Date: 15 June 2025

From: The General Catalyst Institute, regarding RFI CMS-0042-NC

To: Stephanie Carlton, Deputy Administrator of the Centers for Medicare & Medicaid Services, and Steven Posnack, Acting Assistant Secretary for Technology Policy, Acting National Coordinator for Health Information Technology

The General Catalyst Institute (GCI) appreciates the opportunity to respond to CMS's Request for Information on the health technology ecosystem. As a policy platform within General Catalyst, GCI promotes market-based solutions powered by applied AI to improve healthcare delivery, access, and affordability.

We believe CMS is uniquely positioned to lead a digital transformation of American healthcare. The tools and talent are already in place. What is needed now is aligned infrastructure and incentives to ensure these solutions scale equitably and sustainably.

We believe CMS can accelerate this transformation by focusing on five critical areas where our ecosystem has developed deep experience:

1. **Identifying what's already working.** We offer real-world examples of technologies and delivery models that are improving outcomes, expanding access, and reducing costs today.
2. **Understanding what's blocking progress.** We outline structural barriers, such as anti-competitive practices, fragmented regulation, and misaligned payment models, that prevent transformative technologies from reaching scale.
3. **Actionable recommendations to incentivize scale and innovation.** We provide actionable recommendations for CMS to incentivize responsible innovation and nationwide adoption. These include establishing shared data infrastructure, modernizing reimbursement pathways, advancing cross-state licensure, enabling digital identity, and building real-world testbeds for emerging technologies.
4. **Leveraging a coalition-based approach.** GCI works across public and private sectors to advance pragmatic implementation models and national resilience in healthcare.
5. **Driving broad adoption beyond Medicare.** We offer insights into how CMS can ensure technologies reach underserved populations and are sustained across Medicaid, commercial markets, and state programs.

We also include real-world examples from our ecosystem of companies and share lessons from implementation at scale. GCI and our partners stand ready to support CMS in building the infrastructure, policies, and coalitions necessary for transformative impact.

Respectfully submitted,

The General Catalyst Institute

GCI Response to CMS Request for Information: Health Technology Ecosystem (CMS-0042-NC)

Executive Summary

The General Catalyst Institute (GCI) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information regarding the health technology ecosystem. As an organization dedicated to promoting market-driven solutions powered by applied AI to transform healthcare delivery, we believe our insights and the experiences of our portfolio companies can provide valuable perspectives on what's working, what's blocking innovation, and how to incentivize scale and broader adoption.

We are encouraged by the unprecedented alignment across HHS agencies to modernize healthcare through digital transformation and welcome the opportunity to partner with CMS in this critical work. Our response focuses on key areas where we believe immediate action can drive significant improvements in healthcare quality, access, and affordability.

Our message is simple: the tools exist. The talent exists. The policy pathways must now align to ensure these assets can scale equitably and sustainably across every level of the healthcare system.

Company Information

The General Catalyst Institute was launched to promote and strengthen national resilience by backing transformative technologies and shaping public policies that improve society. Our mission is to cultivate a healthy ecosystem for entrepreneurship and serve as a partner to policymakers on technology adoption, with a particular emphasis on applied AI in healthcare.

Our Catalyzing Care: A Framework for a Healthier America incorporated in the recently released "U.S. Healthcare That Works" report outlines five pillars for healthcare transformation:

1. Foster Healthier Outcomes for All
2. Refine Needed Innovations Without Red Tape
3. Advance Patient-First Care, Data and Accessibility
4. Maximize Fiscal Responsibility for U.S. Healthcare
5. Enhance U.S. Medical Talent for Today and Tomorrow

Bottom Line Up Front

The U.S. healthcare system stands at a historic inflection point. After decades of fragmentation, rising costs, and uneven outcomes, we now have the technological capabilities to fundamentally transform healthcare delivery through market-driven solutions powered by applied AI. The

General Catalyst Institute believes CMS can accelerate this transformation by focusing on five critical areas where our ecosystem has developed particular insights.

First, we have concrete examples of what's already working and delivering value. Our portfolio includes companies that have successfully deployed AI-powered platforms integrating patients' medical histories with healthcare providers, reducing redundant tests and improving care coordination. We've seen hybrid virtual, mobile-clinic, and in-home diagnostic services for rural populations that feed vitals, labs, and care-plan adherence data into the healthcare ecosystem. Voice-enabled AI assistants are conducting outreach, education, and chronic condition check-ins for vulnerable populations, while 911 diversion solutions are reducing avoidable emergency department visits. These innovations demonstrate that technology can effectively address geographic disparities, enhance care coordination, and improve patient outcomes while reducing costs.

Second, we can clearly articulate what's blocking innovation. Anti-competitive practices by incumbent vendors who create artificial data silos or block innovative AI solutions remain a significant barrier. We are aware of concerns from both clinicians and patients that information blocking continues to remain an issue in healthcare and want to do all that we can to make sure such information blocking concerns are heard, investigated, and appropriately remedied. Regulatory fragmentation creates unnecessary complexity through state-by-state variation in HIE policies and standards. Current payment models often fail to adequately reward technologies that reduce costs or improve outcomes, creating misaligned incentives across the healthcare ecosystem. These barriers directly impede market-based solutions and slow the adoption of transformative technologies.

Third, we offer actionable insights on how to incentivize scale and innovation. CMS should establish a secure, standardized "Innovation Data Commons" leveraging HL7 standards and modern API architectures to enable responsible access to data resources. Implementing next-generation AI-powered systems for fraud detection and care coordination would address the approximately $62.8 billion in Medicare and Medicaid billing errors annually. Creating regional healthcare innovation sandboxes would allow new models of care and AI-enhanced decision support to be tested at scale. These concrete steps would accelerate the adoption of solutions that improve care coordination, enhance clinical decision-making, and reduce administrative burden.

Fourth, we emphasize GCI's unique coalition-based approach to implementation. As outlined in "U.S. Healthcare That Works," we bring together diverse stakeholders across government, industry, states, communities, and nonprofits to drive sustainable transformation. Our ecosystem of companies is united by the five pillars for Catalyzing Care, working across diverse sectors to deliver U.S. healthcare that works. This includes companies focused on automating healthcare interactions, building rural health systems, working on Medicaid solutions, delivering better health outcomes daily, and pioneering solutions dedicated to preventive care, workforce transformation, and technological innovation. These companies evolve to be "fit for purpose" for the needs of patients, clinicians, and providers, ensuring they are sustainable by design. By

collaborating with state governments, healthcare providers, and community organizations, we create solutions that address real-world needs while maintaining financial viability, ensuring they can scale and sustain operations over time.

Fifth and finally, we provide practical thoughts on driving broad adoption beyond Medicare. By creating a unified national interoperability framework, especially for Medicaid, CMS can prevent state-by-state fragmentation that creates barriers to scaling innovative solutions. Allowing qualified healthcare providers to deliver care across state lines would expand access, particularly in rural communities. The same applies to telehealth flexibilities and continued reimbursement for telehealth consults. Telehealth consults remain an important way to provide healthcare in rural environments. Establishing a clear, unified reimbursement framework for AI-enabled tools would prevent the development of a fragmented landscape where reimbursement varies by payer, state, or local market. Cumulatively, these approaches would create conditions for broader adoption of digital health management and care navigation products across the entire healthcare system, to include rural health needs.

