February 24, 2026

VIA Electronic Submission to http://www.regulations.gov/

Thomas Keane, MD, MBA
Assistant Secretary for Technology Policy and the Office of the National Coordinator for Health Information Technology,
Department of Health and Human Services,
Mary E. Switzer Building
7033A, 330 C Street SW,
Washington, DC 20201

Re: Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions To Unleash Prosperity [RIN 0955–AA09]

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent over 15,100 long term and post-acute care (LTPAC) facilities, or 1.1 million skilled nursing facility (SNF) beds and over 300,000 assisted living (AL) beds. With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living communities as well as residences for individuals with intellectual and developmental disabilities (ID/DD). We appreciate the opportunity to comment on the *Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions To Unleash Prosperity* proposed rule.

We appreciate ASTP/ONC's efforts to streamline certification requirements and reduce regulatory burden. However, we have significant concerns that several proposed removals and revisions may disproportionately impact skilled nursing facility (SNF), assisted living (AL) and intermediate care facilities (ICF) providers and the vulnerable populations they serve, particularly given the foundational role that certification criteria play in ensuring baseline capabilities for cross-setting care coordination. We are eager to work with CMS and the Assistant Secretary for Technology Policy Office of the National Coordinator for Health Information Technology (ASTP/ONC) in identifying a pathway to finding solutions that are attainable to all stakeholders across the information health technology ecosystem. If you have questions about any of our comments, please contact Daniel Ciolek at dciolek@ahca.org.

Sincerely,

Daniel E Ciolek
Associate Vice President, Therapy Advocacy

Summary of Key Recommendations:

AHCA/NCAL recommends that ASTP/ONC:

- **Retain or phase in more gradually** the removal of privacy and security certification criteria, establishing clear baseline expectations for vendor capabilities that protect vulnerable populations served by our members.

- **Maintain transitions of care and clinical information reconciliation criteria critical** for cross-setting handoffs and medication safety.

- **Preserve patient engagement features** including view, download, and transmit (VDT) and patient health information capture that support resident and family caregiver involvement.

- **Ensure AI-enabled decision support transparency** through meaningful oversight mechanisms for algorithm governance and safety.

- **Clarify the impact of information blocking revisions** on LTPAC providers that participate in TEFCA and health information exchange networks rather than using certified technology.

- **Provide sufficient transition timelines and implementation guidance** for LTPAC providers and their technology vendors.

- **Develop model contract language** that LTPAC providers can use in vendor agreements to ensure essential capabilities remain available when certification requirements are removed.

Cross-Cutting Concern: LTPAC-Specific Considerations in Health IT Policy

Throughout the following comments, a consistent theme emerges:

> ***Health IT policies developed primarily for acute care and ambulatory settings often fail to account for the unique characteristics, workflows, populations, and resource constraints of LTPAC providers.***

LTPAC settings differ from hospitals and physician practices in critical ways:

- **Population characteristics:** Older adults, people with multiple chronic conditions, cognitive impairments, functional limitations, and end-of-life care needs - longer stays.
- **Care model:** Interdisciplinary team-based care involving physicians, nurses, therapists, pharmacists, social workers, dietitians, and direct care workers; heavy reliance on family caregivers.
- **Documentation and workflow:** Focus on functional status, cognitive status, behavioral health, social needs, advance care planning, and quality of life—not just acute medical conditions.
- **Regulatory environment:** Subject to unique quality reporting, survey/inspection, and reimbursement requirements (i.e., MDS, OASIS, IRF-PAI, LCDS, Hospice Item Set).
- **Health IT market:** Smaller number of vendors, lower product investment, slower innovation cycles, higher relative cost burden.
- **Facility size:** Unlike most hospitals and health systems with a large patient population and multiple lines of healthcare business that can contribute to more coordinated HIT integration – nursing homes, AL residences, and ID/DD providers generally serve small resident populations, as low as less than ten at a time. Few nursing homes are part of an integrated health system that offers multiple lines of healthcare services, while half have an average resident census of less than 100 people.

- **Resource constraints:** Lower margins, workforce shortages, rural/underserved locations, limited IT staff, and available and affordable IT expertise.

When certification criteria are removed without LTPAC-specific impact analysis, the result is often a **reduction in vendor support for LTPAC-critical functionalities** rather than the intended deregulatory benefit.

Our Recommendation: We urge ASTP/ONC to establish an **LTPAC Health IT Advisory Group** or formalize ongoing engagement mechanisms with LTPAC stakeholders to ensure that future health IT policies, certification requirements, standards adoption, and interoperability initiatives adequately consider LTPAC provider needs, workflows, and populations. This group could provide input on:

- USCDI data element priorities for LTPAC settings
- FHIR implementation guide requirements for cross-setting care coordination
- Algorithm transparency and AI governance policies for vulnerable populations
- Interoperability requirements in CMS quality programs affecting LTPAC (i.e., SNF VBP, HH VBP, Hospice QRP)
- Technical assistance and implementation support needs for LTPAC providers and vendors

Who We Are and Who AHCA/NCAL Members Provide Care To

Before we can provide detailed responses to the HTI-5 proposed rule we believe it is important to share contextual information about our AHCA/NCAL provider members, the resident populations they serve, their current fragmented baseline digital capabilities, and historical financial, legislative, and regulatory barriers to initiating or accelerating the adoption of and use interoperable health information technology (HIT). We believe a critical issue that ASTP/ONC needs to consider as strategies are developed in response to the comments received to this proposed rule, is that increased HIT interoperability and adoption of AI in clinical care will remain extremely challenging if not impossible for LTPAC providers without first providing adequate support to eliminate the digital interoperability infrastructure gaps. True functional interoperability capacity across the healthcare ecosystem would provide the comprehensive information necessary to permit a secure, safe, and effective connectedness.

