



June 16, 2025

Administrator Mehmet Oz
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW

Assistant Secretary Thomas Keane
Assistant Secretary for Technology Policy
U.S. Department of Health and Human Services
330 C St SW

Re: Request for Information Related to the Health Technology Ecosystem

Dear Administrator Oz and Assistant Secretary Keane,

The Children's Hospital Association (CHA) appreciates the opportunity to respond to the *Request for Information (RFI): Health Technology Ecosystem* and we thank CMS, the Assistant Secretary for Technology Policy and the Office of the National Coordinator (ASTP/ONC) for prioritizing this important work to modernize and strengthen our nation's digital health infrastructure. As the federal government continues to advance this important initiative, we urge you to ensure that pediatric needs are explicitly addressed in all health technology policy, standards, and implementation. A strong, interoperable health technology ecosystem is foundational to delivering safe, high quality, and patient centered care—and it is especially critical to supporting the unique needs of children and their families. Children are not simply “little adults”—their clinical needs, consent and privacy considerations, family caregiving structures, and developmentally appropriate care models all require tailored health information technology (HIT) solutions.

CHA represents more than 200 children's hospitals across the country that are dedicated to advancing the health and well-being of our nation's children through innovation in the quality, cost, and delivery of pediatric care. Although children's hospitals make up less than 5% of all hospitals in the United States, they care for nearly half of all hospitalized children and serve the majority of those with complex chronic conditions.

Children's hospitals are regional centers for specialized pediatric care and frequently coordinate care across a diverse network of providers and organizations. Effective care coordination depends on timely information exchange among health care providers, schools, home health services, and other community-based organizations involved in a child's care—including the ability to exchange clinical notes, care plans, medication histories, and educational assessments. However, the absence of standardized electronic health record (EHR) systems and data exchange across many of these organizations creates persistent barriers to building an integrated pediatric health technology ecosystem. As a result, both providers' and families' ability to access the complete, timely information needed to support safe, coordinated, and high-quality care can be impeded.

We urge CMS and ASTP/ONC to address the following priorities to support an effective and accessible pediatric health technology ecosystem:

- Ensure digital health applications are designed to meet the clinical, developmental, and caregiving needs of children and families.
- Strengthen pediatric data exchange and interoperability by promoting standardization, supporting cross-system integration, and reducing administrative barriers to timely information-sharing.
- Revise the information blocking disincentives framework to reflect the unique clinical, technical, and legal considerations involved in pediatric care.

Our detailed comments are below.

1. Digital Health Applications

CMS and ASTP/ONC should promote the development and adoption of digital health tools that reflect pediatric care by requiring features such as multi-user access, easy to understand language and features, and caregiver-friendly interfaces. CMS should offer financial and technical assistance to support adoption, particularly by providers and other organizations, in rural and underserved areas; promote flexible coding and billing policies that support the uptake and sustainable use of pediatric digital health services; and create clear standards for evaluating pediatric-appropriate applications.

We appreciate CMS and ASTP/ONC's attention to the importance of digital health applications in modern care delivery and welcome the opportunity to highlight key considerations for pediatric patients, their caregivers, and providers. Digital health applications are an essential tool of coordinated, family-centered pediatric care—offering new opportunities to improve communication, enhance care management, and promote engagement across care settings. We urge CMS and ASTP/ONC to ensure digital health applications meet the distinct needs of pediatric patients and their caregivers. CMS should engage pediatric stakeholders and caregivers in the design and evaluation of these products to ensure they align with real-world pediatric care delivery.

These applications—ranging from patient-facing mobile apps, caregiver portals, or applications embedded within certified EHR—should include pediatric-relevant features to enhance data access, improve communication across pediatric care settings and support reimbursement structures and systems for care management. To meet the unique needs of children, applications should also include pediatric-specific features like growth tracking, developmental milestones, and age-appropriate educational content. These features support early detection of potential health concerns, guide anticipatory care planning, and promote family engagement in managing a child's health. For example, applications that enable caregivers to log infant feeding schedules and behavior tracking and communication logs shared between families and school-based care teams for children with behavioral health needs are particularly valuable in pediatric settings, where timely information exchange is essential for high quality and coordinated care delivery.