As Teresa Carlson, Founding President of the General Catalyst Institute, has noted: "Throughout my career in both public and private sectors, I've witnessed firsthand that our nation is at its most innovative and effective when private sector partners unite around a shared vision of national impact." The General Catalyst Institute and our ecosystem of innovative companies stand ready to partner with CMS in this transformative journey. Together, we can ensure that the tools of modern healthcare are distributed fairly, used safely, and scaled effectively to create a healthcare system that truly works for all Americans.

What follows is a table of our Detailed Responses to the CMS RFI. In addition, at the end of our response is a table of acronyms employed.

Detailed Responses

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
PC-1. What health management or care navigation apps would help you understand and manage your (or your loved ones) health needs, as well as the actions you should take? a. What are the top things you would like to be able to do for your or your loved ones' health that can be enabled by digital health products? b. If you had a personal assistant to support your health needs, what are the top things you would ask them to help with? In your response, please consider tasks that could be supported or facilitated by software solutions in the future.	CMS should support the development and adoption of AI-powered health management platforms that integrate multiple data sources to provide personalized guidance and care coordination. These platforms should include features for medication management, appointment scheduling, symptom tracking, and care plan adherence. Additionally, CMS should encourage the development of voice-enabled, AI-powered "care concierges" that can conduct outreach, education, and chronic condition check-ins, particularly for older adults and those with limited digital literacy.	We've observed generative AI platforms that deliver non-diagnostic virtual care agents conducting follow-up outreach, patient education, and care navigation via conversational voice and SMS interfaces. These platforms integrate with Medicare claims via Blue Button, leverage FHIR for read/write access to EHRs, and operate in over 14 languages, making them highly accessible for older adults and underserved rural populations by removing the need for smartphones or portals. Compared to traditional call centers or staff-based care navigation, this approach operates at a fraction of the cost, less than $1 per call, and is available 24/7 without workforce fatigue. These systems support health equity by delivering culturally tailored, multilingual outreach and have demonstrated improvements in colorectal cancer screening uptake, wellness visit compliance, and reductions in 30-day readmissions.	By supporting these AI-powered health management platforms, CMS would enable Medicare beneficiaries to better understand and manage their health needs, leading to improved medication adherence, earlier intervention for emerging health issues, and better coordination across multiple providers. Voice-enabled care concierges would be particularly valuable for older adults and those with limited digital literacy, providing accessible support for routine health management tasks and serving as an early warning system for potential health issues. These solutions would reduce unnecessary healthcare utilization while

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
			improving patient satisfaction and outcomes.
PC-2. Do you have easy access to your own and all your loved ones' health information in one location (for example, in a single patient portal or another software system)?	CMS should support the adoption of unified digital front doors that aggregate scheduling, pre-visit intake, results, and messaging, and bi-directionally sync with EMRs. These platforms should also surface patient-generated data and support two-way communication for Medicaid, SNAP, WIC, and other programs.	We've observed experience layers that connect patients, caregivers, and providers across high-acuity care episodes. These platforms include identity resolution, document uploads, real-time appointment APIs, and care plan task-tracking, all integrated through FHIR and EHR APIs. They enable Medicare patients to seamlessly manage surgical and complex care journeys from pre-op through recovery. Technical integration with hospital systems and payer authorization APIs ensures minimal disruption. We've also seen CMS-ready citizen apps for eligibility, enrollment, benefit tracking, and two-way communications across Medicaid, SNAP, WIC, and other programs.	By supporting these platforms, CMS can enable patients and caregivers to access all relevant health and benefit information in one place, improving care coordination, patient satisfaction, and health outcomes.
PC-3. Are you aware of health management, care navigation, or personal health record apps that would be	CMS should support the adoption of several types of digital health applications that have demonstrated value for Medicare beneficiaries:	We've observed remote monitoring platforms that risk-stratify patients based on vitals data, with abnormal readings prompting virtual specialist review or care escalation. This model	By supporting these types of applications, CMS would enable Medicare beneficiaries to receive more timely, appropriate, and

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
useful to Medicare beneficiaries and their caregivers?	(1) Remote patient monitoring platforms that enable longitudinal condition management via connected devices and algorithmic triage; (2) Hybrid virtual and in-person care models that combine telehealth, mobile clinics, and home-based services to reach underserved populations; (3) Voice-enabled AI assistants that conduct regular check-ins and provide education for chronic condition management; and (4) 911 and emergency department diversion solutions that triage non-emergent callers to telehealth or community resources.	enhances access to specialty guidance between visits, reducing avoidable admissions. We've also seen hybrid care models specifically designed for rural populations that feed vitals, labs, and care-plan adherence data into the healthcare ecosystem, demonstrating the potential to address geographic disparities in access. Additionally, we've observed 911 diversion solutions that reduce avoidable emergency department visits while providing structured encounter data to support care coordination.	coordinated care. Remote monitoring would allow for earlier intervention when health issues emerge, reducing complications and hospitalizations. Hybrid care models would expand access for underserved populations, particularly in rural areas. Voice-enabled assistants would provide accessible support for older adults with limited digital literacy, while emergency diversion solutions would reduce unnecessary utilization of high-cost services. Together, these applications would improve health outcomes, enhance patient satisfaction, and reduce overall healthcare costs.
PC-4. What features are missing from apps you use or that you are	CMS should support the development and adoption of voice-based generative AI	We've observed voice-based generative AI platforms optimized for safe, empathetic dialogue with patients	By supporting these voice-based AI platforms, CMS would enable more

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
aware of today? a. What apps should exist but do not yet? Why do you believe they do not exist yet? b. What set of workflows do you believe CMS is uniquely positioned to offer?	platforms purpose-built for healthcare that can conduct non-diagnostic patient interactions at scale. These platforms should be designed for care navigation, chronic disease outreach, preventive screening reminders, and post-discharge follow-ups. CMS should establish a regulatory framework that enables safe deployment of these AI assistants while providing reimbursement pathways that recognize their value in reducing clinician burden and improving patient engagement.	across telephony, SMS, and EHR-integrated interfaces. These platforms support over 14 languages with built-in escalation pathways for human oversight. Evidence from real-world deployments shows 96% completion rates for wellness calls, 4.6% reduction in 30-day readmissions, and 2.6x increase in preventive screening participation among underserved populations. Over 300,000 patient interactions have been completed with 99.38% clinical accuracy, surpassing human clinicians in controlled evaluations. These platforms are particularly effective for patients with low digital literacy, offering culturally tailored, trust-building interactions in patients' preferred languages.	equitable access to consistent, high-quality patient engagement across Medicare populations. This would lead to improved preventive care compliance, reduced hospital readmissions, and better chronic disease management, particularly for underserved populations. The scalable nature of these platforms would allow care teams to extend their reach while maintaining clinical oversight and trust. This approach would be particularly valuable in value-based care environments, supporting health equity, access, and system-wide efficiency while reducing overall healthcare costs.
PC-6. What features are most important to make digital health products accessible	CMS should prioritize support for voice-enabled, AI-powered care concierges and apps that offer clear, simple interfaces,	We've observed generative AI platforms that deliver non-diagnostic virtual care agents via conversational voice and SMS interfaces, validated through	By supporting these features, CMS can ensure digital health products are accessible to all

