March 5, 2026

Senate HELP Committee Holds Hearing on Improving Patient Outcomes Through Next-Generation Care

Overview:

On March 5, the Senate Committee on Health, Education, Labor and Pensions (HELP) held a hearing to discuss improving patient care through enhanced data interoperability. Dr. Thomas Keane, Assistant Secretary for Technology Policy and National Coordinator for Health Information Technology (ASTP/ONC) at HHS, served as the administration witness. The hearing centered on strategies and policy proposals to address information blocking amongst public and private electronic health record (EHR) databases. Information blocking is a practice by an entity "that is likely to interfere with the access, exchange, or use of electronic health information, expect as required by law or specified in an information blocking exception." Dr. Keane stated that his top agency priority was to increase the data liquidity of EHRs, explore opportunities to utilize technology in addressing health care affordability, and to empower patients with access to their personalized health information. Dr. Keane also testified about the use of the Trusted Exchange Framework and Common Agreement (TEFCA) as a national health record exchange offering portability and access to patient health data. TEFCA was established by the 21st Century Cures Act, which instructed the federal government to "develop or support a trusted exchange framework, including a common agreement among health information networks nationally. ASTP/ONC recently unveiled the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5) Proposed Rule, which proposes removal of redundant requirements under the ONC Health IT Certification Program.

When faced with questions regarding the role of vertically integrated health care entities including EHR vendors and health insurers, Dr. Keane struck a markedly different tone than recent witnesses in other health care affordability hearings by positioning such actors as reliable and willing partners in HHS' efforts to increase interoperability. However, Dr. Keane also stressed the willingness of his agency to enforce data and interoperability rules through the issuance of Notices of Nonconformity and referrals to the HHS Office of Inspector General (OIG). Artificial Intelligence (AI) stood as an additional topic of interest, with several Senators positing questions about positive use cases for interoperability as well as potential guardrails to protect patient safety and privacy. Dr. Keane regularly alluded to HHS' Dec. 2025 Request for Information (RFI) on Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care. Several legislative proposals were offered by Senators on both sides of the aisle, including proposals to strengthen the federal government's public health cybersecurity and data infrastructure (the Improving DATA in Public Health Act [awaiting reintroduction] and the Rural Hospital Cybersecurity Enhancement Act [S. 2169]), and provide transparency into health care pricing and utilization management strategies (the Patients Deserve Price Tags Act [S. 2355/H.R. 5582] and Improving Seniors' Timely Access to Care Act [S.1816/H.R. 3514]).

Witnesses:

- Thomas Keane M.D., M.B.A., Assistant Secretary for Technology Policy and National Coordinator for Health Information Technology, United States Department of Health and Human Services.

Committee Leadership:

- Committee Chair – Bill Cassidy (R-LA)
- Committee Ranking Member – Bernie Sanders (I-VT)

Question & Answer Highlights:

Senator Roger Marshall (R-KS) – My Medicare Advantage patients claim that their health care is delayed by prior authorization. It is the number one concern of physicians. The Improving Seniors Timely Access to Care Act could help. What have you and the administration done to reduce the burden of prior authorization?

Dr. Keane – In July of 2025, we finalized HTI-4 final rule that had two provisions to make care more affordable and accessible. One provision was to adopt standards for real time point of care prior authorization. We promulgated a number of standards allowing EHR to communicate with insurers in real time. We've worked with CMS colleagues to ensure that prior authorization adjudications occur in real time, and we pledged to have 80% of prior authorizations covered by Jan. 1, 2027.

Senator Marshall – What are some of the barriers to interoperability you see going forward?

Dr. Keane – With the standards in place for both payers and providers, the barrier is getting them to talk. The insurers and EHR companies are committed to the pledge. Prior authorization creates roughly $2 billion in administrative cost increase each year. We've found great partners in the insurers and EHR providers.

Senator Marshall – Small pharmacies are willing and ready to provide EHR information, as I've seen many do through the use of email. Do you think the large oligopolistic insurers are willing to do the same? Or are they throwing up more barriers?

