TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

June 12, 2025

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Centers for Medicare & Medicaid Services
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P.O. Box 8013
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Submitted via www.federalregister.gov

RE: Comments on Request for Information: Health Technology Ecosystem

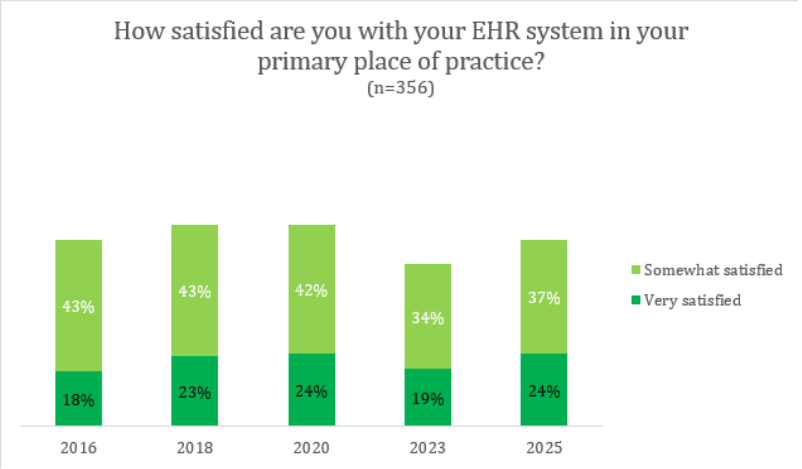
Dear Dr. Oz,

On behalf of the Texas Medical Association (TMA) and our more than 59,000 physician and medical student members, we thank you for the opportunity to provide feedback on the Request for Information (RFI) on the Health Technology Ecosystem.

TMA has a long record of educating physicians about and promoting health technologies. TMA established its Health Information Technology (IT) Department in 2006 when only 22% of physicians used an electronic health record (EHR). In the nearly two decades since, the EHR adoption rate has grown to 91%, making health technologies ubiquitous in most health care settings. TMA continues to advocate for physicians so the technology used in the practice setting provides the right information, at the right moment, for the right patient, allowing physicians to make the right decision for the best possible clinical outcome.

TMA regularly surveys its members on health IT-specific issues, including EHR satisfaction. TMA's 2025 survey showed satisfaction rates slightly improving over 2023 results but still lagging from previous surveys. As depicted in Figure 1, since 2016, the trend in the percentage of physicians "satisfied" at any level is essentially flat. It also is far lower than other industries would accept.

*Figure 1*




After years of EHR use, physicians should be more proficient and more satisfied. EHR vendor enhancements should be reflected through improved usability, better user interfaces, and tools that decrease the user's screen time and cognitive load.

One drag on EHR satisfaction is that the Centers for Medicare & Medicaid Services (CMS) continues to add insufficiently tested quality improvement requirements. For users, these shortcomings create additional complexities that add time and reduce efficiency and physician satisfaction. By addressing the burden of continuously changing quality programs, more time

could be spent on direct patient care that directly impacts health care quality and patient safety. The "pajama time" study published in the *Journal of General Internal Medicine*[1] details how increased clinical effort and excessive time spent in the EHR contribute to physician burnout. TMA implores CMS to use its authority to reverse this trend.

One other area of overarching concern is relevant. TMA strongly objects to the use of the term "provider" as it is ill-defined and offensive to some clinicians. TMA recommends when CMS refers to human beings who provide clinical care, that the agency use "clinicians" instead of "providers" if a general term is needed. When discussing non-humans, such as hospitals or health care systems, TMA recommends using "health care organizations." It costs nothing to do this and has enormous benefits in clarity and respect for the physicians, nurse practitioners, physician assistants, nurses, and other clinicians who work hard to be more than "providers."

**Digital Health Apps**

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?

*TMA Response*
TMA agrees patients should be able to use their personal health record as a source of information regarding their medical status. Additionally, patients should be educated to manage their health information and to periodically inspect it for accuracy and completeness.

Most EHRs include patient portals that give patients access to a subset of their medical records, appointments, and billing information. Many of these portals include the functionality for patients to view, download, or transmit their information. Beyond providing these tools, it should not be up to physicians to "leverage" digital health products for patients. Physicians are already dealing with declining payments and have limited time to devote to each patient. To ask physicians to devote additional time and expense to promote digital health products other than their portal is not feasible and might even detract from patient care if the products do not seamlessly interface with the physician's portal. It also puts a burden of uncompensated support on the physician's practice if the patient requires assistance in using or updating the digital health product.