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and easy to use for Medicare beneficiaries and caregivers, particularly those with limited prior experience using digital tools and services?	multilingual support, and proactive outreach for education and chronic condition management.	hundreds of thousands of patient interactions and thousands of clinician reviews. These platforms operate in over 14 languages and are designed to be highly accessible – particularly for older adults and underserved rural populations – by removing the need for smartphones or portals. These systems support health equity by delivering culturally tailored, multilingual outreach and have demonstrated improvements in preventive care compliance and reductions in hospital readmissions.	beneficiaries, reducing disparities and improving engagement, adherence, and outcomes.
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?	CMS should establish a standardized framework for collecting and analyzing real-world evidence from digital health products, with particular emphasis on those that demonstrate potential for significant cost savings. This framework should include: (1) standardized outcome metrics across clinical, financial, and patient experience domains; (2)	We've observed AI-powered musculoskeletal (MSK) care platforms that combine connected sensors, asynchronous coaching, and predictive analytics to deliver personalized therapy at scale. These platforms integrate de-identified claims data across tens of millions of lives, enabling advanced population health analytics. In one employer population of 50,000+, 3.7% of members were identified as high-risk, and $4,128 in average per-member savings was realized through early engagement—yielding $355,000 in total	By implementing a standardized framework for real-world evidence collection, CMS would create a robust mechanism for evaluating which digital health products truly deliver value. This would enable more informed coverage and reimbursement decisions, accelerate the adoption of high-performing solutions, and create market incentives for continuous improvement.

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	requirements for third-party validation of results; (3) integration with existing CMS data infrastructure like the Innovation Data Commons; and (4) incentives for sharing de-identified outcomes data to accelerate learning across the healthcare system.	projected cost avoidance within the first month. Across broader implementations, outcomes include 70% reduction in surgery intent, 35% fewer spine surgeries, 10% fewer MSK-related MRIs, 42% reduction in ancillary service utilization, and 3.7:1 ROI. These results demonstrate how standardized real-world data collection can quantify both clinical and financial impact of digital health interventions.	Patients would benefit from access to products with proven effectiveness, while providers and payers would gain confidence in recommending and covering digital health solutions. The approach would be particularly valuable for Medicare, where the potential cost savings from reduced surgeries and imaging studies could be substantial. CMS would also contribute to a growing evidence base that could inform clinical guidelines and best practices.
PC-8. In your experience, what health data is readily available and valuable to patients or their caregivers or both? a. What data is valuable, but hard for patients and caregivers, or app	CMS should prioritize making the following data types more accessible to patients and authorized third-party applications: longitudinal claims data, clinical notes and care plans, medication lists with adherence tracking, lab results with trend analysis, social determinants of health	While basic demographic and claims data are increasingly available through initiatives like Blue Button 2.0, patients and caregivers still struggle to access comprehensive clinical data, particularly across multiple providers. We've observed modular data rights platforms combining patient-facing identity and consent portals with backend policy engines.	By making these additional data types more accessible and implementing a standardized consent management system, CMS would enable the development of more comprehensive and effective digital health solutions.

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developers and other technical vendors, to access for appropriate and valuable use (for example, claims data, clinical data, encounter notes, operative reports, appointment schedules, prices)? b. What are specific sources, other than claims and clinical data, that would be of highest value, and why? c. What specific opportunities and challenges exist to improve accessibility, interoperability and integration of clinical data from different sources to enable more meaningful clinical research and generation of actionable evidence?	data, and price and quality information. To improve accessibility and interoperability, CMS should implement a standardized consent management system that gives patients granular control over their data sharing while simplifying the authorization process for developers.	These systems gather patient consents and automate enforcement of data governance policies before sharing clinical data externally. They leverage OAuth, SMART on FHIR, and HL7 APIs and are deployed as middleware alongside EHR and payer data lakes, reducing IT, compliance, and legal overhead while empowering beneficiaries to permission their data for care, analytics, or research. We've also seen tech-enabled, community-based care models for Medicaid and dually eligible populations that capture social determinants of health and clinical data, highlighting the importance of integrating medical and non-medical information for holistic care management.	Patients would gain a more complete view of their health information, empowering them to make better-informed decisions and more effectively manage their conditions. Caregivers would have the information they need to coordinate care across multiple providers and settings. Researchers would gain access to richer, more diverse data sets for generating actionable evidence, while developers would be able to create more sophisticated and personalized digital health tools.
PC-9. Given that the Blue Button 2.0 API only includes basic patient demographic, Medicare coverage,	CMS should evolve Blue Button into a truly patient-centered data access platform by expanding its scope beyond claims data to	We've observed modern data rights platforms that enable fast, scalable, and compliant access to patient data through user-friendly interfaces for consumer-directed data exchange.	By expanding Blue Button's scope and improving its usability, CMS would enable the development of more comprehensive and effective

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and claims data (Part A, B, D), what additional CMS data sources do developers view as most valuable for inclusion in the API to enable more useful digital products for patients and caretakers? a. What difficulties are there in accessing or utilizing these data sources today? b. What suggestions do you have to improve the Blue Button 2.0 API experience? c. Is there non-CMS data that should be included in the API?	include labs, imaging, pharmacy data, clinical observations, and patient-generated data. Additionally, CMS should explore making pre-adjudicated claims data available to improve timeliness. To enhance usability, CMS should implement standardized consent management systems that give patients granular control over their data sharing while simplifying the authorization process for developers. CMS should also launch a certification and developer support program for Blue Button-connected apps with clear integration guidelines and a sandbox environment for testing.	These platforms leverage TEFCA's individual access services and Patient Access APIs, with features for identity verification, patient education, consent, and granular data segmentation. They use IAL2, SMART on FHIR, CMS Blue Button, and LLM-based data segmentation, deployed as lightweight web links in member portals and as middleware alongside EHR and payer data lakes. For payers and value-based care organizations without real-time access to clinical data under the treatment exchange purpose, these platforms provide crucial access to real-time data for meeting quality incentive requirements, closing care gaps, processing prior authorizations, and understanding care value. Current difficulties include lag in data availability, limited data types, complex consent processes, and inconsistent implementation of interoperability standards.	digital health solutions. Patients would gain a more complete view of their health information in one central location, empowering them to make better-informed decisions and more effectively manage their conditions. Payers and value-based care organizations would gain access to real-time clinical data for quality improvement, care coordination, and cost control. Developers would be able to create more sophisticated and personalized digital health tools, while researchers would gain access to richer, more diverse data sets for generating actionable evidence.
PC-12. What are the	CMS should support the	We've observed healthcare marketplace	By supporting integrated