Dr. Keane – In our experience, they have identified where the choke points are and how to address them. The HTI-4 rule also adopted standards for real time prescription benefit determinations. This means that doctors can chose therapeutically appropriate and cost-effective drugs for patients at the pint of care. This ability is really a game changer, which will improve adherence and outcomes.

Senator Tim Kaine (D-VA) – 96% of hospitals use interoperable EHR after passage of the HIGHTECH Act. But, the bill didn't cover all aspects of health care like behavioral health providers, long-term care facilities, etc. Now, the funding that incentivized this funding is no longer available. Can you discuss the uptake of EHR amongst providers who were not covered by the High Tech Act?

Dr. Keane – When I started, I asked HHS career staff to find ways to make an impact. One of the suggestions was to incorporate behavioral care providers into the electronic health data exchange. We're addressing this in a number of ways. The first is the $20 million Behavioral Health Information

Technology initiative. We developed the US Core Dataset for Interoperability for Behavioral Health. We are currently running pilots in 9 states.

Senator Kaine – How about long-term care facilities?

Dr. Keane – Currently there are EHRs that target long-term care facilities. Our hope with the HTI-5 rule is to pivot certification criteria to a new focus on interoperability and that new solutions will enter the market that are affordable and customized to certain types of providers.

Senator Kaine – Data sharing requirements implemented during the COVID-19 Public Health Emergency improved records exchange, but many of those requirements went away with the end of the PHE. The Improving Data in Public Health Act would direct CDC to establish standards for sharing public health information. What'd we learn about the importance of electronic record sharing during the pandemic?

Dr. Keane – We learned a great deal about the importance of and barriers to electronic records sharing. At ONC, we have developed a USCDI+ for Public Health Data reporting set that captures public health datapoints. The lack of data was one of the issues we had in adequately addressing COVID.

Chairman Cassidy (R-LA) – It seems that the future promise of these records would include using AI for clinical support. How can we take this information, upload it, and allow it to be reviewed by AI? There are many implications here, who is liable? Who gets to use the data that flows from it? What are the privacy issues?

Dr. Keane – In December 2025, we put out an RFI on how AI can be safely and effectively deployed in the health system to align with current standards. We have received hundreds of responses and submissions to guide our policy and the policies of our sister agencies. As a radiologist, I've used AI for over 20 years.

Chair Cassidy – Yeah but that's different. You're looking at an X-ray; I'm talking about a set of data to be managed. Would you have governance over this or would FDA?

Dr. Keane – We provide patients the ability to access their EHRs. TEFCA has restrictions on what individual providers can do. They can not sell the data or use it for marketing purposes. They can not use it in employment, credit, or insurance decisions.

Chair Cassidy – If there's clinical decision making support from AI. Do you regulate that or does FDA?

Dr. Keane – I believe that's the purview of FDA. What we regulate is the ability to get ahold of that information. One of my habits is to go online and see what patients say about the procedures we do, to see how to improve my approach.

Chair Cassidy – The 21st Century Cures Act mandated that providers and EHR vendors allow 3rd party apps to access info on behalf of the patients. There are allegations that this is also a point of info blocking. Your thoughts?

Dr. Keane – We're finding different reports on how much of this info is accessible. One provider of AI-augmented care told me they could access 90% of patient records. Another provider said they could pull far less. We've received over 1500 allegations through our information blocking complaint portal.

We share that with OIG who investigates complaints. We're also issuing Notices of Nonconformity to potential information blockers and will put them on a corrective action plan. If they remain noncompliant, we can pull their licenses.

Senator John Hickenlooper (D-CO) – You discussed info exchange barriers. We introduced the Patients Deserve Price Tags Act which requires the publication of "real" prices visible to health care consumers. You've discussed the benefits of transparency; do you worry that current opacity of costs in the system reduces the effect of natural competition on lowering prices?

Dr. Keane – I share your concern. Patients are empowered by price information. To the extent that we can allow shared decision making between the patient and clinician, we will continue to do that. We're working with direct-to-consumer pricing info providers to get not only PBM pricing info but DTC pricing info into electronic health records. As you know, what patients pay in copays can often exceed the cash price. The more info the patient has, the more adherent they are.

Senator Hickenlooper – By most measures, health care is a $5 trillion spend every year, when 25% could be a lack of efficiency or redundancy.