If CMS creates its own campaign to promote products that it has approved and recommends for patients, TMA strongly recommends that these should seamlessly interface with common EHR vendor portals without cost to physicians.

a. What are the current obstacles?

*TMA Response*
The obstacles are many and varied. For some patients, it is a lack of interest, especially for those who are healthy and don't have a chronic health condition requiring continual tracking. For some patients, it's technology limitations including computer or internet access, an understanding of how to use digital tools, and lack of technical support. Some patients will not make the effort to access their information electronically because they believe their physician is already appropriately managing their information. These types of patients should not be left behind, and considerations must be made to encourage them and accommodate assistance for easy access to their information.

[1] Pajama Time: Working After Work in the Electronic Health Record. https://pmc.ncbi.nlm.nih.gov/articles/PMC6712097/

Rural and small practices are often overwhelmed with technological requirements. That and other factors make them less likely to advance digital health products for their patients. Many products are custom solutions that work in narrow use cases and cannot be easily implemented into physician practices and health systems. To address this (and other problems), CMS should revive a national Health IT Extension Program, analogous to Agricultural Extension Centers, to support rural and small practices in implementing and maintaining certified health IT, TEFCA connections, and digital health products. Rural and small practices should have access to grant funding, shared technical resources, and template-based implementation guides to ensure equitable access to technology.

Another obstacle is the lack of a personal health record certification. TMA supports the development of a national framework for standardized, consumer-controlled personal health records (PHRs) that can aggregate and reconcile data from CMS, TEFCA, physician practices, health care organizations, payers, and third-party apps. CMS should fund certification pathways for such apps that require them to offer functionality that presents data with clear source attribution, provides easy-to-use filters and deduplication tools, permits error correction with communication of the fix back to the source for their review, and provides easy connection to their physician's patient portal.

CMS should work towards the ability for patients to voluntarily have a complete, portable, electronic, standardized set of their personal health information. Patients should be able to share that information with their treating physician wherever they are (e.g., in an emergency room). Physicians should be able to easily transmit the patient's information that is new or unknown to the physician into their certified EHR (e.g., a child's vaccine history when the family has changed to a new physician practice). Because this represents a consolidation of patient health information, the source of information should be clearly identified for the patient and any clinician reviewing the information. Tools should be developed that alert patients to inconsistencies across records and advise patients on how to take corrective action.

b. What information should providers share with patients when using digital products in the provision of their care?

*TMA Response*
All health information should be shared with patients using digital products in the provision of their care. That said, there are certain types of information that a clinician should be able to tag easily as private, such as information given in confidence that the patient asks not to be transmitted to their digital tools. If there are tools that allow parents to view a child's digital product, there should be a way to preserve adolescent privacy within the limits of state laws. Similarly, confidentiality must be possible for patients where an adult child is sharing their elderly parent's digital tools. Not all information needs to be seen by everyone.

The other consideration is that while patients are entitled to all of their medical information, it can be overwhelming. Tools that easily filter information that is not useful – e.g., a sodium value of a year ago – without requiring patient intervention should be ubiquitous.

Physicians should not be required to share technical digital product information.

c. What responsibilities do providers have when recommending use of a digital product by a patient?

*TMA Response*
Physicians should not be held responsible or liable for recommending digital products to their patients. Physicians are not equipped with information about the quality of patient-facing digital products, especially in the continuously evolving marketplace. There should be a national process to evaluate and potentially certify health applications for patient use. Patients need assurances that digital health products work as intended and comply with privacy and security regulations, so patient health information is protected. TMA recommends that CMS develop standardized terms of service for application providers that include strong privacy provisions. CMS-approved digital health

product vendors should be required to adhere to these privacy provisions which could give patients confidence to adopt such products.

PR–2. What are obstacles that prevent development, deployment, or effective utilization of the most useful and innovative applications for physician workflows, such as quality measurement reporting, clinical documentation, and billing tasks? How could these obstacles be mitigated?

