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To: Dr. Mehmet Oz, Administrator, Centers for Medicare & Medicaid Services

We welcome the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Request for Information *"Unleashing Prosperity Through Deregulation of the Medicare Program,"* following President Trump's "Executive Order "Unleashing Prosperity Through Deregulation."

For more than four decades, the Massachusetts Health Data Consortium (MHDC) has been the trusted and objective facilitator of health information and technology transformation at the national and state level. With its merger with the New England Healthcare Exchange Network (NEHEN), MHDC provides a range of health data innovations, insights, and services to over 4,000 health professionals across more than 200 organizations. Its mission is to inform and empower the individual in their health journey and reduce the burden healthcare imposes on patients and their families, providers, and payers. MHDC realizes this mission by assisting health organizations in navigating regulations, sharing health data securely and effectively, and reducing the burden and cost of inefficiency.

Rather than investing heavily in large, centralized national exchanges or overly prescriptive reporting systems, we encourage CMS to shift focus and resources to supporting state- and region-led innovation. By leveraging the interoperability standards and policy floor set at the federal level—such as Health Level 7's Fast Healthcare Interoperability Resources (HL7 FHIR) and U.S. Core Data for Interoperability (USCDI)—local efforts can design flexible, scalable tools that address real-world barriers and reduce administrative burden for the participants in their unique ecosystems. This approach allows for more effective feedback loops, encourages true multistakeholder collaboration, and fosters innovation that aligns both community needs and national goals. For example, MHDC's community-led effort to develop a Massachusetts quality measurement specification showcases how multi-stakeholder groups are effectively working together to reduce duplication, harmonize reporting requirements, and tailor solutions to the specific needs of their populations. A coordinated shift that pairs technological advancement with regulatory flexibility will better support the diverse realities of care delivery and ensure that quality improvement efforts are both practical and sustainable.

Overall, local innovations, when recognized and integrated thoughtfully, can serve as powerful accelerators for national progress. We use this frame of thinking as we craft our response to this timely RFI.

Streamlining Regulatory Requirements

Are there specific Medicare administrative processes, quality, or data reporting requirements that could be automated or simplified to reduce the administrative burden on facilities and providers?

MHDC convened its payer and provider members who participate in quality and data reporting programs across CMS, Medicaid (MassHealth), and commercial lines of business to discuss opportunities to automate or streamline administrative burden in these areas. Payers and providers highlighted two primary recommendations.

Accelerate Adoption of FHIR-Based APIs for Real-Time Quality Reporting. CMS should require the implementation of HL7 FHIR-based Application Programming Interfaces (APIs) for real-time clinical data exchange across CMS-sponsored programs. Enabling real-time quality reporting through FHIR APIs offers a material opportunity to reduce administrative burden and improve care delivery. At present, providers often rely on retrospective, manual data extraction and submission processes that are time-consuming, error-prone, and disconnected from clinical workflows. By contrast, real-time, API-enabled reporting allows quality data to be captured and transmitted directly from the point of care, automatically, and in standardized formats.

This reduces the need for duplicative documentation, chart abstraction, and manual reconciliation efforts, saving significant time for clinical and administrative staff. Facilities can streamline compliance by reporting once through interoperable systems that satisfy multiple program requirements. Additionally, real-time feedback enables providers to identify gaps in care more quickly, improving responsiveness and outcomes while also aligning reporting more closely with clinical realities.

Widespread adoption of FHIR APIs will also allow CMS to move toward continuous quality measurement, which supports more agile payment models and policy development—further reducing reliance on quarterly or annual reporting cycles. Overall, this shift can dramatically reduce reporting complexity, lower costs, and ease the burden on frontline clinicians and health systems, enabling them to focus more fully on delivering high-quality, patient-centered care.

Mandate Standardized Data Exchange to Support Key CMS Functions. CMS should mandate the use of nationally recognized data standards—such as the U.S. Core Data for Interoperability+ (USCDI+) and HL7 FHIR—to support critical CMS functions including risk adjustment, payment integrity, and automated quality measure reporting. Standardized data exchange ensures that clinical and administrative data can flow seamlessly and consistently across systems, eliminating the need for manual data abstraction, reformatting, and duplicative submissions.