1. SNF/NF, AL, and ID/DD Provider Setting Profiles and the Populations of Individuals Served

Of importance, and relevant to our comments, is that unlike other healthcare facility-based provider settings that address acute and sub-acute conditions for a limited time-window, or office-based primary care and other practitioners that encounter patients intermittently, most of the individuals our members care for are long-term residents – it is their home. Except for a portion of SNF short-stay post-acute patients who require certain nursing and/or rehabilitation therapy services to return to the community, most people in nursing facilities (SNF/NF) and those in AL or ID/DD residences require residential care to manage chronic conditions reflected through physical and/or cognitive impairments.

Regarding the long-term and post-acute care (LTPAC) provider settings represented by our membership, we first describe the types of healthcare and healthcare-related services they furnish and the characteristics of the residents they serve. Next, we highlight the diversity of payor sources since a provider's reliance on fixed federal and state payors impacts a provider's capacity to assume the significant hardware, software, and administrative costs associated with interoperable digital health technology, including artificial intelligence (AI). Finally, we share information regarding the diversity of the resident population across the SNF, AL, and ID/DD provider community as a reflection of the digital health needs footprint of these residents within the HIT ecosystem.

Of the 14,742 SNFs nationwide, most serve a dual purpose as 93 percent are dually certified for furnishing Medicare and Medicaid services. As mentioned above, SNFs provide short-term post-acute services to patients

who require skilled nursing and/or rehabilitation services on an inpatient basis. Additionally, SNF's/NFs furnish long-term care for residents requiring 24/7 care due to various medical, mobility, activities of daily living, cognition, and behavioral challenges that cannot be addressed adequately in the community. Health care services from various professions may be furnished to residents in the facility, at the offsite office or facility, or via telehealth and remote patient monitoring (RPM) technology. While a small number of SNFs serve pediatric populations, the vast majority serve adults with chronic conditions and related disabilities, for adults over the age of seventy-five. Overall, Medicaid accounts for sixty-three percent of SNF residents while private and other payers represent twenty-three percent, and traditional fee-for-service (FFS) Medicare only fourteen percent.[1]

According to the MedPAC March 2025 Report to Congress[2], SNF facilities range from small to large organizations and operate on minimal net margins:

- **The SNF all-payer profit margin in 2023 was 0.4 percent (negative 1.3 percent in 2022).**
- **The median SNF had 100 beds, while ten percent of facilities had 176 or more beds and ten percent of facilities had 50 or fewer beds.**

There are over 32,000 AL communities that serve older individuals or those with limited disabilities who typically need help with everyday activities and some health care services but do not require 24-hour skilled nursing services for extended periods of time[3]. These communities offer a unique mix of companionship, independence, privacy, and security in a home-like setting. The philosophy of assisted living is built on the concept of delivering person-centered care and services to each individual resident. Some assisted living communities specialize in serving individuals with specific needs. These may include, but are not limited to, Alzheimer's disease or other forms of dementia (such as memory care units), intellectual and developmental disabilities, and particular medical conditions (e.g., Parkinson's disease) or other needs. AL communities do not directly provide certain health care services, such as physical therapy or pharmacy, but work with other providers to offer these services.

- **AL services are not included in Medicare benefits, and Medicaid does not cover AL room and board, so most costs are private-pay, with only one in five residents being eligible for Medicaid home and community-based services (HCBS) such as personal care and supportive services.**
- **Forty-three percent of AL residents are small and serve 4-10 residents at a time, while only ten percent have 100 or more residents.**

There are also over 5,300 ID/DD residences, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) serving over 56,000 residents of all ages daily, with over seventy-five percent being between the ages of 22 and 65[4]. Many of these individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above. ICFs provide active treatment and services for people with significant support needs. They offer 24-hour supervision, health care, therapies, activities, and training intended to maximize residents' autonomy and independence.

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[1] *A Look at Nursing Facility Characteristics in 2025*. KFF. https://www.kff.org/medicaid/a-look-at-nursing-facility-characteristics/ [accessed February 11, 2026]

[2] March 2025 Report to Congress: *Medicare Payment Policy: Chapter 6: Skilled Nursing Services*. Medicare Payment Advisory Commission. https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/ [accessed February 11, 2026]

[3] Assisted Living Facts & Figures. AHCA/NCAL. https://www.ahcancal.org/Assisted-Living/Facts-and-Figures/Pages/default.aspx [accessed February 11, 2026]

[4] AHCA/NCAL internal analysis of the following public and proprietary data sources: A-Certification and Survey Provider Enhanced Reporting (CASPER) data. B-Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES). C-IMPLAN Group LLC, IMPLAN System (data and software)

