**SUBMITTED ELECTRONICALLY VIA REGULATIONS.GOV**

June 16, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary of Health & Human Services
U.S. Department of Health & Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Re: Request for Information, Centers for Medicare & Medicaid Services ("CMS"), Department of Health and Human Service ("Department"); Health Technology Ecosystem; RIN Number 0938-AV68, File Code CMS-0042-NC (the "Health Tech RFI")

Dear Secretary Kennedy,

We are writing to you on behalf of Availity, L.L.C. ("Availity"). Availity is the United States' leading healthcare clearinghouse. We applaud the efforts by CMS and the Department to request information regarding the future of digital health products for Medicare beneficiaries as well as the state of data interoperability and broader health technology infrastructure. Availity believes that our unique position within the American healthcare system provides us a unique perspective on information sharing and opportunities to innovate the health technology ecosystem in a manner that empowers patients and introduces efficiencies to empower a truly great American health system. We appreciate your consideration of our responses, and we would welcome any opportunity to discuss our perspectives in more detail.



**AVAILITY** 5555 Gate Parkway, Ste 110
Jacksonville, FL 32256
1.800.282.4548

Jacksonville, FL
Indianapolis, IN

## Introduction

Availity is the largest dual-sided, real-time healthcare network in the United States, connecting 3.5M+ providers, 95%+ of health plans, and 17K+ technology partners. Built originally on a core clearinghouse / gateway data exchange solution, our portfolio has since grown to include (but is not limited to):

- **Multi-Payer Portal:** The industry's only payer-sponsored multi-payer portal that offers providers a one-stop shop to meet compliance and workflow essentials for their individual payer mix
- **Provider Lifecycle Solutions:** The largest repository of regularly attesting providers, collected through integration with provider workflows and claims information
- **Intelligent Utilization Management / Authorizations:** Real-time, clinical-first authorization approval engine that uses a provider's clinical and claims data against codified payer medical policy
- **Payment Accuracy:** Shifting predictive edits from payer rules into provider workflows to ensure that claims are submitted and paid accurately the first time

Driving these solutions are several principles defining how we develop and deliver dual-sided solutions to both payers and providers:

- **Bring the Network** – We deliver our users with the largest collection of payers and providers in the country, directly into their workflows.
- **Bridge the Ecosystem** – We win only when both payers and providers win. When that happens, patients have a more seamless healthcare experience.
- **Move Upstream** – Through our unique position as a trusted partner to both payers and providers, we proactively resolve friction before it becomes costly after-the-fact cleanup (preventing the "pay-and-chase" model).
- **Drive Behavioral Change** – For a dual-sided solution to work, it requires action from both payers and providers. We are thoughtful in how we incentivize behaviors to drive simplification.

We appreciate the Department's focus on empowering patients and their caregivers throughout their healthcare journey. It is not controversial to suggest that a patient should not worry about whether a provider's listed hours are accurate, whether their authorization decision was made accurately, or whether their claim is processed correctly. However, the solutions to those problems can only be solved in one way: When payers and providers have shared solutions that remove administrative friction. Then, patients, their caregivers, and their care teams focus on what matters most – World-class care.

We will respond to this RFI as a Technology Vendor; but given our role working across both payers and providers, we will also share the perspectives we have gained from them over twenty-five years of engagement. Our responses will focus on the following areas outlined in the Technology Vendor section of the RFI:

- Technical Standards – *Provider Data Management and Directory*
- Data Exchange – *HIPAA, Clearinghouses, and Cybersecurity*

In the May 20th webinar discussing this RFI, CMS Administrator Dr. Mehmet Oz called for "meekness" across the US Healthcare ecosystem – Putting down swords and coming together to deliver better solutions for Americans. With twenty-five years of experience bridging the divide between payers and providers, we celebrate this call, and we feel uniquely positioned to support effective and collaborative solutions. We appreciate the opportunity to respond to this RFI, and we would welcome further discussions on these and other health technology topics.

