Massachusetts Health Data Consortium

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The Honorable Dr. Oz, Administrator, Center for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Oz:

On behalf of the Massachusetts Health Data Consortium (MHDC), we are pleased to provide public comment on the *Centers for Medicare and Medicaid Services (CMS) Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program* proposed rule [CMS-1848-P].

Introduction

As a non-profit, member-based organization focused on improving healthcare quality, transparency, and efficiency through better access to and exchange of health data, MHDC has served as a trusted, neutral convener that advances health information exchange, interoperability, and administrative simplification across Massachusetts and nationally for more than four decades. MHDC operates the New England Healthcare Exchange Network (NEHEN), providing secure data exchange and automation for thousands of health professionals and organizations, and continues to lead the way in transforming healthcare information infrastructure across New England.

As health information technology policy and quality measurement evolve towards API-forward workflows, the central challenge will be to ensure that operational reliability is maintained as Certified Electronic Health Record Technology (CEHRT) transitions to standards-based API-driven exchange. Providers must be confident that CEHRT can continue to support core functionality while enabling new capabilities powered by a FHIR-facilitated future.

MHDC strongly endorses the transition to FHIR-based digital quality measure (dQM) reporting for all CMS quality reporting programs including Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), and incorporation of Electronic Prior Authorization (ePA) measures for the Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS) Promoting Interoperability Program. While both FHIR-based dQM reporting and automation of ePA have significant potential to reduce provider burden and improve the continuity of care for patients, consistent with MHDC's comments on proposed HTI-5 and CMS-0062-P, it is critical to maintain an interoperability floor during the transition to APIs, with realistic timelines for adoption of new standards and reporting requirements.

Eligible clinicians who report ePA measures for the Promoting Interoperability Program are also highly likely to engage with CMS "impacted payers." Therefore, ensuring these clinicians can meaningfully use CEHRT for ePA can improve understanding of how payers implement ePA.

MHDC agrees that MSSP ACOs able to successfully report Medicare (electronic clinical quality measures (eCQMs) will more easily transition to FHIR-based dQM reporting, but cautions CMS that the proposed solution may not be sufficient to resolve attribution issues for ACOs.

Finally, MHDC respectfully requests that CMS maintain alignment between Promoting Interoperability proposals for the Quality Payment Program and policies finalized for the Medicare Promoting Interoperability program in the FY 2027 IPPS/LTCH (CMS-1849-F).

MHDC's recommendations in this letter draw on our long history of successfully engaging payers, providers, vendors, and exchanges in real-world exchange environments. Most importantly, all our comments are intended to support CMS's objectives by highlighting practical considerations to improve the operational reality of interoperability.

Key Recommendations and General Comments

- The two-year transition period to FHIR-based dQM reporting should incorporate a robust testing plan engaging a wide range of payers, providers, vendors and reporting intermediaries for full evaluation of dQM reporting readiness across a variety of CEHRT implementations.

- dQM specification availability is not equivalent to implementation readiness and assessments of dQM feasibility and maturity must incorporate implementation milestones and measure-specific readiness criteria.

- It is questionable if provision of quarterly attribution lists to Medicare Shared Savings Program ACOs as a mechanism to increase utilization of reporting Medicare eCQMs addresses broader implementation challenges for patient attribution in complex multi provider organizations.

- Development of an attribution methodology for Medicare eCQMs should be a collaborative, progressive effort between MSSP ACOs and CMS, critical for a successful transition to FHIR-based quality reporting.

- Successful reporting of the optional Electronic Prior Authorization measure in 2027 may not be indicative of a clinician's capacity to report the modified measure in 2028, resulting in an unfair 25% reduction of the total MIPS score.

- Exclusions for the mandatory Electronic Prior Authorization measure in 2028 should be expanded to accommodate clinicians impacted by workflow limitations involving the payer, EHR product, implementation configuration, delegated utilization-management vendor, or intermediary.

- CMS should leverage solutions for shared infrastructure such as MHDC's NEHEN FHIR for Electronic Prior Authorization Exchange capable of completion of the electronic prior authorization workflow on the clinician's behalf, ensuring that all organizations, large and small have the same access to resources to complete ePA and meet requirements for meaningful measurement.

