



**NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE**
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Acting Health Commissioner

June 16, 2025

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via electronic submission: [Regulations.gov](https://www.regulations.gov)

Re: Request for Information (RFI) on Health Technology Ecosystem (FR Doc. 2025-08701)

Centers for Medicare & Medicaid Services (CMS)
Assistant Secretary for Technology Policy (ASTP)/Office of the National
Coordinator for Health Information Technology (ONC) (collectively, ASTP/ONC)
Department of Health and Human Services (HHS)

Dear CMS and ASTP/ONC Leadership,
The New York City Department of Health and Mental Hygiene (the NYC Health Department) appreciates the opportunity to submit comments in response to the joint Request for Information (RFI) on the [Health Technology Ecosystem](#). We commend the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary for Technology Policy (ASTP) for initiating this critical dialogue on the future of digital health ecosystem.

As the nation advances toward a more integrated, interoperable, and equitable digital health environment, it is imperative that public health agencies particularly those serving complex, high-density jurisdictions are equipped with the resources and frameworks necessary to participate fully. Our agency remains committed to collaborative, cross-sector strategies that elevate public health as a core component of the national health technology ecosystem.

In our comments, we highlighted several priorities:

Advancing digital equity through improved usability, affordability, language access, and digital literacy, particularly for historically underserved communities—supported by investments in community health workers and public health infrastructure.

Mitigating risks related to information blocking and digital identity by promoting standardized, transparent consent practices and ensuring appropriate oversight of third-party applications—while reinforcing providers with dedicated funding, technical assistance, and practical toolkits.

Expanding USCDI standards to reflect the social and structural determinants of health and embedding public health and community-level data into value-based care models to reduce reporting burden and enhance quality outcomes.

As emerging technologies and private-sector innovation accelerate, it is essential that public health agencies are not sidelined. Without sustained investment, clear governance, and structured input channels, the public health

perspective risks being marginalized within the broader health technology conversation. We urge CMS and ASTP to ensure that public health voices—especially those representing large jurisdictions—are meaningfully engaged and resourced as this ecosystem evolves.

Here are our specific comments:

Section B - Patient and Caregivers (PC)

PC-5. What can CMS and its partners do to encourage patient and caregiver interest in these digital health products?

PC-6. What features are most important to make digital health products accessible and easy to use for Medicare beneficiaries and caregivers, particularly those with limited prior experience using digital tools and services?

PC-11. How are health information exchanges (HIEs) currently helping to advance patient access to health information in the real world?

- a. How valuable, available, and accurate do you find the data they share to be?
- b. What changes would you suggest?
- d. 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, TECCA, private exchange networks, etc.)

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?

PC-14. Regarding digital identity credentials (for example, CLEAR, Login.gov, ID.me, other NIST 800-63-3 IAL2/AAL2 credentialing service providers (CSP)):

- a. What are the challenges today in getting patients/caregivers to sign up and use digital identity credentials

PC-5 and PC –6 Comments: The NYC Health Department recommends that CMS prioritize strategies that make digital health tools more accessible to underserved communities. This is a significant opportunity to address critical issues such as language access, health literacy, and overall usability of digital platforms in NYC.

Language Access: Ensure digital health tools support multiple languages and culturally appropriate information.

App Usability: Applications should be designed to be intuitive and accessible for users with limited technological skills, particularly for older populations.

Drawing on fifteen years of experience with our NYC REACH program—where we have empowered providers serving predominantly lower-income and underserved communities through patient-focused technology—we have witnessed firsthand the critical need for direct, personalized assistance. Feedback from both patients and providers underscores that successful technology adoption requires more than just

user-friendly design; it calls for proactive, everyday guidance. We therefore urge CMS to financially support the deployment of Community Health Workers or equivalent roles. These professionals can offer crucial hands-on support, help patients navigate digital tools, and accelerate technology adoption, particularly among those with limited digital literacy.

Affordability: Ensuring the affordability of digital health devices is vital for nonprofit organizations and underserved populations, as universal access to these technologies cannot be assumed. Many individuals depend on public resources—such as libraries, businesses, and community networks—for reliable access to digital health tools.