- **Virtually all funding for ID/DD residents is under Medicaid benefits.**
- **The average number of beds per residence is 14, ranging from 9 for private ID/DD residences to 52 for public residences.**

2. Digital Capabilities Across SNF/NF, AL, and ID/DD Provider Settings

A sizable portion of AHCA/NCAL member care providers are directly tied to the healthcare information exchange ecosystem whether reimbursed by federal, state, commercial, or private health coverage. Many payer quality- and value-based payment models – including long-term care-focused Medicare fee-for-service (FFS) Accountable Care Organizations (ACO), bundled payment models such as the Transforming Episode Accountability Model (TEAM), and the Medicare Advantage (MA) Institutional Special Needs Plan (I-SNP) model of care – involve integrated care across care providers. This would be significantly enhanced by improved digital interoperability capabilities that can efficiently leverage critical health information across all provider types involved with resident care.

All the care provider settings represented by our membership have access to and store Personal Health Information (PHI). Of these, many store this information electronically to varying degrees and generally have limited interoperable connectivity in the current digital health technology ecosystem. The variations in digital capabilities across our LTPAC provider membership is directly the result of historical federal prioritization of hospital inpatient and primary care interoperability support through the implementation of the Health Information Technology for Economic & Clinical Health (HITECH) Act of 2009 and in subsequent coordinated care, bundled care, and other integrated care value-based payment models advanced by CMS. Since LTPAC providers were not specifically identified in the HITECH Act, the federal administrative support necessary to facilitate seamless secure interoperable electronic exchange of patient information between providers, and to the patient, particularly at transitions of care, has been quite limited. Additionally, bundled incentive programs have not historically included mechanisms to ensure that the bundle holder shares incentive payments to partner SNF, AL, and ID/DD providers to support investment in interoperable technology capabilities. Moving forward, the lack of explicit recognition and scaling of SNF, assisted living, and ID/DD setting challenges in federal interoperability and information blocking regulatory guidance not only creates compliance uncertainty for providers, but also discourages vendors from developing and tailoring AI tools for these settings—reinforcing a cycle of market neglect for LTPAC care environments.

In the absence of a federal coordinated effort to support HIT integration, LTPAC providers that have adopted electronic health technologies have often developed internally or obtained commercially non-standardized HIT, including electronic health records (EHR) to support setting-specific clinical and operational activities. In addition to EHR systems, many of the SNF, AL and ID/DD providers in our membership utilize other digital technologies to support resident care. Telehealth technologies are used to expand beneficiary access to care and reduce unnecessary hospitalizations. Remote patient monitoring (RPM) and sensor technologies can provide valuable information to improve resident safety and more timely and effective care interventions. Clinical decision support systems (CDSS) including AI- driven analytics help to improve treatment decisions and outcomes. Resident care management activities are also supported by tools for purposes such as electronic nursing documentation, medication administration, incident reporting and quality assurance, and resident engagement tools such as patient portals and apps. Moreover, HIT tools are also used to facilitate communication with various internal and external clinical support services including pharmacy, laboratory, radiology, rehabilitation therapy professionals, and for administrative purposes such as scheduling, claim processing, compliance programs and more.

However, the current digital ecosystem for many of these technologies today is fragmented and interconnectivity – when present – is commonly built upon customized non-standardized digital ‘work arounds.’ This fragmentation is a significant barrier to attaining the level of effective interoperable digital capabilities needed to

support patients, families, and other caregivers in making informed health decisions, and for provider stakeholders to improve health outcomes.

For example, as recently as December 23, 2023, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within HHS published a report titled *Health Information Technology Adoption and Utilization in Long-Term and Post-Acute Care Settings*[5] which found that most LTPAC providers, including SNFs, have generally adopted EHRs to support clinical and business needs at a rate comparable to hospitals and primary care providers, but adoption of EHRs in residential care settings such as AL and ID/DD is limited.

> ***"Yet despite the lack of a federally-funded program and policy requirements, estimates of EHR adoption rates among nursing home and SNF providers, as well as HHAs, were greater than 78% in 2018, which is on par with EHR adoption in office-based primary care settings. Residential care settings were estimated to be much lower overall, at 26% -- higher than that for larger facilities and much lower for small facilities."***

However, the authors also emphasized that interoperable exchange of health information is not routine or widely used. In other words, LTPAC providers utilize their internal EHR, but modernization to improve interoperability capabilities remains slow without focused and realistic policy levers. Despite barriers, the authors concluded that there are opportunities for emerging policies to support secure interoperability in LTPAC.

The breadth of this digital divide was reflected in a recent May 2024 ONC Data Brief titled *Interoperable Exchange of Patient Health Information Among U.S. Hospitals: 2023*[6].

