



February 25, 2026

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

Submitted electronically via regulations.gov

RE: Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions To Unleash Prosperity Proposed Rule; RIN: 0955-AA09

Dear National Coordinator Keane:

On behalf of the American Academy of Family Physicians (AAFP), representing 128,300 family physicians and medical students across the country, I write in response to the Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology's (ASTP/ONC) [Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions To Unleash Prosperity](#) (HTI-5) proposed rule. The AAFP appreciates ASTP/ONC's desire and intent to work with stakeholders to reduce burden on physicians and their care teams while also pursuing new technologies to better enable patient care. We stand ready to partner with ASTP/ONC and the whole of the Department of Health and Human Services (HHS) to ensure the health care system maintains a robust health information technology (IT) landscape while also reducing administrative burden and spurring innovation.

The AAFP has [long supported](#) ASTP/ONC's efforts to advance interoperability of health IT. Interoperability is essential for ensuring family physicians have access to meaningful, actionable data at the point of care, which in turn enables them to provide high-quality, patient-centered care across the lifespan. Truly interoperable health records will also reduce administrative tasks for physicians and facilitate patients' access to their health data. We appreciate ASTP/ONC proposing several changes that seek to advance interoperability; improve transparency; and support the access, exchange, and use of electronic health information (EHI).

The AAFP [understands and appreciates](#) the value of reducing compliance costs associated with health care regulations; we have repeatedly [shared](#) that the high costs of health IT products are burdensome to our members, especially those in small and independent practices. We believe there must be a balance with ensuring

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safety and interoperability of health IT solutions and achieving the national goal of the best patient care at the lowest cost. To achieve this goal, it is essential to have the technology needed to support care, and unfortunately, current market forces do not highly value interoperable, safe health IT development and deployment. Therefore, some amount of regulation is essential to push the market toward solutions that incent responsible, meaningfully interoperable behavior from health IT developers.

The AAFP has long been supportive of a data-focused, application programming interface (API) approach to interoperability, and we believe that a transition from document-focused exchange to data-focused exchange is critical for the future of health care. We strongly support ASTP/ONC's goal of modernizing the Health IT Certification Program (Certification Program) to prioritize Fast Health Interoperability Resources (FHIR) advancements that enhance automation and API performance, move beyond read-only interactions, and appropriately expand the scope of data available to improve patient care. Establishing standardized APIs is a critical step toward enabling a modern, scalable, and innovation-friendly health IT ecosystem. However, based on our experience working with companies that integrate across certified electronic health record (EHR) technology (CEHRT) products, we believe that reliance on standardized APIs alone is insufficient to achieve the policy goals articulated in the HTI-5 proposed rule. While we agree the transition to a FHIR-based API health ecosystem will require the collective commitment of policymakers, patients, physicians, payers, and software developers, we believe it's equally important to align and incent business forces to reward successful interoperability.

Today, the effort required to integrate with CEHRT using supposedly "standard" APIs varies dramatically. In some cases, onboarding a third-party application can be completed in a matter of days, while in others, the process can take months and require extensive engineering work specific to each EHR client. These disparities are not driven by differences in the FHIR standard itself, but by the lack of consistent implementation practices, supporting infrastructure, and operational processes across EHR developers. To truly support an API-driven ecosystem, ASTP/ONC should consider establishing, at a minimum, a defined set of best practices that CEHRT developers must follow to ensure predictable, efficient, and low-cost integration for third-party applications. These best practices could address areas such as:

- Standardized onboarding workflows and documentation;
- Consistent authentication and authorization patterns;
- Clear expectations for API performance, reliability, and versioning;
- Transparent processes for enabling write-back and bidirectional data exchange;
- Reasonable timelines for provisioning access and completing necessary configuration; and

- Support for production-level sandboxes for testing.

Over time, ASTP/ONC may need to move beyond voluntary best practices and require CEHRT to adopt these supporting capabilities as part of certification. Without such guardrails, current market incentives will continue to encourage many EHR developers to meet only the minimum regulatory requirements for API availability, rather than embracing the broader intent of enabling rapid, scalable, and cost-effective integration of third-party applications. We encourage ASTP/ONC to consider these additional measures to ensure that the promise of a FHIR-based API ecosystem with true interoperability and reduced integration burden can be fully realized.

