close coordination between providers, health plans, and trusted infrastructure partners. CAQH supports this through a streamlined experience that enables providers to submit and attest to their information in one place, reducing redundancy while meeting multiple regulatory and business needs. To further enhance accuracy, our platform also incorporates data from third-party sources and data validation methods to flag discrepancies and fill gaps. As CMS advances its work, partnering with CAQH can help ensure the directory reflects the most current, complete provider information—without adding unnecessary burden to providers.

CAQH welcomes the opportunity to work in collaboration with CMS to build on existing infrastructure—minimizing disruption, avoiding duplication, and accelerating progress toward shared goals. By working together, we can focus industry attention on the root causes of provider data inaccuracy and ensure that any national solution meaningfully improves patients' ability to find providers who are truly available to deliver care. Collaboration, alignment, and the use of proven tools will be essential to achieving lasting improvements in provider data usability and patient access.

Section II: Interoperability, Data & Security Related RFI Questions

The responses in this section are based on CAQH's long collaboration with HHS as a national convener on interoperability through our CORE initiative. The CORE Operating Rules are developed through a multi-stakeholder, consensus-based process that includes input from more than 100 participating organizations—health plans, providers, vendors, associations, standards development organizations, and others. These responses are grounded in insights from this broad stakeholder community whose engagement and real-world adoption are vital to the effective implementation of the strategies outlined in the RFI.

Achieving Interoperable Exchange in a Fragmented Landscape: PC-2c; PR-3a; TD-4; TD-7; TD-9

Healthcare data exchange relies on a mix of proprietary formats (e.g., Excel, PDF, TXT), EDI formats (e.g. HIPAA mandated and voluntarily implemented X12 standards), and web-based formats (e.g., HL7 FHIR, AI/LLM). While each format effectively supports specific use cases, the fragmentation is a barrier to achieving truly seamless, standardized data exchange between trading partners. This complicated environment hinders care coordination and limits opportunities for patients to actively engage in their healthcare.

It's unrealistic to fully uproot the current technology landscape, especially given how tightly ingrained these solutions are in day-to-day workflows. Because of this, the focus must shift to ensuring that data flows seamlessly between existing standards. This approach promotes a fully interoperable environment without costly or inefficient "lift-and-shift" implementations.

Three principal considerations can help realize an interoperable environment that leverages current infrastructures and advances innovative solutions for data exchange:

1. Enhancing access to high quality, uniform data
2. Aligning industry use cases to standards-based data transmission and exchange
3. Expanding certification to affirm the capability of APIs

Enhancing Access to High-Quality, Uniform Data: PC-9; PC-10; PC-11; PA-1; TD-1; TD-2a; TD-7;

Consistency of data formats and definitions across contexts of data use and exchange standards is essential for interoperability. Without this consistency, considerable time, resources, and computing power must be spent translating data to preserve its meaning for end users.

- For administrative exchange, semantic interoperability can be achieved between X12 and HL7 FHIR formats by referencing common code sets and formats. For example, familiar financial elements found in the X12 835 transaction can support value-based care performance reporting carried out using HL7 FHIR-based application programming interfaces (APIs), eliminating extra mapping steps and improving clarity for health plans and providers.

- For clinical data exchange, adherence to a common data set, such as the United States Core Data for Interoperability (USCDI), helps ensure key aspects of patient care, like diagnosis, experience, and other moderating factors (e.g., social risk) are fully communicated and incorporated into their record. Though USCDI is tied to the build of HL7-based APIs and associated certification criteria, it also has strong potential to assist the conversion of unstructured documentation into digestible, structured formats.

> Exchanging unstructured information, traditionally housed in clinical notes and similar reports, is critical to advancing data accessibility and enabling broader adoption of federally mandated HL7 FHIR-based APIs. Initiatives that align with and incorporate data structured according to the USCDI framework can significantly enhance data availability for programs such as Blue Button 2.0 and Data at the Point of Care (DPC). Additionally, the USCDI framework can complement administrative transactions, by helping ensure that essential information is consistently captured and used across various contexts. This approach has been successfully demonstrated through the consensus-driven development of CORE Operating Rules.