> **Specifically, ONC indicated that only <u>17 percent</u> of hospitals can routinely send interoperable health information to LTPAC providers and only <u>8 percent</u> of hospitals were able to routinely receive such information from LTPAC providers.**

We appreciate the recent ONC efforts in late 2023 in launching the Trusted Exchange Framework and Common Agreement (TEFCA) to enable nationwide health information exchange that could provide opportunities for LTPAC providers with nonstandard health IT to exchange information interoperably through a Health Information Exchange (HIE). However, many smaller and under resourced providers indicate that current HIE participation is cost prohibitive. In addition, an August 2024 Health Affairs Scholar article titled *The state of health information organizations and plans to participate in the federal exchange framework*[7] has revealed that this alternative method for information exchange will likely be insufficient to resolve the interoperability gap for LTPAC providers as 32 percent of the current Health Information Organizations (HIOs) that could facilitate this information exchange through their HIEs have indicated they may not participate in TEFCA. As the authors summarized,

> ***"While TEFCA appears to have successfully engaged the majority of HIOs, achieving nationwide exchange will require policy efforts to either attract the remaining HIOs or ensure that nonparticipating HIOs' providers have another option for TEFCA participation."***

Another barrier to interoperable HIT adoption in some LTPAC providers is the lack of adequate high-speed internet infrastructure in specific geographic locations. For example, KFF Health News recently published a

[5] Health Information Technology Adoption and Utilization in Long-Term and Post-Acute Care Settings. Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health & Human Services by RTI International. December 2023.

[6] Interoperable Exchange of Patient Health Information Among U.S. Hospitals: 2023. Office of the National Coordinator for Health Information Technology (ONC). May 2024.

[7] Jordan Everson, Wei Chang, Vaishali Patel, Julia Adler-Milstein, the state of health information organizations and plans to participate in the federal exchange framework, *Health Affairs Scholar*, Volume 2, Issue 8, August 2024

report[8] that included a national map, by county, where there is broadband 'deserts' where providers who may be motivated to deploy interoperable HIT to improve the quality of care cannot do so.

Finally, with increased digital interconnectedness necessary to support comprehensive interoperable EHR, AI and other digital technology in LTPAC settings, and improvements in patient access to their digital healthcare information, the risk for cybersecurity breaches increases and will require additional investments in financial and personnel resources to manage and to establish and maintain emergency plans during digital blackouts including emergency backups for data recovery, and manual procedures to assure resident safety and care quality is maintained at times when the digital information is offline.

Since the enactment of the HITECH Act, AHCA/NCAL, other LTPAC Associations and the LTPAC Health IT Collaborative[9] have commented on various Agency HIT interoperability programs and have sought the support of HHS both in funding and policy. HHS has provided limited support to support secure HIT interoperability and cybersecurity infrastructure within the constraints of the current statutory framework, but we believe more is necessary. Unlike large health systems with dedicated IT departments and capital reserves, most LTPAC providers lack the staffing and financial capacity to engage in complex, enterprise-style procurement processes, underscoring the need for direct infrastructure support rather than adopting poor fitting HIT designed for hospitals.

Comments on Specific Provisions of the HTI-5 Proposed Rule

1. Removal of Privacy and Security Certification Criteria (§ 170.315(d))

AHCA/NCAL Recommendations:

We urge ASTP/ONC to retain core privacy and security certification criteria or, at minimum, establish clear guidance on alternative mechanisms through which LTPAC providers can verify that health IT vendors meet baseline security expectations. If removal proceeds, we recommend:

- Publishing comprehensive guidance on how LTPAC providers should evaluate vendor security capabilities in the absence of certification requirements, including model language for vendor agreements and Business Associate Agreements (BAAs) addressing privacy and security requirements, audit trail preservation, breach notification obligations, and data use restrictions.
- Clarifying how HIPAA Security Rule requirements apply to health IT vendors when privacy and security certification criteria are removed and providing guidance on contractual provisions that ensure vendor compliance with applicable federal security frameworks, especially given that vendors may not be direct HIPAA covered entities.
- Requiring vendors to maintain transparent documentation of security controls and testing results accessible to prospective LTPAC purchasers.
- Establishing a voluntary security attestation framework that vendors can use to demonstrate HIPAA Security Rule compliance.
- Extending the effective compliance dates to allow adequate time for LTPAC organizations to update procurement policies and vendor contracts, recognizing that small, rural, under-resourced, and Medicaid-reliant LTPAC providers often lack dedicated legal and IT security expertise to negotiate complex vendor agreements.

Discussion:

[8] Dead Zone. KFF Health News. May 31, 2025. https://kffhealthnews.org/dead-zone/
[9] LTPAC Health IT Collaborative: https://www.ltpachit.org/

The proposal to eliminate all privacy and security certification criteria (pp. 60989-60990) creates substantial uncertainty for LTPAC providers regarding baseline security expectations for certified health IT. While ASTP/ONC asserts that HIPAA Security Rule and other federal frameworks provide sufficient coverage, the removal of these certification requirements eliminates a critical verification mechanism that LTPAC providers have relied upon when evaluating and procuring health IT systems.

LTPAC settings serve highly vulnerable populations—including residents with cognitive impairments, complex medical needs, and limited ability to advocate for their own privacy rights. These populations are at heightened risk for privacy breaches and identity theft. The certification criteria provided LTPAC providers with assurance that vendors had demonstrated baseline technical capabilities for authentication, access control, auditing, encryption, and integrity protection.

The removal of audit trail, authentication, access control, and integrity certification requirements eliminates critical capabilities for investigating security breaches, validating data provenance for secondary use (quality reporting, legal proceedings, regulatory compliance), and protecting vulnerable residents. LTPAC providers were excluded from HITECH Act funding and current Promoting Interoperability programs, resulting in persistently low certified health IT adoption and limited resources to independently assess and negotiate vendor security capabilities.