Dr. Keane – The administrative burden related to health care is enormous and there's no reason this can't be automated. The first step is getting data captured, the second is getting it exchanged by standards. Once that happens, prior authorization, price discovery, even scheduling and appointments can be done in an automated fashion.

Senator Hickenlooper – The GOP reconciliation package cut billions in rural health funding. How do we get funding to rural hospitals to prevent closures?

Dr. Keane – I was a rural practitioner for years and I understand the unique challenges. My hope is we can leverage information technology to close those gaps and would be happy to provide technical assistance on this legislation.

Senator Angela Alsobrooks (D-MD) – When tech works well, it can improve the patient and provider experience. But when data systems fail, the consequences can be serious. Delayed care, privacy risk, etc. The policies governing these technologies should prioritize patient safety, clinical trust, and the integrity of our health care system. We need to ask: are we strengthening the guardrails that protect patients or weakening them? You served with Nikki Tripathy, the former Assistant Secretary for Technology Policy. In 2024, HHS elevated the Office of the National Coordinator and expanded its authority to elevate data, technology, and AI policy for the department, following the Change Healthcare data breach. The idea was to create a forward-facing office that coordinates technology policy and strategy across the department. Can you share why it was important to create a centralized system within the department for better coordination?

Dr. Keane – The Office of the National Coordinator has coordination as its main role. Our ability to convene and work with partners across HHS to promulgate standards is essential to our mission. We were doing this before and after the reorganization and are doing everything we can to protect patient privacy and security. The agency dealing with cybersecurity breaches is the HHS Assistant Secretary for Preparedness and Response, as well as the FBI and law enforcement agencies.

Senator Alsobrooks – What role should ASTP play in establishing guardrails to ensure that these technologies are safe, transparent and trustworthy.

Dr. Keane – As a physician, we are absolutely forensic in examining what the AI is capable of doing and making sure it's safe for patients. This is why released the RFI last December asking the public for feedback on the best approach for regulating AI. We intend to share this info with Congress and our sister agencies.

Senator Alsobrooks – Do you believe the current authorities across HHS are sufficient to regulate AI in clinical settings? Or is there an additional framework Congress should be paying attention to?

Dr. Keane – Our RFI will surface that. I can't comment on the authority of other agencies, but I believe our agency has sufficient authority to regulate health IT and manage a nationwide system to ensure the AI is safe and effective. We collaborate closely with our colleagues at CMS and FDA.

Senator Marshall – We do have two bills, between the price tags bill and prior authorization bill, that would transform the patient experience. I'm glad we'll be getting a markup soon to get these bills across the finish line. The biggest failure of EMR was interoperability, with systems not talking to each other. DOD and VA are not on the same EMR. Your goal is to have entities receiving federal funding on the same system to communicate with CMS. What's keeping us from doing that?

Dr. Keane – In order to make interoperability work, there has to be clear standards. There have to be tools for conformance with these standards. We fund and operate our own standard conformance tools.

Senator Marshall – There are probably three or four companies out there that manage 90% of the nation's EMRs. Is there one that isn't cooperative?

Dr. Keane – We don't pick winners and losers, and work with the assumption that everyone in the market wants to be a good actor. When we find information blocking, we inform them, discuss what should be done correctly, and share a notice of nonconformity and refer the case to OIG if they continue.

Senator Marshall – Have any of those cases gone forward? I think we need to start holding these companies accountable.

Dr. Keane – I can't comment on what OIG is doing, as I'm barred from knowing specific details regarding their investigations.

Senator Marshall – My goal is to have personalized medical records that a patient control. While we're taking good steps, how do we make this a reality?

Dr. Keane – The TAFCA network we've created has a particular exchange purpose called individual access services. The idea is that a patient can get information, in a form they want, including on their phone, so that it can be shared with providers or caregivers or 3rd party apps, consistent with HIPAA guidelines. With consistent support from the Senate and Congress, we should reach a point where everyone is empowered to utilize their health records.

Senator Marshall – What can Congress do to put the "wind beneath your sails?" Is it just financial resources?