*TMA Response*
Most Substitutable Medical Applications and Reusable Technologies (SMART) on Fast Health Interoperability Resources (FHIR) applications are add-ons. While the EHR vendor may offer an application programming interface (API), it often does not necessarily offer a reasonable workflow. To be effective, applications must start with workflows.

Other barriers include cost, lack of technical support, and custom products with narrow use cases. Many practices don't have on-site technical support, and numerous health care organizations lack a board-certified physician informaticist. CMS should support and expand residency training and board certification in clinical informatics from the American Board of Preventive Medicine and American Board of Pathology and consider payment options for physician informaticist work.

Another major obstacle is that EHR vendors must spend time on development and upgrades to comply with ever-changing measures such as those required for physicians participating in the Merit-based Incentive Payment System (MIPS). If less time were spent on these, vendors could spend more time on innovation.

Quality improvement and other performance measures need to be evidence-based rather than consensus-driven and should have meaningful post-implementation evaluation to ensure their continued value. It is important for there to be standardization of quality measures and data collection across all payers when physicians participate in various quality improvement programs to help reduce physician burden and increase health care efficiency. TMA recommends that CMS consider quality measure development reflective of TMA policy[2]:

> "Evidence-based quality-of-care measures must be the primary measures used in any program.
>
> 1. All performance measures used in the program must be defined prospectively and developed collaboratively across physician specialties.
> 2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
> 3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
> 4. Performance measures should be scored against both absolute values and relative improvement in those values.
> 5. Performance measures must be subject to the best available risk adjustment for patient demographics, severity of illness, and comorbidities.
> 6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
> 7. Performance measures must be selected for clinical areas that have significant promise for improvement."

Other obstacles include the following:

[2] TMA Policy Compendium; 265.017 Pay-for-Performance Principles and Guidelines; www.texmed.org/Policy.

"In-basket" management. Physicians are overly burdened with in-basket message management by the influx of messages from patient portals, admit-discharge-transfer data feeds, lab and imaging reports, and other messages. TMA urges CMS to study time spent on in-basket management and prioritize solutions that make in-basket message management more usable and efficient. This includes requiring EHRs to have a mechanism that easily tracks and reports the amount of time physicians spend on in-basket management. Physicians should be compensated for in-basket management time.

"Favorites" Lists Destroyed in Upgrades and Outages. Many EHR vendors allow physicians to build "favorites" lists within the EHR. These allow physicians to create a drop-down list with commonly used orders or medications prescribed or macros that eliminate keystrokes. While this functionality is not yet available in all EHRs, for those vendors with this capability, the lists and macros should be stable enough to not require a reset or rebuild after an upgrade or outage. TMA recommends adding upgrade-stable "favorites" lists to EHR certification criteria.

Capability to Report EHR and Interoperability Issues. There should be a standardized way to report technology issues and opportunities for improvement, especially if patient safety is at risk. CMS should consider requiring certified technology vendors to have a single-click standardized approach to capturing the information (such as a screenshot, time, date, and computer/server) in a user's session that includes editing tools to highlight, mark, and add text describing the issue. This information should be submitted to the vendor and these issues should then be shared with ASTP to monitor certified technology compliance. This must be accomplished with minimal effort by the user and technology vendor and could be part of the ASTP "surveillance for maintenance of certification requirements." ASTP should pilot this functionality to determine feasibility and best practices for implementation and use. This type of reporting becomes more important as artificial intelligence tools are implemented.

Read-Only Access to Patient Records After a Practice Closes. When a physician retires or closes a practice and no longer has access to their EHR, there are not always good options for retaining patient records as required by record retention laws and regulations. Some physicians and patients solve this problem by printing reams of paper. TMA recommends standardized options for read-only access to patient records so medical record companies that handle medical record requests upon a practice's closing don't have to have EHR-specific knowledge or training. This is a known problem that could be addressed through EHR certification criteria.

PR–3. How important is it for healthcare delivery and interoperability in urban and rural areas that all data in an EHR system be accessible for exchange, regardless of storage format (for example, scanned documents, faxed records, lab results, free text notes, structured data fields)? Please address the following:

a. Current challenges in accessing different data formats.
b. Impact on patient care quality.
c. Technical barriers to full data accessibility.
d. Cost or privacy implications of making all data formats interoperable.
e. Priority level compared to other interoperability needs.