Widespread adoption of pediatric-specific digital health applications is a critical tool for improving pediatric health outcomes and supporting the unique care delivery models used in children's hospitals. Pediatric care is family-centered and often involves multiple adults coordinating services across settings including providers,

schools, and community-based services. Unlike adults, children typically rely on their families to coordinate appointments, monitor symptoms, and follow care plans—responsibilities that become more complex for children with chronic or medically complex conditions. Well-designed digital applications with features such as multi-user access, family account management, and appropriate consent controls can support shared caregiving structures and centralize vital health information. They can also help reduce the likelihood of missed appointments and improve continuity of care. To be accessible to all families, applications should be intuitive, easy to use, and offer navigation features that accommodate varying levels of digital literacy and reading ability and include options to access content in multiple languages.

It is imperative to address administrative barriers that limit effective uptake and use of these tools in pediatric settings. Coding and billing policies should allow for greater flexibility to accommodate the team-based, episodic nature of pediatric digital health services and ensure the tools are not underutilized due to misaligned administrative requirements. For example, 99457 and 99458 CPT codes, which reimburse remote physiologic monitoring (RPM) treatment management, require cumbersome and frequent time tracking. Pediatric digital encounters often involve multidisciplinary care teams—such as pediatric specialists, therapists, and care coordinators—who contribute brief, targeted input across multiple touchpoints. Current time tracking requirements, which rely on cumulative thresholds assigned to a single billing provider, do not account for shared team-based interactions and make it difficult to document and appropriately bill for this type of collaborative digital care.

Together, these design elements are critical for ensuring digital health applications support family engagement and care coordination across care settings. Broad adoption will require financial and technical support for providers—particularly in rural areas—and a transparent process for identifying approved applications that meet defined standards for security, interoperability, and usability.

2. Data Exchange and Interoperability

Agencies should promote FHIR-based data exchange, require pediatric-relevant data elements in national standards, support integration of pediatric platforms and documentation tools with certified EHRs, and enforce and strengthen the Interoperability and Prior Authorization Final Rule across Medicaid, the Children’s Health Insurance Program (CHIP), and Marketplace plans.

Data fragmentation remains a critical challenge in pediatric care. Accelerated adoption of FHIR standards and incorporation of pediatric elements (such as developmental milestones and age-adjusted vitals) into national data models like the U.S. Core Data for Interoperability (USCDI) will help to overcome current silos that hinder care coordination and delay clinical decision-making.

Children with complex medical needs often rely on services delivered across hospitals, primary care providers, community providers, and schools—yet many of these partners operate outside of hospital EHR systems or use

a wide range of electronic medical record platforms, if any. Communications between those entities can be enhanced via the use of standardized remote platforms that can help coordinate care and share information.

Integration among EHRs should be enabled through affordable APIs that support real-time data sharing between pediatric providers across hospitals and other provider settings. Currently, integration often requires costly custom builds or complex manual workarounds. Supporting broader use of these APIs will help to close gaps in the pediatric care continuum. Platforms used by community-based partners are not always interoperable with core EHR systems in children's hospitals. For example, a children's hospital using a certified EHR may be unable to integrate real-time data from a home-based monitoring device or school nurse encounter unless both systems can exchange data through compatible platforms, such as a shared FHIR API. To overcome the lack of coordinated platforms, some children's hospitals have offered subsidized EHR solutions to referring primary care providers. However, they report difficulties scaling these efforts or promoting widespread adoption due to high support costs and the fragmented EHR landscape in clinically integrated networks.

Furthermore, to reduce delays in care, CMS must fully enforce the Interoperability and Prior Authorization Final Rule across Medicaid, Children's Health Insurance Program, and Marketplace plans. We also believe that the final rule can be strengthened to better support electronic communications between payers, providers and patients and enhance timely care. In particular, we believe that CMS should strengthen prior authorization timelines and denial notice requirements.

