



February 19, 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

RE: HHS Health Sector AI RFI

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) request for information (RFI), "[Accelerating the Adoption and Use of Artificial Intelligence as part of Clinical Care](#)". The AAFP appreciates ASTP/ONC's desire and intent to work with stakeholders to accelerate the adoption and use of artificial intelligence (AI) solutions as part of clinical care, and we support the administration's efforts to deliver AI tools that will help physicians provide better patient care and experience less administrative burden. We stand ready to partner with ASTP/ONC and the whole of the Department of Health and Human Services (HHS) to facilitate the responsible, safe, and effective adoption of AI tools in clinical care.

The family medicine experience is based on a deeply personal patient-physician relationship that benefits from many supportive technologies, including AI. In 2023, the AAFP developed an initial set of [principles](#) that we believe must be applied to AI's implementation across the broad range of settings in which family physicians practice. The AAFP believes AI tools should be evaluated with the same rigor as any other tool utilized in health care, and that these tools have the potential to support the core functions of primary care, which are frequently characterized as first contact, comprehensiveness, continuity, and coordination of care.

As detailed further below and in addition to other recommendations, the AAFP [urges](#) ASTP/ONC to prioritize the development of AI-focused educational and training resources for the health care workforce in collaboration with specialty societies and other stakeholders. In particular, we would like to work with ASTP/ONC to develop a suite of educational resources designed specifically for small and independent physician practices that strengthens their ability to review and assess newly available AI tools. Many small and independent practices are located in rural and underserved communities where care is hard to find—and where new technologies can have an outsized impact. Family physicians want and need to know about new AI and digital

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health products that could help their patients, but they are overburdened by the inefficiencies and requirements of the current system, which leaves them with limited ability to seek out these tools. For optimal impact, developed resources should be concise and actionable, pointing busy practice owners and technology champions to the highest impact AI use cases and outlining the steps practices can take to assess, implement, and utilize new AI capabilities.

Additionally, we urge ASTP/ONC to prioritize the inclusion of family physicians and other end-users across the AI product lifecycle: design, validation, implementation, and post-market surveillance. As frontline clinicians and advocates for comprehensive, patient-centered care, family physicians are uniquely positioned to inform the development and deployment of AI technologies. Unfortunately, physician and end-user perspectives are frequently underrepresented in decisions related to the selection and deployment of health information technology (IT) and AI tools. An [AAFP survey](#) conducted jointly with Rock Health in September 2024 found that many primary care physicians reported having little to no involvement in these decision-making processes. The absence of meaningful clinician input contributes to technologies that are poorly aligned with clinical workflows and real-world patient and practice needs, which undermines adoption, effectiveness, and physician buy-in.

The AAFP [believes](#) HHS agencies should embed practicing physicians throughout the AI lifecycle, establish advisory panels that include primary care physicians to ensure AI tools are aligned with real-world clinical workflows and patient needs, and invest in testbeds and pilot programs that simulate clinical environments, particularly in primary care settings. The AAFP stands ready to collaborate on initiatives that evaluate the safety, usability, and effectiveness of AI tools in family medicine.

To support embedding practicing physicians into the AI lifecycle, the AAFP is establishing the Primary Care Innovation Network (PCIN) to create a sustainable, physician-led mechanism that connects frontline primary care teams with developers of AI and digital health solutions. The purpose of PCIN is to ensure that AI adoption in primary care does not repeat the missteps of prior health IT waves—particularly the lack of physician involvement that contributed to poor usability and increased administrative burden. Through a governance structure led by primary care physicians and supported by technology innovators, the PCIN seeks to strengthen primary care by ensuring AI tools meaningfully advance access, outcomes, patient experience, and workforce satisfaction.

PCIN is designed to accelerate responsible and trustworthy AI integration in primary care by fostering real-world testing environments; aligning innovators with actual care-delivery needs; and ensuring transparency, ethical design, and equitable implementation. Expected outcomes include empowering clinicians as organizational AI leaders, improving the alignment of technology development with high-impact primary care needs, and supporting national efforts

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to create safe, effective, human-centered AI systems. PCIN's activities, such as innovation accelerators, collaborative research communities, and coordinated multi-stakeholder leadership efforts, provide a model for how federal agencies and policy can partner with and amplify private-sector initiatives that are grounded in frontline care priorities. **The AAFP would welcome ASTP/ONC's support and involvement as we facilitate the meaningful collaboration of family physicians and technology developers to improve the practice and delivery of primary care for patients and physicians.**

Regulation

The AAFP strongly supports patients' ability to access and use their health information to inform care decisions, power digital tools, and share data with their care teams in ways that safeguard their privacy. We have consistently supported regulatory efforts that advance patient access to their health data. However, while patients' access to electronic health information (EHI) has expanded rapidly in recent years, corresponding technologies that enable physician practices to manage and operationalize this increased data flow have not advanced at the same pace. This challenge is heightened by the lack of mechanisms to reliably segment data according to laws, regulations, and patient sharing preferences, which are essential for ensuring that health information is exchanged in compliance with the specific privacy obligations attached to each data element.