- To generate more meaningful reporting data, future development of the Electronic Prior Authorization for Prescription Drugs measure should include standards used (NCPDP and/or FHIR) for completed transactions and structured, computable data for prior authorization dispositions.

Request for Information: Fast Healthcare Interoperability Resources-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs

MHDC commends CMS' direction toward interoperable, standards-based quality measurement. MHDC firmly believes that FHIR-based dQMs have the potential to improve data liquidity, reduce manual reporting burden, increase access to structured clinical data, and enable more timely quality measurement.

MHDC recognizes that CMS and ONC have established an increasingly coordinated roadmap toward standards-based interoperability and digital quality measurement through recent interoperability, certification, prior authorization, and quality reporting initiatives. Clear regulatory direction and implementation milestones are important because providers, payers, vendors, and intermediaries need confidence that investments in FHIR-based quality measurement capabilities will be required and sustained over time.

MHDC strongly supports a phased transition to FHIR-based digital quality reporting while maintaining parallel quality reporting options during the transition period. At the same time, CMS should not assume that publication of specifications, implementation guides, or implementation timelines is equivalent to implementation readiness. The two-year transition period is an opportunity for CMS to validate implementation readiness through real-world testing and experience before requiring FHIR-based quality reporting or retiring existing reporting options.

Assessments of dQM feasibility and maturity should include end-to-end specification testing, validation of data availability and quality, evaluation of workflows and implementation challenges across different CEHRT implementations, including multiple provider types and reporting recipients. CMS must ensure regulatory flexibility during the transition period. Payers, providers, vendors, and reporting intermediaries should be included in these assessments to ensure consistent implementation of data exchange and measure execution across the ecosystem. It is critical for CMS to evaluate readiness through both technical conformance and operational implementation experience, including workflow integration, patient attribution, patient matching, multi-vendor interoperability testing, and successful production use rather than focusing solely on provider reporting capabilities.

MHDC recommends that CMS incorporate measure-specific readiness criteria and implementation milestones when assessing dQM feasibility and maturity,
before requiring dQM reporting or retiring alternative reporting options. These assessments should include objective readiness criteria, availability of structured data elements, demonstrated multi-vendor implementation success, validated attribution methodologies, reliable patient matching approaches, and evidence of operational use in production environments.

Transition Approach and Design
MHDC supports CMS's proposal to establish a two-year transition period for FHIR-based dQM reporting and appreciates CMS's willingness to provide early visibility into the anticipated transition timeline. However, transition milestones should be informed by demonstrated implementation experience and objective readiness assessments throughout the transition period.

MHDC recommends a robust testing plan engaging a range of stakeholders reporting quality across different CEHRT implementations, together with flexible scoring policies, participation incentives, and regulatory flexibility during the transition period.

The 2-year transition period will only be successful if CMS implements a robust testing plan and uses lessons learned from implementation activities to inform readiness determinations, adoption milestones, and retirement of legacy reporting approaches. that engages a range of payers, providers, vendors and reporting intermediaries to fully evaluate dQM reporting readiness across a variety of CEHRT implementations. Testing that compares legacy reporting methods to dQM reporting for the same measures within organizations can help identify differences in denominator construction, data availability, measure calculations, attribution methodologies, and reporting results before FHIR-based reporting becomes mandatory.

As early adopters of dQMs may encounter specification, data-quality, or workflow issues that do not affect organizations reporting via legacy methods, CMS should avoid scoring policies that disadvantage these organizations and instead consider participation incentives such as credit or bonus points for early adopters.

CMS must remain vigilant during the transition period and enact enforcement discretion or other protections for documented implementation issues that impact data submission criteria, completeness or other regulatory elements when they are outside the reporting entity's control.

Factors Affecting Readiness for FHIR-Based Reporting

MHDC supports CMS's efforts to establish common standards, implementation expectations, and a predictable transition pathway for FHIR-based digital quality measurement. However, readiness should not be measured solely by publication of specifications. True readiness requires successful implementation and operational use across diverse organizations, workflows, technologies, and reporting environments. For many measures, operational readiness will also depend on reliable patient matching, attribution, and cross-organizational data reconciliation processes.

