ConnectedHealthInitiative

June 9, 2026

Submitted electronically via www.regulations.gov

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Comments of the Connected Health Initiative, Medicare Promoting Interoperability Program Proposals in the Fiscal Year 2027 IPPS/LTCH PPS Proposed Rule, Docket No. CMS-2026-1256, 91 Fed. Reg. 19312 (April 14, 2026)

Dear Administrator Oz:

The Connected Health Initiative (CHI) appreciates the opportunity to comment on the fiscal year (FY) 2027 Hospital Inpatient Prospective Payment Systems (IPPS) and Long-Term Care Hospital Prospective Payment System proposed rule issued by the Centers for Medicare & Medicaid Services (CMS).[1]

CHI is a broad multistakeholder effort that brings together patients, providers, and technology innovators, including many small and medium-sized software developers, to advance a connected and interoperable health care system. Our comments focus on the proposed changes to the Medicare Promoting Interoperability (PI) Program, which fall within CHI's core interests in interoperability, patient access to health data, and the responsible use of digital health tools.

I. CHI Strongly Supports Advancing the Electronic Prior Authorization Measure

CHI has long urged CMS to reduce the administrative burden that prior authorization places on patients, clinicians, and developers. We therefore welcome the proposal to modify the Electronic Prior Authorization measure to align its description with the Office of the National Coordinator for Health Information Technology (ONC) HTI-4 and HTI-5 rulemakings and with the recently proposed

1 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2027 Rates; Requirements for Quality Programs; and Other Policy Changes, 91 Fed. Reg. 19312 (Apr. 14, 2026) (Docket No. CMS-2026-1256) (the Proposed Rule). The Medicare Promoting Interoperability Program proposals discussed below appear at 91 FR 19621-19631. Comments are due June 9, 2026.

Interoperability Standards and Prior Authorization for Drugs rule.[2] Standardized, application programming interface (API) based prior authorization built on Fast Healthcare Interoperability Resources (FHIR) reduces the manual work that consumes clinician time and delays patient care. We support treating the measure as a bonus measure for calendar year (CY) 2027 and requiring it beginning with the CY 2028 EHR reporting period. This phased path gives hospitals and their technology partners, including smaller developers, a realistic runway to implement the relevant FHIR prior authorization APIs. We encourage CMS to keep its requirements consistent across CMS programs and ONC certification criteria so that developers can build once and deploy across settings rather than maintain duplicative implementations.

CMS also requests comment on a future performance-based electronic prior authorization measure.[3] CHI supports movement toward measures that reflect real adoption and use. We urge CMS to design any performance-based measure so that hospitals are not penalized for delays that originate on the payer side or for circumstances outside their control. A measure that captures end-to-end electronic exchange, rather than provider effort alone, will better reward the outcomes that patients experience. CHI also encourage CMS to pursue payer-provider symmetry in API requirements and to establish API response time standards, because certified provider technology can support electronic prior authorization only if payer API systems perform reliably on the other side of the transaction.

II. CHI Supports Adoption of the Unique Device Identifier Measure With Attention to Patient Access

CHI supports the proposal to adopt a Unique Device Identifiers (UDI) for Implantable Medical Devices measure within the Public Health and Clinical Data Exchange objective.[4] Capturing UDI in interoperable records advances patient safety, supports postmarket surveillance, and improves the ability of patients and clinicians to identify affected devices quickly in the event of a recall.
As CMS considers the future directions described in its accompanying request for information, we encourage two priorities. First, CMS should rely on existing standards, including the United States Core Data for Interoperability, so that UDI capture does not impose new and duplicative data entry burdens. Second, UDI data should be made available to patients through the same standards-based, patient-facing FHIR APIs that support broader patient access. Device information is among the data that patients most need when they move between care settings or use connected applications to manage their own care. CHI also recommends that CMS advance UDI through electronic health record capture and standards-based exchange rather than new claims-based reporting obligations, which would add workflow and systems burden for providers without a corresponding gain over surveillance grounded in electronic health records and registries.

