



June 16, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

RE: Request for Information; Health Technology Ecosystem

Dear Administrator Oz:

SYNCRONYS, the State of New Mexico's designated health information exchange (HIE) and emerging health data utility (HDU) appreciates the opportunity to submit public comments on the Request for Information, Health Technology Ecosystem (CMS-0042-NC), published in the Federal Register on May 16, 2025. SYNCRONYS is a New Mexico not for profit organization providing support to healthcare providers, hospitals, state agencies and managed care organizations statewide. Our HIE contains medical records from 90% of hospital beds in the state, the FQHCs, clinical laboratories, diagnostic imaging facilities, behavioral health agencies, NM Corrections facilities, detention centers and Medicaid claims in a central location, allowing an efficient and cost-effective system to share medical records. Exchanging data through SYNCRONYS is aligned with HIPAA and the New Mexico Medical Record Act.

In response to the request by CMS and ASTP/ONC for feedback on the state of data interoperability and health technology infrastructure to develop an efficient patient-centered system, using existing resources, breaking down barriers and bring together patients, physicians, payers, health systems and technology experts, our simple response is that the foundation to build upon your desired outcome exists in New Mexico and many other states. The infrastructure built using HITECH funding by the HIEs throughout the country have built their state and regional ecosystems and many came together through our national association, Civitas Networks for Health to develop the Patient-Centered Data Home (PCDH) national framework for statewide HIEs utilizing an expansion of ADT capability to notify each-other in real time when patients from the "home" state are receiving out-of-state care to ensure record consistency. While the foundation to achieve your stated desire for interoperability exists using the HIEs previously funded with federal HITECH funds, the continued financial support and inclusion of these networks in policy decisions is crucial. Below you will find our input on the areas of the RFI that pertain to the New Mexico HIE.

TEFCA

PC-10. PR-6. Is TEFCA currently helping to advance patient, and provider access to health information in the real world?



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While TEFCA represents a significant policy milestone that solves data sharing struggles by creating open standards for security, privacy, anti-competitive business practices and technical standards by the implementation of the “common agreement.” TEFCA real-world impact remains limited due to slow implementation and lack of nationwide participation. The functionality of TEFCA use-cases remains far below what state and regional HIEs are offering in their own service areas.

SYNCRONYS has not integrated TEFCA capabilities per the current approach where QHINs are formed by EHR vendors, like Epic or eCW. The administrative burden to re-contract with all organizations currently sharing data with the HIE to agree to the terms of the Common Agreement has not been a priority for us. The additional administrative work and joining a QHIN provides no benefit to the HIE and in fact may allow for profit EHR vendors, the ability to use the health data that we have developed for their own profit, in the absence of a business model that provides funding to the state and regional HIEs for building the “last mile” of track to exchange data. In a rural state like New Mexico, it is important that the interoperability ecosystem, includes all patients and providers in the state. The current TEFCA model undermines the trust factor by the public and creates additional silos in healthcare data.

SYNCRONYS sees potential in TEFCA if adjusted for QHINs to be aligned with existing HIE and future Health Data Utilities (HDU) infrastructure as non-profit, trusted custodians of healthcare data. Point to point integration is costly and inefficient. Hub integration by leveraging HIEs and HDUs solidifies existing health exchange infrastructure to become public data utilities that will enable TEFCA long-term ability to simplify access, standardize and secure interoperability.

The federal government could accelerate TEFCA adoption by empowering HIEs and HDUs, incentivizing and mandating large data holders to connect to state designated HIEs/HDUs hubs, fostering national standards, and subsidizing smaller providers to onboard rapidly to enable last mile connectivity data. Incorporating HIEs in TEFCA enables a cost-effective approach by leveraging, upgrading, and certifying existing health data exchange infrastructure.

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

Current limitations include unclear QHIN roles, undermining existing trusted health exchange infrastructure, delayed onboarding, and identity verification weaknesses. If QHINs continue they should be required to be non-profit organizations to enhance trust, enhance access controls and streamline participation processes through centralized identity services.

TD-6. What unique interoperability functions does TEFCA perform and what existing alternatives should be considered?