Interoperability initiatives also benefit from a commitment to data uniformity. Health information exchanges (HIEs) are challenged by varying data formats. Standardizing the intake and processing of data within HIEs will enhance their effectiveness and value. The same can be said for the broad reach of the Trusted Exchange Framework and Common Agreement (TEFCA). It is important that the data exchanged by participants of Qualified Health Information Networks (QHINs) and TEFCA adheres to commonly accepted formats; otherwise, the impact of "bad data" could rise exponentially. Organizations like the National Association of Health Data Organizations (NAHDO) and their associated All-payer Claims Database (APCD) Council, as well as the Sequoia Project, have made meaningful progress in defining common data layouts and exchange use cases. Building on this foundation through continued public-private collaboration can help expand these efforts.

High quality, uniform data is essential to interoperable exchange across hybrid contexts and serves all of the stakeholders named in the RFI.

Aligning Industry use-cases to standards-based data transmission and exchange: PR-9; PR-10; PA-3; PA-4; TD-1; TD-3; TD-4; TD-5

Industry stakeholders must ensure that widely adopted data exchange standards are embedded in their interoperability frameworks. An incomplete or exclusionary standards strategy can stall the seamless flow of information between trading partners.

In addition to technical standards, common business rules can play a helpful role in supporting consistency and adoption at scale. Much like in the financial industry, where operating rules have enhanced the usability of standards by aligning business processes, similar approaches in healthcare can ensure that data exchange supports real-world workflows. As APIs are deployed more widely, opportunities may exist to align emerging standards with complementary guidance that supports implementation and drives value across the ecosystem.

To fully enable the exchange and use of interoperable, HL7 FHIR-based data, initiatives must align to a strong, common approach to security and authentication. Although modern security protocols – for example, OAuth 2.0 with X.509 client certificates – are widely recognized, many systems still rely on usernames and passwords which pose greater security risks. Requiring a single, federated credential (e.g., CLEAR, ID.me, Login.gov) aligns the industry to a common baseline and provides benefits to interoperable data flow by diminishing the need for separate logins across different apps or context.

The trust anchors for a federated credential can be collected independently or scaled as part of complementary initiatives, such as the creation of a FHIR endpoint directory for providers and health plans. CAQH acknowledges the importance of a comprehensive resource of provider and health plan FHIR endpoints. A well-maintained, validated, and regularly updated FHIR endpoint directory provides industry benefit by quick cataloguing changes that result from shifting affiliations, credential updates, and organizational restructuring.

A comprehensive FHIR endpoint directory strengthens security and gives providers, health plans, and developers a single, reliable routing source. Because the directory's data could serve many purposes—including the population of a public provider directory—the agencies are encouraged to build on and coordinate with existing industry initiatives, including CAQH. By collaborating with already-in-place structures to gather data, CMS can more quickly advance its priorities using existing provider engagement channels. This avoids the creation of additional, required interaction points for providers and payers, who are already challenged by a complex and fragmented landscape.

Certification as an essential tool to validate capabilities, not just functionality: TD-8; TD-9; VB-3; VB-12; PA-5; PR-5

Certification of health IT remains a widely used and trusted mechanism for promoting interoperability and functionality. For example, CAQH CORE certifies conformance with operating rules for the conduct of administrative transactions. The ASTP/ONC certification program supports the development of comprehensive EHR technologies. Recent updates expanded its scope to include verification of API standards and modern interoperable technologies. These certifications offer confidence to providers, vendors, health plans, value-based entities, and the patients they serve that the technologies employed in day-to-day workflows adhere to regulatory requirements and other best practices. As the ecosystem moves to API-centric exchange, these programs must evolve—confirming not just that an API and associated technologies are in place, but that it reliably delivers the promised performance and workflow improvements.

Certification of CMS-mandated HL7 FHIR-based prior authorization APIs should confirm not just functionality, but also real workflow improvements—measured by factors like data transit time, exchange latency, and error-free completion rates. Extending this performance oriented approach to additional core functions—such as CDS Hooks, SMART on FHIR, and Bulk FHIR—ensures each can meet real-world demands of API-driven data exchange. This is especially critical for use cases like prior authorization, which relies on responsive CDS Hooks, and value-based care analytics, which depends on high-throughput Bulk FHIR exports to support population-level data analysis and quality reporting.

Though this commentary primarily focuses on enhancements to the federal certification program, it is equally important to incorporate insights from independent certification efforts to ensure a more comprehensive and inclusive approach. For example, as more APIs invoke administrative data drawn from X12 transactions, ASTP/ONC could collaborate with CORE and leverage the outputs of CORE Certification to ensure that the data adheres to uniform technical and content requirements. Doing so would increase confidence in modern API builds and create a more cohesive health data ecosystem.