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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? a. Examples may include the following: (1) Binding cost estimates for pre-defined periods. (2) Viewing provider schedule availability. (3) Using third-party apps for appointment management. (4) Accessing patient-facing quality metrics. (5) Finding the right provider for specific healthcare needs. b. What use cases are possible today? c. What should be possible in the near future? d. What would be very valuable but may be very	development of integrated healthcare marketplaces that combine transparent pricing, quality metrics, and streamlined scheduling into a consumer-friendly shopping experience. These platforms should enable providers to offer pre-negotiated, episode-based bundles with transparent pricing and quality guarantees, while allowing patients to compare options based on both cost and procedure-specific quality indicators. CMS should establish standards for quality metrics and price transparency that can be embedded into these marketplaces, and create incentives for providers to participate in such platforms.	platforms purpose-built to simplify how care is discovered, priced, and purchased—enabling true consumerism while embedding clinical quality into every transaction. These marketplaces allow providers to offer pre-negotiated, episode-based bundles with transparent pricing and quality guarantees, integrating directly with scheduling, intake, billing, and clinical systems without adding administrative burden. Patients and navigators access care through mobile-first, e-commerce-like interfaces that support comparison shopping based on total cost and procedure-specific quality indicators. This model has demonstrated significant value, including hundreds of millions in savings across hundreds of thousands of procedures, 20-40% average savings off commercial rates for self-insured employers, and high patient satisfaction scores (92 NPS) from users who selected and purchased care via the marketplace—especially those who might otherwise delay or forgo treatment due to uncertainty around cost or quality.	healthcare marketplaces, CMS would enable true price and quality transparency that drives value-based purchasing decisions at the point of care. This would create more efficient care navigation by allowing patients to easily find and schedule care based on their specific needs, preferences, and financial considerations. It would also eliminate barriers to competition among providers by creating a level playing field where providers compete on both price and quality, rather than network status or opacity. This approach would accelerate the transition to value-based care by rewarding providers who deliver high-quality care at competitive prices, while empowering patients to make informed decisions that align with their clinical needs and financial

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hard to achieve?			resources.
PC-13. How can CMS encourage patients and caregivers to submit information blocking complaints to ASTP/ONC's Information Blocking Portal? What would be the impact? Would increasing reporting of complaints advance or negatively impact data exchange?	HHS, CMS, and FDA should actively partner with state attorneys general (AGs) to leverage the existing authorities of the 21st Century CURES Act to prosecute anti-competitive practices impeding market-based solutions including healthcare technology and data sharing to advance better health outcomes. Federal agencies should consolidate authority under ONC to create a more streamlined and effective enforcement mechanism that makes it easier for patients to report violations and ensures that complaints receive proper investigation.	Evidence shows that many vendors create artificial data silos or block innovative AI solutions that could improve patient outcomes. These anti-competitive behaviors include blocking data access or requiring innovative companies to share their intellectual property as a condition of market access. We are aware of concerns from both clinicians and patients that information blocking continues to remain an issue in healthcare and want to do all that we can to make sure such information blocking concerns are heard, investigated, and appropriately remedied. This aligns with our recommendation in "U.S. Healthcare That Works" to transfer authority for monitoring and enforcing anti-competitive practices in healthcare technology to ONC and possibly HL7 to monitor for information blocking and take action, enabling more proactive and specialized oversight.	By working with State AGs, federal agencies can create a more competitive marketplace that encourages innovation while protecting patient interests. This enforcement strategy will emphasize the CURES Act's original intent to promote interoperability and prevent information blocking, while ensuring that health data can be responsibly used to develop and deploy AI solutions that improve care quality and reduce costs. Increased reporting and enforcement will advance data exchange by creating consequences for information blocking practices that currently persist without penalty.

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
PR-1. What can CMS and its partners do to encourage providers, including those in rural areas, to leverage approved (see description in PC-5) digital health products for their patients? a. What are the current obstacles? b. What information should providers share with patients when using digital products in the provision of their care? c. What responsibilities do providers have when recommending use of a digital product by a patient?	CMS should allow qualified healthcare providers to deliver care across state lines, with particular benefits for rural communities. This would be supported by automated verification systems to reduce administrative costs. CMS should also upgrade rural health clinics with enhanced technological capabilities for greater access and AI-augmented care, and leverage Data at the Point of Care (DPC) to enable rural providers to operate with the same longitudinal insights as large urban systems. This aligns with our recommendation to "Advance U.S. Healthcare Provider Mobility" as outlined in our	Rural healthcare providers face significant obstacles in adopting digital health tools, including limited technological infrastructure, insufficient training resources, and complex regulatory requirements. The full launch of the DPC API gives Medicare-participating providers access to up to three years of longitudinal claims data for their attributed patients, supporting risk stratification, care coordination, and chronic disease management. We've observed platforms that deliver hybrid care to rural Medicare populations using mobile clinics, community health workers, and virtual care. These platforms integrate patient geolocation, real-time ADT event feeds (FHIR Subscriptions), and Medicare claims to maintain attribution and	By implementing these recommendations, CMS can significantly expand access to quality healthcare in rural communities. Cross-state care delivery would increase the available provider pool, while automated verification systems would reduce administrative burden. Enhanced technological capabilities in rural clinics would enable AI-augmented care, improving diagnostic accuracy and treatment planning. Rural providers with access to longitudinal data would be able to deliver more informed and coordinated care, reducing

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
	framework.	coordinate care. A centralized dashboard displays shared care plans, risk scores, and care gap alerts. These approaches are particularly effective in managing chronic conditions in rural areas with limited access. However, friction in cross-state licensing, variability in Medicaid credentialing, and the absence of universal MA interoperability impede consistent reach.	disparities between rural and urban healthcare quality.
PR-3. How important is it for healthcare delivery and interoperability in urban and rural areas that all data in an EHR system be accessible for exchange, regardless of storage format (for example, scanned documents, faxed records, lab results, free text notes, structured data fields)?	CMS should require that all EHR data, regardless of format, be made accessible via standardized APIs, and incentivize the use of AI-powered data normalization and credentialing tools to ensure data quality and integrity.	We've observed cloud-based credentialing and directory infrastructure platforms that ingest data from 1,000+ primary sources, including licensing boards, NPPES, DEA, and self-reported attestations. Using graph databases and entity resolution engines, these platforms build unified provider records, enabling real-time updates and credential reciprocity across states. Open APIs support CMS-aligned workflows like state licensing, payer credentialing, and enrollment. This architecture reduces onboarding time from 60 days to less than 10 and dramatically improves provider data quality for network adequacy. We've also seen platforms that coordinate hand-offs and transitions of care,	Ensuring all EHR data is accessible and normalized will reduce care fragmentation, improve transitions of care, and enable more accurate analytics for quality measurement and payment innovation, especially in rural and underserved areas.

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
		surfacing care-continuity data for analytics and payment innovation.	
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 establish a clear, unified reimbursement framework for artificial intelligence (AI)-enabled tools to prevent the development of a fragmented landscape where reimbursement varies by payer, state, or local market. This framework should include a two-tier pathway for AI reimbursement: one for real-world pilots under defined quality management standards, and one for scaled reimbursement based on demonstrated outcomes and cost savings. Additionally, CMS should create financial incentives for payers to implement and utilize standardized APIs, potentially through shared savings models or preferential treatment in Medicare Advantage plan ratings.	Our broad portfolio of 100+ companies reflects the market across digital health, AI, infrastructure, and care delivery. Feedback indicates strong market readiness to support CMS in this journey. These companies have expressed willingness and technical ability to integrate with standardized APIs within months, provided clear guidelines and incentives are available. We've observed platforms that enable payers to more effectively utilize claims data for care coordination and risk stratification, demonstrating the potential value of accelerated API implementation. The market is ready and eager, with the primary limitation being the lack of standardized approaches and clear financial incentives.	A unified reimbursement framework would create predictability and encourage the adoption of safe, effective AI tools across the healthcare system. By providing clear financial incentives for API implementation and utilization, CMS would accelerate the development of a more interoperable healthcare ecosystem where data flows seamlessly between patients, providers, and payers. This would lead to improved care coordination, reduced administrative burden, and enhanced patient experiences. Patients would benefit from increased access to their health data and more personalized care, while payers would gain

