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Statement of

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Introduction
Chairman Cassidy, Ranking Member Sanders, and distinguished Members of the Committee, thank you for the opportunity to testify in support of the Assistant Secretary for Technology Policy and Office of the National Coordinator for Health IT (ASTP/ONC) within the U.S. Department of Health and Human Services (HHS) and our work to create systemic improvements in health and care through the access, exchange, and use of data.

As Assistant Secretary for Technology Policy and National Coordinator for Health IT, I lead nationwide efforts to advance health information technology and to expand electronic health information exchange capacity to reduce costs, empower patients and ultimately, make health care more affordable. As a practicing interventional radiologist, I have experienced firsthand how the bipartisan leadership of this Committee has helped move the United States from an antiquated paper-based system to a global leader in digital health.

My top priority is fostering greater data liquidity in the U.S. health care system so that patients and their clinicians are in the driver's seat. I see how modern data standards, combined with artificial intelligence (AI), can make health care more affordable, accessible and can support improved health outcomes.

No patient should be treated like a stranger at their next health care encounter simply because their records did not follow them. Patients and their caregivers must be able to see accurate, up-to-date health information in one place, rather than spending days or weeks chasing records that should be available in seconds. Access to data will empower patients to take control of their own health and help inform providers' clinical decision making which can lead to improved care and patient safety. Our work at ASTP/ONC will not only help realize these goals, but will also improve public health, and accelerate scientific research and discovery.

Affordability and Access
For too long, health care has been too expensive, with crushing administrative burdens, workforce shortages, and uneven access to high-quality care. America spends nearly one-third of the federal budget on health care yet ranks near the bottom of developed nations in health care outcomes. CMS recently reported that the U.S. national health expenditure (NHE) grew 7.2% to $5.3 trillion in 2024, or $15,474 per person, and accounted for 18% of Gross Domestic Product (GDP). Spending on Medicare, Medicaid, private health insurance, and out-of-pocket costs all continue to increase.[1] Health IT plays a role in reducing costs and we are doing all we can to support the Administration's focus on making health care more affordable.

To that end, in July 2025, we published the Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization (HTI-4) Final Rule, which makes important policy changes that will result in doctors and their patients having unprecedented real-time access to prescription drug information.[2] This information will help prescribers identify the most appropriate, cost-effective treatments while reducing unnecessary delays in the prior authorization process.

Thanks to this rule, health care providers will be able to compare drug prices, view out-of-pocket costs, and access prior authorization requirements as part of their workflow. Instead of a

clinician's staff spending an hour on the phone and fax just to discover that a prescribed drug is not covered by insurance, real-time benefit tools let the providers see covered alternatives at the point of care, allowing them to choose the option the patient can actually pick up.

Showing a provider the patient-specific cost at the time of prescribing results in savings of hundreds of dollars for common medications for diabetes, and thousands of dollars for higher cost specialty drugs.[3] For a senior on a fixed income or a parent managing a child's chronic illness, the ability of a prescriber to choose a covered, low-cost drug can mean the difference between skipping a prescription and being able to afford an essential medication.

This rule also establishes criteria for certified health IT, which most providers use today, to support the necessary functions to facilitate electronic prior authorization, including automation. Developers can begin testing for certification to these criteria now and we expect to see the first health IT modules completing certification over the next few months. When health IT certified to these criteria are fully implemented, we estimate that electronic prior authorization will save millions of hours of clinician time annually, totaling $19 billion in labor cost savings over ten years.

Today, a physician's office might fax the same information multiple times to different insurers, while a patient waits for weeks for an MRI. With electronic prior authorization built into certified health IT, the request can be submitted once from the electronic health record and tracked electronically, cutting days or weeks from that wait. That savings is time that can be spent with patients rather than on paperwork. That's the difference between a cardiologist wasting an afternoon on hold with a health plan and investing time in caring for her patients.

These reforms directly address a major pain point: patients, caregivers, clinicians, and payers continue to struggle with information exchange barriers, especially in the case of prior authorization, where a lack of adopted standards and coordination across stakeholders leads to administrative burdens and care delays.

Trusted Exchange Framework and Common Agreement

Core to addressing affordability and access while enabling data liquidity is our work to develop a trusted, nationwide infrastructure for secure data exchange. Since the 21st Century Cures Act was signed into law almost a decade ago, my office has implemented key provisions from title IV of the Act to establish a Trusted Exchange Framework and Common Agreement™ (TEFCA®), for nationwide health information exchange across health information networks. As consumers are able to enroll in a cell phone network of their choice and communicate with customers across all other networks, TEFCA allows health information to be exchanged across different health data networks nationwide.