TEFCA centralizes governance and trust, differentiating it from private networks. However, existing HIEs, Carequality, and CommonWell offer broader real-time utility and more impactful and quicker real-world impact. A federated model integrating TEFCA with these alternatives should be considered. A hybrid model where TEFCA anchors governance and local HIEs serve as exchange hubs—like the currently functioned Patient Centered Data Home, built in partnership with Civitas Networks for Health and its member HIEs—would be more scalable.

TD-5. How would a nationwide provider directory of FHIR endpoints improve access to health data for stakeholders and how would this differ from TEFCA?

A nationwide directory would provide dynamic, real-time API access locations, essential for application developers and providers, reducing manual endpoint discovery. This complements TEFCA by supporting patient-facing applications and real-time data pull mechanisms. Building national patient and provider directories will serve both clinicians and citizens. This builds on what TEFCA offers, extending usability especially for consumer apps.

Data Standardization, Access, & Exchange

PC-10d. What data standards are currently working well to advance patient and provider access and existing exchange purposes and if they are not in wide use how can federal agencies help advance them?

HL7 FHIR and USCDI v3 are advancing interoperability but are still unevenly adopted. Federal support should focus on training, funding implementation grants, and mandating adoption in all CMS-participating providers, including behavioral health. Federal financial incentive, similar to UK's NHS Digital's standards compliance grants could rapidly accelerate adoption.

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, structure data fields)?

Universal EHR data access is critical for continuity of care, especially in rural areas to ensure care coordination. Behavioral Health (BH) Providers were left out of the HITECH Act, this resulted in BH using manual paper records / BH EHR systems lacking interoperability functions, this is a significant technical barrier to enabling full data access for integrated whole patient care services. Should enforce minimum standards requiring EHRs to render all data exchangeable regardless of format. Ideally, CMS should require normalization of all data formats to structured elements where possible and provide funding to BH Providers to invest in interoperable EHR systems that can exchange data.

PR-8c. Are there requirements for data registries to support digital quality measurement and/or better real-time data collection that CMS should consider?

CMS should establish uniform APIs and reporting schemas to standardize digital quality reporting. Enabling Bulk FHIR data export from HIEs to CMS will ensure more complete coverage for attributed patients that are being seen outside the network and simplify quality data submissions. Shifting quality measures from claims data to collecting clinical data in real time by HIEs and sharing the insights across the health ecosystem would measure quality outcomes timelier, making digital quality measures meaningful for providers by identifying issues earlier, by enabling early interventions and positively impacting patient outcomes. Registries should align with USCDI and support near real-time submissions. For example, we should implement real-time data integration standards, mandating registries use interoperable APIs to support continuous monitoring and feedback loops.

PR-9. Do stakeholders have commentary on the technical and operational merits of replacing proprietary logins with digital identity credentials (CLEAR, ID.me, Login.gov) for widespread payer and provider use?

Identity systems like Login.gov or ID.me must meet NIST standards and align with privacy principles. A unified, trusted identity improves access, interoperability, and security. CMS should establish a unified trust framework using NIST 800-63-3 standards that uniquely tracks and identifies a patient to enable whole person care and ensure quality outcomes.

The use of single IAL2 Digital Identity Federation means that a patient can prove their identity once via CLEAR and authenticate on a Healthcare application that uses the service by sending the patient demographic information to find their records. Patient matching logic does not change, instead the same Enterprise Master Patient Index (EMPI) logic is used to validate the digital identity demographics to return the data.

This would result in the same rate of false negatives, and frustrations from miss-matches or duplicative patient records that are created per the lack of a national patient registry and a unique patient identifier that can be used across the healthcare ecosystem.

A unique identifier will empower both providers and patients in fully unlocking their digital journey and dramatically improve the healthcare experience and care outcomes.

TD-7. To what degree has USCDI improved interoperability and exchange; what are its limitations, and is there value in adding more data elements?