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
			insights that enable more effective population health management and cost control.
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?	CMS should establish a secure, standardized "Innovation Data Commons" leveraging HL7 standards and modern API architectures to enable secure and responsible access to CMS's data resources while maintaining robust privacy protections. In the short term, CMS should create clear accountability frameworks and market-driven access protocols, while expanding the successful Data at the Point of Care (DPC) API. For longer-term impact, CMS should support patient APIs as the primary vehicle for consumers to access and control their health data. This aligns with our recommendation to "Create Patient-Controlled Health Data Infrastructure" as outlined in	Our portfolio companies consistently identify data access as a primary barrier to developing effective solutions for Medicare beneficiaries. Companies that have successfully navigated these challenges have created significant value, such as AI-powered platforms that seamlessly integrate patients' medical histories with healthcare providers. These platforms have demonstrated reduced redundant tests, improved care coordination across multiple providers, and enhanced patient experiences while addressing healthcare costs. The evolution of CMS's Patient Access APIs beyond FHIR compliance to improve usability, scalability, and developer-friendliness, including new data types like digital insurance cards, cleaner documentation, and a more consistent developer experience, represents a significant step forward.	Creating an Innovation Data Commons would dramatically accelerate the development of digital health products targeted specifically to Medicare beneficiaries by providing developers with secure, standardized access to the data needed for innovation. This would lead to a proliferation of new tools addressing the unique needs of older adults and people with disabilities, from medication management applications to remote monitoring solutions. By supporting patient-controlled data access, CMS would empower Medicare beneficiaries to benefit from the full range of digital health innovations while maintaining appropriate privacy protections.

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
	our framework.		
TD-5. How could a nationwide provider directory of FHIR endpoints improve access to health information for patients, providers, and payers? Who should publish such a directory, and should users bear a cost?	CMS should establish and maintain a live, national provider registry powered by AI-driven credentialing and license-verification engines, ensuring up-to-date provider status, sanctions, and privileges. This directory should be open-access and integrated with FHIR endpoints.	We've observed cloud-based credentialing and directory infrastructure platforms that ingest data from 1,000+ primary sources, including licensing boards, NPPES, DEA, and self-reported attestations. Using graph databases and entity resolution engines, these platforms build unified provider records, enabling real-time updates and credential reciprocity across states. Open APIs support CMS-aligned workflows like state licensing, payer credentialing, and enrollment. This architecture reduces onboarding time from 60 days to less than 10 and dramatically improves provider data quality for network adequacy. However, the lack of a federal provider data standard, fragmented enrollment rules, and limited incentive alignment remain barriers to scale.	A nationwide, open-access provider directory would improve care coordination, reduce fraud, and enhance program integrity by ensuring all stakeholders have access to accurate, real-time provider information.
TD-12. Should CMS endorse non-CMS data sources and networks, and if so, what criteria or metrics should CMS consider?	CMS should endorse and support clinical research infrastructure platforms that integrate with EHRs to expand access to clinical trials across community and rural care	We've observed clinical research infrastructure platforms that integrate with EHRs to streamline protocol feasibility, automate patient prescreening, and support site workflows through digital tools like	By endorsing clinical research infrastructure platforms, CMS would significantly expand access to cutting-edge therapies for Medicare and Medicaid

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
	settings. CMS should establish criteria for endorsement including: (1) seamless EHR integration with minimal provider burden; (2) demonstrated improvements in trial access equity; (3) robust data security and privacy protections; (4) support for decentralized and hybrid trial models; and (5) ability to generate real-world evidence that can inform CMS coverage decisions. CMS should also consider creating reimbursement pathways for providers participating in endorsed clinical trial networks, particularly in underserved areas.	eConsent and remote data entry. In real-world implementations, these platforms have more than doubled screening volume for oncology clinical trials—from 10,200 to over 21,200 visits annually—while increasing enrollment rates from 4% to 11%. With another system, this approach enabled a 45% increase in overall trial participation over a two-year period by replacing manual screening with AI-driven matching that incorporates high-precision data such as genetic markers. By embedding clinical trial operations into routine care workflows, these platforms reduce friction for physicians and allow patients to be evaluated for trial eligibility regardless of geography or care setting. This aligns with our recommendation in "U.S. Healthcare That Works" to establish regional healthcare innovation sandboxes where new models of care can be tested and validated.	beneficiaries, particularly those in rural and underserved communities who have historically been excluded from clinical trials. This would advance health equity by ensuring that all patients, not just those at major academic centers, have the opportunity to participate in research. It would also accelerate medical innovation by increasing the speed and diversity of clinical trial enrollment, leading to more generalizable results and faster development of new treatments. Additionally, the real-world evidence generated through these platforms could inform CMS coverage decisions, potentially reducing the time between FDA approval and Medicare coverage for breakthrough therapies.
TD-13. What new opportunities and	CMS should establish a FHIR-native developer and	We've observed modular data rights platforms combining patient-facing	With APIs providing access to the entirety of a patient's

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
advancements could emerge with APIs providing access to the entirety of a patient's electronic health information (EHI)? a. What are the primary obstacles to this? b. What are the primary tradeoffs between USCDI and full EHI, especially given more flexible data processing capabilities today?	interoperability platform providing secure APIs and an event bus for health systems. This infrastructure would enable CMS to ingest EMR data from a wide breadth of hospitals once and expose it across the healthcare ecosystem. Additionally, CMS should implement an AI-driven consent-management layer that captures and enforces patient data-sharing permissions, providing the trust and compliance guardrails necessary for broader data access.	identity and consent portals with backend policy engines. Organizations use these systems to gather patient consents and automate enforcement of data governance policies before sharing clinical data externally. These systems leverage OAuth, SMART on FHIR, and HL7 APIs and are deployed as middleware alongside EHR and payer data lakes. They reduce IT, compliance, and legal overhead, while empowering beneficiaries to permission their data for care, analytics, or research. We've also seen eligibility and data-normalization engines that convert Medicaid/SNAP and other benefit files into a unified schema – ready for beneficiary apps and analytics, and deploying 10× faster than legacy systems. Primary obstacles include inconsistent implementation of interoperability standards, concerns about privacy and security, and the technical challenges of integrating data from multiple sources with varying formats and quality.	EHI, we would see the emergence of more sophisticated clinical decision support tools, more effective population health management solutions, and more personalized patient engagement platforms. Researchers would gain access to richer data sets for developing and validating new treatment approaches, while public health officials would have better visibility into emerging health trends. Patients would benefit from more coordinated care across providers, reduced duplication of tests and procedures, and more personalized health guidance. These advancements would lead to improved health outcomes, reduced healthcare costs, and a better patient experience.