When privacy breaches occur, providers cannot track or support investigations without robust audit functions. The removal also lowers barriers to entry for new vendors that may offer insufficient baseline protection. This may shift the burden of ensuring security capabilities entirely to contractual negotiations where LTPAC providers have limited leverage. For example, it is unclear whether the proposed reduced vendor requirements might open the door for a third party seeking modification (including bots) to bypass an organization's authorized user authentication process, or HIPAA protection requirements for sensitive data, and to access or overwrite health information without the provider being to identify through an audit trail that the third party performed such action(s). Existing vendors who have already invested in these security capabilities will likely retain them, but new market entrants will face no requirement to build these protections. One approach to partially mitigate this would be to address AI transparency in HL7 so that any time AI interacts with the provider's EHR, such interactions must be included in the audit trail.

If ASTP/ONC proceeds with removal of the privacy and security certification criteria at (§ 170.315(d)) as proposed, we recommend, at minimum, that ASTP/ONC establish clear guidance on alternative mechanisms through which LTPAC providers can verify that health IT vendors meet baseline security expectations.

2. Revisions to Transitions of Care and Clinical Information Reconciliation (§ 170.315(b)(1) and (2))

AHCA/NCAL Recommendations:

We urge ASTP/ONC to retain the clinical information reconciliation and incorporation criterion and strengthen—rather than weaken—the transitions of care requirements to ensure that:

- Structured, computable data elements (i.e., medications, allergies, problems, procedures, immunizations) are transmitted and reconciled across care settings.
- LTPAC-relevant data elements are included in standardized transition summaries and standardized medication profiles. The HL7 PACIO FHIR Workgroup is finalizing and preparing for release of the balloted HL7 Transition of Care Standard for Trial Use FHIR Implementation Guide including a USCDI-compliant transition of care dataset. Similarly, PACIO has developed standardized medication profile specifications to support medication reconciliation. Lack of funding for mandatory certification has resulted in these standards remaining in voluntary certification pathways with low adoption rates.

- ASTP/ONC provide assistance with awareness and adoption of the PACIO-developed transitions of care and medication reconciliation standards by all certified EHR vendors. Certified vendors serving acute and ambulatory settings must be required or incentivized to adopt LTPAC-relevant standards to enable bi-directional data exchange.

Discussion:

The proposed removal of the clinical information reconciliation and incorporation criterion (§ 170.315(b)(2)) effective January 1, 2027 (pp. 61018-61020) directly threatens patient safety in LTPAC settings. Care transitions—particularly from acute care hospitals to skilled nursing facilities, long-term care facilities, home health, and hospice—are high-risk events where medication errors, missing clinical information, and incomplete reconciliation can lead to adverse outcomes, readmissions, and mortality.

LTPAC providers were excluded from HITECH Act funding and current Promoting Interoperability programs, resulting in persistently low adoption of interoperability standards (including FHIR) despite sector-led standards development efforts. LTPAC providers rely heavily on the reconciliation capabilities embedded in certified health IT to ensure accurate medication lists, allergy information, and problem lists when patients transition across settings. Unlike acute and ambulatory settings where patients may have continuity with a single provider or system, LTPAC patients frequently move across multiple unaffiliated organizations and care settings, making standardized reconciliation capabilities essential.

The revision to the transitions of care criterion (§ 170.315(b)(1)) may reduce requirements for structured data exchange, potentially reverting to unstructured document-based approaches that increase manual reconciliation burden and error risk.

If ASTP/ONC proceeds with proposed revisions to the transitions of care criterion at § 170.315(b)(2) despite our objections, we request that ASTP/ONC establish clear guidance on alternative mechanisms for ensuring medication reconciliation safety and cross-setting data integrity, including model contract language that providers can incorporate into vendor agreements to require reconciliation capabilities and LTPAC-relevant data element support.

3. Revisions to Patient Engagement Features (§ 170.315(e)(1) and (e)(3))

AHCA/NCAL Recommendations:

We urge ASTP/ONC to:

- Retain the patient health information capture criterion (§ 170.315(e)(3)) and expand it to explicitly include family caregiver-contributed data relevant to LTPAC care (functional status observations, behavioral changes, fall incidents, pain assessments, advance care planning preferences)
- Strengthening rather than weakening accessibility requirements in the VDT criterion to ensure that patient portals and access technologies meet the needs of older adults, people with cognitive impairments, and people with disabilities.
- Clarify how the shift toward FHIR-based APIs will support family caregiver access, including proxy access mechanisms, delegation workflows, and caregiver-contributed data capture through third-party applications.
- Provide implementation guidance and technical assistance to LTPAC health IT vendors on integrating caregiver engagement capabilities.

Discussion:

The proposed revisions to view, download, and transmit (VDT) capabilities and removal of patient health information capture (pp. 60990-60992, 61020) may reduce support for patient and family caregiver access and patient-generated health data—both critical for LTPAC populations.

In LTPAC settings, "patient engagement" often means family caregiver engagement for residents with cognitive impairments, dementia, or decisional incapacity. We recognize and support ASTP/ONC's strong emphasis on app-based patient engagement tools; however, in LTPAC settings, meaningful engagement must be designed for and through family caregivers and facility staff because many residents cannot independently manage technology or use consumer apps. Family caregivers play essential roles in understanding care plans, coordinating across providers, monitoring health status changes, and contributing observations about functional decline, behavioral changes, and quality of life.