III. Health Information Technology Standards, Implementation Specifications, and Certification Criteria and Certification Programs for Health Information Technology (Part 170)

a. Certification Criteria for Health Information Technology

Out of 60 total current certification criteria, ASTP/ONC proposes to remove 34 and revise seven. As ASTP/ONC considers the comments submitted on this proposed rule and moves forward with the final rule, the AAFP urges the agency to work with the Centers for Medicare and Medicaid Services (CMS) to ensure both agencies' programs align requirements and timelines as much as possible. For example, we would welcome CMS' Merit-based Incentive Payment System (MIPS) aligning with ASTP/ONC to remove the same criteria in certification as will be finalized for removal in the forthcoming HTI-5 final rule.

The AAFP joins ASTP/ONC in hoping that by lowering the burden of certification, and therefore barrier to entry, new health IT developers may emerge in the market. This could potentially be a great benefit to family physicians nationwide, particularly those in small, independent, and safety-net practices that may not be able to afford one of the more established developers' products.

a.2 Care Coordination Certification Criteria

Since enactment of the 21st Century Cures Act, primary care physicians have worked collaboratively with health IT developers and policymakers to thoughtfully transition toward a FHIR-based interoperability ecosystem. The principles underlying FHIR, including the exchange of discrete, computable data through standardized, trusted formats with minimal burden align strongly with the needs of physicians delivering care across settings and over time. While the AAFP supports continued movement

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toward a FHIR-enabled future, we believe that transition must be deliberate and grounded in real-world readiness. It cannot be successfully achieved by dismantling existing, widely relied upon exchange mechanisms before viable replacements are fully mature.

Consolidated Clinical Document Architecture (C-CDA) remains a foundational element of nationwide health information exchange and continues to serve as a reliable baseline for transitions of care, referrals, and care planning. This is particularly true in primary care, where physicians routinely coordinate with hospitals, specialists, long-term care, and community-based providers using diverse IT systems. While document-based exchange is not the goal or desired end-state, it remains an essential “data exchange floor.” Proposals throughout this rule to remove or significantly narrow C-CDA-related certification requirements (§ 170.315(b)(1)) risk destabilizing that floor before a universally implemented and proven alternative exists.

For family physicians, the integration of external clinical data into the electronic health record is a foundational component of interoperable health IT and a core patient safety function. Accurate reconciliation and incorporation of medications, allergies, and other clinical information from outside sources are essential to maintaining a complete longitudinal record and supporting safe transitions of care. When certified health IT lacks reliable reconciliation functionality, the burden is shifted directly onto physicians and clinical staff, increasing manual work, workflow inefficiencies, and the risk of incomplete or inaccurate records.

Given the foundational nature of reconciliation and the uneven maturity of interoperability across the health care ecosystem, the AAFP believes removing the “Clinical Information Reconciliation and Incorporation” certification criterion (§ 170.315(b)(2)) at this time is premature. Instead, we recommend ASTP/ONC revise this criterion to support FHIR-based exchange, expand the range of data elements required for reconciliation in alignment with USCDI, and establish a realistic implementation timeline grounded in real-world readiness. If the agency ultimately determines that removal is appropriate, we do not support retaining the criterion for an additional year, as doing so would create regulatory ambiguity without providing meaningful value to physicians or patients.

From a family physician perspective, the ability to appropriately tag sensitive health information with distinct permissions is critical to meeting privacy, confidentiality, and patient safety obligations. As interoperability expands, physicians are increasingly required to navigate complex federal and state privacy requirements while preserving patient trust and ensuring continuity of care. The AAFP believes ASTP/ONC should continue to play an active role in driving the health IT market toward meaningful,

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usable solutions that support granular data tagging and protect sensitive information without fragmenting the medical record or increasing administrative burden.

Given the narrow scope and limited real-world utility of the current “Security Tags – Summary of Care” certification criteria (§ 170.315(b)(7) and § 170.315(b)(8)), we support their removal at this time. Existing technology has not yet demonstrated the ability to support comprehensive, clinically usable data tagging in a way that aligns with physician workflows and patient safety needs. Once the market is capable of reasonably adopting a more complete, tested, and scalable approach to tagging sensitive health data, the AAFP would support ASTP/ONC revisiting and reintroducing a revised certification criterion that is able to support confidentiality without undermining care coordination or clinical decision-making.

Care planning is a core function of primary care and is essential to managing patients with chronic, complex, and multi-factor needs over time. Family physicians routinely develop, update, and coordinate care plans across care settings and with patients, caregivers, and interdisciplinary teams. Yet today, most EHRs do not adequately support physicians in creating, maintaining, or sharing care plans in a structured, usable way. As a result, care planning is often fragmented, inconsistently documented, or relegated to free text, which severely limits its usefulness for coordination and continuity of care.