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
TD-16. What are the tradeoffs of maintaining point-to-point models vs. shared network infrastructure? a. Do current rules encourage scalable network participation? b. What changes would improve alignment (for example, API unification, reciprocal access)?	CMS should establish a national provider data trust framework built on a graph database architecture that serves as the foundation for trusted data exchange between networks. This framework should: (1) ingest and validate provider data from authoritative sources; (2) implement identity resolution to create unified, deduplicated provider records; (3) enable real-time credential verification across state lines; and (4) make this trusted data available through standardized APIs. CMS should also develop clear governance standards for what constitutes a "trusted" data source and incentivize participation through reduced administrative requirements.	We've observed cloud-based credentialing and provider data platforms that ingest real-time data from over 1,000 sources including NPPES, licensing boards, and DEA registries. These platforms use identity resolution engines to deduplicate and link provider records, while APIs power onboarding, network adequacy, and enrollment workflows. This infrastructure ensures that accurate, granular provider data—including participation status, location affiliations, specialties, languages spoken, and cultural identifiers—is readily available across networks. This aligns with our recommendation in "U.S. Healthcare That Works" to advance U.S. healthcare provider mobility through a national licensure model and create patient-controlled health data infrastructure. The CMS Listening Session Takeaways document also highlighted that "lack of a national standard for patient and provider identity	A national provider data trust framework would address several key challenges in establishing trust between networks: 1) Data quality and currency issues would be resolved through continuous validation against authoritative sources; 2) Provider identity verification would be standardized, eliminating duplicate records and ensuring accurate attribution; 3) Credential verification would be streamlined across state lines, supporting provider mobility and telehealth expansion. By establishing this trust framework, CMS would create the foundation for secure, efficient data exchange between networks while reducing administrative burden and improving healthcare access.

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
		verification makes it difficult to securely and consistently link health records across systems."	
TD-18. Information blocking: a. Could you, as a technology vendor, provide examples for the types of practices you have experienced that may constitute information blocking. Please include both situations of non-responsiveness as well as situations that may cause a failure or unusable response? b. What additional policies could ASTP/ONC and CMS implement to further discourage healthcare providers from engaging in information blocking practices? c. Are there specific categories of healthcare	ASTP/ONC should evaluate existing HTI-1 rules and do more to eliminate anti-competitive barriers for innovative AI companies. This would prevent electronic health record (EHR) vendors from blocking or stealing innovations from emerging companies. CMS should establish clear disincentives for information blocking across all healthcare provider categories, including mechanisms to penalize persistent violators through reimbursement adjustments or exclusion from certain programs. As recommended in our "U.S. Healthcare That Works" whitepaper, HHS should immediately transfer the authority for monitoring and	Our portfolio companies and partners have encountered numerous instances of information blocking, including EHR vendors requiring excessive fees for API access, implementing unnecessary technical barriers to data exchange, and imposing contractual terms that discourage data sharing. These practices particularly impact AI-powered solutions that require access to comprehensive health data to function effectively. Current enforcement mechanisms have proven insufficient, as many healthcare actors calculate that the business advantages of information blocking outweigh the potential consequences. The full alignment across HHS agencies presents a historic opportunity to address these issues comprehensively.	Strengthened enforcement and elimination of anti-competitive barriers would accelerate innovation in healthcare technology by ensuring that emerging companies can access the data needed to develop effective solutions. By implementing these recommendations, CMS would create conditions for a more robust marketplace of digital health tools that can improve care quality and reduce costs. Patients would benefit from increased data liquidity, enabling them to access their complete health records and share them with providers of their choice.

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
actors covered under the definition of information blocking in section 3022(a)(1) of the Public Health Service Act (PHSA) that lack information blocking disincentives?	enforcing anti-competitive practices in healthcare technology to ONC potentially in partnership with a vendor-neutral standards partner such as HL7.		
VB-1. What incentives could encourage APMs such as accountable care organizations (ACOs) or participants in Medicare Shared Savings Program (MSSP) to leverage digital health management and care navigation products more often and more effectively with their patients? What are the current obstacles preventing broader digital product adoption for patients in ACOs?	CMS should create a unified national interoperability framework, especially for Medicaid, to prevent each state from developing its own approach, which creates fragmentation in HIEs and state-specific policies. This framework should include standardized technical requirements for admission, discharge, and transfer (ADT) feeds using FHIR subscription resources, and tie Medicaid interoperability funding to adoption of national standards (USCDI, FHIR, API-first	Our portfolio companies working with ACOs have identified fragmentation in data exchange standards and reimbursement policies as major obstacles to broader digital product adoption. We've observed care coordination platforms that have demonstrated significant improvements in patient outcomes and cost savings for ACOs, but implementation has been hampered by inconsistent data access and reimbursement policies across different regions. With today's improved digital identity, data access, and monitoring capabilities, CMS is now well-positioned to maintain high program integrity while	A unified national interoperability framework would significantly reduce the implementation costs and complexity for digital health products targeting ACOs and other APMs. By standardizing data exchange requirements and extending telehealth flexibilities, CMS would create conditions that encourage broader adoption of digital health management and care navigation products.

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
	design). Additionally, CMS should permanently extend the telehealth flexibilities that were granted during the public health emergency, as these have expanded access, improved patient satisfaction, and helped close care gaps, particularly in rural and underserved communities.	protecting against fraud, waste, and abuse in telehealth. The combination of modern tech infrastructure and extended telehealth authority will enable CMS to expand access in a cost-effective way without sacrificing oversight or quality.	This would lead to improved patient engagement, better care coordination, and ultimately better health outcomes and cost savings. ACOs would be able to more effectively leverage digital tools to manage population health, identify high-risk patients, and intervene proactively to prevent costly complications.
VB-2. How can key themes and technologies such as artificial intelligence, population health analytics, risk stratification, care coordination, usability, quality measurement, and patient engagement be better integrated into APM requirements?	CMS should implement next-generation AI-powered systems for fraud detection and care coordination, with particular emphasis on creating standardized data environments that can support pattern detection and predictive analytics. These systems should be embedded into APM requirements, with specific performance metrics tied to	In 2024, Medicare Fee-for-Service and Medicaid will experience approximately $31.7 billion and $31.1 billion, respectively, in billing errors and potential fraud. We've observed platforms that combine wearable motion sensors, asynchronous virtual physical therapy, and predictive AI engines to identify patients at high risk of undergoing unnecessary musculoskeletal surgery. These platforms ingest claims, demographic, and self-reported data, flagging members up to 40x more likely to	By integrating these technologies into APM requirements, CMS can accelerate the adoption of AI-powered solutions that improve care coordination, enhance clinical decision-making, and reduce administrative burden. This integration will lead to more sophisticated risk stratification, enabling providers to focus resources

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
	their implementation and use. Additionally, CMS should establish regional healthcare innovation sandboxes where new models of care and AI-enhanced decision support can be tested within value-based frameworks. This aligns with our recommendation to "Implement AI-Driven Measurements to Eliminate Waste and Red Tape" as outlined in our framework.	proceed to surgery and routing them into evidence-based virtual PT programs, driving a 70% reduction in surgery intent and significant per-member savings. We've also seen platforms that sit atop hospital PACS and EHR systems, using FDA-cleared AI models to flag urgent findings such as stroke and pulmonary embolism. These solutions shorten time-to-treatment and reduce diagnostic miss rates. These real-world applications show that AI can meaningfully transform care delivery when integrated into healthcare workflows and supported by appropriate incentives.	on patients who need them most. Enhanced care coordination through AI will lead to fewer adverse events, reduced hospital readmissions, and improved patient outcomes, while simultaneously addressing the significant financial losses currently experienced in Medicare and Medicaid programs.
VB-3. What are essential health IT capabilities for value-based care arrangements? a. Examples (not comprehensive) may include: care planning, patient event notification, data	CMS should prioritize support for AI-powered care transition platforms that seamlessly integrate with existing clinical workflows to reduce hospital readmissions and improve post-discharge outcomes. These platforms should include automated risk stratification, personalized patient	We've observed care transitions platforms that leverage AI and EHR integration to identify patients at high risk for poor outcomes following hospital discharge. These systems restructure discharge instructions into clear, actionable formats, personalize outreach based on patient risk and demographic data, and automate follow-up through generative AI	By supporting these care transition platforms, CMS would enable value-based care organizations to significantly reduce avoidable readmissions, improve continuity of care, and enhance patient satisfaction with the discharge process. The