For risk adjustment, standardized data enables timely, accurate capture of patient complexity, improving fairness in reimbursement without requiring providers to perform additional chart reviews. Interoperable documentation also improves payment integrity processes, enabling auditability, reducing the likelihood of overpayments, underpayments, or disputes—and minimizing costly reconciliations. For quality reporting, standards like FHIR support automated extraction of clinical quality measures (e.g., HEDIS, CAHPS, eCQMs) directly from electronic health records, reducing time-consuming manual reporting and enhancing data accuracy.

Together, these efficiencies reduce administrative overhead, lower compliance costs, and free up provider and facility resources to focus more fully on delivering high-quality patient care.

Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?
Through regular Data Governance Collaborative meetings, MHDC member health plans and providers cited duplicative quality reporting program requirements that incite burden and should be simplified or automated.

Duplicative Quality Reporting Program Requirements. Providers participating in multiple quality reporting programs—such as those required by commercial payers, MassHealth (Medicaid), and CMS—often face the significant burden of reporting the same or extremely similar quality measures multiple times, each with different specifications, formats, and timelines. For example, commercial insurers typically require

submission of NCQA's HEDIS measures, while MassHealth mandates its own quality measures that may overlap with HEDIS yet include nuanced differences in population definitions or reporting periods. CMS programs, such as the Merit-Based Incentive Payment System (MIPS; CMS-0938-134), add another layer of complexity by requiring separate submissions for overlapping topics such as diabetes care, hypertension control, and preventive screenings. Clinicians report that the MIPS program alone demands unique data extracts, formats, and submission processes—despite measuring many of the same clinical concepts already reported elsewhere. This fragmented approach creates a cycle of duplicative administrative work, draining clinical resources and time without generating substantially new insights or improvements in care quality.

This administrative burden falls especially hard on small and medium-sized practices, which often lack the dedicated staff, advanced IT systems, or financial flexibility to manage the complex and overlapping demands of multiple quality reporting programs. Unlike large health systems that can undertake reporting requirements through centralized teams and scalable infrastructure, smaller practices must divert clinical or administrative staff—often wearing multiple hats—to manage reporting tasks. The relative cost of compliance is significantly higher for these practices, as the time and expense involved in extracting data, meeting divergent specifications, and submitting reports strain already limited resources. This not only exacerbates financial pressure but also pulls focus away from patient care and practice-level quality improvement. As a result, well-intentioned reporting programs may unintentionally widen disparities in provider capacity and quality outcomes.

Opportunities to Reduce Administrative Burden of Reporting and Documentation

Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?

While quality reporting is vital to ensuring accountability and improving outcomes, CMS has a critical opportunity to lead in simplifying and aligning the system. A streamlined, interoperable, and outcome-focused reporting framework would not only reduce burden on Medicare providers, but also improve data quality and usability, encourage meaningful improvement over metric compliance, and support clinician well-being and patient-centered care. We expand on these opportunities below.

Streamline Reporting to Reduce Administrative Burden and Costs. CMS can significantly reduce the administrative burden and associated costs of quality reporting by streamlining and aligning requirements across programs. Simplifying documentation through the use of interoperable systems and improved integration with electronic health record (EHR) workflows would allow for more automatic data capture, returning valuable clinical time to direct patient care. In addition, aligning and consolidating reporting programs across Medicare, Medicaid, and commercial payers would help eliminate duplicative documentation efforts that currently require providers to submit the same or similar information multiple times in different formats. By reducing the need for complex and resource-intensive reporting infrastructures, CMS can lower overall compliance costs, allowing providers—particularly smaller practices—to reinvest those resources into care delivery and quality improvement efforts.

Promote Standardization to Minimize Fragmentation. CMS can reduce fragmentation and make quality reporting more consistent and meaningful by leading efforts to standardize and harmonize quality measures across federal and private programs. By adopting and promoting universal measure definitions and standardized data formats, CMS can enable providers to report once and fulfill multiple program requirements, significantly reducing duplication and administrative complexity. Establishing a centralized quality reporting framework that Medicare providers can use across various contracts and programs would further streamline processes, minimize confusion, and enhance the clarity and comparability of reported data.

Shift Incentives Toward Meaningful Outcomes. CMS can reduce reporting burden and improve overall care quality by shifting the focus of quality measurement toward meaningful, outcome-driven metrics. Current process-based checklists often require extensive clinician time without directly contributing to better patient outcomes. By refocusing on outcomes that matter to patients—such as improvements in health status, functional ability, or care experience—CMS can ensure that quality measurement aligns more closely with the goals of care. Additionally, emphasizing whole-person care in metric design, rather than isolated administrative tasks, helps discourage efforts to game the system and promotes more holistic, coordinated care delivery.