The AAFP agrees with ASTP/ONC that the current “Care Plan” certification criterion (§ 170.315(b)(9)) has not effectively driven the market toward meaningful, physician-usable care planning functionality, and we recognize that a future, FHIR-based approach would better support interoperable and patient-centered care planning. However, this criterion remains one of the only mechanisms within the Certification Program that signals the importance of care planning to health IT developers. **If ASTP/ONC proceeds with removing this criterion, we strongly recommend the agency identify and advance alternative programs, pilots, or certification pathways to actively accelerate the development and adoption of robust care planning functionality.** Without a clear replacement strategy, removing this criterion risks further delaying progress on a function that is fundamental to primary care, care coordination, and value-based care (VBC) delivery.

The AAFP does not support ASTP/ONC’s proposal to narrow the scope of the Decision Support Interventions (DSI) certification criterion (§ 170.315(b)(11)) or to fully remove the artificial intelligence (AI) “model card” and source attribute transparency requirements. While we recognize the agency’s interest in reducing burden and reassessing regulatory approaches, transparency in clinical decision support – particularly AI-enabled tools – is essential to patient safety, physician trust, and

responsible adoption. Eliminating source attribute transparency requirements would deprive physicians and health care organizations of critical information needed to evaluate the appropriateness, limitations, and potential risks of DSI used in clinical care.

Clinical decision support is already a core component of modern health IT, and its role will only expand as AI-driven tools become more prevalent in clinical workflows. Unlike other certification criteria that may be more readily evaluated by individual physicians based on direct use, the safety and reliability of DSI cannot be easily assessed without access to transparent information about data sources, development, and limitations. Removing these transparency requirements would make it significantly more expensive and challenging for physicians, practices, and health systems to independently assess DSI for bias, applicability, and safety. This change would effectively shift risk away from the developers and onto physicians, end-users, and patients.

The AAFP understands that many frontline physicians do not routinely access source attribute information, but we strongly believe that does not diminish the information's value to physicians writ large. As with open-source software, a smaller subset of experts and organizations rely on transparency to audit, evaluate, and identify potential issues that ultimately protect the broader sector. Without source attribute transparency, only the DSI developer would be able to meaningfully assess the tool's design and limitations. **For these reasons, the AAFP strongly opposes the elimination of the source attribute transparency requirements, and we urge ASTP/ONC to retain these provisions as a critical safeguard in an increasingly AI-driven clinical decision support ecosystem.**

a.3 Clinical Quality Measures Certification Criteria

The AAFP supports efforts to modernize the infrastructure supporting electronic clinical quality measures (eCQM), but we do not support eliminating the "Clinical Quality Measures – Filter" certification criterion until a fully functional, standardized replacement is available. A variety of EHRs are being used by health systems and physician practices nationwide, and the ability to generate comparable quality measure outputs across those systems is essential for performance improvement, accountability, and trust in quality data. Introducing variability in how quality data are filtered and calculated across certified systems would undermine comparability and diminish confidence in reported results.

Many of the 71 active eCQMs represent performance measures that primary care physicians are required to report and use to drive ongoing quality improvement

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across multiple federal and commercial programs. These measures must be comparable across systems to remain meaningful for benchmarking, care improvement, and payment purposes. Removing this criterion would be particularly detrimental to primary care, but the impact would extend across specialties and VBC models. In practice, it would shift responsibility to health systems and physician practices to “clean,” reprocess, or re-engineer quality data to restore comparability across EHRs through either custom internal solutions or the purchase of third-party analytic tools.

We believe eliminating this criterion would introduce substantial risk to the consistency and reliability of quality measurement nationwide. Vendors may implement filtering logic differently, comparability across systems may be lost, and quality data may become increasingly difficult to interpret across sites of care. This variability would undermine the integrity of quality reporting and disproportionately affect health systems and physician practices that rely on multiple EHR vendors. For these reasons, the AAFP urges ASTP/ONC to retain the “Clinical Quality Measures – Filter” certification criterion until a standardized, tested alternative is available that preserves consistency, comparability, and usability of quality data across certified systems.

a.4 Privacy and Security Certification Criteria

The AAFP is concerned by the proposed removal of privacy and security certification criteria from the Certification Program. Our members rely on CEHRT every day to care for patients across the lifespan, and they depend on certification requirements to ensure that core security functions including authentication, access control, and authorization are built into their health IT products. Eliminating these criteria (§ 170.315(d)) shifts the responsibility for maintaining basic cybersecurity safeguards away from developers and onto individual practices, many of which lack the technical expertise or financial resources to independently implement and maintain these protections. Rather than removing these criteria, we urge ASTP/ONC to retain and strengthen privacy and security requirements within the Certification Program to better support physicians’ obligations to protect patient data under the Health Insurance Portability and Accountability Act (HIPAA).