As not all practice types, organizational settings, CEHRT developers and supporting health IT entities will achieve readiness for reporting dQMs at the same rate, MHDC encourages CMS to recognize the value of shared infrastructure and trusted intermediaries as part of the transition to FHIR-based quality reporting.

Requiring each provider, payer, ACO, CEHRT developer, and reporting entity to establish separate point-to-point implementations could recreate the fragmentation and burden the transition to dQMs is intended to reduce. Shared models can provide reusable connectivity, common implementation specifications, governance, onboarding, testing, and issue resolution across multiple participants.

CMS can address barriers and facilitate adoption of dQMs and support a coordinated testing framework that includes standardized test cases and synthetic data, validation tools, reference implementations, clear conformance expectations, multi-vendor testing, and a process for resolving implementation questions. Smaller or less-resourced providers may also need access to shared technical services rather than educational materials alone.

During the 2-year transition period, CMS should evaluate not only technical conformance to dQM specifications, but also operational performance, including data availability, attribution accuracy, patient matching performance, workflow integration, multi-vendor interoperability, and successful submission of quality data in production environments. These measures of operational readiness should inform future decisions regarding mandatory reporting requirements.

Proposals for the Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS) Reporting Program for the Promoting Interoperability Reporting category: Electronic Prior Authorization

Proposals for Promoting Interoperability Objectives and Measures for Electronic Prior Authorization

MHDC commends CMS's continued commitment to advancing ePA processes by inclusion of Electronic Prior Authorization measures in the HIE objective of the Promoting Interoperability Program.

MHDC agrees that measures for eligible clinicians that provide care for both Traditional Medicare enrollees and beneficiaries enrolled in plans administered by impacted payers is an effective support for payer policies to implement and maintain Prior Authorization APIs. These measures maximize the potential to improve prior authorization processes for providers and patients.

MHDC supports CMS's direction transitioning to measures for the Promoting Interoperability Program that fully define ePA as a complete workflow supported by CRD, DTR, and PAS and offers recommendations to ensure this transition is successful.

Proposal for the Electronic Prior Authorization (medical) measure to become optional for 2027
MHDC agrees with CMS' proposal to reclassify this measure as optional for 2027 and award bonus points for successful attestation. This approach creates an incentive for early implementation without penalizing clinicians whose payers, EHR vendors, or other trading partners are not yet operationally ready (or are operationally ready but are unable to transact with payers due to their vendor pursuing a proprietary business model).

MHDC's experience with the NEHEN FHIR for Prior Authorization Exchange implementation demonstrates that readiness to implement electronic prior authorization (ePA) workflows varies among payers and providers. Consistent with MHDC's findings, MHDC notes the availability of a payer API does not by itself establish provider readiness. Successful ePA requires coordinated implementation across payers, providers, EHR developers, intermediaries, and workflow owners, including contracting, configuration, testing, issue resolution, and production support.

Proposal to Update the Measure Description: Electronic Prior Authorization (medical) measure for 2027

CMS' proposed language in the measure description could be interpreted inconsistently across implementers because it does not distinguish between initiation of an electronic workflow, successful submission of a standards-based ePA transaction, or portal-based processes.

MHDC recommends:

1. The measure description should include the acceptable source(s) for a request that can initiate workflow for a qualifying electronic prior authorization

2. Results from the 2027 performance period should be considered regarding implementation evidence to identify barriers before making the measure mandatory

Proposal to require the Electronic Prior Authorization (medical) measure in 2028
While MHDC agrees that future versions of the Electronic Prior Authorization (medical) measure should incorporate a complete set of actions to support robust prior authorization, reporting of the optional measure for 2027 may not indicate a provider's capacity to report the modified measure in 2028.

Considerations that can impact ePA workflow include limitations involving the payer, EHR product, implementation configuration, delegated utilization-management vendor, or intermediary—not because the provider has failed to make meaningful use of available technology.