*TMA Response*
Different data formats are especially challenging when exchanging information, but even when data is in the same format, it's not necessarily useful if the same standards are not applied to how the information is organized. For care quality, "complete" information is rarely desirable. Rather, physicians need "relevant" information delivered and organized usefully. As a simple example, a patient's one-minute Apgar score at birth is part of the patient's "complete" record but is totally irrelevant when the patient is being seen for a sexually transmitted disease as an

adolescent. Clinicians need tools that can "tag" information as more or less relevant, so they are not overwhelmed. Another example is .pdf documents consisting of dozens of pages, which are of limited use.

"Accurate" information is always desirable, but sometimes errors exist. There should be standardized ways to correct erroneous information so it does not persist while being exchanged to other settings. As an example, a TMA member had another patient's record merged into his, with multiple, serious, incorrect allergies, medications, procedures, surgical history, and more. If this incorrect information is passed to other organizations (e.g., through a health information exchange), there must be a mechanism for completely removing it from all recipients once it is determined to be incorrect; to do otherwise is unsafe. There is another instance of incorrect data (e.g., patient has cancer when in fact it was a suspicion of cancer that was ruled out) that has been propagated to other systems without the patient's awareness or consent and eventually appears to be the truth. There should be methods to correct health information, no matter where it is.

Other barriers include cost, privacy concerns, and lack of technical support.

PR–4. What changes or improvements to standards or policies might be needed for patients' third-party digital products to have access to administrative workflows, such as auto-populating intake forms, viewing provider information and schedules, and making and modifying an appointment?

*TMA Response*
Patient's third-party digital applications should not have access to a practice's administrative workflows. Allowing third parties to access systems creates risk as we saw with the Change Healthcare and Ascension attacks. Not only do these types of cyberattacks create a financial crisis, but patient care can also be jeopardized.

**Data Exchange**

PR–5. Which of the following FHIR APIs and capabilities do you already support or utilize in your provider organization's systems, directly or through an intermediary? For each, describe the transaction model, use case, whether you use individual queries or bulk transactions, and any constraints:

a. Patient Access API.
b. Standardized API for Patient and Population Services.
c. Provider Directory API.
d. Provider Access API.
e. Payer-to-Payer API.
f. Prior Authorization API.
g. Bulk FHIR—Do you support Group ID-based access filtering for population specific queries?
h. SMART on FHIR—Do you support both EHR-launched and standalone app access? What does the process for application deployment entail?
i. CDS Hooks (for clinical decision support integrations).

*TMA Response*
Pediatricians at hospitals in urban areas use an API to access an external tool that provides clinical decision support for bilirubin management in infants. This requires integration into the EHR, and each organization's EHR must be individually configured to have this functionality. This is just one example of the clinical value and challenges of implementing these tools.

PR–6. Is TEFCA currently helping to advance provider access to health information?

a. Please provide specific examples.

b. What changes would you suggest?

*TMA Response*
Progress with TEFCA seems to be taking place at the qualified health information network (QHIN) level as common agreements are implemented, however, it is not always evident at the practice level.

An area of concern is when a QHIN ceases operations in the future, which could be caused by a variety of factors. TMA recommends that each QHIN be required to have a contingency plan in place that allows another designated QHIN to quickly take over a failed QHIN's data exchange and record-locating capabilities, including migration support for clinicians and organizations.

c. What other options are available outside of TEFCA?

*TMA response*
Health care is largely local, so it is important to support local health information exchange organizations (HIEs) where they exist. These organizations can also serve as health data utilities that communities can use to identify public health needs and opportunities for improvement. The CMS Extension Centers recommended above should also provide support for local HIEs.

d. Are there redundant standards, protocols or channels or both that could be consolidated?

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?

*TMA Response*
Interoperability isn't just about creating the "pipes" to move data. It's also not just programming computers to "read" what is received. Equally important is the relevance and usability of the data received. The approach taken to date is that it's the recipient's responsibility to make sense of all incoming data, rather than having standards that focus the flow on what's needed, relevant, and appropriate at the point of care. TMA strongly supports efforts to foster this approach using FHIR.