Cybersecurity threats to the health care sector are persistent, well-documented, and growing in sophistication. Family physicians routinely care for patients with highly sensitive medical and behavioral health information, making primary care practices particularly vulnerable to cyberattacks. Patient health data remains highly valuable on the black market, and breaches can severely undermine patient trust and continuity of care. While the proposed rule asserts that the security capabilities being removed

are “widely adopted,” widespread adoption does not ensure continued availability if certification requirements are eliminated. From a physician perspective, this creates a real risk that vendors may downgrade or unbundle essential security features, potentially charging additional fees for functionality that was previously standard. **Claims that removing these requirements will reduce costs for developers overlook the reality that such costs are likely to be shifted downstream to physicians who are least able to absorb them, particularly small, rural, and independent practices.**

If finalized as proposed, these changes would leave many family physicians responsible for identifying, procuring, and financing standalone privacy and security solutions to compensate for gaps in certified technology. This approach would disproportionately harm independent and small practices, which form the backbone of primary care in many communities and already face significant administrative and financial pressures. While CEHRT is only one component of a practice’s broader technology environment, it is the foundational system upon which others depend. **Ensuring that certified health IT includes baseline privacy and security protections reduces risk, supports compliance, and allows family physicians to focus their limited time and resources on patient care rather than cybersecurity management.** Retaining these certification criteria is essential to safeguarding patient information and maintaining a secure, functional primary care infrastructure.

a.5 Patient Engagement Certification Criteria

The AAFP does not support ASTP/ONC’s proposal to remove the Web Content Accessibility Guidelines (WCAG) conformance requirement from the certification criterion (§ 170.315(e)(1)). Eliminating this requirement would effectively shift responsibility for accessibility compliance away from health IT developers and onto physician practices and other health care organizations. Many practices, particularly small, independent, and rural practices, are highly dependent on their EHR and patient-facing health IT to meet accessibility obligations under the Americans with Disabilities Act (ADA). These organizations lack the resources and technical expertise to independently assess whether their certified health IT products provide sufficient accessibility features to support compliance.

The AAFP believes that maintaining accessibility as a certification requirement appropriately places responsibility on developers to build patient engagement tools that are usable by individuals with disabilities and accessible by default. Rather than removing this criterion entirely, we encourage ASTP/ONC to consider revising it to an attestation-based approach. Such an approach would reduce the burden associated with formal testing while preserving an explicit expectation that certified health IT

includes accessible functionality. This would better support physician practices in meeting their legal and ethical obligations to patients, while ensuring that accessibility remains a shared responsibility of the health IT ecosystem rather than an unfunded mandate on health care organizations.

a.7 Public Health Certification Criteria

The AAFP believes that design and performance requirements within the Certification Program play an essential role in ensuring that certified health IT is not only technically capable, but also usable, safe, and supportive of real-world clinical workflows. Poor system performance directly contributes to physician frustration, inefficiency, and burnout, and it can negatively affect patient care when delays or system failures occur. Design and performance transparency can help practices make more informed decisions and encourage vendors to compete on usability and reliability, not just feature checklists. However, these requirements must be implemented in a way that provides actionable information without introducing excessive testing or documentation burden that ultimately increases costs for physician practices.

We believe the requirements outlined in subsections (c), (d), and (e) would be more appropriately implemented as developer attestations rather than formal certification testing criteria. An attestation-based approach would improve transparency for purchasers and end-users of CEHRT by clearly identifying how a product supports these design and performance concepts, while avoiding unnecessary regulatory and testing burden on developers. Physicians and practices need clear, accessible information about system capabilities and limitations to make informed purchasing and implementation decisions, but excessive certification requirements ultimately increase development costs that are passed on to end-users. Attestations would preserve visibility into these areas without creating additional complexity or cost that does not meaningfully improve patient care or physician experience.

b. Standards and Implementation Specifications for Health Information Technology

ASTP/ONC proposes to adopt the United States Core Data for Interoperability (USCDI) Version 3.1 (v3.1), instead of continuing the long-planned and ongoing transition to USCDI Version 3 (v3), followed by USCDI Version 4 (v4). Changes to USCDI v3.1 include the removal or update of the sex, sexual orientation, and gender identity data elements to align the proposed rule with [Executive Order 14168](#).