Since TEFCA Exchange began in earnest in January 2024, 11 Qualified Health Information Networks, or QHINs, have signed up and been vetted to facilitate data exchange. Since Secretary Kennedy took office, we have seen exponential growth in use of the network. TEFCA now connects more than 70,000 locations nationwide and has supported exchange for well over 400 million health records, supplying a durable national backbone for interoperability. These numbers are not just statistics; they represent people. When TEFCA reaches its full potential, a

person moving from Virginia to Ohio will be able to have access to their health history at their new provider, even if their new clinic uses an electronic health record (EHR) system different from their old clinic. A child with asthma can present to an emergency department while visiting grandparents out of state and may find that the treating physician knows her medications, allergies, and entire health history in real time.

The TEFCA infrastructure also supports our federal partners' delivery of more efficient services. In December 2025, we collaborated with the Social Security Administration to release the *Exchange Purpose Implementation Standard Operating Procedure (SOP): Government Benefits Determination* to improve the costly and time-consuming process of retrieving, reviewing, copying, and transmitting medical records in support of patients seeking eligibility determinations for Social Security Disability Insurance.[4] We also see public health agencies across the country using TEFCA to share electronic case reports.

TEFCA is able to scale connectivity nationwide by, among other things, establishing the trust conditions necessary to automate responses to queries between parties that are new to health information exchange. TEFCA safeguards data privacy, including by enforcing specific eligibility criteria and rigorous vetting processes for organizations to become QHINs. TEFCA reinforces participants' existing obligations to comply with applicable privacy and security requirements, such as the HIPAA Rules and state laws. TEFCA requires that entities supporting patient access to health information agree to meet not only select privacy and security requirements of HIPAA, but also more stringent protections unique to TEFCA.

Under the Trump Administration and with continued Congressional support for ASTP/ONC, TEFCA's future is bright. We have attracted more QHINs, enhanced transparency around TEFCA processes, and expanded stakeholder participation in governance so that patients, providers, and payers can all benefit from seamless, trusted exchange, building on the bipartisan foundation this Committee helped to establish.

Addressing Information Blocking

Technology alone is not enough. Despite technological advancements and improved exchange infrastructure through TEFCA, information does not always move the way it is supposed to, the way any patient or clinician would expect. One of the biggest obstacles to data liquidity is information blocking. We hold the view that health records belong to the patient, and that the patient determines how they are used. No actor — whether a provider, developer of certified health IT, or health information network/health information exchange — should be able to hoard health information for competitive advantage or convenience. As Congress recognized in the 21st Century Cures Act, information blocking can materially discourage the access, exchange, and use of electronic health information. At ASTP/ONC, we know the impact. Years of public and private investment in digital infrastructure are undermined, delays in care occur, and patients and clinicians are frustrated as their attention must turn away from care and toward understanding why information they need is not available to them.

The Trump Administration's commitment to unblocking the flow of health information continues efforts that began during the President's first term, under which the ONC Cures Act Final Rule[5] was published. Since opening the information blocking complaint portal, HHS has received over

1,500 submissions, with a majority filed by patients, underscoring the real-world impact of these practices.[6] For instance, a patient eligible for a cancer clinical trial may miss the opportunity because key pathology or imaging reports are trapped in a system that will not share them. A mother caring for an aging parent may spend hours chasing medical records that should be at her fingertips.

We are a quarter of the way through the 21st century, and these practices are unacceptable. In some cases, missing information is not just frustrating, it is dangerous. A patient with a known drug allergy who shows up at a new facility without their records may be prescribed improper medication that could have been avoided if their history were available. The 21st Century Cures Act authorized ASTP/ONC and the HHS Office of Inspector General (OIG) to take enforcement actions to hold those who block electronic health information accountable and to prevent future violations. In September 2025, HHS announced a major enforcement initiative to increase resources, prioritize high impact cases, and work closely with the HHS OIG so that bad actors face meaningful consequences and compliant actors can compete on a level playing field.[7] This announcement was a warning to actors still engaging in information blocking to come into compliance with the rules governing the flow of patient information and a call to action for patients, providers, payers, local health departments, and health IT companies to report alleged information blocking.

In February, ASTP/ONC initiated actions by sending out notices of potential non-conformity to developers of certified health IT. These notices request information and explanations related to potential non-conformities under the ONC Health IT Certification Program.

We are also collaborating with colleagues at the Federal Trade Commission (FTC), the Department of Justice, and state governments to look at possible anti-competitive business practices and other behaviors in the market that prevent the access and exchange of health. As many states allow for an individual right of action in instances of interference with the exchange of electronic health information, we plan to develop educational resources for compliance officers and attorneys.

It’s also our intention to continue to work with providers, health information networks, and health IT developers and provide education materials to help them understand what information blocking is and how to comply with the law.

ONC Health IT Certification Program

At ASTP/ONC, we focus on ensuring that the technology used in clinics and hospitals can plug into this data exchange infrastructure and keep pace with innovation. Nearly every hospital and ambulatory care provider relies on health technology certified through the ONC Health IT Certification Program (Certification Program).