Enhance Data Quality and Interoperability to Eliminate Duplicative Efforts. Improving data quality and interoperability is another essential step toward reducing duplicative reporting and administrative inefficiencies. CMS should mandate the use of HL7 FHIR APIs for seamless data exchange across EHRs, clinical registries, and CMS systems. Eliminating data silos and standardizing information flows will reduce the need for manual data entry and reconciliation, allowing providers to meet reporting requirements more efficiently while improving the accuracy and consistency of the data used for care delivery and policy evaluation.

Identification of Duplicative Requirements

How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

Adopt a Flexible, Outcomes-Based Approach. Instead of prescriptive rules, CMS should use outcome-based measures that focus on patient results rather than step-by-step compliance. This approach would allow providers flexibility in choosing the technologies and processes that best achieve those outcomes. For instance, in telemedicine, CMS could focus on access and quality measures (e.g., patient satisfaction, reduction in hospitalizations) rather than detailed platform requirements or usage quotas.

Leverage Industry-Led Standards. CMS should mandate and adopt existing consensus standards developed by recognized bodies like HL7, NCQA, or National Council for Prescription Drug Programs (NCPDP) instead of developing new Medicare-specific requirements. This approach would ensure interoperability and safety without adding extra regulatory steps. For example, digital health tools could be required to meet HL7 Fast Healthcare Interoperability Resources (FHIR) implementation guides for interoperability, rather than creating Medicare-specific data format mandates.

Streamline Reporting and Documentation. To avoid layering new administrative burdens, CMS should align its reporting requirements with existing industry reporting frameworks (e.g., aligning with National Quality Forum [NQF]-endorsed measures or CMS quality programs). This approach would reduce duplicative reporting by accepting certifications or accreditations from recognized industry groups. For instance, for integrated care systems, CMS could accept NCQA or URAC accreditations as evidence of compliance rather than requiring separate CMS-specific documentation.

Promote Interoperability. Rather than imposing additional regulations, CMS should promote interoperability by encouraging voluntary certification programs for technologies (e.g., digital health apps and remote monitoring) to ensure interoperability and safety without adding extra regulatory steps. CMS can align with best practices and industry standards by emphasizing flexibility, aligning with existing frameworks, streamlined reporting, interoperability, partnerships, outcome-focused requirements, and ongoing dialogue. This approach avoids additional regulatory burdens while fostering innovation and quality improvements.

CMS should also incentivize or reward participation in existing data-sharing initiatives, such as state-based initiatives, e.g., MHDC in Massachusetts (NEHEN 3.0), UHIN in Utah, and national initiatives (TEFCA), where

state-based efforts are lacking. Medicare must also support API-based access to Medicare data, like Blue Button 2.0, to encourage digital health innovation without prescribing every detail.

It is also imperative to collaborate with industry groups, technology vendors, and provider associations to develop implementation guides, toolkits, and best practice resources that align CMS requirements with industry norms. It could also launch pilot programs with selected industry partners to co-design and test standards-based solutions. For example, a telemedicine pilot could align CMS coverage with existing American Telemedicine Association best practices, ensuring alignment with established clinical guidelines.

Instead of requiring the use of specific technologies, CMS should recognize technology as an enabler rather than a requirement. It could leave the choice of tools up to providers, focusing on interfaces (APIs), outcomes, and patient experience instead of mandating specific apps, devices, or platforms. For instance, CMS could focus on the required integration of HL7 FHIR APIs and metrics like care coordination success and patient health outcomes for integrated care systems rather than dictating which care management software must be used.

Overall, CMS should align with best practices and industry standards by emphasizing flexibility, aligning with existing frameworks, investing in state-based multi-stakeholder initiatives, and directing policy toward streamlined reporting, interoperability, outcome-focused requirements, and ongoing dialogue. This approach avoids additional regulatory burdens while fostering innovation and quality improvements.