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The AAFP does not support the proposal to transition to USCDI v3.1 instead of continuing the transition to USCDI v3, followed by USCDI v4. We have long supported the progression to USCDI v3, followed by USCDI v4, and we believe USCDI v4 would likely improve data exchange across health care settings by including new and relevant data elements, thereby enhancing patient care. The data elements related to sex, sexual orientation, and gender identity are voluntary in nature; no physician or care team member is required to collect that information, so we do not believe it is necessary to disrupt long-standing regulatory plans for USCDI to make this change. Instead, we [support](#) ASTP/ONC continuing to advance USCDI – as outlined in the August 2024 [Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability](#) proposed rule – to expand the breadth and depth of highly structured clinical data to support deep integration across EHR systems. We believe the phased implementation proposed there allowed sufficient time for health IT developers to update their systems and for health care practices to adapt to the new standards. **Continuing with the long-existing plan for USCDI version progression would provide the consistency and clarity family physicians need, and it would allow for more effective care coordination, which will ultimately improve patient outcomes. This consistency is important for improving the quality, safety, and efficiency of health care in the United States.**

d. Conditions and Maintenance of Certification Requirements for Health IT Developers

ASTP/ONC proposes to alter several Conditions and Maintenance of Certification requirements, including proposing to descope the “Real World Testing” Condition and Maintenance of Certification requirements. The agency notes this proposal is consistent with the enforcement discretion notice issued in June 2025. ASTP/ONC also proposes to remove and descope measures related to the “Insights” Condition and Maintenance of Certification requirements, which aligns with separate enforcement discretion that the agency issued in April 2025.

The AAFP does not support ASTP/ONC descopeing the “Real World Testing” Condition and Maintenance of Certification requirements and urges the agency not to move forward with this proposal. The AAFP is [extremely supportive](#) of real-world testing, and we believe it is critical to ensure products and standards facilitate the intended uses without negative, unintended uses. Health care is a complex, adaptative system that cannot always be predicted, which means testing must be done. We strongly encourage ASTP/ONC to advance, not withdraw from, real-world testing to assess standards and criteria before they are mandated in regulation.

Should ASTP/ONC wish to proceed with the proposed descopeing of “Real World Testing” Condition and Maintenance of Certification requirements, the AAFP offers these alternate requirement recommendations (as authorized by Sec. 4002 of the 21st Century Cures Act) for the agency’s consideration.

- Defined and enforceable expectations for API performance, reliability, and versioning, including transparent communication of uptime targets, latency expectations, version support timelines, and deprecation policies.
- Transparent, documented processes for enabling write-back and bidirectional data exchange, including clear criteria for approval, testing, and production use, rather than discretionary or opaque vendor-specific practices.
- Reasonable and predictable timelines for provisioning access and completing required configuration, with limits on delays that can functionally impede interoperability despite purported API availability.
- Standardized onboarding workflows and documentation that are complete, publicly accessible, and consistently applied, enabling third-party applications to integrate without product-specific custom development.
- Consistent authentication and authorization patterns that conform to adopted standards and are implemented uniformly across products and versions, minimizing variability that increases integration complexity and cost.

IV. Information Blocking (Part 171)

ASTP/ONC proposes revisions to information blocking regulations with the goal of curbing the misuse of exceptions; promoting fair competition; and strengthening the access, exchange, and use of EHI. The proposals seek to clarify that “access,” “exchange,” and “use” of EHI include automated means such as robotic process automation and autonomous AI systems; remove the “third party seeking modification use” condition from the Infeasibility Exception due to concerns about anti-competitive misuse; and substantially narrow or potentially eliminate the “manner exception exhausted” condition to prevent actors from denying access to EHI through APIs or other mechanisms already made available to others. Additional proposals would prohibit reliance on unconscionable or non-market-based contracts under the Manner Exception and remove the TEFCA-specific information blocking exception, reaffirming that participation in TEFCA does not exempt actors from core information blocking obligations.