USCDI has created a strong foundation but lacks breadth per current element sets are too narrow. Expansion should include Social Determinants of Health (SDOH), Behavioral Health (BH), imaging metadata, and care plans. Studies demonstrate that value-based risk assessment population health models yield better outcomes when adjusted with SDOH like homeless or food insecurity and Behavioral Health data as key factors when selecting high risk population cohorts for care coordination team to focus on, for instance for high-risk diabetic populations identification, treatment and monitoring.

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

Yes. Endorsement should be contingent on performance metrics such as uptime, data volume and scalability, adherence to FHIR, privacy and cybersecurity compliance, and patient access features.

APIs

TD-4. How can CMS better encourage use of open, standards-based, publicly available APIs over proprietary APIs?

Tie reimbursement eligibility to certified, open API use and increase technical assistance funding. Incentivize their use by linking them to program participation and offering certification preference. Denmark's model mandates open standards for national services.

TD-9. How can ASTP/ONC's health IT certification program be optimized to promote interoperability and prioritize the use of APIs?

Require biannual recertification based on API performance and adoption metrics; emphasize end-to-end access across the care continuum. Certification should emphasize outcomes, API response time, patient portal utility, third-party app integration, and benchmark best-in-class global API use.

A patient typically sees multiple providers every year, from primary care provider to urgent care provider to several specialists. A single EHR is not a complete source for patient records. HIEs consolidate the longitudinal health record for a patient. Health IT Certified EHR should include reverse API workflows for Provider's EHR systems to use APIs to connect to and frequently query HIEs. For instance, prior to the visit a Provider EHR would use an API to query if there is any new data about my patient in the HIE? Health IT Certification Program should make it mandatory for Providers EHR to share clinical and encounter data with HIEs in real time, as soon as the visit notes are completed.

TD-13. What new opportunities and advancements could emerge with APIs providing access to the entirety of a patient's electronic health information (EHI) and what obstacles or drawbacks to this idea exist?

Opportunities include patient empowerment and engagement in their own health and real-time clinical decision support. Benefits include democratized health access, whole-person patient-centric care, preventive alerts, and reduced costs.

Drawbacks include data overload and privacy risks. Risk mitigation policies are essential. Observance of 42 CFR Part 2 data privacy practices would be required to be implemented across the health ecosystem. Information overload can be mitigated using structured AI-powered summaries that are tailored to the requester role and personalized dashboards.

HIEs

PC-11. How are HIEs currently helping to advance patient and provider access and health information in the real world? Is their data valuable, available and accurate? Are there particular examples of high-performing HIE models that should be promoted?

SYNCRONYS is the state of New Mexico's designated HIE. We enable bi-directional, real-time data exchange, supports ADT alerts, and enriches clinical decision-making by aggregating patient data into one longitudinal health record. Data quality is ensured through normalization and reconciliation engines. Our data streams are certified by the National Committee for Quality Assurance (NCQA) through their Data Aggregator Validation (DAV) program. SYNCRONYS is a certified module of the State's Medicaid Management Information System, participating in the CMS Streamlined Modular Certification process.

Our HIE provides a Clinical Portal that brings together health information from participating health organizations across the state, supporting providers and support staff to securely access clinical patient information across the community. Health information is exchanged electronically, privately, and securely consistent with HIPAA, SOC2 and HITRUST frameworks. SYNCRONYS

provides Diagnostic Quality Images and Radiology reports together with Patient Alerts and Event Notifications. For example, our HIE significantly reduced Emergency Department (ED) revisit rates through real-time ADT alerts, ensuring ER staff has access to critical information for improved decision making when time is of essence for saving a patient's life.

Our HIE enables maternal health summaries, population health dashboards for risk stratification, behavioral health dashboards and insights on hepatitis C. The health equity map enables users to analyze global and attributed populations overlaid with over 150 publicly available data sets that can be overlaid and combined with patient health data and claims for a comprehensive view of care gaps in a region or local area, enabling policy makers, community-based organizations and providers to plan targeted interventions.

HIEs are foundational and essential, particularly where TEFCA is immature and not trusted by the public. HIEs enhance care coordination and transitions among regional and local provider networks, sharing critical information, preventing costly duplicated tests by sharing essential clinical data, test results and images among all providers in the area, coordinating resources, expanding access, efficiency, and reliability of healthcare services.