While deregulation can reduce developer burden and lower barriers to market entry for new AI products, it shifts significant responsibility onto purchasers to evaluate whether these tools meet required functionality and interoperability standards. This shift disproportionately affects low-resourced practices, placing a heavier burden on rural and safety-net health care organizations that may lack the capacity to conduct thorough product assessments.

As AI systems become deeply integrated into clinical and operational environments, their exposure to sophisticated cyber threats presents an increasing risk to patient safety and organizational integrity. Family physicians depend on AI tools that are secure by design, yet they often lack visibility into the system's vulnerabilities or have control over its defenses. AI developers and technology organizations, not physicians or health systems, are best positioned to mitigate and respond to cyberattacks given their direct access to system architecture, code, and infrastructure. The AAFP recommends HHS strengthen regulatory guardrails to ensure that developers bear primary responsibility for securing AI systems against intrusions, data exfiltration, and model manipulation. Holding physician practices liable for breaches or system failures they cannot control would undermine trust and deter adoption. Robust, enforceable cybersecurity requirements for developers, aligned with federal health data protections, are essential to protect patients, sustain trust in AI, and accelerate responsible innovation in health care.

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We encourage HHS to work across its agencies and throughout the federal government to harmonize existing guidance and resources into a single federal framework for AI usage in clinical care. In addition to ASTP/ONC, the Centers for Medicare and Medicaid Services (CMS), the Food and Drug Administration (FDA), the National Institute of Standards and Technology (NIST), the Cybersecurity and Infrastructure Security Agency (CISA), and other agencies will be essential to ensure consistent governance and oversight of AI tools appropriately spans the entire federal government.

Reimbursement

The same market forces that created the current health IT landscape still prioritize administrative efficiency over clinical functionality. This misalignment leaves family physicians without the tools they need to deliver optimal patient care. Without addressing the underlying business incentives that shape the design, deployment, and use of health technologies, AI developers and health care organizations are likely to follow the same trajectory as electronic health records (EHRs), repeating existing shortcomings rather than advancing care delivery. The AAFP believes that the fee-for-service (FFS) model will continue to drive the creation of AI tools to maximize utilization, instead of AI tools to actually improve patient care. As such, we urge HHS to continue pursuing the transition to value-based payment (VBP) models that align financial incentives with high-quality care and improved affordability of care across all stakeholders. This will drive the market to adopt AI solutions that drive quality care and cost-effectiveness.

Despite overwhelming evidence that primary care is the only health care component where an increased supply is associated with better population health and improved patient outcomes, the United States continues to underinvest in this cornerstone of the health system.ⁱ In many large organizations, primary care is still treated as a loss leader used to generate referrals to high-margin specialty and hospital services. The policy challenge, and opportunity, is to identify how AI can support greater investment in primary care, such as by enabling meaningful, low-burden reporting measures and supporting practices in delivering the four key functions defined by Dr. Barbara Starfield: first contact, continuity, coordination, and comprehensiveness. We encourage HHS to focus its efforts and resources on how AI tools can meaningfully strengthen primary care in the U.S. and improve patient outcomes.

Research and Development

The AAFP strongly believes that AI tools should enhance, not burden, clinical practice. We [support](#) HHS prioritizing research on AI products that streamline documentation, reduce administrative burden, and support clinical decision-making. If implemented and managed

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appropriately, the AAFP believes AI could deepen, not disintermediate, the patient-physician relationship by allowing physicians to spend more time engaging with their patients instead of clicking boxes on a screen.

The AAFP [strongly believes](#) AI tools must be developed and deployed in ways that reduce health disparities and promote equity. The AAFP believes companies providing AI tools must also address implicit bias in their design. While implicit bias cannot always be eliminated, companies should have standard processes to identify and mitigate the AI tool learning those same biases. In addition, when applicable, companies should have processes for monitoring for differential outcomes, particularly those that affect vulnerable patient populations. **We recommend HHS fund research on bias detection and mitigation, support the use of diverse and representative datasets, and engage communities in participatory research models.**

Additionally, we support investments in training and education to prepare the health care workforce for AI integration. High upfront and ongoing costs may make AI tools inaccessible to independent, safety-net, or rural physicians, which could negatively impact patient care. Further, limited access to AI could make clinician recruitment even harder at these practices and lead to less representative data collection. As AI tools continue being integrated into clinical workflows, it's crucial for the federal government, health care systems and hospitals, and other stakeholders to work together to ensure physicians have the AI literacy and AI-adjacent skills they need to be successful, including data stewardship, workflow design, and informatics abilities.