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
extraction/normalization, quality performance measurement, access to claims data, attribution and patient ID matching, remote device interoperability, or other patient empowerment tools. b. What other health IT capabilities have proven valuable to succeeding in value-based care arrangements?	engagement, and structured follow-up protocols that don't add operational burden to providers. CMS should establish reimbursement pathways and implementation guidance for these technologies, particularly for ACOs and other value-based care organizations where readmission reduction directly impacts financial performance.	powered SMS and Voice. They connect directly with case management systems and care coordination workflows, allowing implementation in under 30 days without adding operational burden. These platforms have demonstrated strong early results—achieving over 50% patient engagement and more than 60% adherence to follow-up appointments—through a model that embeds intelligence into clinical workflows rather than layering it on. This approach aligns with our recommendation in "U.S. Healthcare That Works" to implement AI-driven patient engagement and monitoring tools to proactively identify and support high-risk patients, creating a scalable model for value-based care.	seamless workflow integration would address a key barrier to technology adoption in healthcare settings by minimizing additional work for clinical staff. This would lead to better health outcomes for patients, reduced costs for the healthcare system, and improved performance on key quality metrics for value-based care arrangements. The approach would be particularly valuable for ACOs and MSSP participants, helping them achieve shared savings goals while improving patient care quality.
VB-4. What are the essential data types needed for successful participation in value-based care	CMS should prioritize support for remote patient monitoring (RPM) platforms that collect, analyze, and act upon real-time patient vitals and	We've observed technology-enabled remote monitoring and care platforms that risk-stratify patients based on vitals data, with abnormal readings prompting virtual specialist review or care	By supporting these remote monitoring platforms and standardizing the essential data types they collect, CMS would enable more effective

RFI Question	GCI Recommendation	Supporting Evidence	Expected Impact
arrangements?	medication adherence data. Essential data types include: (1) continuous biometric monitoring data (blood pressure, weight, glucose, etc.); (2) medication adherence tracking; (3) patient-reported outcomes and symptoms; (4) social determinants of health data; and (5) care escalation events. CMS should establish standardized data models for these elements and create reimbursement pathways that incentivize their collection and integration into clinical workflows, particularly for chronic disease management in value-based care arrangements.	escalation. For heart failure patients, adoption of RPM plus medication optimization led to three times more patients taking guideline-directed medical therapy and resulted in monthly savings averaging over $1,000 per patient. Published data also show that these programs led to twice as many patients achieving blood pressure goals compared to standard care. A cost and utilization analysis of 5,872 patients enrolled in an RPM program compared to 11,449 patients in a propensity-score matched control group demonstrated annual total savings of $1,308 per patient across all chronic disease programs (heart failure, hypertension, and type 2 diabetes), primarily driven by a 27% reduction in hospital admissions. These positive clinical outcomes extend equally to patients in rural and non-rural areas, aligning with our recommendation in "U.S. Healthcare That Works" to upgrade rural health clinics for greater access.	chronic disease management within value-based care arrangements. This would lead to improved clinical outcomes, reduced hospitalizations, and significant cost savings for Medicare and other payers. The approach would be particularly valuable for ACOs and other risk-bearing entities, helping them achieve quality targets while reducing total cost of care. By ensuring these platforms work equally well in rural and urban settings, CMS would also advance health equity and expand access to specialty care for underserved populations.

Implementation Barriers and Mitigation

Despite the promise of digital health transformation, several high-level barriers persist: data quality and trust, workflow integration, and fragmented standards. Data from EHRs and APIs is often inconsistent, incomplete, or duplicative, leading to alert fatigue and diminished trust among clinicians. Workflow integration remains a challenge, as providers must navigate multiple logins and systems to reconstruct a patient's history. Fragmentation in HIEs and state-specific policies impedes consistent reach and data liquidity.

GCI's approach addresses these barriers by working with established partners – including HL7 and other vendor-neutral forums – to advance CMS objectives alongside industry companies. For example, GCI portfolio companies have deployed FHIR-native developer platforms, AI-driven consent management layers, and eligibility/data-normalization engines that convert disparate data into unified, analytics-ready formats. These solutions support the creation of a FHIR Bulk Data Quality Coalition to make clinical data usable and auditable for risk and quality programs. By shifting to FHIR-based quality submission and launching a coalition focused on bulk data quality, CMS can ensure that data is both accessible and trustworthy.

Additionally, GCI supports the idea that CMS should work with vendor-neutral forums like HL7 to establish clear criteria for what makes a data exchange "trustworthy." This includes transparency for patients, support for opt-out, adherence to baseline standards like USCDI and FHIR, and practical integration into quality and risk workflows. By leveraging modern identity solutions and federated digital identity verification, CMS can simplify patient onboarding, support secure data sharing, and enable provider credentialing and mobility across state and health system lines.

GCI's coalition-based approach to overcoming implementation barriers brings together diverse stakeholders across government, industry, states, communities, and nonprofits. As outlined in our recent "U.S. Healthcare That Works" report, we believe that healthcare transformation requires coordinated action across multiple sectors, with each stakeholder bringing unique capabilities and perspectives. Our portfolio companies are already collaborating with state governments to establish clear metrics for success in healthcare innovation, focusing on measurable improvements in patient outcomes, cost reduction, and accessibility of care. These partnerships facilitate data sharing and analysis while maintaining patient privacy and security standards, creating a foundation for sustainable innovation.

The regional healthcare innovation sandboxes we propose would serve as proving grounds where innovative companies can test new patient engagement tools and value-based care solutions without navigating unnecessary regulatory barriers. By bringing together federal agencies, state governments, healthcare providers, technology companies, and community organizations, these sandboxes would create environments where barriers to implementation

can be identified and addressed collaboratively. This approach is particularly valuable for rural and underserved communities, where traditional models of care delivery often fall short. By testing new approaches in real-world settings with input from all stakeholders, we can develop solutions that are both technically sound and practically implementable.

Scaling Beyond Medicare: Enabling Nationwide Impact

To drive broad adoption and impact beyond Medicare, CMS should ensure that Patient Access APIs go beyond FHIR compliance to improve usability, scalability, and developer friendliness. This means supporting new data types (e.g., digital insurance cards), providing cleaner documentation, and ensuring a consistent developer experience. GCI-backed solutions are already delivering results in Medicaid, commercial, and multi-program environments by leveraging open APIs and modular architectures.

CMS should build a national directory of healthcare providers that is always up to date, accurate, and easy for systems to access. This would serve as the foundation for a new kind of licensing system that enables providers already credentialed in one state to be quickly recognized in another, especially for telehealth or mobile care. Cloud-based credentialing and directory infrastructure platforms can ingest data from thousands of primary sources, using graph databases and entity resolution engines to build unified provider records. These solutions enable real-time updates and credential reciprocity across states, reducing onboarding time from 60 days to less than 10 and dramatically improving provider data quality for network adequacy.