For a decade, TMA has advocated for the universal use of extensible markup language (XML) or a similar standard (e.g., FHIR) as a way of exchanging meaningful health data, as is used in accounting and other industries. Universal common encoding of all data elements permits disparate systems to share and consume information much more easily. Information consumed by a receiving EHR could be placed correctly within the system to give it meaning and make it useful. Standardized coding of data elements would make this easy and inexpensive. This allows the information in the receiving EHR to be searchable, extracted for reports (such as medication or device recalls), and available for clinical decision support. This isn't a simple or quick approach, but it is necessary.

The United States Core Data for Interoperability (USCDI) efforts are working to advance data-sharing with the standardization of data elements to facilitate the interoperability of patient information. However, of the 132 data elements in USCDI version 6, *57 do not have a correlating vocabulary standard*. Without vocabulary standards, electronic health record (EHR) vendors can choose their preferred vocabulary, which inhibits interoperability. TMA strongly encourages CMS and ASTP to work with physicians, EHR vendors, and others to reach a consensus on vocabulary standards for each USCDI data element. Before advancing additional USCDI requirements, ASTP should conduct testing among certified EHR vendors, QHINs, and HIEs to understand if the existing required

USCDI data elements can all be exchanged bidirectionally, seamlessly, and without additional user effort.

Additionally, it is important to understand that not all data elements apply to all medical specialties. EHR vendors should program systems with the ability to suppress non-applicable fields and thus reduce EHR-screen clutter to improve EHR usability. This will reduce EHR complexity, which will help increase physicians' satisfaction while reducing frustration and burnout. CMS should support professional medical specialty societies in the creation of data use cases, tools, and filters to provide clinicians with focused, meaningful information.

CMS should use policy levers requiring certified EHR vendors to develop and test interfaces with HIEs that can easily be deployed to physicians with little effort on their part. In many cases, it is a capital expense in physician budgets to connect to external sources. This causes undue financial burden to physicians who are continuously challenged with increased expenses and declining revenues. In addition to interface fees, physicians must pay ongoing monthly fees to maintain the interface. Interoperability tools should be included in the base EHR and no longer be viewed as an add-on.

An example of seamlessly having relevant information at the point of care is through state prescription monitoring programs (PMPs) as offered to more than 40 states and territories by Bamboo Health[3]. The interface was provided by Bamboo Health to the EHR vendors in such a way that when it is installed and updated, physicians automatically, within their workflow, have access to PMP information on a patient when launching a prescription requiring the PMP check. The Texas Legislature allocated funding for the interface build and for continued access since checking the PMP is mandated when prescribing certain drug classes. Once physicians consented to the integration, the PMP was available within the workflow and worked as intended and to the satisfaction of physicians needing access to the PMP.

Although standardized data elements have been defined in the C-CDA, there is a lack of consistency in what elements are shared. Additionally, the data are not prioritized in a way that a physician would logically review the document after a patient's discharge from the hospital.

TMA adopted a policy[4] related to the organization of clinical content shared with treating physicians when patients are discharged. TMA recommends that ASTP, EHR vendors, and HIEs adopt the following list as the content and priority of items displayed on a C-CDA when a patient is discharged from the hospital. This is the minimum suggested data set of elements and the order in which they should be listed. This recommendation is now published by the Sequoia Project in the Data Usability Workgroup Implementation Guide Version 1[5].

> "Discharge C-CDA Minimum Data-Set Content and Display Order:
>
> 1. Discharge summary narrative (i.e., hospital course)
> 2. Discharge medications
> 3. Allergies
> 4. Admission diagnosis
> 5. Discharge diagnosis
> 6. Procedures: Includes interventional radiology, cardiac catheterization, operative procedures
> 7. Diagnostic imaging: Advanced imaging (e.g., MRI, CT, PET), nuclear imaging, ultrasound, echo, and venous doppler

[3] Bamboo Health; Improving Patient Safety Across the Nation; https://bamboohealth.com/category-rx-monitoring/
[4] TMA Policy Compendium; 118.010 Consolidated Clinical Document Architecture (C-CDA) Data Prioritization Upon Hospital Discharge; www.texmed.org/Policy
[5] Sequoia Project; Data Usability Workgroup Implementation Guide Version 1, page 41; https://sequoiaproject.org/wp-content/uploads/2022/12/2022-12-14-Sequoia-DUWG-IG-Version-1.pdf

