

February 27, 2026

The Honorable Thomas Keane  
Assistant Secretary for Technology Policy  
Office of the National Coordinator for Health Information Technology  
200 Independence Ave SW Washington, DC 20201

**RE: RIN 0955-AA09; Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5 Proposed Rule)**

***Submitted electronically via regulations.gov.***

Dear Secretary Keane,

The National Rural Health Association (NRHA) appreciates the opportunity to comment on the HTI-5 Proposed Rule, Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity. We appreciate ASTP's continued efforts to improve quality and transparency, while recognizing the unique challenges faced by rural hospitals and providers. NRHA is committed to working with ASTP to ensure that the needs of the more than 60 million Americans that reside in rural areas are supported by regulatory changes that strengthen rather than erode the rural health safety net, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA has consistently supported thoughtful modernization of health information technology policy to expand interoperability, improve care coordination, and enhance data-driven public health response. We supported the HTI-1 Final Rule because it strengthened interoperability standards, improved algorithm transparency, clarified information blocking exceptions, and aligned certification criteria with evolving clinical needs.<sup>1</sup> Rural hospitals undertook significant investments to comply with HTI-1, including upgrades related to USCDI v3 adoption, enhanced interoperability requirements and certified Decision Support Interventions (DSIs) as part of the Base EHR definition. While NRHA recognizes ASTP's intent to reduce burden and promote innovation, regulatory recalibration must account for the operational realities of rural providers and the compliance investments already made under HTI-1.

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<sup>1</sup> <https://www.ruralhealth.us/blogs/2025/04/breaking-down-hti-1-and-the-future-of-health-it>

## Rural Health Information Technology Challenges.

Rural providers operate within a persistent digital divide characterized by limited broadband access, constrained capital investment capacity, workforce shortages, and reduced participation in advanced interoperability frameworks compared to their urban counterparts. According to ONC's data, awareness and planned participation in the Trusted Exchange Framework and Common Agreement (TEFCA) among U.S. hospitals varies markedly, and rural facilities in particular report lower levels of readiness and engagement. While national survey data indicate high rates of certified EHR adoption, these figures do not fully capture disparities in infrastructure robustness in which many rural health care facilities still lack access to broadband; cybersecurity preparedness; or operational maturity necessary to safely sustain increasingly digital health environments.

Many rural health care organizations face insufficient funding, infrastructure, resources, and personnel to achieve the level of cybersecurity necessary to protect patient information in an increasingly digital care delivery environment. Health care delivery is now fundamentally dependent on electronic medical records that are widely distributed, shared, and accessible, making cyber preparedness essential to continuity of care. Cyber threats are escalating rapidly. Approximately 66 percent of health care organizations reported experiencing some form of cyberattack in 2021, and security breaches increased 84 percent from 2018 to 2021.<sup>2</sup> Cyberattacks currently impact more than 88 million patients annually. Rural hospitals are increasingly targeted precisely because they are perceived as less resourced and less prepared than large urban systems.<sup>3</sup> The financial consequences are severe as cybersecurity attacks disruptions are more detrimental in rural areas given the outsized impact that lost revenue may have on rural hospital finances. The estimated cost of remediating a health care record breach is approximately \$418 per affected individual, and recent rural hospital closures have been attributed in part to the financial impact of cyberattacks.<sup>4</sup>

These realities will be impacted by HTI-5's proposed removal of numerous criteria involving securities, integrity, authentication, auditing, and certification guardrails. Rural hospitals frequently operate on low-to-negative margins and lack dedicated cybersecurity staff or comprehensive training programs. In such environments, certification standards are not redundant administrative requirements; they often serve as the minimum enforceable floor ensuring that vendor products include basic protections.<sup>5</sup> In addition to cybersecurity vulnerabilities, rural facilities face structural interoperability constraints. Participation in TEFCA and other advanced exchange frameworks requires broadband reliability, technical staffing, and legal contracting capacity that many small facilities do not possess.<sup>6</sup> Limited connectivity impairs access to cloud-based security solutions, real-time threat intelligence, and secure exchange capabilities. Without targeted federal alignment, deregulatory actions that assume uniform technological maturity may unintentionally widen the operational gap between urban integrated systems and small rural hospitals and clinics.

State Rural Health Transformation Program (RHTP) initiatives proposed in applications demonstrate that rural states are investing proactively in interoperable data platforms, broadband-enabled telehealth expansion, and modernization of rural delivery systems.<sup>7</sup> However, these state-led efforts depend upon stable federal certification expectations and predictable national interoperability frameworks. HTI-5's proposed deregulatory changes should therefore be evaluated in light of their cumulative impact on rural cybersecurity posture, vendor accountability, and the sustainability of interoperable infrastructure in small facilities.