MHDC recommends:

1. Inclusion of additional exclusions or hardship provisions as there are disproportionate consequences for clinicians with regards to MIPS scoring when CEHRT functionality is technically available but has not been made operationally usable by the clinician's trading partners including payer, the EHR developer, or delegated utilization-management vendor.

2. CMS response when clinician use of exclusions establishes a pattern that points to consistent failure of clinician trading-partners to complete prior authorization workflow.

3. Provision of detailed testing guidance and clarification of responsibility across the payer, provider, EHR, and intermediary components of the workflow

4. Evaluation of results from the 2027 performance period to identify implementation barriers and use of that information to establish clear readiness criteria before transitioning to a mandatory measure.

Proposal to require an Electronic Prior Authorization measure for Prescription Drugs
MHDC agrees with CMS that a separate Electronic Prior Authorization measure for Prescription Drugs is a valuable assessment of meaningful use of CEHRT under the MIPS Promoting Interoperability performance category, and an opportunity to improve timeliness and transparency of medication access within provider EHR workflows to support care coordination and help close the prescriber-to-dispenser loop.

MHDC recommends:

1. Clearly define the minimum criteria for a qualifying electronic prior authorization transaction, including whether the transaction must be successfully transmitted and whether standards-based transactions such as NCPDP SCRIPT are required.

2. Establish a minimum reporting framework that includes standards-based transaction submission, common ePA status definitions, and standardized identification of drugs requiring prior authorization through electronic coverage discovery tools.

MHDC's recommendations are consistent with MHDC's plans to conduct a NEHEN FHIR Prior Authorization Exchange for Drugs demonstration project, with payers and providers agreeing that standardized semantics for prior authorization decision dispositions and coded denial rationale category reported separately from claims denials are key for successful electronic prior authorization transactions. MHDC notes that these details are also consistent with policy established in 42 CFR 422.122(a) for communicating denials for medical prior authorization.

1. Standardized prior authorization decision dispositions for drugs should enumerate:

- Approved
- Denied
- Partially approved
- Pended for additional information
- Withdrawn

2. Standardized, coded prior authorization denial rationale for drugs should enumerate:

- Missing clinical documentation
- Step therapy not met; specific step therapy required, including preferred alternatives and necessary trial durations.
- Diagnosis mismatch
- Quantity limit exceeded
- Non-covered drug
- Site-of-care restriction
- Benefit exclusion
- Medical necessity not established
- Duplicate therapy
- Payer needs additional information

Inclusion of these recommendations will promote more reliable measurement, reduce implementation variation, and generate more meaningful performance data for future program evaluation.

Request for Information: Future Potential Performance-Based Measures of Electronic Prior Authorization

Future Potential Performance-Based Measures of Electronic Prior Authorization

MHDC supports CMS' vision to expand the scope of the Electronic Prior Authorization measures in future rulemaking and agrees that a more substantial measure requirement will demonstrate meaningful adoption of electronic prior authorization over time.

CMS should recognize the value of shared infrastructure hosted by regional collaboratives to address the barriers and challenges of small, rural and under-resourced practice settings when reporting performance-based electronic prior authorization measures.

Rather than lowering the bar for small and rural practices without the resources to operationalize multiple point to point integrations with payers for electronic prior authorization workflow, CMS should partner with regional collaboratives that can leverage solutions for these settings. MHDC's NEHEN FHIR for Prior Authorization Exchange demonstration project will assess functionality to complete the electronic prior authorization workflow on the clinician's behalf, meeting requirements for more meaningful measurement without creating undue burden for MIPS eligible clinicians in under-resourced practice settings.

MHDC recommends a progressive approach to measure design before CMS adopts a performance threshold or rate-based score. A progressive approach would incorporate assessments of measure feasibility across specialties, practice sizes, payer mixes, and technology environments. Clinicians should not be disadvantaged because a payer, benefit type, delegated vendor, or EHR workflow did not support the required electronic transaction. Clinicians in small, rural or otherwise under-resourced practice settings should have a glide path that preserves limited portal use as they transition to standards-based transactions.