LTPAC providers were excluded from HITECH Act funding and current Promoting Interoperability programs, limiting resources to independently develop patient and caregiver engagement technologies.

The removal of patient health information capture certification requirements may reduce vendor support for caregiver-contributed data (e.g., observations, symptoms, functional assessments, goals, and preferences). The revision to VDT that removes Web Content Accessibility Guidelines (WCAG) references may reduce accessibility for older adults and persons with disabilities—the core populations served by LTPAC providers. We therefore urge ASTP/ONC to provide guidance and pilots on how app-based engagement models can be adapted for LTPAC—such as caregiver portals, proxy access, and staff-mediated applications—and to clarify how FHIR-based API strategies will support caregiver engagement and facility-mediated access, not only individual consumer apps.

If ASTP/ONC proceeds with removing view, download, and transmit capabilities and removal of patient health information capture despite our concerns, we request development of model contract language that LTPAC providers can use in vendor agreements to ensure patient and family caregiver access and patient-generated health data remains available and functional.

4. AI-Enabled Decision Support and Algorithm Transparency (§ 170.315(a)(9) and § 170.315(b)(11))

AHCA/NCAL Recommendations:

We urge ASTP/ONC to retain and strengthen algorithm transparency requirements for AI-enabled decision support integrated with certified health IT, including:

- Mandatory disclosure of the algorithm purpose, intended use populations, validation data sources, performance metrics (sensitivity, specificity, positive/negative predictive value), known limitations, and potential bias risks through AI model cards that describe the tool's design, intended use, and validation.
- Audit trail requirements that preserve documentation of the evidence sources and reasoning pathways underlying specific AI recommendations, enabling providers to understand whether recommendations are based on current, high-quality evidence or outdated studies.
- Requirements that algorithms be validated on LTPAC-relevant populations (i.e., older adults, persons with multiple chronic conditions, persons with cognitive impairments) rather than only acute care or ambulatory populations.
- Clear documentation of how algorithmic recommendations should be interpreted and integrated into clinical workflows.
- Mechanisms for LTPAC providers to report algorithm performance issues, unexpected outcomes, or suspected bias to ASTP/ONC and FDA where applicable.

- Ongoing surveillance and post-market monitoring requirements for AI-enabled decision support tools.

Discussion:

The proposal to remove AI model card requirements from the decision support interventions criterion while simultaneously promoting "AI-enabled interoperability solutions" (pp. 61017-61018, 60973-60974, 60982) creates a transparency and governance gap that is particularly concerning for LTPAC populations.

AI-enabled clinical decision support tools are increasingly deployed in LTPAC settings for multiple purposes including fall risk prediction, pressure injury risk assessment, sepsis detection, functional decline prediction, and hospice eligibility determination. These algorithms directly influence clinical decision-making for vulnerable populations who may have limited ability to question or appeal algorithmic recommendations. Without transparency requirements—including both AI model cards and audit trails—LTPAC providers and patients cannot meaningfully evaluate the appropriateness, bias risks, or limitations of AI tools integrated into certified health IT.

The removal of model card requirements eliminates accountability mechanisms for algorithm developers and makes it difficult for LTPAC providers to fulfill their ethical and legal obligations to ensure that clinical decision support tools are evidence-based, validated for their patient populations, and free from harmful bias. From a patient safety and population health perspective, providers need transparency not only about how algorithms were developed (AI model cards) but also about the evidentiary basis for specific recommendations (audit trails). Without an audit trail, providers cannot determine whether an AI recommendation is based on a 25-year-old study that has since been disproven or on contemporary, high-quality evidence specific to the intended LTPAC population. If a provider faces legal or professional accountability questions about a clinical decision influenced by AI, stating "the AI told me, so I accepted its decision" is not a defensible response.

LTPAC providers were excluded from HITECH Act funding and current Promoting Interoperability programs, limiting resources to independently validate AI tools or develop internal AI governance programs.

If ASTP/ONC proceeds with removing AI model card requirements and audit trail requirements from certification, we request establishment of an alternative oversight framework—potentially coordinated with FDA, CMS, and the Office for Civil Rights—to ensure AI safety and equity in LTPAC settings. Additionally, we urge development of model contract language that small, rural, and under-resourced LTPAC providers can use in vendor agreements to ensure patient safety and population health protections, including requirements for AI transparency, evidence-based validation, and provider liability protection.

5. Information Blocking Revisions and TEFCA (45 CFR 171.102)

AHCA/NCAL Recommendations:

We urge ASTP/ONC to:

- Provide clear guidance and examples on how LTPAC providers can evaluate whether contracts or participation agreements constitute "contracts of adhesion" or contain "unconscionable terms" in the context of TEFCA participation and HIE connectivity.
- Clarify how the removal of the TEFCA Manner Exception impacts LTPAC organizations that participate in TEFCA Qualified Health Information Networks (QHINs) or are considering participation, particularly with respect to cost barriers and operational requirements.
- Ensure that information blocking enforcement recognizes the unique resource constraints, technical limitations, and market dynamics facing LTPAC providers, particularly small, rural, under-resourced, and Medicaid-reliant organizations.