## Technical Standards - Provider Data Management and Directory

In this section, our responses will cover the following RFI questions:

*PA-4. What would be the value to payers of a nationwide provider directory that included FHIR end points and used digital identity credentials?*

*TD-5. How could a nationwide provider directory of FHIR endpoints improve access to health information for patients, providers, and payers? Who should publish such a directory, and should users bear a cost?*

*VB-15. How could a nationwide provider directory of FHIR endpoints help improve access to patient data and understanding of claims data sources? What key data elements would be necessary in a nationwide FHIR endpoints directory to maximize its effectiveness?*

**The value of centralized provider data:**

We believe a central store of provider data, accessible through FHIR endpoints, can establish a single source of shared truth for American consumers. This data would drive access to care by matching a patient's health needs to capable and available providers, all while driving out harmful "ghost networks." Beyond this direct benefit to patients and their caregivers, a single source of truth on provider data would positively impact the entire US healthcare system. With better, up-to-date provider data, nearly every transaction between a patient, provider, and payer becomes more accurate and less administratively burdensome. When done properly, this process then becomes self-generating: More

accurate transactions in turn drive even more accurate provider data. The Department and CMS have an opportunity to achieve this promise of improved provider data by taking the learnings from existing private and public sector solutions and delivering them at scale.

Our perspective on how to solve the complex problem of provider data capture, management, and transmission has been shaped by our leadership in this space for the previous decade. Through our Provider Data Management product and our role as the sole technology partner for Integrated Healthcare Association's (IHA) Symphony Provider Directory utility in California, Availity currently offers the technology behind provider directory data intake and management in multiple markets for seven of the ten largest health insurance companies in the US, including Elevance, Aetna, and HCSC, as well as for leading regional payers such as BCBS Michigan. Through these efforts, we span all major lines of business as well: Commercial, Medicare, and Medicaid.

**Current challenges with provider data:**

When considering how to achieve accurate and refreshed provider data, the Department and CMS must first acknowledge an inherent challenge of prior efforts: While a provider directory is an important first step, any solution will require more than a traditional directory, and more than just technical assembly. Mandates for directory reporting - such as H.R. 133, Consolidated Appropriations Act, 2021 or The Requirements Related to Surprise Billing; Part I (No Surprises Act) - have already been established. Despite those, the problem of missing, inaccurate, or expired provider data remains. Our belief is that these mandates have failed due to two critical aspects: The current channels for sharing data are too complex, and providers are not incentivized to engage with them.

Regarding channels, providers are consistently plagued with burdensome administrative processes that distract from caring for their communities. Directory mandates to date have not consolidated intake channels, which multiplies the burden on providers. On average, a provider will contract with between 8 and 20 payer products, each potentially with its own data intake process. A CMS solution that adds another channel to this process without relieving the others will struggle to see adoption.

With respect to incentives, mandates have been written to penalize payers for non-adherence. Providers, meanwhile, rarely feel the effect of non-adherence, despite the payer being reliant on those providers to update and attest to their data. A payer's primary penalty for non-compliance - removing a provider from their directory - only harms their network and their members' access to care. This lack of incentive has led to provider under-engagement and poor directory quality. Solving the incentive challenge requires both payers and providers to directly benefit from improved provider data. Availity has

addressed this need for mutual benefit by using the data associated with a directory solution to streamline transaction processing across claims adjudication, authorization decisioning, utilization management, etc. This creates a business benefit for the provider, which has resulted in improved and differentiated engagement.

**Current market solutions - Provider Data Management, Symphony:**

Our perspectives and recommendations are informed by our experience as a trusted provider data intermediary with multi-payer, multi-provider solutions. These solutions include our Provider Data Management product, which sits on Availity's industry-leading multi-payer portal, and our technology support of IHA's Symphony product in California. 95% of US providers already use Availity's multi-payer portal (Essentials) to service their healthcare transaction needs, and approximately 70% have used it to submit provider data to their contracted payers. This results in a dataset of over 5.7M attested-to providers records.

By taking on the burden of coordination across payers, we offer providers a single, tailored workflow that meets the needs of all contracted health plans, all while minimizing administrative burden. Within our solution, we uplift providers' self-reported data with primary source data, payer data, and data we sense through analyzing the billions of healthcare transactions processed by Availity (authorizations, claims, eligibility & benefit checks, etc.). With that data, we then provide a guided experience that identifies elements most important to review for an accurate profile.

We also understand and have overcome the challenges in seeking to centralize the fragmented provider data picture into a universal directory. In partnership with IHA, Availity has built and implemented Symphony, the nation's largest operational provider directory utility. Created to assist provider organizations and health plans in complying with California State Bill 137, Symphony helps the largest healthcare organizations in California standardize and share provider data under a common language. Symphony addresses the challenges that CMS will find with centralizing provider data – that to present a directory to a consumer, a uniform picture must be established around the data model and the data elements reflecting a provider. Symphony does that through a proprietary tuning algorithm that takes in primary source, payer, and provider data to reach a common understanding about the providers. It serves as a north star for over 100,000 individual providers and over 700,000 combinations of provider, location, and network in the state of California.