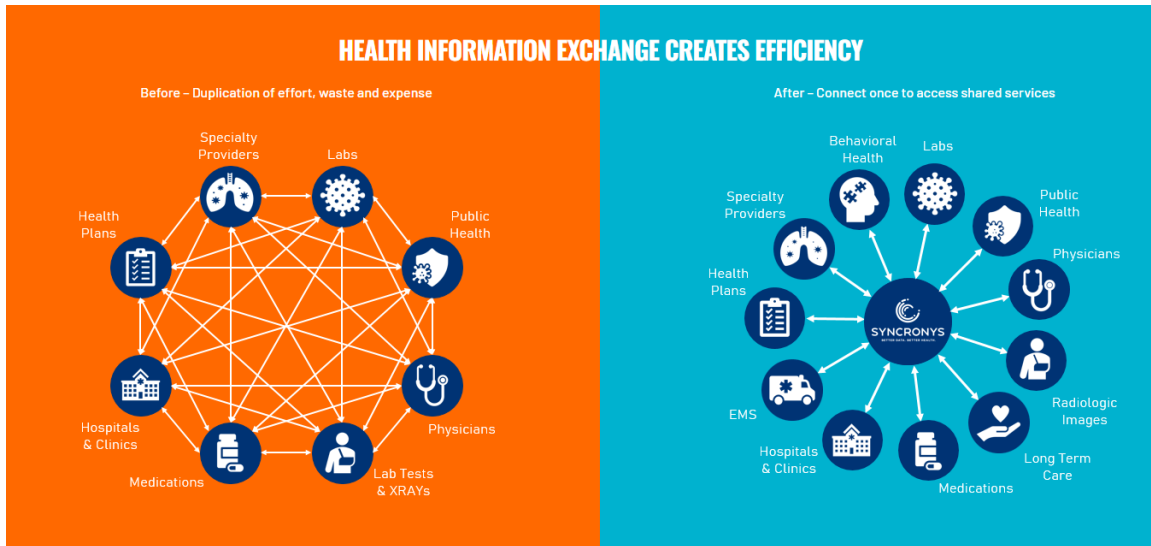
SYNCRONYS has been the agent for the New Mexico Department of Health (NMDOH) since 2016 developing the eReporting repository for Electronic Lab Reporting (ELR) and Syndromic Surveillance (previously known as Emergency Department Reporting). The SYNCRONYS team continues to support the NMDOH with the reporting of notifiable conditions and in supporting their efforts to comply with the CDC Data Modernization Initiative (DMI). The NMDOH was selected as one of two jurisdictions by CDC to participate in the RESP-Net Pilot, to develop eCR for public health reporting. SYNCRONYS successfully partnered with the CDC vendor, to provide the required bundles of data.

SYNCRONYS is used by other NM State agencies and programs. We receive data from the NM Corrections Department facilities infirmaries and clinics, and the NMCD healthcare teams access the HIE to obtain records for inmates who receive specialty care outside of the prison.

PC-11d. What is the ongoing role of HIEs amidst other entities facilitating data exchange and broader frameworks for data exchange (for example, vendor health information networks, TEFCA, private exchange networks, and digital health applications)?

HIEs remain essential for local and regional coordination, especially critical for enabling public health surveillance, access to small provider practices, rural health providers and underserved populations. HIEs are trusted organizations in their communities that create efficiencies, by connecting once to access shared services as opposed to the point-to-point connectivity that results in duplication of efforts, high waste, and higher expense.

HIEs should be integrated into TEFCA, not displaced. HIEs should evolve into state-level hubs and Health Data Utilities for the state to empower providers and patients by aggregating health data and ensuring secure data exchange, connected via TEFCA but maintaining local flexibility.