- Establish clearer guardrails around third-party access that protect LTPAC providers and their vendors from liability when third parties use access rights for purposes unrelated to patient care, including protections against broad discovery requests and unreasonable access demands.
- Coordinate with CMS and state Medicaid agencies to align information blocking policies with LTPAC quality reporting, value-based payment, and interoperability incentive programs.

Discussion:

The proposed removal of the TEFCA Manner Exception and revisions to the Manner Exception's "manner requested" condition (pp. 60974) create uncertainty for LTPAC providers who are evaluating participation in TEFCA-enabled health information exchange networks.

LTPAC providers often face significant technical, financial, and operational barriers to participating in health information exchange. Many LTPAC organizations are small, under-resourced, and located in rural or underserved areas where HIE infrastructure is limited. The removal of the TEFCA Manner Exception may eliminate flexibilities that could have facilitated LTPAC participation in nationwide exchange networks. Additionally, there are already substantial cost barriers to entry for LTPAC providers seeking to participate in TEFCA Qualified Health Information Networks (QHINs).

The clarification that the Manner Exception does not apply to non-market-rate contracts, contracts of adhesion, or contracts with unconscionable terms is important for establishing clearer guardrails. However, we are concerned that LTPAC providers may lack the legal and technical expertise to evaluate whether specific contract terms meet these criteria, potentially exposing them to information blocking liability. Shifting more of the accountability burden from vendors to providers through complex contracting processes may reduce vendor compliance burden but will commensurably result in more net information blocking risk and burden costs to providers due to fragmentation away from a centralized governance process.

Our primary concern relates to third-party access risks that could impact both LTPAC providers and their health IT vendors. The HTI-5 proposal tightens information-blocking expectations around how and when data must be made available (including automation and third-party access), narrows practical flexibility under "manner" and "infeasibility," and raises questions about how providers will manage security risk, cost, and oversight as access demands expand. For example, EHRs may be required to provide data to "all comers," including third parties seeking to accumulate and analyze PHI for purposes unrelated to patient care—such as trial attorneys conducting broad discovery to identify potential litigation targets by examining health records of patients not related to specific cases. This risk is particularly acute for LTPAC providers, as their systems may serve as the "pipeline" for information flowing to third parties, even though vendors themselves may not be subject to the same HIPAA obligations as covered entities. While supporting patient access, we urge ONC to provide clearer guardrails—particularly around reasonable timelines, operational feasibility, and protections against unintended consequences from unbounded third-party or automated access.

If ASTP/ONC proceeds with removal of the TEFCA Manner Exception, we recommend that information-blocking enforcement for LTPAC explicitly account for provider scale, historical exclusion from federal health IT funding, and dependencies on vendor capabilities, rather than assuming the same baseline as large, tech enabled health systems. HTI-5 should include a reasonable on-ramp and scalable expectations for LTPAC participation, with technical assistance and model contract tools as primary levers before penalties are applied.

6. Implementation Timelines and Transition Support

AHCA/NCAL Recommendations:

We urge ASTP/ONC to:

- Extend implementation timelines for criteria removals that significantly impact LTPAC care coordination, patient safety, or family engagement (transitions of care reconciliation, patient engagement features, security capabilities) to no earlier than January 1, 2028.
- Establish a hardship exception process for LTPAC providers facing feasibility challenges (e.g., lack of high-speed broadband access in rural areas) that prevent timely compliance with new requirements.
- Provide comprehensive implementation guidance, technical assistance, and best practice resources specifically tailored to LTPAC settings, workflows, and vendor ecosystem.
- Conduct targeted stakeholder engagement with LTPAC providers, health IT vendors serving LTPAC markets, and LTPAC quality and accreditation organizations to assess implementation readiness and identify barriers.
- Establish mechanisms for LTPAC stakeholders to request technical assistance, report implementation challenges, and provide ongoing feedback on the real-world impact of certification program changes.
- Monitor and publicly report on the impact of HTI-5 changes on LTPAC interoperability, care transitions, patient safety outcomes, and health equity metrics.

Discussion:

LTPAC providers were excluded from HITECH Act funding and current Promoting Interoperability programs, limiting resources to absorb rapid implementation costs and technical changes. The staggered effective dates (immediate upon final rule publication vs. January 1, 2027) for extensive removals and revisions (pp. 61018-61021) create operational challenges for LTPAC providers and their health IT vendors. Imposing aggressive timelines and expanded obligations without commensurate support creates a double constraint and fairness disparity where the least resourced providers face new penalties for failing to do things they were never funded or scaled to do.

LTPAC health IT vendors often serve smaller and rural markets, have fewer development resources, and operate on longer product development and release cycles compared to acute care and ambulatory EHR vendors. Rapid changes to certification requirements raise concerns about vendor capacity to support implementation across all care settings simultaneously, with LTPAC support potentially being delayed as vendors prioritize acute and ambulatory markets. This may result in:

- Extended delays in updating LTPAC systems to comply with new requirements or remove deprecated functionality.
- Increased costs passed through to LTPAC providers for system upgrades, interfaces, and technical support.
- Functionality gaps where previously certified capabilities are removed before alternative solutions (e.g., FHIR-based APIs) are fully implemented and validated in LTPAC workflows.
- Feasibility challenges in certain LTPAC settings, such as rural facilities lacking high-speed internet infrastructure necessary to support new interoperability requirements.