CMS should implement strategies that effectively address both financial and infrastructural barriers to technology adoption. Thus, engaging directly with community insights will help CMS develop policies that promote digital health adoption across diverse populations.

PC- 11 (a) Comments: The NYC Health Department has observed a significant variability in the quality, availability, and accuracy of the data shared, largely depending on the provider, EHR vendor, or HIE involved. To ensure uniformly high-quality data, we recommend several strategies:

Enhance EHR Vendor Accountability: Our experience implementing EHR systems across 1,000 providers in NYC indicates that vendors can and should do more to ensure proper data mapping and comprehensive provider training, thereby improving interoperability.

Strengthen Local-Level Partnerships: Collaboration with local accountability partners—such as NYC REACH, which understands both the providers and the local context—can play a crucial role in addressing these inconsistencies.

Improve Data Readability: Although some HIEs provide valuable information, many have yet to optimize their data for human readability. Addressing this issue would further improve the utility of the shared data.

PC- 11 (b) Comments:

Patient-Facing Portals: Encourage local HIE like Regional Health Information Organizations (RHIOs) to provide patient-facing portals that centralize clinical information. For example, leveraging the SHIN-NY (statewide HIE) could offer a unified, accessible platform.

Privacy-by-Design: Adopt strong privacy-by-design practices so that systems build in data minimization measures automatically.

Minimum Necessary Access: Implement strict controls to ensure that only the minimum necessary information is shared or accessed.

De-Identification: Regularly evaluate de-identification processes using statistical privacy guidelines and consider synthetic data methods to effectively mitigate re-identification risks.

Secondary Use Controls: Establish robust controls to monitor and restrict secondary uses of patient information accessed through HIEs.

Foundational Privacy: Recognize privacy as a foundational element in the design of HIEs and formalize it through standardized data privacy and security language in all HIE-related agreements.

Ethical, Privacy, and Security Protocols: Develop and integrate comprehensive ethical, privacy, and security protocols for patient matching to ensure accuracy and protection of patient information.

Mobile and Broadband Accessibility: Embrace a mobile-first design approach to ensure that those who do not use traditional computers still have access to digital health tools.

Align digital health initiatives with broader strategies that promote broadband and wireless access.

Patient and Provider Engagement and Technical Assistance: Increase funding and partnerships to boost patient and provider awareness of available tools. Initiatives should include clear guidance on accessing, interpreting, and using digital health information, such as sharing records securely and integrating data into patient-chosen apps.

Expand technical assistance programs—drawing on models from initiatives like Meaningful Use and QPP—that include webinars, toolkits, and other supportive resources.

Infrastructure and Federal Funding: Advocate for dedicated federal funding to support HIEs in building and maintaining the necessary infrastructure, managing digital health products on an ongoing basis, and conducting evaluations to measure effectiveness.

PC- 11 (d) Comments: While broader frameworks such as vendor health information networks, TEFCA, and private exchange networks are vital for national-level data sharing, local HIEs maintain a critical, complementary role. Their agility and responsiveness enable them to address the unique needs and nuances of their communities. For example, a regional HIE serving New York City can tailor its development and features to meet the specific challenges and requirements faced by local providers, patients, and the broader healthcare ecosystem. This localized focus not only enhances data usability and integration for community stakeholders but also strengthens the overall continuum of care by bridging standardized national initiatives with on-the-ground realities.

PC-13 Comments:

To enhance the reporting mechanism without adversely impacting data exchange, particularly within clinic operations, we suggest several key changes:

Stronger Access Controls: CMS should implement enhanced access control requirements for patient information subject to the information blocking rule. This will help ensure that data is accessed only by authorized parties while safeguarding patient privacy.

Standardized Informed Consent Procedures: Developing a clear, standardized informed consent process is critical. Patients must be thoroughly informed about the information blocking rule and understand their rights, thereby fostering trust and transparency.

Investment in Privacy-Enhancing Technologies: We further encourage CMS to allocate funding toward the development and implementation of advanced privacy-enhancing technologies. These tools would facilitate compliance with the information blocking rule while ensuring that patient data remains secure.