8. Laboratory: Recommend first and last laboratory results for every test. Rare tests are only done once, so would be included (e.g., anti-nuclear antibodies (ANA) for rheumatoid arthritis)
9. Consultations
10. Assessment and plan: Includes future orders for follow-up with a primary care physician and diagnostic tests)
11. Problem list"

TMA also recommends CMS require all exchanged clinical data to include standardized provenance metadata, including source system ID, timestamp, and record transformation history. Certified systems should implement a mechanism to retract or correct erroneous data previously disseminated, using either FHIR delete/patch capabilities or a standardized correction flag that propagates across recipients.

CMS should support and expand residency training and board certification in clinical informatics from the American Board of Preventive Medicine and American Board of Pathology and consider payment options for the work of physician informaticists.

PR–8. What are ways 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?

b. In what ways can the interoperability and quality reporting responsibilities of providers be consolidated so investments can be dually purposed?

*TMA Response*
CMS could reduce the number and complexity of current quality metrics. Harmonization of quality and data collection across payers when physicians participate in various quality improvement programs would help reduce physician burden and increase health care efficiency.

c. Are there requirements CMS should consider for data registries to support digital quality measurement in a more efficient manner? Are there requirements CMS should consider for data registries that would support access to real-time quality data for healthcare providers to inform clinical care in addition to simplifying reporting processes?

**Digital Identity**
PR–9. How might CMS encourage providers to accept digital identity credentials (for example, CLEAR, ID.me, Login.gov) from patients and their partners instead of proprietary logins that need to be tracked for each provider relationship?

*TMA Response*
When considering patient matching and digital identity credentials intended for and controlled by the patient, it is imperative to involve the patient and to conduct focus groups that include a variety of demographics (e.g. age, education, disability, socioeconomic status, and geographic region). Before regulating and implementing digital matching and identity tools, all significant challenges to adoption (e.g., identity verification of children) must be considered and mitigated.

TMA encourages CMS to invest in federated digital identity infrastructure that enables patients and clinicians to authenticate using interoperable credentials (e.g., Login.gov, ID.me) rather than relying on separate logins for every health system. These credentials should be natively integrated into EHR login flows and support single sign-on across TEFCA, portals, and APIs. If implemented, CMS would need to support a national education campaign so

physicians, health care organizations, and patients are all aware of the program and implementation procedures.

a. What would providers need help with to accelerate the transition to a single set of trusted digital identity credentials for the patient to keep track of, instead of one for each provider?

*TMA Response*
Physicians should not bear the responsibility of assisting patients with digital identity credentials. Physicians are already dealing with increased expenses and declining revenues and have limited time to devote to patient care. To ask physicians to now devote time to assisting with patient digital credentials is not feasible. CMS could consider advancing single sign-on tools for patients who are using approved digital identity credentials.

**Information Blocking**

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) and to promote market competition?

*TMA Response*
None of the information-blocking exceptions or conditions within the exceptions should be removed. Another exception should be added that allows sensitive test results to be held for three days before being released to the patient. TMA agrees patients should have prompt access to most of their electronic health information upon request. However, there is concern that patients are receiving sensitive test results, such as for a cancer diagnosis before their physician has a chance to review the results. Cancer-related test results can be confusing, scary, and life-changing. Physicians are trained to convey such information in a timely, informative, and supportive manner, so patients understand not only what the test means, but also what options they have.

TMA has heard from numerous physicians about problems arising from the immediate release of test and imaging results that contain negative news about a patient's health. One oncologist told us that his patients have learned about having cancer:

- From a smartphone notification in the middle of a business dinner;
- While reading a bedtime story to a 3-year-old child; and
- During a rush-hour commute.

One patient's wife had to go to the emergency room for treatment of an anxiety attack after reading her husband's CT scan report, only to later learn the scan showed the cancer treatment was working. Even when the news is good, some medical test results are too complex to be clear.

CMS should add an exception to the immediate release of sensitive tests allowing clinicians and health care organizations at least three business days to respond to a request for cancer and genetic test results. Additionally, certified EHR products need to have a standardized way for physicians to hold test results, so those results are not automatically pushed to the portal when received by the practice. This is also necessary with the current "preventing harm" exception.