MHDC recommends the following considerations for this approach:

1. Measure denominators limited to only prior authorizations for which all necessary electronic capabilities were operationally available from the payer and the clinician's health IT.

2. Measure design that distinguishes between technical transaction completion and the outcomes of successful prior authorization.

3. Initial collection of numerator and denominator information without attaching payment consequences.

MHDC notes that measurement inclusive of both technical transaction completion and the outcome of successful prior authorization will lend the most insight with regards to administrative burden and impact on access to care. Measures could incorporate elements such as processing times for complete electronic prior authorization transactions, the need for manual interventions to complete prior authorization transactions, and validate patient access to care or drugs.

Proposal to establish the Medicare eCQMs collection type for Medicare Shared Savings Program ACOs.

Consideration of the Medicare eCQM Collection Type for Shared Savings Program ACOs

MHDC agrees that eCQMs, leveraging structured clinical data, are integral to value-based care, enabling clinicians to track patient outcomes, adhere to evidence-based guidelines and monitor population health trends. MHDC also acknowledges that eCQMs can be challenging for MSSP ACOs to implement, as eCQMs are structured to report across all patients and payers served by an organization, and not easily restricted to a single payer relationship.

Fifteen MSSP ACOs are headquartered in Massachusetts, with 747 participant TINs among them, and approximately 468,000 Massachusetts beneficiaries are ACO-assigned.[1] [2] [3] Barriers to reporting quality via eCQMs for ACOs include beneficiary attribution, patient identity management, patient matching, data reconciliation, and aggregation of clinical data from multiple sources. These challenges can create a significant source of administrative burden for complex organizations that include multiple TINs, specialty practices, and/or multiple EHR platforms.

While attribution and patient matching are often discussed together, they represent distinct implementation challenges. Attribution determines whether a beneficiary belongs within a measure population, while patient matching determines whether clinical data from multiple organizations can be accurately associated with the correct individual. CMS's proposal may assist with attribution, but it will not fully resolve the broader patient identity and patient matching challenges that many ACOs encounter when aggregating data across organizational boundaries.

Additional Considerations for the Shared Savings Program transition to FHIR-based Quality Measurement

MHDC supports the intent behind CMS' proposal for Medicare eCQMs as an interim step to accelerate provider readiness for future FHIR-based digital quality measurement (dQM) for ACOs. However, ACOs that incorporate multiple TINs, specialty practices, and/or multiple EHR platforms are particularly challenged, attribution isn't static. Successful electronic quality measurement depends on standardized attribution methodologies, reliable patient matching, consistent access to structured clinical data, and the ability to aggregate and reconcile information from multiple organizations.

MHDC encourages CMS to publish and test the underlying attribution methodology and measure-specific population logic used to generate these files. While CMS can provide attributed beneficiary lists for MSSP participants because it controls beneficiary assignment, the methodology behind those lists may offer broader lessons for future multi-payer interoperability initiatives.

Lessons learned from early adopters of FHIR-based quality measurement are valuable resources that CMS should consider in evaluating the proposed attribution methodology and measure-specific population approach for Medicare eCQMs, especially in consideration of the transition to FHIR dQMs. Participants in MHDC's NEHEN FHIR for Quality Measurement pilot have found that attribution, roster management, patient matching, and cross-organizational data reconciliation are major implementation challenges between payers and providers.

[1] ACO organization file (PY2026): https://data.cms.gov/sites/default/files/2026-04/358ddf60-c203-41ef-a0c6-a62a79f466ee/PY2026_Medicare_Shared_Savings_Program_Organizations.csv

[2] ACO participant file (PY2026): https://data.cms.gov/sites/default/files/2026-01/453bc69c-61a4-4030-8d03-e33895fd1cfd/PY2026_Medicare_Shared_Savings_Program_Participants.csv

[3] Assigned beneficiaries by county (PUF vintage 2024-01-01, the most recent CMS publishes): https://data.cms.gov/sites/default/files/2025-11/c9b8923e-5bb4-4d28-8387-48d9bde5e74c/Number_Of_ACO_Assigned_Beneficiaries_by_County_PUF_2024_01_01.csv

Even when measure specifications are understood, organizations must still establish operational processes to manage attribution challenges, validate patient identity, reconcile rosters, and aggregate clinical data from multiple sources.