### 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.*

The proposed rule explains that certain certification criteria are identified for removal or revision because they are considered “widely adopted” or “widely implemented,” based in part on their inclusion in the Base EHR definition in § 170.102 or in the Certified Electronic Health Record Technology (CEHRT) definitions established by CMS for purposes of the Medicare Promoting Interoperability Program, the Merit-based Incentive Payment System Promoting Interoperability performance category, and Alternative Payment Model determinations. The preamble further cites survey data indicating that 96 percent of hospitals and 78 percent of physicians report having a certified EHR.

**NRHA respectfully urges caution in equating high rates of certified EHR adoption with uniform operational capacity.** Rural hospitals and Critical Access Hospitals (CAHs) that participate in the Medicare Promoting Interoperability Program or Advanced Alternative Payment Models must use CEHRT to participate in federal payment programs.<sup>8</sup> For these facilities, CEHRT serves as the structured compliance framework ensuring baseline standards for interoperability, clinical functionality, and security.

However, adoption of CEHRT does not equate to possession of internal cybersecurity teams, informatics specialists, or capital reserves necessary to independently sustain functionality if certification guardrails are removed. The 96 percent hospital adoption statistic aggregates large integrated delivery systems with small, independent rural hospitals operating under markedly different resource constraints. For many CAHs, which are statutorily limited to 25 inpatient beds and operate under cost-based reimbursement, certification criteria function as baseline safeguards rather than operational enhancements. **Removal of criteria deemed “widely implemented” may disproportionately affect rural providers that lack the ability to replicate or independently validate those capabilities outside the certification framework.**

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<sup>2</sup> Stringfellow A. Healthcare and Cybersecurity: 35 Key Statistics and Facts You Should Know. [tausight.com](https://www.tausight.com). Published November 1, 2022. Accessed September 13, 2023. [www.tausight.com/healthcare-andcybersecurity-key-statistics/](https://www.tausight.com/healthcare-andcybersecurity-key-statistics/)

<sup>3</sup> Schwartz N, ed. Rural Hospital Cybersecurity Protection Bill Moves Forward. *Beckers Hospital Review*; 2023.

<sup>4</sup> Hassell, M., Niblock, J. (2024). Cybersecurity: A path to increase rural health care preparedness. National Rural Health Association. <https://www.ruralhealth.us/getmedia/ad0774a2-49b4-4f9a-b2c5-2edf0eaf6bcf/2024-NRHA-Cybersecurity-Rural-Health-policy-brief.pdf>

<sup>5</sup> Mclaughlin J. Cyberattacks on Hospitals “Should Be Considered a Regional Disaster. *npr.org*. Published June 2023. Accessed September 13, 23AD. [www.npr.org/2023/06/25/1184025963/cyberattacks-hospitalsransomware](https://www.npr.org/2023/06/25/1184025963/cyberattacks-hospitalsransomware)

<sup>6</sup> Hains L, Kovoor JG, Stretton B, et al. When one size does not fit all—artificial intelligence in Australian rural health. *Aust J Rural Health*. 2025;33(3). doi:10.1111/ajr.70037

<sup>7</sup> [https://nrha-prod-eastus-be.azure.silverttech.net/NationalRuralHealth/media/Documents/Advocacy/2025/RHTP%20Application%20Material%202025/RHTP-State-Tracking-Guide\\_Final.pdf](https://nrha-prod-eastus-be.azure.silverttech.net/NationalRuralHealth/media/Documents/Advocacy/2025/RHTP%20Application%20Material%202025/RHTP-State-Tracking-Guide_Final.pdf)

<sup>8</sup> Centers for Medicare & Medicaid Services. (2025, November 24). *Promoting Interoperability Programs*. <https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs>

NRHA recommends that, prior to finalizing removals justified on the basis of widespread adoption, ASTP conduct and publish a rural-stratified impact analysis evaluating whether small rural hospitals, rural health clinics and CAHs possess the operational and financial capacity to sustain affected functionality absent enforceable certification requirements.

## 2e. Care Coordination Certification Criteria — Decision Support Interventions (§ 170.315(b)(11)).

NRHA is concerned with the proposal to remove transparency and risk management requirements applicable to predictive decision support interventions (DSIs), including the removal of source attribute requirements in §170.315(b)(11)(iv), related access and modification requirements in §170.315(b)(11)(v), and risk management requirements in §170.315(b)(11)(vi). Under HTI-1, transparency requirements for predictive and generative AI applications were introduced to promote fairness, validity, effectiveness, and safety. As of January 1, 2025, hospitals participating in CMS Promoting Interoperability programs were required to own software certified to the DSI criteria.<sup>9</sup> Rural hospitals invested significant resources to comply with these requirements in good faith.

Rural clinicians frequently practice in environments characterized by limited specialist availability, workforce shortages, and broader scopes of practice. In such settings, embedded clinical decision support and predictive tools may play a particularly important role in supporting diagnostic accuracy, care coordination, and early intervention. Transparency regarding how predictive algorithms were designed, developed, tested, evaluated, and intended to be used enables clinical users to make informed decisions about deployment and reliance. Therefore, this is not merely an administrative consideration; it is a clinical safety consideration.