1. What are the biggest barriers to private sector innovation in AI for health care and its adoption and use in clinical care?

There are several significant barriers to private sector innovation in AI for health care, which include but are not limited to the following:

- Limited AI literacy among both end-users and purchasers. This knowledge gap contributes to hesitancy in evaluating, procuring, and effectively implementing emerging AI tools.
- The complexity of cleaning and preparing health data, as well as the limited generalizability of AI models due to wide variability in how data are captured and stored across systems.
- The significant mismatch between the rapid AI innovation cycle – typically six to seven months – and the much longer research and evidence-generation cycle, which often spans 18 to 36 months. This gap limits the timely validation of new AI tools and slows their adoption in clinical care.

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- The absence of clear national guardrails governing the safe and ethical use of AI in health care, coupled with the lack of a liability framework that reflects shared responsibility between health care professionals and AI developers.
 - Obstacles related to data access, interoperability, and variability in payer requirements. These challenges impede the adoption of health IT solutions like AI tools, because AI systems depend on interoperable, high-quality, structured data. Lack of broadband access in rural and underserved communities also limits patients' and physicians' ability to engage with digital solutions, including AI-enabled tools.
2. What regulatory, payment policy, or programmatic design changes should HHS prioritize to incentivize the effective use of AI in clinical care and why? What HHS regulations, policies, or programs could be revisited to augment your ability to develop or use AI in clinical care? Please provide specific changes and applicable Code of Federal Regulations citations.

The AAFP [recommends](#) modernizing payment policies so practices, especially small and independent practices, can invest in the infrastructure needed for AI integration. Variability in payer coverage and prior authorization requirements creates substantial administrative burden, limiting physician ability and willingness to adopt new AI tools. We strongly support reducing such variability, improving real-time access to patient data, and strengthening interoperability requirements so AI tools can function reliably. Below are additional recommendations.

- Develop and publish a risk-based framework for health IT, including AI, to provide clear guidance to the private sector on assessing and managing risk associated with AI use in clinical settings. The framework could serve as the foundation for a tiered approach to AI oversight that appropriately balances innovation, patient safety, and accountability.
- Accelerate the transition to meaningful VBP models that genuinely reward improved outcomes and lower costs, rather than programs that simply impose administrative burdens for data submission without driving significant clinical change. This will align financial incentives with high-quality primary care, which improves outcomes and lowers the total cost of care. Such alignment would encourage the development and adoption of AI solutions that support care quality, efficiency, and improved patient outcomes. In contrast, continued reliance on the FFS model will incentivize AI adoption primarily to increase volume and utilization of high-margin services, rather than to improve access to high-quality primary care.
- Develop and promote best practices for human-AI collaboration in clinical care, informed by recent NIST guidance, including establishing a clear liability framework that reflects shared accountability between health care professionals and AI developers. From a broad perspective, this could include collaborating with the Department of Justice on the False Claims Act and the Federal Trade Commission on truth in advertising, as each pertains to AI in health care.

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- Invest in initiatives that advance AI transparency and explainability in order to build workforce and public trust, support informed clinical use, and promote responsible adoption of AI technologies in health care. This could include establishing a national registry of AI solutions used in clinical care that publishes standardized transparency, performance, and efficacy information to support physicians' informed adoption, oversight, and accountability when using these tools. This should build on, not replace, existing transparency enabled by ASTP's Decision Support Intervention requirements.
 - Develop a standardized data set, similar to the Structured Product Labeling framework used for medications, to promote consistency, interoperability, and reliable AI development and usage across health care systems. Again, we would support this building on, not replacing, existing transparency requirements. Adopting a Structured Product Labeling-like approach for AI could mean requiring AI tools that integrate with EHRs to provide source attributes and related information in consistent, interoperable, and reliable structures so that this information can "surface" within EHRs.
 - Seek NIST's input in developing guidelines for post-market surveillance of clinical AI solutions, which would support ongoing monitoring of performance, safety, and real-world impact. While we acknowledge that NIST's work is not sector-specific, the agency is deeply resourced and knowledgeable on AI governance and monitoring, and we believe there is much to be learned from their work and insight. Though FDA is making strides towards this objective with its guidance around predetermined change control plans, no similar guidance exists for non-device AI solutions. We therefore believe this is particularly urgent for the large swath of AI tools that are viewed as non-device clinical decision support by FDA or are not used for a medical purpose but nevertheless can have a high impact on patient populations.
3. For non-medical devices, we understand that use of AI in clinical care may raise novel legal and implementation issues that challenge existing governance and accountability structures (e.g., relating to liability, indemnification, privacy, and security). What novel legal and implementation issues exist and what role, if any, should HHS play to help address them?