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2 Proposed Rule, Proposed Changes to the Medicare Promoting Interoperability Program, 91 FR 19625-19626 (proposing to clarify the Electronic Prior Authorization measure to align with ONC HTI-4 and HTI-5 and the proposed drug prior authorization rule, to treat the measure as a bonus measure for CY 2027, and to require it beginning with the CY 2028 EHR reporting period). See also Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs, Proposed Rule, 91 FR 19890 (Docket No. CMS-2026-1255).
3 Proposed Rule, 91 FR 19626 (request for information on a future performance-based electronic prior authorization measure).
4 Proposed Rule, 91 FR 19631 (proposing to adopt a Unique Device Identifiers for Implantable Medical Devices measure within the Public Health and Clinical Data Exchange objective and requesting comment on future directions for the measure).

III. CHI Supports Aligning the CEHRT Definition With the FHIR-Forward Certification Reset

CHI supports reducing unnecessary regulatory burden on health IT developers, and we endorsed the FHIR-forward reset of the ONC Health IT Certification Program in our comments on the ONC HTI-5 proposed rule, including the removal of legacy, functionality-oriented certification criteria that no longer drive interoperability.[5] We therefore support the proposal to update the definition of certified electronic health record technology (CEHRT) to reflect the certification changes ONC has proposed, including the removal of references to family health history, patient health information capture, automated numerator recording, and automated measure calculation.[6]

As CMS and ONC streamline certification, CHI continues to emphasize that a truly interoperable system must welcome patient-generated health data through open, FHIR-based APIs. Patient-generated data is central to remote patient monitoring, chronic disease management, and the patient-centered model of care that CHI has long championed.[7] We encourage CMS to ensure that the FHIR-based foundation now being established continues to support the safe and secure introduction of patient-generated health data into the record. We also reiterate our view that reduced certification burden must be paired with robust information blocking enforcement, so that this data actually reaches patients and their care teams.

IV. CHI Encourages Alignment With the CMS Interoperability Framework and TEFCA

CHI continues to believe that a seamless and interoperable health care system must prioritize data generated by patients outside of the traditional care setting. We encourage CMS to ensure that the PI Program, the CMS Interoperability Framework and its aligned networks, and the Trusted Exchange Framework and Common Agreement work together so that remote patient monitoring tools, consumer wearables and connected devices, and patient-facing applications connect reliably to the broader exchange ecosystem.[8] Coordination across these efforts will reduce confusion for providers and developers and will help realize the patient access goals that CMS has set. To that end, CHI reiterates its recommendation that CMS align its own API and interoperability requirements with those of ONC, so that certified provider technology and payer systems share a common technical interface.

V. CHI Supports the Proposed Reductions in Administrative Burden

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5 ASTP/ONC, Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions To Unleash Prosperity, 90 Fed. Reg. 60970 (RIN 0955-AA09). See Comments of the Connected Health Initiative on the HTI-5 Proposed Rule (Feb. 27, 2026).

6 Proposed Rule, 91 FR 19621-19631 (Medicare Promoting Interoperability Program) (proposing to update the definition of certified electronic health record technology to align with ONC proposals, including removal of references to family health history, patient health information capture, automated numerator recording, and automated measure calculation).

7 See, e.g., prior Comments of the Connected Health Initiative to CMS on the Medicare Promoting Interoperability Program and the IPPS rulemakings urging CMS to prioritize patient-generated health data and data generated outside of the traditional care setting.

8 See CMS, Interoperability Framework and CMS Aligned Networks (announced July 30, 2025). See also Trusted Exchange Framework and Common Agreement (TEFCA).

CHI supports the proposal to remove the ONC Direct Review and ONC-Authorized Certification Body surveillance attestations, neither of which requires any specific action by hospitals.[9] We also support the removal of the two Support Electronic Referral Loops measures from the Health Information Exchange objective and the removal of duplicative electronic clinical quality measures where more outcome-focused measures take their place.[10] These changes are consistent with CHI's view that reporting requirements should be meaningful, should avoid duplication, and should not divert limited resources, particularly for smaller developers and the hospitals they serve, away from improving patient care.

9 Proposed Rule, 91 FR 19621-19631 (proposing to remove the ONC Direct Review and ONC-Authorized Certification Body surveillance attestations, neither of which requires any specific action).
10 Proposed Rule, 91 FR 19621-19631 (proposing to remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures from the Health Information Exchange objective, and to remove the VTE-1, VTE-2, and STK-02 electronic clinical quality measures).

VI. Conclusion

CHI appreciates CMS's continued work to advance interoperability and patient access through the Medicare Promoting Interoperability Program. We welcome the opportunity to serve as a resource as CMS finalizes this rule and pursues related interoperability initiatives. Please contact the undersigned with any questions.

Sincerely,

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