Symphony has successfully proven the feasibility and benefit of a large-scale provider directory by powering Covered California, California's Affordable Care Act health insurance marketplace. Symphony intakes provider data from all 12 Qualified Health Plans (QHPs),

applies its tuning algorithms to establish a clear, accurate, and common view of the California provider marketplace. That cleansed dataset is presented to California consumers as they shop for care. It allows Consumers to query a searchable directory to select providers and health plans that meet their care needs. Availity recommends that the Department and CMS consider replicating this model to establish a singular national provider directory without adding administrative burden to a provider population already sharing their data through alternative channels.

**Path forward for the Department and CMS:**

To address historical challenges and drive meaningful provider uptake, we recommend that first, the Department and CMS utilize an existing multi-payer provider data intake solution to reduce complexity and administrative burden, rather than add to it.

Second, we recommend that the collection of provider directory data is coupled with collection of the data required to properly adjudicate healthcare transactions. From our experience, providers will engage with the data transmission process when they know that those data updates will result in a clean claim adjudication process or a fair and timely prior authorization determination.

Third, CMS should develop its foundational National Provider Directory in a way that eliminates the burden associated with all exchange of provider data. This involves establishing a dataset and collection mechanism that can fuel not only a directory, but also standardized enrollment and credentialing processes. There is a high degree of data overlap across these processes. However, providers today are constantly tasked with enrollment, credentialing, and directory refreshes, often requiring teams of FTEs dedicated solely to this. This disproportionately impacts the smallest and most resource-constrained providers and the patients they serve. Availity recommends that CMS consider how the National Provider Directory can be designed against this larger industry problem to multiply the impact to providers, payers, and patients: Any process, data schema, and data set should tie across all related processes (e.g., network management, enrollment, credentialing) to limit administrative burden and duplicative efforts.

Fourth, CMS should consider which data elements will be collected within its provider directory to meet the recommendations above. With our existing products and customers, we take a broad approach, as there is no universal data taxonomy standard or requirements for provider data. Availity understands that CMS may be pursuing specific outcomes and thus may prioritize certain data elements above others. We believe the most important categories of provider data to be those that 1) increase transparent access to quality care; 2) ensure accurate adjudication of claims and other transactions; and 3) make

the enrollment and credentialing process an eventless, perpetual process. The data elements most critical to accomplishing those outcomes are:

1. Increase transparent access to quality care:
    a. Provider demographics: Tax ID number(s), NPI, name, professional certifications, languages spoken
    b. Provider location: Service location address, clinic name, scheduling phone number, office hours & days, accessibility, affiliations and relationships to other businesses
    c. Provider service details: Specialties, services performed at that location, telehealth availability, patient appointment availability, network participation
2. Ensure accurate adjudication of claims & other transactions:
    *a. The above data fields*
    b. Billing information: Billing address, phone number
    c. Provider qualifications: Licensure, DEA number, sanction / exclusion monitoring
3. Eventless enrollment & credentialing:
    *a. The above data fields*
    b. Provider qualifications: Educational information, work history

Lastly, during the 6/3 CMS Tech Day, there was discussion of hosting responsibilities. We believe that a CMS-published directory would provide a level of trust across the consumer base and healthcare industry - especially if free for searchable consumer utilization - that could not be replicated by a third party. This is in line with what we have seen in the private sector. Payers view member experience as a core aspect of their business, and they recognize the value of an up-to-date provider directory in that experience. We appreciate that the Department and CMS also recognize the value of providing their members with a modern consumer experience, and we welcome the opportunity to discuss our experiences delivering this in more detail.

## Data Exchange – HIPAA, Clearinghouses, and Cybersecurity

Regulatory inertia (especially around the Health Insurance Portability and Accountability Act of 1996's ("HIPAA")) continues to prevent meaningful data exchange, increase administrative expense and waste, and obstruct transformative innovation. This is particularly true in the treatment of clearinghouses under HIPAA and the chilling effect innovation has on reducing fraud, waste, and abuse. Regulatory reform is needed to ensure

that HIPAA continues to protect patients without being manipulated to entrench inefficiencies.