In recent years, ASTP/ONC has used the Certification Program to create the digital foundation for a modern app ecosystem that we have seen in every other major sector. Specifically, the Certification Program includes the use of Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) application programming interfaces (APIs) for patient and population services.[8] America's interoperability arc in health care has bent decisively toward

FHIR-based APIs. An open, interoperable health data ecosystem invites entrepreneurship, drives innovation, and cements American leadership and competitiveness in the expanding digital health marketplace.

As part of our focus on data liquidity, we have taken actions to modernize the Certification Program, to reflect today's needs and tomorrow's innovation. In December 2025, ASTP/ONC issued the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5) Proposed Rule to streamline outdated certification criteria, reduce regulatory burden, and recenter the program on standards-based APIs and interoperability solutions enabled by AI that can improve automation and health IT performance.[9]

The transition to a FHIR-based API ecosystem is a strategic imperative and an investment in the United States interoperability future. The proposed changes would enable ASTP/ONC to reset the Certification Program's regulatory scope and establish a new foundation on which to build FHIR-based API requirements in the future. This would allow more creative AI-enabled interoperability solutions that combine FHIR with newer standards to emerge, as well as provide the potential for better, faster, and more consistent ways to address emerging market needs and policy imperatives.

Specifically, HTI-5 proposes to remove over 50% of the Certification Program's criteria; to revise several other criteria so as to reduce health IT developer compliance burdens; and to permanently implement previously issued enforcement discretion notices. Taken together, these proposals are estimated to save certified health IT developers more than 1.4 million compliance hours in their first year and $1.5B in compliance costs over 10 years, giving developers new capacity to deliver innovative solutions for their customers.

We also recently issued a request for information (RFI) to address another interoperability pain point, the access and exchange of diagnostic imaging.[10] Behind every image is a patient waiting for answers. Ensuring those images move seamlessly between care teams means those answers can come faster, with greater accuracy and at a lower cost. In this RFI, we are soliciting public feedback on how standards and certification criteria can support the exchange of diagnostic images for the benefit of patients and providers.

Building a Foundation of AI-enabled Interoperability Solutions

The same infrastructure that supports interoperability today must also position us to use artificial intelligence safely and effectively. As a radiologist, I've been using AI for over 20 years, as more than three-quarters of FDA authorized AI devices support radiology.[11] The power and potential of AI to transform medicine, to improve access, to empower patients, to automate costly administrative functions and to optimize diagnosis and treatment cannot be overstated. AI scribes have helped clinicians focus less on documentation and more on delivering patient care, decreasing "pajama time" that has been the curse of primary care providers.[12] In a typical primary care visit, clinicians can spend more time looking at the screen than at the patient.[13] AI scribes flip that ratio, allowing the clinician to maintain eye contact and conversation while still meeting documentation requirements.

Now, with generative AI, we're at a tipping point where technology can truly improve health and wellness. Our Administration believes in the power of AI to improve health care. This Administration is leading with a "try-first" culture of AI. The AI Action Plan released by the White House in July 2025 discusses how health care has been slow to adopt AI due to a variety of factors, including distrust or lack of understanding of the technology, a complex regulatory landscape, and a lack of clear governance and risk mitigation standards.[14]

In December 2025, in collaboration with the HHS Deputy Secretary's office, ASTP/ONC released a RFI focused on one big question: What would it look like if we put the whole of HHS toward accelerating the use of AI in clinical care?[15] This RFI builds on the recently published HHS AI Strategy and the administration's overall AI policy framework. HHS is especially interested in comments from those leveraging AI tools for clinical settings. Feedback will inform how HHS uses three major levers: regulation, reimbursement, and research and development.

Imagine an AI-enabled system that flags early signs of heart disease for a rural clinician who does not have a team of specialists on hand. That is the kind of innovation we seek to enable, particularly in communities that have historically had less access to specialty care. In primary care, AI tools embedded in the EHR could scan years of lab results and visit notes to identify patients whose diabetes control is quietly worsening, prompting outreach before complications occur.

Conclusion

ASTP/ONC's efforts are all aimed at a simple but ambitious goal: a health system where people can see, manage, and share their health information as easily as they manage their finances or travel. In this not-so-distant future, an individual with multiple chronic conditions can keep all their health information in one secure digital place and share it instantly with a new provider, a caregiver, or a trusted app—no matter where they live or where they receive care. For a patient with heart failure, that might mean their bathroom scale, their cardiologist, their pharmacy, and their local grocery delivery service are all connected—so when small changes signal trouble, care teams can adjust medications and diet before a hospitalization is needed.

TEFCA, a modernized Certification Program, and strong information blocking enforcement together make possible a world where a patient's data is leveraged to provide optimal care, at the right time, for low cost.

With continued support from Congress, ASTP/ONC will turn this person-centered, data-driven vision into an everyday reality for people and families across the country. Together, we can ensure that data is not a barrier, but a bridge, connecting patients to safer care, clinicians to better tools, and communities to a more resilient health system for years to come.

Citations

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