Benefits of being part of the state and regional HIE network

- Provides caregivers with clinical decision support tools for more effective care and treatment
- Eliminates redundant or unnecessary testing
- Provides a vehicle for improving quality and safety of patient care by reducing medication and medical errors
- Facilitates the right care, at the right time
- Stimulates consumer education and patients' involvement in their own health care
- Increases efficiency by eliminating unnecessary paperwork
- Improves public health reporting and monitoring
- Creates a potential loop for feedback between health-related research and actual practice
- Facilitates efficient deployment of emerging technology and health care services
- Provides the backbone of technical infrastructure for leverage by national and state-level initiatives
- Provides a basic level of interoperability among electronic health records maintained by individual physicians and organizations
- Quality outcomes reduce health care related costs

Delivering high-quality, comprehensive care requires complete health data enabling whole-person care, improving outcomes, reducing health disparities, and enabling patient trust. For more than a decade, federal, state, and private investments in health data infrastructure have made concerted efforts at facilitating better communication and more coordinated care through HIE platforms. Most states have existing infrastructure in place for clinical data exchange through local, regional, or statewide HIEs.

States, HIEs, and community partners are expanding the availability of electronic health data to support broader clinical and public health purposes. Advancing exchange capabilities using combined clinical and non-clinical data sets is the evolution of HIE to function as a Health Data Utility (HDU). HDUs represent a new paradigm to support multi-stakeholder, cross-sector

needs by serving as a data resource for use cases beyond clinical care delivery through multi-directional exchange.

Care Coordination & Value-Based Care

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

Patients struggle with navigating the complex, siloed and broken healthcare system. HIEs play a critical role in simplifying access, aggregating, consolidating, and coordinating all patient health data unlocking a better healthcare journey and experience for the patients. HIEs are trusted custodians of patients and public health data that enable access to a patient's longitudinal health record, by connecting health data for the entire ecosystem in their states and regions. Many HIEs have improved the patient experience by making the HIE data available via a patient portal. SYNCRONYS plans to provide patient access to the portal by the end of 2027. HIEs that transition to be HDUs can empower patients to select their plan based on needed coverage, select the provider that accepts their insurance, estimate out of pocket costs, manage their consents for privacy access, securely share their health data, engage in their care and monitor their health outcomes by providing patient-facing care metrics. HIEs provide cross-provider data, closed-loop referral tracking, transitions of care alerts gaps-in-care reporting, and longitudinal patient views that are crucial for reducing duplication and improving outcomes. For instance, a chronic care program can use HIE data to integrate such views at the point of care, showing cost reductions and resulting in higher patient engagement.

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

Cross-provider referral tracking, transitions of care alerts, and longitudinal patient timelines are crucial for reducing duplication and improving outcomes. Predictive analytics and population health dashboards for patient risk stratification and to drive targeted interventions, together with payer-provider data reconciliation. Home-based monitoring integration for patients with chronic conditions. SYNCRONYS offers a robust NCQA certified population health models where Primary care and Specialty or BH providers are digitally supported with risk-adjusted data and payment tracking solutions.

Information Blocking

PR-14. How can CMS encourage patients and providers to submit information blocking complaints to ASTP/ONC's Information Blocking Portal—and what that advance or negatively impact interoperability in practice?

CMS should fund public awareness campaigns and allow anonymous submissions by integrating complaint submission links in patient portals, provider portals, and HIE platforms. Public CMS dashboards on information blocking findings, like Australia's privacy transparency reports, can enhance trust and accountability across the industry.

CMS should direct national clinical laboratories, i.e. LabCorp and Quest, to share all laboratory

data with state and regional HIEs.

PR-12. Should ASTP/ONC consider removing or revising any of the information blocking exceptions or conditions within the exceptions to promote interoperability?

Yes. "Security risk" should not shield EHR vendors from enabling interoperability or competition. "Infeasibility" should require documented evidence. Delays in responding to requests should be time-bound and exceptions should be independently auditable.

PR-13. For any category of healthcare provider without a current information blocking disincentive established by CMS, what would be the most effective disincentive for that category of provider?

Implement financial penalties or recertification restrictions for repeated offenders. Enforce payment reductions or exclusion from federal subsidies or incentive programs. Transparency penalties, like publicizing offenders, can also deter behavior.

What additional policies could ASTP/ONC and CMS implement to further discourage healthcare providers from engaging in information blocking practices?