**HIPAA's Constraints and the Barrier to Innovate:**

The U.S. healthcare system suffers from fragmentation and complexity, with data-sharing impeded by inconsistent standards, opaque privacy regulations, and outdated governance. HIPAA was enacted nearly 30 years ago with essential objectives: "to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery…[and]…to simplify the administration of health insurance."[1] However, HIPAA was designed in a pre-digital era and is no longer sufficient to govern a modern healthcare system, as the technological changes and challenges presented by today's healthcare operations have evolved far beyond the initial legislative scope. Despite significant advances in electronic health records and infrastructure, HIPAA's limitations result in excessive risk aversion due to fear of enforcement, unclear boundaries on how patient data may be shared or reused (especially for legitimate treatment, payment, and healthcare operations), and a failure to reflect modern cybersecurity best practices for risk-based data protection.

What was meant to serve the patient is increasingly being used to obstruct the very innovations that would improve patient care, efficiency, and access. HIPAA is now too often invoked not as a shield for the patient, but as a weapon to block beneficial uses of data. Healthcare organizations, particularly large incumbents, are using HIPAA as a justification to hoard vital patient data from use by other regulated entities that could otherwise reduce administrative costs, enhance care coordination, and inform analytics. The patient is harmed: Instead of protection, they experience fragmented care, increased cost, potential fraud, and limited access to their own records, all under the guise of "privacy."

Despite those challenges, there remains a real and attainable possibility: HIPAA can protect the patient and reduce fraud, waste, and abuse (FWA) while still enabling innovation. Within the boundaries of HIPAA, patients can and should benefit from increased care coordination, better analytical health tools, reduced waste, and smarter operational systems. These are not mutually exclusive goals.

We believe that HIPAA was created with laudable objectives: to protect patient privacy, enable portability, and reduce FWA. We welcome the opportunity to revisit HIPAA and its implementing regulations as a means of finding new or novel ways of accomplishing HIPAA's intended purposes: Recognizing the critical role of clearinghouses, restoring HIPAA

[1] Health Insurance Portability and Accountability Act of 1996

as a framework for patient empowerment and innovation (instead of institutional protectionism), and embracing AI as a tool for administrative relief are essential steps toward a more affordable, innovative, and responsive health system.

**Recognizing Clearinghouses as Covered Entities:**

Availity serves as a clearinghouse for millions of providers, health plans, and other healthcare organizations. HIPAA regulations explicitly name healthcare clearinghouses as covered entities. Clearinghouses process highly sensitive data and are instrumental in the administration of care. These entities sit uniquely on both sides of the transaction network and facilitate the exchange of claims, eligibility, and coordination of benefits data between payers and providers. Despite this, clearinghouses are subjected to all the obligations of HIPAA compliance but denied the functional benefits of being treated as fully covered entities. Instead, due to current HIPAA framework, contractual arrangements imposed by payers and providers to protect their interest, and legacy business associate agreements, clearinghouses are treated in practice as business associates. As a result, clearinghouses are restricted from using data to improve their own systems, or to build tools that could eliminate duplicative processes and reduce FWA. This dual status under HIPAA is a contradiction that leads to several damaging consequences:

- Clearinghouses shoulder HIPAA burdens without operational flexibility;
- Clearinghouses are barred from using data for legitimate treatment, payment, or healthcare operations improvements;
- Clearinghouses are prohibited from aggregating or de-identifying data unless an explicit grant has occurred from either a payer or provider, even if such aggregation would benefit the patient's treatment, payment and / or healthcare operations; and
- Business associate contracts often prohibit use, even in scenarios where the data use is otherwise lawful and beneficial to the patient and industry.

Several common examples:

- Coverage: HIPAA prohibits a clearinghouse from aggregating data (absent express permission from a payer) to help identify insurance coverage. The result is provider confusion and a large industry that works after the patient visit to find coverage.
- AI Use Cases Utilizing De-Identified Data: HIPAA prohibits a clearinghouse from de-identifying data (absent express permission from a payer or provider). AI models have demonstrated broad abilities for improving administrative efficiency, but exploring potential use cases (including use cases for FWA) is frustrated by HIPAA.
- Because clearinghouses receive data as business associates, all their data uses must be contractually granted. Thus, even if a patient were to consent that data be shared with a third party, a clearinghouse cannot share that data unless the payer or

provider granted the contractual right for the clearinghouse to share data as requested by the patient. This is the antithesis of patient control over their own data.

We note in all three use cases, the privacy of the patient is not compromised in any inappropriate manner and that all three use cases would satisfy the payment, treatment and healthcare operation guardrails.