PC-14 Comments: A primary challenge for agencies like the NYC Health Department is integrating third-party digital identity tools (such as CLEAR, Login.gov, ID.me, and other NIST 800-63-3 IAL2/AAL2 credentialing service providers) with existing information systems. All external tools must first receive IT approval, and the NYC Health Department must establish legally binding agreements with tool manufacturers to ensure data privacy and security.

Key considerations include:

Enhanced Privacy Protections: These tools must incorporate privacy-by-design principles to safeguard patient data from the outset.

Minimum Necessary Access: Systems should enforce strict controls, limiting access to only the necessary patient information.

Controls on Secondary Use: Effective measures must restrict the secondary use of data accessed via these tools.

CMS Limitations: There should be adherence to CMS-imposed limitations that prevent tool manufacturers from commercially exploiting patient information.

Section C - Providers

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

PR-7. What strategies can CMS implement to support providers in making high-quality, timely, and comprehensive healthcare data available for interoperability in the digital product ecosystem? How can the burden of increasing data availability and sharing be mitigated for providers? Are there ways that workflows or metrics that providers are already motivated to optimize for that could be reused for, or combined with, efforts needed to support interoperability

PR-8. What ways can CMS or partners can help with simplifying clinical quality data responsibilities of providers?

- a. What would be the benefits and downsides of using Bulk FHIR data exports from EHRs to CMS to simplify clinical quality data submissions? Can CMS reduce the burden on providers by performing quality metrics calculations leveraging Bulk FHIR data exports?

PR-12. Should ASTP/ONC consider removing or revising any of the information blocking exceptions or conditions within the exceptions (45 CFR part 171, subparts B through D) to further the access, exchange, and use of electronic health information (EHI) as well as to promote market competition?

PR-1 Comments: To encourage providers, including those in rural areas, to leverage approved digital health products, we recommend that CMS and its partners adopt a multi-faceted support strategy that minimizes adoption burdens while enhancing patient care. Key initiatives include:

Targeted Funding and Financial Incentives: Provide dedicated funding to help providers, particularly public health clinics, safety-net facilities, and rural practices, invest in the necessary digital health infrastructure. Additionally, consider financial incentives such as seed funding or reimbursable services (e.g., a designated CPT code) to offset the costs associated with integrating digital health tools.

Technical Assistance and Tailored Training: Invest in robust technical assistance programs and targeted training modules that address the unique challenges of under-resourced providers. Drawing on the extensive experience of initiatives like NYC REACH, these programs should aim to enhance provider adoption by offering guidance on technology implementation, care coordination, and patient education—ensuring that providers feel supported throughout the transition.

Development of a Digital Health Toolkit and Curated Tool List: Develop a comprehensive digital health toolkit for providers that includes patient education materials and step-by-step guides. Moreover, establishing a short list of CMS-recommended digital health products—organized by specialty and based on key criteria such as patient-centeredness, efficacy, safety, privacy, and innovative use of AI—will simplify the selection process and reduce information overload.

Enhancing Awareness and Patient Engagement: Expand efforts to build awareness among both providers and patients regarding the benefits of these digital tools. Training should not only cover how to integrate these systems into clinical workflows but also how to educate patients on accessing and effectively utilizing these resources to manage their care.

PR – 7 Comments:

Enhance EHR Certification for Data Quality and Transparency CMS should update EHR certification criteria to include robust tools that assess the quality of data exchanged through HIEs. Providers often have little insight into how effectively they are sharing data or which documentation practices inhibit interoperability. For example, a real-time dashboard could report metrics such as: “100% of your lab results are accessible via FHIR, portal, and HIE; only 20% of your problem lists are available because SNOMED terminology isn’t fully utilized.” This type of feedback would empower providers to adjust documentation practices to optimize data quality and interoperability.

Strengthen Local Support Through Community Partners Recognizing the challenges faced by providers serving underserved populations, CMS should allocate funds to support local community partners—such as Community Health Workers, community-based organizations, and technical assistance vendors. These partners can play a critical role in helping providers enhance data

quality and capture, especially on local HIE systems. By integrating local support, providers can receive expert guidance without bearing the full brunt of administrative or technical burdens.