Dr. Keane – We're looking at increasing the number of demographic variables for more reliable patient matching. We're also increasing the number of security controls so that people are more willing to share. In the event of a suspected breach, the information isn't compromised. One reason people are uncomfortable or unwilling to share is because they don't want there to be "improper sharing."

Senator Lisa Murkowski – As you're working to push out these advancements, I'd ask you to keep in mind that those who'd benefit the most from advances in technology may also have the least capacity to do so. Alaska also has significant veteran and native American populations treated by the Indian Health Service and Veterans Administration. Are multiple agencies engaged in your interoperability training? Are we inadvertently creating barriers?

Dr. Keane - Hopefully not. I'd like to say we have a good collaboration with the Indian Health Service on their health IT modernization efforts. We meet with them monthly and give routine consultations on workforce and staffing needs. It is getting better, and we'd be happy to work with you for more insights.

Senator Josh Hawley – I want to discuss cybersecurity at rural hospitals. Can you tell us how cyberattacks on rural hospitals directly affect the quality of care they provide?

Dr. Keane – There's no question that cybersecurity attacks on any hospital, particularly under-resourced hospitals, can be devastating. The programs we administered are focused on data protection and secure systems. Our current HTI-5 rule is giving providers of EHR tech the ability to be consistent with the risk-based framework under the HIPAA security rule. The HIPAA security rule requires transmission security, audit controls, access security and the like. We'd like the certification program to move at the pace of cybersecurity to ensure these attacks are rare.

Senator Hawley – How does rural hospital cybersecurity factor in?

Dr. Keane – The HTI-5 rule is updating the certification to adopt the most modern standards for cybersecurity. For example, our current program asks people if they use multi-factor authentication, although newer standards now exist.

Senator Hawley – In June last year, I introduced the Rural Hospital Cybersecurity Enhancement Act. It directs HHS to develop a comprehensive rural hospital cybersecurity workforce development strategy. Would this help your office further its goals?

Dr. Keane – Anything the Senate can do to help us improve the cybersecurity posture of all hospitals would be welcome.

Chair Cassidy – I'm told ASTP recently proposed a rule to remove 34 certification criteria required for health IT products. Is it because they're merely regulatory burdens, or does it mean our data is less secure and has fewer protections for privacy?

Dr. Keane – The pivot towards a more modern certification program will allow for the most advanced protections. We did an assessment of all 60 criteria to determine which outdated, redundant, or not widely adopted because people didn't certify to them.

Chair Cassidy – Not certifying doesn't mean not valid, correct?

Dr. Keane – Correct, but if the uptake for a certain certification criterion is low, it's not having an impact on the market. Certification to a criterion also does not mean it's employed. All of the EHRs and hospitals have to comply with the HIPAA security rule.

Chair Cassidy – So it isn't that we're relaxing, we're modernizing?

Dr. Keane – That's correct.

Chair Cassidy – Returning to AI, we discussed uploading personal health data to an AI platform that could integrate their data. Under HIPAA, would that AI platform be a covered entity with all the protection to a patient's data?

Dr. Keane – CMMI just released their access model, in which individual aps can enroll as Part B providers in Medicare. Under those situations, those apps are providers and covered by HIPAA. But to your point, a large portion of the apps people upload health data to are not considered providers and thus not covered by HIPAA.

Chair Cassidy – Can that be done by rule? There's not a philosophical difference between an app and AI.

Dr. Keane – Patients have autonomy in how data is used.

Chair Cassidy – Let me stop you there. I have many patients that are not aware of these issues whatsoever. Most people will not understand the implications of uploading genetic information to AI. There are some consumer safeguards that should be implemented, do you agree?

Dr. Keane – We agree that anything that improves the privacy and security posture of patients is something worth looking at.

Chair Cassidy – But do you need new authorities for that or does Congress have to pass a law?

Dr. Keane – I understand that patients don't always know what to do with their data. I don't think that we are able to regulate data that patients have consented to be released. What I can say is that the standards we promulgate create a clean surface for any future legislation or regulation to act effectively.

Hearing Recording:

- https://www.help.senate.gov/hearings/transforming-health-care-with-data-improving-patient-outcomes-through-next-generation-care