Regardless of whether ASTP/ONC proceeds with the implementation timelines as proposed, it is imperative that ASTP/ONC design implementation supports—technical assistance, pilots, and model language resources—specifically to help small, rural, and Medicaid-reliant LTPAC providers and their niche vendors meet expectations without driving vendor consolidation or loss of specialist innovators that serve this sector.

7. Model Contract Language and Technical Assistance Resources

Throughout our comments, we have consistently identified the need for model contract language that LTPAC providers can use in vendor agreements to ensure essential capabilities remain available when certification requirements are removed. Given that different personnel at ASTP/ONC may review different sections of these comments, we consolidate here a comprehensive request for model language development across multiple domains:

AHCA/NCAL Recommendations:

We urge ASTP/ONC to develop and publish model contract language, Business Associate Agreement (BAA) provisions, and procurement guidance that small, rural, under-resourced, and Medicaid-reliant LTPAC providers can use in vendor negotiations, covering:

1. **Privacy and Security Requirements** — Model BAA provisions and vendor agreement language addressing privacy and security capabilities (authentication, access control, audit trail preservation, encryption, integrity protection), breach notification obligations, data use restrictions, and vendor compliance with HIPAA Security Rule when certification criteria are removed.

2. **AI Transparency and Safety** — Model language is needed requiring vendors to provide AI model cards documenting algorithm purpose, intended use populations, validation data sources, performance metrics, limitations, and bias risks; audit trail requirements showing evidence sources underlying AI recommendations; validation on LTPAC populations; provider liability protections; and mechanisms for reporting algorithm performance issues.

3. **Transitions of Care and Clinical Reconciliation** — Model language requiring structured data exchange, clinical information reconciliation capabilities, support for LTPAC-relevant data elements, and adoption of PACIO transitions of care and medication reconciliation standards.

4. **Patient and Caregiver Engagement** — Model language ensuring patient health information capture capabilities, family caregiver access (including proxy access and delegation workflows), and accessibility features for older adults and people with disabilities.

5. **Third-Party Access Guardrails** — Model language addressing appropriate limitations on third-party access to protect LTPAC providers from liability when third parties use information for purposes unrelated to patient care, including protections against broad discovery requests and unreasonable access demands.

Discussion:

We view model contract language and standardized BAA provisions as core mitigation tools for LTPAC providers, particularly small and rural organizations with limited legal and IT resources. These tools are essential to compensating for the removal of certification-based protections in areas such as privacy and security (including audit trails and breach notification), AI transparency and liability (including model cards, audit trails, and evidence sources), third-party access guardrails under information blocking and TEFCA, and patient and caregiver engagement obligations when certification criteria are removed. This consolidated model language should be developed in coordination with LTPAC provider associations, legal experts, and health IT vendors to ensure practical applicability while providing LTPAC providers with negotiation leverage and baseline protection of critical capabilities. Because ASTP/ONC has already recognized rural and under-resourced providers as a priority, we further request that LTPAC providers in rural and underserved communities be

explicitly identified as key beneficiaries of any technical assistance and model-language initiatives emerging from HTI-5.

Conclusion

AHCA/NCAL appreciates HHS/ASTP/ONC's goals of reducing regulatory burden and promoting innovation through deregulation. We support efforts to eliminate duplicative requirements, streamline certification, and advance FHIR-based interoperability. However, we urge ASTP/ONC to carefully consider the unintended consequences of removing certification criteria that provide baseline assurance of critical capabilities for patient safety, care coordination, privacy protection, and family engagement—particularly for the vulnerable populations served in AHCA/NCAL member settings.

The U.S. healthcare system is more than acute care hospitals and ambulatory physician practices. Patients with complex chronic conditions, functional limitations, and end-of-life care supports rely on a continuum of LTPAC services—skilled nursing facilities, home health agencies, hospice programs, assisted living communities, and long-term care facilities. Effective, safe, person-centered care for these populations depends on a robust and connected health IT ecosystem. ASTP/ONC must apply rational supportive and not punitive approaches to reducing the historical HIT interoperability disparities holding LTPAC providers back by creating policies that facilitate LTPAC provider capabilities that support cross-setting information exchange, medication safety, family caregiver engagement, and protection of privacy and dignity.

We urge ASTP/ONC to:

- **Retain or phase more gradually** the removal of privacy/security, transitions of care reconciliation, and patient engagement certification criteria.
- **Strengthen algorithm transparency** for AI-enabled decision support affecting vulnerable populations.
- **Provide clear implementation guidance** on information blocking requirements and TEFCA participation for LTPAC providers.
- **Extend compliance timelines and provide targeted technical assistance** to ensure successful transition for LTPAC organizations and vendors.
- **Establish ongoing LTPAC stakeholder engagement** to inform future health IT policy development.

We appreciate the opportunity to comment and stand ready to work collaboratively with ASTP/ONC, CMS, and other federal partners to advance interoperable, patient-centered health IT that serves all people across all care settings. Please contact Daniel Ciolek at AHCA/NCAL at dciolek@ahca.org. for questions or needed follow-up.