Introduce Financial Incentives for High-Quality Data Sharing Existing programs like MIPS have proven insufficient as both a carrot and a stick, particularly for small practice providers. CMS could launch targeted financial incentives that reward providers for contributing high-quality, comprehensive data to HIEs. By aligning these incentives with existing clinical and operational metrics, providers would be motivated to integrate data quality improvements into their everyday workflows, all while minimizing additional administrative overhead.

Hold EHR Vendors Accountable with Clear, Transparent Metrics EHR vendors should be required to provide user-friendly dashboards that track the flow and quality of data across digital systems. These dashboards would allow providers to see, at a glance, how effectively their data is being exchanged, identify issues in real time, and communicate directly with vendors for timely resolutions. Additionally, vendors need to invest in robust educational initiatives that ensure providers fully understand the interoperable features of their systems and how to optimize them.

Interweaving with Existing Workflows and Metrics These strategies can be integrated into workflows that providers already prioritize. For instance, many practices track quality metrics, utilization statistics, and reporting outcomes. By embedding data-sharing performance metrics into these familiar dashboards, the transition toward improved interoperability can occur without imposing additional burdens on providers. This dual-purpose approach not only facilitates better interoperability but also reinforces routine clinical quality improvement efforts.

PR-8 comments

Leveraging Bulk FHIR Data Exports for Clinical Quality Submissions Bulk FHIR data exports from EHRs offer a promising path to simplifying clinical quality data responsibilities for providers. Centralizing quality metric calculations at the CMS level could significantly reduce the administrative burden on providers, lead to increased accuracy of quality data and measurements, and streamline the submission process. By shifting computation and data curation to a centralized authority, providers can focus more on patient care rather than on technical documentation challenges.

Benefits and Downside Considerations

Benefits:

Increased Accuracy: Centralized calculations reduce the variability and errors that often arise from fragmented reporting systems.

Ease of Submission: Providers would no longer need to navigate complex internal reporting workflows; instead, a bulk data transmission could serve multiple validation and submission purposes.

Enhanced Data Comparability: Standardizing data extracts promotes uniform calculation of quality measures across different systems and practice settings.

Downsides:

EHR Configuration Challenges: Many providers struggle with current EHR configurations. Shifting to bulk data exports will necessitate significant refinements to ensure that all pertinent data are captured accurately.

Training and Quality Assurance: A steep learning curve associated with configuring, validating, and maintaining bulk data exports means robust training programs and ongoing quality assurance mechanisms will be crucial.

Data Integrity Risks: Incomplete or misconfigured data exports could lead to inaccurate quality measure reporting, potentially compromising the integrity of the data and the credibility of reported outcomes.

Enhancing Technical Assistance and Support: Drawing on nearly two decades of insights from initiatives like the NYC REACH program, successful quality data submission requires more than just a technical fix. Providers need comprehensive support in:

EHR Configuration and Data Capture: Optimal performance hinges on well-configured systems, proper documentation practices, and reliable local HIE interactions.

Provider Training: Hands-on training and continuous learning support are essential, as the evolving nature of EHR systems and quality reporting standards may introduce periodic changes that challenge existing workflows.

Long-Term Technical Assistance: During significant transitions or major updates, timely TA is critical. Both financial support and dedicated technical assistance are indispensable to ensure providers can maintain high data quality standards over the long term.

Integrating Artificial Intelligence and Accountability for EHR Vendors CMS should also consider the integration of artificial intelligence to further support clinical quality data efforts. AI has considerable potential to:

Align Measures: AI-driven tools can help synchronize quality measures across disparate systems, ensuring consistency in how data is captured and reported.

Improve Documentation: Intelligent analysis can aid providers in understanding the nuances of documentation practices that affect quality metrics, recommending changes that optimize data capture.