The AAFP remains deeply concerned about health data privacy, security, and the inadequacy of current protections for tools and solutions developed outside the purview of the Health Insurance Portability and Accountability Act's (HIPAA) guidance. We urge HHS to strengthen regulatory expectations for entities handling health-related data, including AI vendors not subject to HIPAA, and to clarify responsibilities for cybersecurity, data stewardship, and transparency of data use for these entities.

Separately, a core legal and implementation challenge for non-medical device AI tools used in clinical care is the absence of a standardized approach for assessing risk and determining the appropriate level of oversight and governance. Without clear, consistent criteria to differentiate

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low-, moderate-, and high-risk AI applications, health care organizations and developers face uncertainty that complicates deployment, procurement, and accountability. HHS should build on the work initiated under the Food and Drug Administration Safety and Innovation Act (FDASIA) and related health IT statutes to establish a robust, risk-based framework for health IT, including AI, that provides clear guidance to the private sector and serves as the foundation for a tiered approach to oversight and governance proportional to clinical risk.

In addition, the lack of a clearly defined liability model for clinical AI remains a significant barrier to adoption. In the absence of shared liability frameworks that appropriately allocate responsibility among physicians, health care organizations, and AI developers, clinicians may be reluctant to integrate AI tools into clinical workflows, even when such tools have the potential to improve care quality and efficiency. HHS can play a critical convening and policy-setting role by facilitating the development of governance and liability models that promote accountability while reducing uncertainty and supporting responsible innovation. **While we acknowledge that most current liability frameworks exist at the state level, not federal, the AAFP strongly believes this is a crucial space for HHS to be engaged.** We would support HHS collaborating with the National Conference for State Legislatures (NCSL), the American Legislative Executive Council (ALEC), and state medical societies to develop model liability legislation for AI developers and health care professionals.

As noted above, many non-device AI tools may nevertheless pose substantial risk or have substantial impact across a population. The absence of a widely endorsed risk framework and guidance on post-market surveillance of non-device AI tools limits implementers' ability to select a reasonable strategy to monitor AI tools to ensure they are effective and do not introduce new liability risks.

5. How can HHS best support private sector activities (e.g., accreditation, certification, industry-driven testing, and credentialing) to promote innovative and effective AI use in clinical care?

The AAFP [supports](#) industry-led and federal efforts to improve transparency and standardization among AI products. Certified or accredited AI tools should be required to meet usability, data governance, and patient privacy criteria. We would support HHS encouraging certifying bodies to include primary care perspectives to help ensure AI tools are safe and usable in diverse practice settings. Additionally, we support HHS collaborating with NIST and leveraging that agency's expertise, technical credibility, and standards-development experience to generate guidance for both the public and private sectors on the responsible development, evaluation, and testing of AI applications in health care. We recommend ASTP/ONC and HHS engage in a national, consensus-based effort to promote alignment between public policy objectives and

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private-sector initiatives related to AI tools' evaluation, accreditation, and certification in health care.

The AAFP would strongly support ASTP/ONC's increased engagement in private sector-led coalitions that are already doing meaningful work regarding AI accreditation, certification, testing, credentialing, and governance. We participate in many groups that are engaged in this important work, and we would welcome ASTP/ONC's participation, guidance, and support. Both the Council for Medical Specialty Societies (CMSS) and the National Academies of Science, Engineering, and Medicine (NASEM), among many others, have health care-focused AI workgroups that have developed or are in the process of developing accreditation, certification, and credentialing frameworks that would benefit from increased federal engagement and insight. We urge ASTP/ONC to consider joining these collaborative efforts, at least as federal observers. **We strongly agree with the Administration that voluntary, private sector coalitions can move more quickly than the federal government in many instances, but the government's perspective and support is still very much needed and wanted.** We also believe that consistent engagement with private coalitions will be essential to target and design effective policies and that policymakers could learn from ongoing initiatives. The AAFP believes it is crucial for ASTP/ONC to partner more closely with private sector coalitions on AI – both financially and intellectually – and we are eager to help facilitate closer collaboration in this space.