Texas joined Kentucky in passing a state law effective Sept. 1, 2025, that requires physicians to hold for three days a pathology or radiology report that has a reasonable likelihood of showing a finding of malignancy, or a test result that may reveal a genetic marker.

Some patients appreciate and anticipate that they will get a phone call from their physician rather than having to read about it in their patient portal, which they may not use. Patient portals should have an easy-to-use

functionality that allows patients to choose how they want their results delivered. Tools should be provided to clinicians to easily communicate with patients who do not want to receive their results electronically.

PR–13. For any category of healthcare provider (as defined in 42 U.S.C. 300jj(3)), without a current information blocking disincentive established by CMS, what would be the most effective disincentive for that category of provider?

*TMA Response*
CMS should remove physician information-blocking disincentives. CMS should instead focus on promoting the safe, private, and secure exchange of electronic health information to increase its value such that it becomes a business and clinical imperative for physicians, hospitals, and other stakeholders to share patient information.

PR–14. How can CMS encourage providers to submit information-blocking complaints to ASTP/ONC's Information Blocking Portal? What would be the impact? Would it advance or negatively impact data exchange?

*TMA Response*
CMS does not need to encourage the submission of information-blocking complaints. Rather, CMS should focus on promoting the safe, private, and secure exchange of electronic health information to increase its value such that it becomes a business and clinical imperative for physicians, hospitals, and other stakeholders to share patient information.

**Technology Vendors, Data Providers, and Networks**

TD-5. How could a nationwide provider directory of FHIR endpoints improve access to health information for patients, providers, and payers? Who should publish such a directory, and should users bear the cost?

*TMA Response*
TMA supports the creation of a centralized, publicly accessible nationwide directory of FHIR endpoints indexed by a National Provider Identifier (NPI). CMS should partner with TEFCA-designated entities or the Sequoia Project to maintain the directory. Maintenance responsibilities must not fall to individual physicians or practices, and any usage fees should be federally subsidized. An easy-to-use clinician portal to allow individuals to securely update their demographics should be provided.

TD-9. Regarding certification of health IT:

d. What policy changes could CMS make so providers are motivated to respond to API-based data requests with best possible coverage and quality of data?

*TMA Response*
CMS should incorporate API performance Standards and Service-Level Agreements (SLAs) into the ASTP/ONC Health IT Certification Program. These should include:

- Minimum uptime thresholds (e.g., >99.99%)
- Maximum response times (e.g., ≤500 milliseconds for most endpoints)
- Data-freshness requirements for near real-time APIs

APIs that fail to meet SLAs should face corrective action or certification risk.

**Value-Based Care**

VB-2. How can key themes and technologies such as artificial intelligence, population health analytics, risk stratification, care coordination, usability, quality measurement, and patient engagement be better integrated into APM requirements?

*TMA Response*
TMA recommends that ASTP/ONC revise certification criteria to address the increasing integration of artificial intelligence (AI) into clinical workflows. Both patients and clinicians are likely to have AI-created material in their records, increasingly without their awareness. Certified Health IT should be required to:

- Provide a means for physicians to see AI-generated content that they did not personally create in the patient record.
- Provide the ability to easily access algorithm provenance, training data source, and performance characteristics.
- Enable physicians to provide structured feedback on AI-created material easily.
- Notify users of material AI changes following vendor updates.

This transparency is critical to ensure safety and build trust in AI-assisted care.

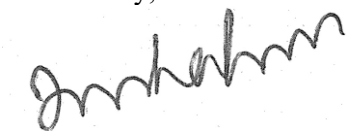
TMA urges CMS to align CEHRT requirements with real-world VBC workflows, including:

- Risk stratification and care coordination dashboards
- Event notification integration for attributed patients
- Customizable templates for longitudinal outcome tracking

CMS should also ensure that health IT capabilities specific to APMs are certified under the ASTP/ONC program and accessible to smaller, resource-constrained providers.

TMA appreciates the opportunity to provide feedback on the "Request for Information: Health Technology Ecosystem." Any questions may be directed to Shannon Vogel, associate vice president of health information technology, by emailing shannon.vogel@texmed.org or calling (512) 370-1411.

Sincerely,



Jayesh "Jay" Shah, MD
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