After finalization of HTI-5 proposed regulations, the AAFP urges caution regarding further alterations to the information blocking program and its exceptions. With a continued state of change, it remains difficult for physicians and end-users to build strong compliance and education programs in preparation for future enforcement. Continued changes will create additional burden and unpredictability, leading to an

enforcement environment where an information blocking actor may be found non-compliant due to lack of clarity instead of deliberate information blocking. Programmatic consistency is the best way to attain high levels of understanding and compliance, and we believe this will be true for the information blocking program in the long-term.

a. "Access" and "Use" Definitions

The AAFP supports ASTP/ONC's alternate proposal to revise the definitions of "access", "use", and "exchange" to explicitly include automated means, such as robotic process automation and autonomous AI systems. As family physicians increasingly rely on health IT tools to manage population health, clinical workflows, and care coordination, regulatory clarity is essential to ensure that emerging technologies are not improperly restricted through information blocking practices. As we've [shared previously](#), the AAFP agrees that interference with automated access, exchange, or use of EHI should be treated no differently than interference with manual processes. This clarification will help prevent actors from selectively restricting automated access to EHI in ways that undermine innovation, competition, and clinical efficiency while preserving appropriate safeguards under existing privacy and security exceptions. We do not object to the primary proposal to update only the definitions of "access" and "use"; however, we believe also updating the definition of "exchange" would provide increased clarity and certainty for actors subject to information blocking provisions.

b. Infeasibility Exception Revisions

b.1 Third Party Seeking Modification Use Condition: The AAFP does not support ASTP/ONC's proposal to remove the "third party seeking modification use" condition from the Infeasibility Exception. We have [supported](#) the creation of this condition from the outset, which we believed would reduce physician administrative burden. We do not agree with the agency's conclusion that the market has developed to the point of this condition no longer being necessary, and we do not believe its susceptibility to misuse by health IT developers is justification for its removal. Rather, the AAFP believes such susceptibility implies that the regulatory language governing this condition needs further clarity and detail in order to ensure health IT developers and other actors are not misusing it. We recommend ASTP/ONC not finalize this proposal of removal.

b.2 Manner Exception Exhausted Condition: The AAFP does not object to ASTP/ONC's proposal to narrow the "manner exception exhausted" condition of the Infeasibility Exception. We appreciate ASTP/ONC's recognition that this condition

has, in some cases, been applied in ways that undermine the intent of the information blocking regulations. We support the agency's proposed revisions to narrow this condition, including requiring actors to exhaust *all* alternative manners (as described in § 171.301(b)), rather than a limited subset; replacing "same" with "analogous" access, exchange, or use to prevent overly narrow interpretations; and eliminating the "substantial number" and "similarly situated" concepts that have contributed to inconsistent and discriminatory application. These changes would significantly improve clarity and reduce the risk that actors deny access to EHI in manners already available to others, including through APIs or automated processes. The AAFP does not support the alternative proposal to remove this condition entirely.

c. Manner Exception

The AAFP supports ASTP/ONC's alternate proposal to remove paragraph (a)(2) from the "manner requested" condition of the Manner Exception and instead explicitly apply the conditions of both the Fees Exception and the Licensing Exception to any agreement an actor makes with a requestor related to fulfilling the request for access, exchange, or use of EHI in any manner requested. We agree that this proposed revision to the Manner Exception would promote greater consistency in actors' practices specific to fees and licensing terms for fulfilling EHI access, exchange, and use requests by following specified provisions of regulatory exceptions. Ensuring that the Manner Exception cannot be used to justify excessive fees, restrictive licensing terms, or one-sided contractual requirements is critical to protecting physician practices from anticompetitive practices that increase cost and administrative burden without improving patient care.

d. Removal of Subpart D Exception and Other Provisions Specific to TEFCA

The AAFP does not object to ASTP/ONC's proposal to remove the TEFCA-specific information blocking exception. We continue to believe that participation in TEFCA should not provide actors with a broader shield against information blocking requirements than applies to nonparticipants. Family physicians benefit most when interoperability expectations are consistent across the health care ecosystem, regardless of whether an entity participates in TEFCA. The AAFP agrees that information blocking obligations must continue to apply to all actors and that TEFCA participation should complement, not replace, core information blocking protections.

Conclusion

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Thank you for the opportunity to provide written comments on this important topic and its potential impact on physicians' ability to access and exchange data in the United States. We appreciate ASTP/ONC and HHS' commitment to patient-centered technology policy, and we stand ready to collaborate on next steps. For more information or questions, please contact Mandi Neff, Senior Strategist, Regulatory and Policy, at mneff2@aafp.org.

Sincerely,

A handwritten signature in black ink that reads "Jen Brull, MD". The signature is written in a cursive, flowing style.

Jen Brull, MD, FAAFP
Board Chair
American Academy of Family Physicians