We appreciate the changes included in the final rule that establish standardized response timelines. However, we believe these timelines must be further shortened to ensure that children do not experience avoidable delays in medically necessary care. Specifically, CMS should require all payers to adopt FHIR-based electronic prior authorization systems with defined maximum response times of no more than 48 hours for standard requests and 24 hours for urgent cases. Payers should also be required to provide clear denial notices electronically that include clinical rationale, recommended alternatives, and appeal instructions. CMS should also clarify that these requirements apply to out-of-state Medicaid services, prohibit midstream changes to authorization rules, and strengthen continuity-of-care protections to require incoming payers to honor existing authorizations for a defined transition period.

Pediatric providers continue to face significant administrative burden navigating manual and inconsistent prior authorization processes—especially when caring for children with complex conditions who travel across state lines or shift coverage sources. These reforms would reduce delays, minimize administrative waste, and protect timely access to care for medically complex children.

3. Information Blocking

CMS and ASTP/ONC should withdraw, or substantially revise, the current information blocking disincentive framework to reflect the unique needs of pediatric providers. Enforcement should be paused for children's hospitals until further pediatric-specific stakeholder engagement has occurred. In the meantime, ONC should prioritize education, clarify exception categories, and support developmentally appropriate data-sharing in pediatric care.

We urge CMS and ASTP/ONC to revise disincentive implementation for pediatric providers and provide clearer guidance on how exceptions should be applied in pediatric contexts. Children's hospitals support transparent and effective health information exchange; however, current policies fail to reflect the clinical, legal, and technical realities of pediatric care. For example, children's hospitals also operate in broad care ecosystems that include schools and community providers who may not use certified EHR systems. Hospitals have limited control over how data is received or used downstream but may still face penalties for interoperability issues beyond their control.

Additionally, children's hospitals must manage a complex web of state and federal privacy laws—many of which vary by state and patient age—while also attempting to comply with federal data sharing mandates. Current technology and policies do not offer a reliable way to fully align these requirements, creating unavoidable compliance barriers for children's hospitals. In addition, pediatric providers must carefully manage access to information for their young patients in order to prevent potential harm or confusion. For instance, automatic release of sensitive diagnoses to an adolescent patient without the opportunity for a provider to offer clinical context could inadvertently cause distress, family conflict, or misinterpretation.

Similarly, neonatal records often contain maternal health information protected under Health Insurance Portability and Accountability Act (HIPAA) or state privacy laws. Providers must be able to tailor access to these records to protect maternal privacy and ensure family safety. The current disincentives framework does not account for these scenarios and may discourage proper documentation or communication between care teams. Penalizing providers for these practices—particularly under broad or ambiguous information blocking standards—undermines their ability to exercise sound clinical judgment while complying with HIPAA and local law.

Moreover, disincentives are tied to Medicare programs—like the Merit-Based Incentive Payment System and Promoting Interoperability—that excludes most pediatric providers, making enforcement mechanisms both ineffective and inequitable. Any future penalties should be relevant to pediatrics, proportionate, transparent, and include clear due process protections. Educational efforts should be expanded to help providers understand their obligations and appropriately use ONC's Information Blocking Portal, with simplified reporting options, anonymity protections, and regular feedback on how complaints are addressed. These changes would better support appropriate, safe, and effective information sharing for children and families.

In conclusion, we share the agency's commitment to improving the health technology ecosystem to strengthen care coordination and quality health care and urge you to consider the unique implications for the pediatric population. We look forward to working with you to collaboratively advance a pediatric HIT infrastructure that can efficiently and effectively allow for a system that supports child patients, their providers, and their families and caregivers. Please contact Sam Mitchell at sam.mitchell@childrenshospitals.org should you need more information.

Sincerely,



Aimee Ossman
Policy, Vice President
Children's Hospital Association