6. Where have AI tools deployed in clinical care met or exceeded performance and cost expectations and where have they fallen short? What kinds of novel AI tools would have the greatest potential to improve health care outcomes, give new insights on quality, and help reduce costs?

AAFP members frequently describe shortcomings in digital tools that fail to integrate with existing workflows or provide complete patient information. AI tools present similar risks if interoperability and data availability are insufficient. The primary care workforce needs AI tools that reduce documentation burden, surface actionable clinical insights, support population health management, and improve care coordination. Two use cases where AI tools have been showing great promise in helping primary care physicians and practices deliver more cost-effective, higher-quality care are AI ambient listening tools for documentation purposes and tools that can accurately summarize the EHR, which can improve appropriate and timely care and expand the capacity of physicians and other health care professionals. Most importantly in primary care settings, these tools support more meaningful interactions between patients and their physician-led care teams by allowing clinicians to focus on the patient – not the computer – during their limited interactions. Additionally, we are starting to see AI applied to accessing and summarizing medical research. To fully realize the benefits of these summary capabilities, within both EHRs and research publications, the AAFP believes these currently siloed solutions

must be integrated to improve physicians' ability to make thorough, timely, and evidence-based clinical decisions for their patients.

7. Which role(s), decision maker(s), or governing bodies within health care organizations have the most influence on the adoption of AI for clinical care? What are the primary administrative hurdles to the adoption of AI in clinical care?

Thanks to the broad range of environments our members practice in, the AAFP knows that the decision-makers and governance bodies for adopting AI tools in health care organizations vary widely depending on their organizational resource depth and decision-making structures. In large health systems and hospitals, there are often ample resources and multiple teams of people with various areas of expertise (IT, finance, legal, clinical) that contribute to decision-making, with frontline physicians too often excluded from these discussions. In small, physician-owned practices, resources are more limited, and physicians are often the sole decision-makers. Family physicians, particularly those in small and independent practices, have consistently shared that excessive administrative burden reduces their bandwidth to research and assess new AI and other digital health tools. The AAFP believes clear standards, streamlined administrative requirements, and investment in small practices' infrastructure and education are essential to increasing the adoption of AI solutions in clinical care.

8. Where would enhanced interoperability widen market opportunities, fuel research, and accelerate the development of AI for clinical care? Please consider specific data types, data standards, and benchmarking tools.

A robust health information exchange environment supported by all ecosystem actors is essential to aggregating patient data at the scale and completeness required for reliable implementation of AI in clinical care. This ecosystem encompasses health information exchange entities; all points of patient care (e.g., clinics, hospitals, labs, surgery centers, and pharmacies); payers; and, increasingly, patients themselves, as patient-generated data become more prevalent and integral to care delivery. For family physicians and other clinicians, the EHR is the primary mechanism for delivering vast amounts of information to inform care recommendations. EHRs must facilitate full accessibility to vast amounts of patient data on a timely and efficient basis—including scanned documents, lab results, free text, and unstructured formats. We urge HHS to ensure EHR vendors provide system-wide access to patient data and adopt modern application programming interfaces (APIs). The AAFP also supports:

- Robust enforcement of information blocking provisions, particularly for EHR developers that impose unnecessary technical, contractual, or administrative barriers. This would expand access to health data for third-party developers and enable the development of interoperable AI tools that deliver meaningful value to physicians and practices.

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- Expanding certified electronic health record technology (CEHRT) interoperability requirements to include standardized write-based APIs that enable authorized third-party applications to write data back into the EHR. This would support seamless integration into clinician workflows and improve usability for physicians and other end-users.
- Moving beyond a singular focus on exchange standards and instead require EHR functionality that supports a robust ecosystem of third-party applications. Certain developers have demonstrated that enabling this level of integration can significantly lower the cost and complexity of third-party connectivity with CEHRT, which can accelerate time-to-market for innovative tools.

10. Are there specific areas of AI research that HHS should prioritize to accelerate the adoption of AI as part of clinical care?

The AAFP encourages HHS to prioritize research in several key areas to accelerate the safe and effective adoption of AI in clinical care, including: the impact of AI on primary care workflows, administrative burden, and clinician usability; strategies to identify and mitigate bias in AI-enabled tools; patient-facing AI applications that support self-management and improve access to care; and best practices for integrating AI solutions within existing interoperability frameworks, such as the Trusted Exchange Framework and Common Agreement (TEFCA).

Conclusion

Thank you for the opportunity to provide written comments on this important topic and its potential impact on primary care access in the U.S. 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, FAF". The signature is written in a cursive, flowing style.

Jen Brull, MD, FAF

Board Chair

American Academy of Family Physicians

ⁱ National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. 2021. <https://doi.org/10.17226/25983>.