Additionally, CMS should establish a federated digital identity ecosystem enabling seamless authentication and access for patients, providers, and caregivers. This should include support for patient-managed consent platforms that combine identity and policy engines to gather patient consents and automate enforcement of data governance policies. By deploying these solutions as middleware alongside EHR and payer data lakes, organizations can reduce IT, compliance, and legal overhead while empowering beneficiaries to permission their data for care, analytics, or research.

CMS should expand Data at the Point of Care (DPC) beyond Medicare fee-for-service to include all Medicare Advantage and Medicaid beneficiaries. The full launch of DPC gives Medicare-participating providers access to up to three years of longitudinal claims data for their attributed patients, supporting risk stratification, care coordination, and chronic disease management. CMS should also enhance Blue Button to become a truly patient-centered data access platform, expanding its scope to include labs, imaging, pharmacy data, and clinically relevant observations.

Furthermore, CMS must establish a clear, unified reimbursement framework for artificial intelligence (AI)-enabled tools. This should include a two-tier pathway: one for real-world pilots under defined quality management standards, and one for scaled reimbursement based on demonstrated outcomes and cost savings. Such a framework would create predictability and encourage the adoption of safe, effective AI tools across the healthcare system, from generative AI platforms delivering virtual care via voice and SMS to AI triage systems for diagnostic imaging that flag urgent findings.

Finally, it is critical that CMS and Congress permanently extend the telehealth flexibilities that were granted during the public health emergency. With today's improved digital identity, data access, and monitoring capabilities, CMS can maintain high program integrity while protecting against fraud, waste, and abuse. The combination of modern tech infrastructure and extended telehealth authority will enable CMS to expand access in a cost-effective way without sacrificing oversight or quality, particularly benefiting rural Medicare populations receiving hybrid care through mobile clinics and virtual services.

GCI's approach to scaling beyond Medicare leverages our unique position at the intersection of government, industry, states, communities, and nonprofits. As outlined in "U.S. Healthcare That Works," we believe that transformative healthcare solutions must be designed with input from all stakeholders to ensure they address real-world needs and can be implemented effectively. Our portfolio companies are united by the five pillars for Catalyzing Care, working across diverse sectors to deliver U.S. healthcare that works. This includes companies focused on automating healthcare interactions, building rural health systems, working on Medicaid solutions, delivering better health outcomes daily, and pioneering solutions dedicated to preventive care, workforce transformation, and technological innovation.

The key to successful scaling is ensuring that solutions are "fit for purpose" for the needs of patients, clinicians, and providers, making them sustainable by design. Our portfolio companies have demonstrated this approach by developing solutions that address specific pain points in the healthcare system while creating sustainable business models. For example, companies building rural health systems leverage technology to provide AI-augmented care in underserved areas, enabling rural providers to operate with the same longitudinal insights as large urban systems. These solutions are designed to be financially viable while addressing critical healthcare needs, ensuring they can scale and sustain operations over time.

The groundbreaking 'Make America Healthy Again' Credentials Program proposed in our whitepaper exemplifies how innovative approaches can scale nationwide. This voluntary federal licensure framework would enable providers already credentialed in one state to deliver care throughout all U.S. states and territories, dramatically expanding access to quality healthcare. By leveraging existing federal authorities and creating a streamlined pathway for qualified providers to serve both federal health program beneficiaries and private insurance patients

across state boundaries, this initiative would address provider shortages while maintaining high standards of care.

Just as CMS seeks to pursue external AI innovation, we encourage the agency to consider undergoing its own internal AI transformation. This will require strategic partnerships and a shared mindset around speed and execution. The FDA has established a helpful model with its AI-forward posture that can also be applied at CMS. We've observed successful AI-based solutions that span healthcare, public sector, and infrastructure, and seen these solutions help partners with large workforces implement AI-driven solutions to streamline operations, reduce administrative burden, and improve service delivery. This includes AI-based deployments that have reduced processing times by 70%, cut expenses by over 83% and empowered more frequent and improved stakeholder engagement. Such approaches demonstrate how thoughtful policy innovations, supported by technology, can create nationwide impact by addressing structural barriers to healthcare access and quality.

Conclusion

The General Catalyst Institute believes that the U.S. healthcare system stands at a crossroads: embrace transformation or protect the status quo. After decades of fragmentation, rising costs, and uneven outcomes, we're witnessing an unprecedented opportunity to fundamentally reshape the industry through market-driven solutions powered by applied AI.

The full alignment across HHS agencies presents a historic opportunity to transform U.S. healthcare through digital innovation. By implementing these recommendations, CMS can foster a more competitive marketplace that encourages innovation while protecting patient interests and improving health outcomes.

Our message is simple: the tools exist. The talent exists. The policy pathways must now align to ensure these assets can scale equitably and sustainably across every level of the healthcare system.

We appreciate CMS's openness to industry partnership and stand ready to collaborate on implementing these solutions. This is a turning point that requires real solutions from both the public and private sectors working together. Our ecosystem of innovative companies is already delivering results in outcomes-based care, with real-world data from tens of millions of patients served. We can provide coordination support for pilots and testbeds aligned with CMS infrastructure goals, as well as ongoing feedback loops to ensure CMS programs meet evolving technology and patient needs.

Together, CMS and the private sector can ensure that the tools of modern healthcare are distributed fairly, used safely, and scaled effectively. We believe the moment is now and that partnership is the way to make U.S. healthcare truly work for all.

Respectfully submitted,

The General Catalyst Institute

Table of Acronyms

Acronym	Definition
ACO	Accountable Care Organization
ADT	Admission, Discharge, and Transfer
AG	Attorney General
AI	Artificial Intelligence
API	Application Programming Interface
APM	Alternative Payment Model
ASTP	Assistant Secretary for Technology Policy
CDISC	Clinical Data Interchange Standards Consortium
CHW	Community Health Worker
CMS	Centers for Medicare & Medicaid Services
DEA	Drug Enforcement Administration
DPC	Data at the Point of Care
ED	Emergency Department
EHI	Electronic Health Information
EHR	Electronic Health Record
EMR	Electronic Medical Record
FDA	Food and Drug Administration
FHIR	Fast Healthcare Interoperability Resources
GCI	General Catalyst Institute
HIE	Health Information Exchange
HL7	Health Level Seven International
HHS	Department of Health and Human Services

IT	Information Technology
LIS	Low-Income Subsidy
LLM	Large Language Model
MA	Medicare Advantage
MSK	Musculoskeletal
MSP	Medicare Savings Program
MSSP	Medicare Shared Savings Program
NCQA	National Committee for Quality Assurance
NPPES	National Plan and Provider Enumeration System
NTAP	New Technology Add-on Payment
ONC	Office of the National Coordinator for Health Information Technology
PACS	Picture Archiving and Communication System
PE	Pulmonary Embolism
PMPY	Per Member Per Year
PT	Physical Therapy
RPM	Remote Patient Monitoring
SDOH	Social Determinants of Health
SMS	Short Message Service
SNAP	Supplemental Nutrition Assistance Program
TEFCA	Trusted Exchange Framework and Common Agreement
TPO	Treatment, Payment, and Operations
USCDI	United States Core Data for Interoperability
VA	Veterans Affairs
VBC	Value-Based Care

WIC	Women, Infants, and Children (Program)
Z-codes	ICD-10 codes for social determinants of health factors