Enhance Vendor Accountability: Mandating that EHR vendors integrate clear, user-friendly dashboards and provide proactive communication channels can ensure that data flows are transparent. CMS and partners should hold vendors accountable for the responsible adoption of AI technologies, ensuring that such tools are used effectively and ethically.

PR-12 comments: CMS should modify the information blocking rule to include carve-outs and support mechanisms for public health departments, FQHCs, and public health clinics. Given the unique challenges these organizations face with rapid data exchange and complex local circumstances, tailored exemptions are necessary to avoid inadvertently penalizing resource-constrained entities. CMS should also fund EHR upgrades, enforce stronger access controls on patient information, establish a standardized informed

consent process (recommend including language that consent is not required by law for public health activities by public health authorities), and invest in privacy-enhancing technologies to ensure compliance while maintaining effective data sharing.

Section E – Technology Vendors, Data Providers, and Networks (TD)

TD-7. To what degree has USCDI improved interoperability and exchange and what are its limitations?

TD-9. Regarding certification of health IT:

- a. What are the benefits of redefining certification to prioritize API-enabled capabilities over software functionality?

TD- 7 Comments: We recommend that CMS conduct a thorough evaluation of USCDI’s effectiveness in advancing interoperability. While USCDI has spurred progress in data sharing across clinical and public health systems, critical gaps remain—especially in capturing essential public health data. To address these limitations, we urge the following:

Expand USCDI Scope: Include key data elements such as social determinants of health (SDOH), community-level metrics, and other contextual factors that directly influence health outcomes.

Enhance Health-Related Social Needs: Improve processes for collecting and integrating health-related social needs (HRSN) data. Providers should receive support to implement interoperable HRSN screenings as prescribed by USCDI standards.

Accountability for EHR Vendors: Despite the removal of SOGI requirements in CEHRT, EHR vendors must be held accountable for ensuring their systems capture critical public health indicators accurately and facilitate seamless data exchange.

TD –9 Comments:

Cost Implications: Ensure that adopting open standards does not increase costs for local health agencies or impose undue financial burdens on the public sector.

Risk of Vendor Influence: Guard against vendor-driven standards that might exclude open-source or locally innovative solutions. CMS should adopt balanced, inclusive criteria to promote diverse technological contributions.

Certification Criteria for API Vendors:

Enhanced Privacy Protections: Require privacy-by-design implementations.

Access Controls: Ensure that APIs limit access to only the minimum necessary information.

De-identification Procedures: Evaluate de-identification methods for re-identification risk, including the use of statistical privacy guidelines and synthetic data.

Secondary Use Controls: Impose effective restrictions on secondary data uses.

Foundational Privacy: Privacy should be a foundational design element of APIs.

Standardized Agreements: Use uniform data privacy and security language in contracts with API manufacturers.

Ethical Protocols: Establish ethical, privacy, and security standards for patient matching.

Commercial Use Limits: Impose comprehensive limitations on the commercial use of patient information.

Section F – Value-based Care Organizations (VB)

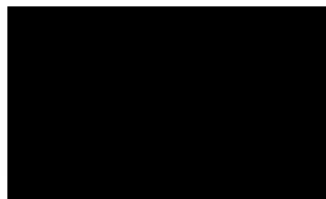
VB-11. What specific interoperability challenges have you encountered in implementing value-based care programs?

VB-11 Comments: The NYC Health Department urges CMS to address IT system fragmentation that hampers seamless care coordination under value-based care (VBC). Public health data and community health metrics must be integrated into shared care planning and analytics tools so that VBC measures capture both clinical outcomes and broader population health indicators, including social determinants of health.

Current VBC measurement often depends on chart reviews and manual data submission. This approach undermines accuracy and efficiency, especially for safety net and smaller practices with limited interoperability. CMS should simplify and streamline data transmission for VBC, supporting providers through funding for technical assistance vendors.

Finally, technology should not only measure quality and cost but also enhance care coordination and navigation. Incorporating provider feedback into interoperability efforts is essential to ensure that digital tools effectively support coordinated care across the healthcare ecosystem.

The NYC Health Departments remains committed to advancing a more interoperable and equitable healthcare system and we thank you for the opportunity to comment on this RFI.



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