Healthcare clearinghouses play a unique and powerful role in the digital health ecosystem. They often operate on both sides of data exchanges. Given their central role in handling sensitive claims and eligibility data, we believe clearinghouses should be explicitly and uniformly recognized as HIPAA covered entities, not merely intermediaries. Clearinghouses should be held to the same standards of accountability, transparency, and compliance as payers and providers, especially when their activities fall squarely under treatment, payment, and healthcare operations. Clearinghouses are ideally positioned to innovate and drive down FWA – they just need the proper guardrails to allow them to do so.

We believe the Department and CMS should formally recognize clearinghouses as covered entities in both law and practice and allow full utilization of the treatment, payment, and healthcare operations framework, including allowing aggregation and de-identification rights. The Department and CMS can and should endorse certified clearinghouses and hold them to heightened security standards while empowering them to support administrative simplification and interoperability goals.

**Clearinghouse Registration and Security Obligations:**

In line with the original goals of HIPAA, and in parallel with expanded clearinghouse capabilities across treatment, payment, and healthcare operations as covered entities, we believe that clearinghouses should meet higher standards for security and recovery. Clearinghouses should be held to higher security expectations, commensurate with their systemic importance. Such standards would help ensure that clearinghouses are not only empowered to improve the system, but also held accountable for protecting it. To do this, we provide the Department and CMS with two recommendations:

A. Mandated Clearinghouse Registration

Formally endorse and certify compliant clearinghouses as trusted conduits in national data exchange; subject certified clearinghouses to enhanced security, auditability, and recovery standards, given their systemic importance and exposure risk.

To eliminate the potential abuse of a clearinghouse designation, require that clearinghouses register with the federal government in a manner similar to our current National Provider Information Registry.

B. Increased Security Standards

Availity supports increased security standards to coincide with its increased responsibilities within the healthcare ecosystem. Examples of enhanced security controls the Department and CMS could endorse for certified clearinghouses include:

- Mandatory NIST 800-66/171 or HITRUST certification;
- Increased security requirements and annual independent third-party security audits; and
- Organizational resiliency.

**Benefits of Clearinghouses as Covered Entities:**

Sitting at the center of the healthcare ecosystem, Availity is uniquely situated to help innovate healthcare technology, empower patients, and utilize data in ways that will benefit all Americans. If the Department and CMS deem clearinghouses as covered entities and require appropriate security obligations, Availity can provide solutions to several issues that plague the healthcare industry. Below are select innovations that could be made possible:

A. Coverage and Payment Innovation

Availity's position between providers and health plans could be utilized to make determinations of coverage with patient identifiers and without the need for a coverage card. While coverage cards would make the determination of coverage easier, Availity possesses data to identify coverage and / or the means to reach out to nearly every insurer in the United States and determine whether a patient is covered, by whom, and with what conditions. Regulatory hurdles and the ambiguity of healthcare clearinghouses as business associates of other covered entities prohibit Availity from introducing a unified system of healthcare coverage determinations or coordinating those benefits across plans. This would remove barriers to patient treatment and coverage while also easing administrative burdens currently in our system.

B. Payment Innovation and Identification of Fraud, Waste, and Abuse (FWA)

As a central repository of healthcare transactions, Availity could work with payers and the Department to accurately document government healthcare expenditures using a real-time network. As a part of that effort, Availity and payers could utilize AI and advanced analytics to improve the industry's understanding and prevention of FWA patterns and vulnerabilities.

C. National Provider Directory

Availity could be utilized as a national provider directory to connect patients, payers, and providers. By leveraging data already in administrative workflows (e.g., claims data), a National Provider Directory could be kept accurate and up-to-date while still reducing provider burden. See the previous section of our responses for more detail.

D. A National Health Card

Availity could work with EHRs to aggregate and assess broader health outcomes - a report card on our national health. Against this, the Department and CMS could use their resources to identify the highest-risk trends and segments, design preventative / interventional programs, and measure progress of those efforts.

**Clearinghouse Definition:**

Alongside our belief that clearinghouses should be given additional rights and capabilities, Availity also supports a more rigorous definition of a healthcare clearinghouse (currently found at 45 C.F.R. 160.103) that is commensurate with those responsibilities. This definition, originating in the early days of electronic health data standardization, was intended to foster administrative efficiency at little-to-no cost for standard transactions. However, in today's complex and highly commercialized data ecosystem, the definition allows a range of third-party intermediaries to functionally operate as clearinghouses with little-to-no oversight, especially around security and fees. Availity suggests that clearinghouses be required to meet higher security and disaster recovery standards as well as size and scope requirements. These increased standards would modernize the definition to promote transparency, safeguard patient privacy, and ensure that only qualified, accountable organizations (even those that functionally meet the definition today) serve as intermediaries in the health information infrastructure.