Additional Requirements

MHDC provides the following recommendations:

Support the National Adoption of Electronic Quality Reporting and FHIR Standards. CMS should support the national adoption of electronic quality reporting and FHIR standards to improve consistency, reduce administrative burden, and modernize data exchange across the healthcare system. This includes promoting and incentivizing the use of electronic quality reporting among providers and payers, which can streamline workflows and enhance data accuracy. CMS should also work collaboratively with NCQA and other standards development organizations to further refine and operationalize FHIR-based eQuality measures, enabling more efficient, interoperable reporting. To ensure successful implementation, CMS is encouraged to invest in technical assistance and infrastructure support to help stakeholders transition from legacy or manual systems to fully electronic quality reporting platforms.

Lead Stakeholder Alignment to Advance eQuality Measures. CMS should take a leadership role in aligning stakeholders to advance the development and adoption of high-value electronic quality (eQuality) measures. This includes convening and facilitating collaboration among key groups—such as payers, providers, health IT vendors, and NCQA—to ensure that eQuality measures are both practical and impactful. To support ongoing progress, CMS is encouraged to establish a federal advisory or collaborative body dedicated to the continuous improvement of electronic quality measures, incorporating direct input from those working in the field. Prioritizing transparency and stakeholder engagement is essential; CMS should create formal pathways for feedback and participation to ensure that the evolution of eQuality standards reflects real-world needs and fosters broad adoption.

Ensure Regulatory and Standards Alignment Across Federal Agencies. CMS should ensure regulatory and standards alignment across federal agencies to minimize duplication and reduce implementation burden for providers and payers. Close coordination with ASTP/ONC and NCQA is essential to harmonize the standards used in quality reporting across federal programs and initiatives. To support consistent compliance, CMS is encouraged to issue consolidated guidance that clearly outlines how stakeholders can meet quality reporting requirements without needing to navigate overlapping or conflicting federal standards. Additionally, CMS

should work to synchronize regulatory timelines and updates related to quality measurement, helping reduce uncertainty and allowing stakeholders to plan and implement changes more efficiently.

Strengthen Requirements for Certified Health Record Technology in CMS Programs. CMS should strengthen and consistently enforce the requirement to use ONC-certified health information technology (health IT) across all applicable Medicare and Medicaid quality reporting programs. Ensuring that providers use certified electronic health record (EHR) systems will help standardize data collection, improve reporting efficiency, and support broader health system goals such as interoperability and patient-centered care. Certified health IT should be required to demonstrate specific capabilities, including robust support for patient engagement tools, real-time access to clinical and administrative data, and seamless extraction of data relevant to key CMS quality initiatives. These include programs such as HEDIS, MIPS, and ACO performance reporting requirements. By reinforcing the use of certified systems that meet these functional expectations, CMS can promote more accurate, timely, and less burdensome quality measurement while driving continued innovation and accountability in health IT.

Engage with Local, Multi-stakeholder Health Data Collaboratives to Inform National Learning Models. While national standards are essential as a foundational framework for quality measurement and data exchange, healthcare is ultimately delivered at the local and regional level. To ensure that national policies reflect on-the-ground realities, CMS should engage directly with local, multi-stakeholder health data collaboratives to inform the development of national learning models. For example, organizations like the MHDC have successfully brought together payers and providers to create and maintain a shared Quality Measurement Specification that standardizes data exchange and reduces reporting burden. CMS is encouraged to meet with such collaboratives to learn from their governance and implementation strategies, and to explore opportunities for scaling effective regional models. These locally driven initiatives offer valuable insights into how quality reporting can be streamlined, aligned with health equity goals, and implemented in a way that supports meaningful care improvement.

Incentivize Interoperability through CMS Value-Based Payment Programs. CMS should incentivize the adoption of interoperable data exchange by embedding FHIR-based capabilities as a core requirement in the design, evaluation, and advancement of its value-based payment programs—such as the Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACOs) and ACO REACH. These programs are well-positioned to drive industry-wide change, and incorporating FHIR-based interoperability—particularly for quality reporting—would help ensure that participating entities are not only improving care but also advancing data modernization goals. CMS should consider offering preferential scoring, bonus points, or financial incentives to organizations that demonstrate advanced use of interoperable technologies, such as real-time data exchange and automated electronic quality measure submission. Doing so would reduce reporting burden, improve data accuracy, and reward organizations that invest in scalable, standards-based infrastructure to support care coordination and quality improvement.

Closing

We appreciate the opportunity to provide input on behalf of the MHDC community and look forward to opportunities to support CMS as it looks to automate and streamline requirements to reduce burden for providers, payers, and the patients for which they care.

Sincerely yours,

Denny Brennan
Executive Director