February 23, 2026

Department of Health and Human Services
Assistant Secretary for Technology Policy and the
Office of the National Coordinator for Health Information Technology

Attention: Request for Information – HHS Health Sector AI RFI
Mary E. Switzer Building
Mail Stop: 7033A
330 C Street SW
Washington, DC 20201

Re: RFI: Accelerating the Adoption of Artificial Intelligence as Part of Clinical Care (FR Doc. 2025-23641)

Dear Assistant Secretary Keane,

Community oncology practices are the backbone of cancer care delivery in the United States, caring for most patients close to home across urban, suburban, rural, and underserved communities. Texas Oncology, an independent, physician-led community oncology practice with more than 280 sites of service across Texas and a network of more than 530 physicians, reflects this model of care. Because the community setting is where most cancer care is delivered, supporting digital transformation in community settings is essential to achieving national goals for access, quality, outcomes, and affordability in oncology.[1]

The digital transformation required to integrate artificial intelligence (AI) into clinical care is substantial, requiring not only financial investment but also significant time and human resources. Implementing AI involves workflow redesign, staff training, cybersecurity upgrades, and data integration, burdens that fall disproportionately on independent practices operating with lean staffing and limited capital. Without targeted incentives and guardrails, the risks of adoption may outweigh potential benefits, limiting meaningful participation by community practices.

The experience with electronic health record (EHR) adoption provides a clear precedent. Federal incentives enabled practices to invest in technology and training while offsetting transition costs. A similar approach is needed for AI to ensure community oncology practices remain viable, avoid consolidation into higher-cost hospital settings, and continue to deliver high-quality cancer care close to home.

1. **Barriers to Private Sector Innovation and Adoption of AI in Clinical Care**
   Several practical barriers limit the adoption of AI in clinical care, particularly for independent and community-based practices.

   - **Financial and operational barriers.** Up-front, non-recoverable implementation costs, including integration, training, cybersecurity, and workflow redesign, are significant. Once implemented, the lack of reimbursement for AI-enabled clinical and administrative functions undermines long-term sustainability. Even short-term operational disruptions can negatively affect patient care and revenue, making experimentation far riskier for small practices than for large health systems.

[1] https://www.cancer.gov/research/areas/disparities/chanita-hughes-halbert-clinical-trials-community-access

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- **Cybersecurity as an unfunded prerequisite.** AI adoption increases baseline cybersecurity requirements due to cloud access, APIs, and reliance on third-party vendors, while ransomware and hacking threats continue to rise. Independent practices often lack the capital to meet these expectations without dedicated funding, making security a gating barrier to AI use.

- **Regulatory and liability uncertainty for non-device AI tools.** Providers must trust the AI tools they use, yet uncertainty around accountability, malpractice exposure, audit risk, and documentation standards discourages adoption. The potential for bias, hallucinations, and errors underscores the need for transparency, clear governance expectations, and consistent enforcement.

- **Interoperability gaps.** AI tools depend on access to clean, interoperable data across laboratories, pharmacies, imaging, and claims systems. Persistent data silos reduce real-world return on investment and disproportionately disadvantage smaller practices that lack data integration teams.

- **Burnout and workforce trust concerns.** Providers are wary that AI may increase oversight and validation burdens rather than reduce workload. Adoption will stall unless AI is clearly positioned as a tool that reduces administrative burden and preserves clinician autonomy.

- **Equity and access risks.** Community oncology practices disproportionately serve rural, elderly, and underserved patients. Uneven AI adoption risks creating a two-tier cancer care system, undermining national goals for equitable access to high-quality oncology care.

2. Regulatory, Payment Policy, and Programmatic Changes HHS Should Prioritize

HHS should pursue a multi-faceted strategy to support AI adoption while protecting patient safety, equity, and independent practice viability.

Financial Incentives and Infrastructure:

- **Grants and direct funding.** Establish grant programs for community practices to support AI implementation, including non-recoverable start-up costs such as integration, data governance, bias testing, and cybersecurity, paired with transparent reporting on safety, performance, and outcomes.