**Medical Policy License Transparency:**

Transparency in payer medical policies is fundamental to ensuring fair, accurate, and timely decisions in healthcare. Payers develop medical policies (sometimes licensing all or parts of those policies from third parties) that serve as the backbone for determining coverage, authorization, and reimbursement decisions. These policies often dictate whether a patient receives access to a certain treatment or service and are used as explanation for payer denials. It is therefore essential that both patients and providers have meaningful access to these medical policies. This is particularly true when the medical policies in question govern essential medical care. Medical policies are not just internal payer tools; they directly affect clinical care and financial outcomes. Presently, payer contracts or proprietary claims stretch the bounds of copyright, asserting rights that go

beyond what we believe copyright law was intended to protect. This results in a lack of transparency, innovation, and fair use. When a payer mandates that a policy must be followed, the policy cannot remain a proprietary document shielded from examination.

When these policies are shared or obtained legally (e.g., through payer's portal, disclosure, or licensing) there should be reasonable rights to reference and create derivative works. This may include the development of educational materials, prior authorization tools, or decision-support systems aimed at improving compliance and clarity for patients and providers. Current practices that restrict the ability to reuse or adapt these policies under the guise of copyright law serve only to entrench information asymmetry and reduce accountability. Once a policy is shared or licensed, there should be no blanket prohibition on using that information to develop clinical pathways, examine denials, or enhance transparency.

While the goal is not to undermine legitimate copyright protections, the issue should be examined by Congress, the Department, and/or CMS to ensure that copyright protections do not override healthcare transparency and public interest. Specifically, it should be required that any license to use medical policies also allows use of the medical policy to make clinical decisions and inform patients and providers of the policy's components that were or were not met. Doing so would restore balance between intellectual property rights and the broader need for open, understandable, and accessible standards of care.

**Artificial Intelligence ("AI") Clarity:**

AI holds enormous potential to improve healthcare affordability, detecting/preventing fraud, and administrative improvements. Yet, HIPAA's ambiguous stance on permissible uses of health data for model training, prediction, and analysis has created a chilling effect that restricts healthcare organizations from acting, even for legitimate use cases and operational optimization. Organizations are routinely barring or delaying the use of AI (through contract) for legitimate treatment, payment, and healthcare operation functions due to regulatory uncertainty and enforcement anxiety. This is not a matter of ethics or safety but a failure of clarity and regulatory alignment.

Availity urges the Department to:

- Issue clear guidance allowing the use of protected health information for AI-enabled treatment, payment, and healthcare operations, especially with de-identified data;
- Establish pathways for de-identified or limited dataset use in AI model development, aligned with current HIPAA de-identification standards and bolstered by risk-based controls; and

- Encourage adoption of AI for treatment, payment, and healthcare operations uses, including administrative simplification, fraud prevention, and quality improvement.

AI offers a powerful set of tools to reduce costs, detect fraud, enhance care delivery, and streamline administrative tasks. It is not a technical limitation stifling innovation but the regulatory uncertainty serving as the barrier. Organizations fear that even permitted uses under HIPAA may result in unpredictable enforcement or contractual disputes. As a result, patients and payers are deprived of cost-saving innovations that could simplify their experience and reduce overhead.

**Summary:**

HIPAA is meant to protect patients' privacy while enabling healthcare portability, fraud prevention, and administrative efficiency. It was never intended to block progress; yet HIPAA has not evolved in alignment with its original intent. HIPAA must now be modernized to enable secure, ethical, and patient-centered innovation. The healthcare industry is at a critical juncture: the healthcare system is technologically capable of transformation but is policy-bound by a framework that has not evolved with innovation. Modernizing HIPAA, recognizing and securing the role of clearinghouses, and embracing AI with guardrails (not fear) will lay the foundation for a more affordable, connected, and innovative system.

## Conclusion

Thank you for considering our comments on the Health Tech RFI. We welcome the opportunity to work with the Department to seek greater efficiencies within healthcare and to collaborate on the path to innovation. If we can ever be of service, please do not hesitate to reach out to us. We are happy to meet with the Department to discuss our comments or to participate in any federal committee or program.

Sincerely,

/s/ Russ Thomas

**Russ Thomas**
Chief Executive Officer
Availity, L.L.C.