Large integrated delivery systems may maintain internal data science teams, compliance personnel, and AI governance structures capable of independently evaluating predictive model performance and mitigating risks. CAHs and small rural facilities typically do not. Removal of source attribute transparency and risk management requirements would increase reliance on vendor assurances without standardized disclosure expectations. This dynamic may disproportionately affect rural providers that lack the capacity to independently assess algorithmic bias, data representativeness, or model limitations.

NRHA recognizes the importance of fostering innovation in AI applications in health care. However, innovation and transparency are not mutually exclusive. For rural facilities operating with limited analytic capacity, baseline transparency and risk management standards provide essential guardrails for safe and effective implementation. **We encourage ASTP to consider whether alternative approaches to streamline requirements could be pursued without eliminating foundational transparency and risk management standards that support safe deployment in small and under-resourced facilities.**

## IV. Information Blocking (Part 171)

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<sup>9</sup> Breaking down HTI-1 and the future of health IT. (2025). National Rural Health Association. <https://www.ruralhealth.us/blogs/2025/04/breaking-down-hti-1-and-the-future-of-health-it#:~:text=An%20important%20aspect%20of%20meeting,valid%20for%20meaningful%20use%20reporting.>

## *7B. Standards and Implementation Specifications for Health Information Technology*

NRHA appreciates ASTP's continued support for the Trusted Exchange Framework and Common Agreement (TEFCA). We understand the rationale for proposing removal of the TEFCA Manner Exception based on maturation of the framework and concerns regarding potential misunderstanding. However, rural participation in TEFCA and related exchange networks remains uneven. Many CAHs and small rural hospitals participate in health information exchange through vendor-mediated connectivity or regional HIE structures rather than as direct Qualified Health Information Networks, Participants, or Sub-participants.<sup>10</sup>

Although the proposed removal of the TEFCA Manner Exception does not automatically render any practice information blocking and requires case-by-case evaluation, regulatory uncertainty can have disproportionate effects on small providers. Facilities with limited compliance capacity may adopt conservative exchange practices to mitigate perceived enforcement risk, potentially slowing interoperability rather than accelerating it. **NRHA encourages ASTP to consider whether additional rural readiness assessment, technical assistance, or clarification regarding enforcement discretion may be appropriate as TEFCA continues to mature.** Ensuring that rural providers are not inadvertently disadvantaged during this transition will help promote equitable participation in national exchange frameworks.

### **Applicability to Critical Access Hospital.**

NRHA respectfully requests clarification regarding how the proposed revisions affect CAHs participating in federal programs that require CEHRT. CAHs are not uniformly situated; however, those participating in CMS Promoting Interoperability programs rely on CEHRT to meet federal requirements. HTI-1 required hospitals to adopt certified DSI capabilities and other interoperability enhancements as part of the Base EHR definition. Rural facilities have invested in system upgrades and vendor transitions to comply with these evolving standards. HTI-5 proposes to remove or revise several recently implemented requirements. Given CAHs' statutory structure, limited IT staffing, and constrained operating margins, regulatory shifts occurring shortly after mandatory compliance may create operational instability. **NRHA urges ASTP to provide explicit clarification regarding CAH applicability and to evaluate whether transition timelines, phased implementation, or rural impact assessments are appropriate.**

### **Future Certification Direction and FHIR Prioritization**

NRHA recognizes ASTP's continued prioritization of Fast Healthcare Interoperability Resource-based (FHIR) interoperability and incremental certification updates. Rural hospitals support modernization efforts and are actively participating in state and federal initiatives, including RHTP investments in interoperable data platforms and broadband-enabled telehealth expansion. However, given persistent broadband limitations and capital constraints in rural healthcare settings, a transition to FHIR-forward may add unnecessary administrative burdens to these facilities. **Therefore, NRHA recommends these architectures align with infrastructure readiness and vendor support**

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<sup>10</sup> Johnson, N., Murphy, A., McNeese, N., Reddy, M., & Purao, S. (2013). A survey of rural hospitals' perspectives on health information technology outsourcing. AMIA ... Annual Symposium proceedings. AMIA Symposium, 2013, 732–741.



**timelines.** NRHA supports the goals of interoperability, innovation, and administrative simplification. At the same time, rural hospitals and CAHs operate within structural capacity constraints distinct from large health systems. Certification standards, algorithm transparency requirements, and clearly defined information blocking exceptions provide foundational guardrails that support safe and sustainable rural adoption of health IT.

Thank you for the opportunity to comment on this proposed rule. We look forward to continuing to work together towards our mutual goal of improving health care and access for rural Americans. If you have any questions or would like to discuss further, please contact NRHA's Senior Government Affairs and Policy Coordinator Marguerite Peterseim at [mpeterseim@ruralhealth.us](mailto:mpeterseim@ruralhealth.us).

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan".

Alan Morgan  
Chief Executive Officer  
National Rural Health Association