- **Tax incentives.** Provide refundable tax credits, deductions, or accelerated depreciation for qualifying AI technologies and digital infrastructure investments, including interoperability and cybersecurity upgrades.

- **Pilot and demonstration programs.** Support early adopters through funded pilots that allow AI testing in controlled clinical environments with technical assistance and evaluation support.

- **Shared digital infrastructure.** Enable access to common digital infrastructures such as secure cloud environments and standardized data management tools, to reduce duplicative costs and implement barriers for small practices.

Interoperability, Training and Partnerships:

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- **Interoperability and data liquidity.** Strengthen interoperability standards and government-led data sharing initiatives, including alignment with 45 CFR Part 171, to ensure AI tools can function effectively across care settings.

- **Workforce training and change management.** Develop and subsidize role-based training for clinicians, nurses, pharmacists, navigators, and administrative staff, paired with change-management support to reduce burnout and adoption friction.

- **Public-private partnerships.** Foster collaborations between government and technology developers to create AI solutions tailored to community practices. These partnerships should include shared implementation playbooks, model contracts, and standardized governance frameworks for privacy, accountability, and auditability.

Regulatory Clarity and Reimbursement Alignment:

- **Clear governance for non-device AI.** Establish consistent guidance for accountability, transparency, and HIPAA-aligned privacy protections under 45 CFR Part 164 to reduce uncertainty and compliance risk.

- **Performance-based reimbursement pathways.** Create reimbursement approaches that reward effective AI use through improved outcomes, efficiency, and reduced administrative burden, including per-member-per-month payments or shared savings models under SSA §§ 1899 and 1115A.

- **Ongoing valuation of AI tools.** Ensure CMS reimbursement methodologies under the Physician Fee Schedule appropriately reflect the scalable and evolving nature of AI tools.[2] Continued recognition and coverage of AMA CPT codes related to augmented intelligence are essential to sustaining adoption.[3]

3. Research and Development Priorities

HHS investment in applied research and development should focus on real-world clinical implementation, particularly in community-based settings. Priority areas include evaluating AI performance across diverse patient populations, developing tools that integrate seamlessly into existing workflows, and generating evidence on how AI can reduce administrative burden while improving quality and equity of care. Public-private research partnerships can accelerate learning while lowering risk for smaller practices.

4. Patient and Caregiver Perspectives

Patients and caregivers generally support technologies that improve access, reduce delays, and enhance care coordination, while expecting transparency, strong privacy protection, and continued human oversight.

Concerns are particularly acute around payer use of AI in utilization management, where providers and patients bear clinical and financial risk while payers capture efficiency gains. Greater transparency, reporting, and oversight of AI-driven prior authorization and coverage decisions are necessary to maintain trust and prevent inappropriate denials.

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[2] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2025.00672
[3] https://www.ama-assn.org/practice-management/cpt/288-new-cpt-codes-cover-digital-health-ai-and-more

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Given the rise in healthcare data breaches and ransomware attacks, patients must be confident that their data are used in a HIPAA-compliant manner, that AI involvement in care is disclosed, and that safeguards exist in the event of a breach.

Conclusion

AI has the potential to improve cancer care quality efficiency, but only if adoption is supported by deliberate policy design. Structured incentives, regulatory clarity, and infrastructure investment are essential to ensure community oncology practices can participate fully in the digital transformation of healthcare. Without targeted support, underinvestment in AI will accelerate consolidation, reduce patient choice, and increase overall healthcare costs.

A federal approach modeled on the successful EHR incentive programs can help ensure AI strengthens, rather than destabilizes, the community-based oncology care system.

Thank you for the opportunity to provide input on this Request for Information. We appreciate HHS's leadership in advancing thoughtful, practical approaches to accelerating the adoption and use of artificial intelligence in clinical care, particularly in community-based settings.

If you have questions or would like additional information, please contact: Debra.Patt@usoncology.com.

Sincerely,

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Texas Oncology