Require real-time transparency dashboards and include blocking behavior in quality reporting metrics to CMS. For instance, incorporate real-time exchange metrics and audits as a CMS reporting requirement, tied to both patient satisfaction and provider quality scores.

Payer & Provider Burden

PR-7. How can the burden of increasing data availability and sharing be mitigated for payers and providers? Are there ways that workflows or metrics that providers have demonstrated a preference for be modified to further support interoperability?

Streamline and improve EHR reporting tools to enable configurable data extracts on demand, implement Bulk FHIR transactions, consolidate and align measure sets across programs.

PR-8. How can CMS simplify clinical quality data to reduce payer and provider burden and increase program participation (for instance, would bulk FHIR data exports to CMS simplify submissions and streamline operations)?

Require EHR vendors to support CMS bulk FHIR exports natively. Merge and align quality and operational data fields across value-based programs.

State and regional HIEs should serve as intermediaries to facilitate and work collaboratively with healthcare providers and payer organizations to improve their data quality by creating organization-specific quality dashboards and metrics. Reducing the burden for interoperability loads by aggregating data and enabling shared services for electronic case reporting, HEDIS and Value Based Program reporting and Prior Authorization processes by consolidating and sending bulk requests from multiple Providers to multiple Payers.

PR-8b. Are there ways to consolidate or “dually-purpose” payer and provider interoperability and quality reporting requirements to achieve efficiencies without losing program efficacy and if so, what recommendations do stakeholders have?

Create unified measure sets and timelines for payer and provider reporting to avoid duplication. Aligning MIPS, ACO, and Medicaid reporting around unified FHIR resources and schedule harmonization. Australia’s national dashboard strategy simplifies this for providers.

Privacy & Cybersecurity

PR-9b. How might CMS balance patient privacy with convenience and access to digital health products and services that may lead to significant improvements in health?

Require consent management with tiered access levels that is made available to consumers via an App or HIE platform that consolidates all their health data and consents for sharing. Use consent management platforms integrated into Patient Portals with patient education campaigns and multi-factor authentication protocols.

TD-3b. How would requiring digital identity credentials (for example, CLEAR, Login.gov, ID.me, other NIST 800-63-3 IAL2/AAL2 CSPs) impact cybersecurity and data exchange?

Improved data security using stronger authentication as digital credentials offer MFA reducing unauthorized access and minimizes fraud, reducing identity theft risk. Increases trust across organizations with a federated identity system, HIEs and healthcare providers do not need to re-verify identity across systems. Enables seamless, trusted data sharing across healthcare systems.

Empower patients with more control and access, for instance improve consent authorization and management; Digital IDs allow for digitally signed consent from patients for data sharing.

Streamline operations and regulatory compliance for HIEs and Providers, by lowering administrative burden by eliminating the need to maintain and verify separate login systems per organization. Improve accountability with clear audit trails for data access improving compliance with HIPAA and 21st Century Cures Act. Patients could access multiple portals with one secure digital ID if standardized across the industry.

Access to digital ID tools must be inclusive, not everyone has smartphones or government IDs, the solution must include support for rural and underserved communities with offline identity provisioning. Systems must support federated identity protocols (SAML, OAuth) to prevent integration challenges. Privacy design: Centralized ID systems must be implemented with strict controls by trusted custodians like HIEs to avoid surveillance or overreach.

Alignment with CMMI Strategy

Strategic Pillars Commentary:

SYNCRONYS HIE fully supports the CMMI pillars of prevention, empowerment, and competition. We are developing health related social needs data integrations and have in our HIE Roadmap to implement a Patient portal and mobile access tools to help patients access their HIE health data, view and manage their health and chronic conditions, while supporting providers through shared savings models, providing population health dashboards and metrics for supporting value base payment models and prospective analytics.

Thank you for requesting information on the interoperability ecosystem. We look forward to seeing how the input from the many constituents in this space is used to enhance patient experiences with healthcare and improve the health of our nation.

Sincerely,

A handwritten signature in cursive script, reading "Teresa L. Stewart". The ink is dark and the signature is fluid, with a large initial 'T' and 'S'.

Teresa L. Stewart

CEO and President