CMS should publish the proposed attribution methodology and a test file well ahead of PY2027, allowing sufficient time for multi-ACO field testing. MHDC also recommends that Medicare eCQMs remain optional with incentive scoring until multi-ACO field testing is complete and CMS has demonstrated that attribution methodologies, structured data requirements, and reporting workflows can be implemented consistently across a diverse set of ACO structures and EHR environments.

CMS should recognize that readiness for Medicare eCQMs and future FHIR-based dQMs depends on organizational governance, attribution operations, patient matching capabilities, data quality, and cross-organizational workflow coordination in addition to technical measure specifications. ACOs need governance structures incorporating operational workflows for attribution processes and access to standardized clinical data to validate testing across organizations. As many MSSP ACOs operate across multiple provider organizations, EHR environments, and reporting structures, their experiences can provide valuable insight into the operational realities of electronic quality reporting and future FHIR-based quality measurement.

MHDC firmly believes that readiness, and ultimately success, for future FHIR-based dQMs will depend on more than measure specifications and quarterly attribution lists. It will require demonstrated implementation success across diverse ACO environments. Critical are standardized attribution methodologies, roster management, reliable patient matching, cross-organizational data reconciliation, consistent access to aggregate clinical data from multiple sources and operational experience managing quality measurement across organizational boundaries.

Proposals for the Quality Payment Program (QPP) Merit-based Incentive Payment System reporting program for the Promoting Interoperability reporting category

Proposal to Align the Promoting Interoperability Definition of CEHRT and Objectives and Measures with HTI-5

Based on MHDC's extensive experience, collaborations, and a careful examination of implementations and outcomes, MHDC has concluded that *burden reduction* succeeds only if it decreases total friction across the ecosystem – not if it shifts cost, risk, or bespoke integration work onto providers, payers, exchanges, and implementers. MHDC cautions that the removal of criteria from the definition of CEHRT, as well as certain objectives and measures in the Promoting Interoperability Program could impact key CEHRT functionality for health information reported by patients, exchanged in transitions of care, quality measure reporting, and security of health data.

The ONC Health IT Certification Program criteria for recording *Family health history* and *Patient health information capture* are critical to the creation, maintenance and electronic exchange of information provided by patients and are essential to inform the patient's longitudinal health record.

The criteria for *Clinical information reconciliation and incorporation* assures that CEHRT can incorporate and reconcile data that represent a patient's active medication list, allergies and intolerance list and problem list upon receipt of a transition of care or referral summary. The criteria for *Application Access – All Data Request*, specifies CEHRT functionality to respond to requests for patient data with a summary record aligned with the Continuity of Care Document (CCD) document template. CCDs are still in wide use for exchanging disparate clinical data and until FHIR is universally implemented for patient data exchange, this functionality must be maintained,

While removal of these certification criteria would not likely immediately impact the functionality of CEHRT or a clinician's ability to record or exchange health data, there is no assurance that all developers of CEHRT will maintain this functionality over time before FHIR standards for interoperability are widely in use. Inconsistent CEHRT performance to record, change, access or exchange health data is a potential risk to patient safety, especially in transitions of care. A clinician might not know this functionality was compromised until it was needed.

As CMS has yet to finalize a timeline for full transition to FHIR-based quality reporting, certain eCQMs could remain in use until 2030. Removing certification criteria for quality measurement, resulting in inconsistent CEHRT performance could impact thousands of clinicians reporting quality measures.

Elimination of certification criteria for *Automated numerator recording* and *Automated measure calculation,* and failure of CEHRT to consistently maintain this functionality would impact clinicians reporting Promoting Interoperability Program percentage-based measures. This criterion assures that CEHRT enables a user to review the patients or actions that make the patient or action eligible to be included in the measure's numerator, and access reporting that details the numerator, denominator and resulting percentages associated with each applicable measure.

CEHRT functionality associated with *Clinical quality measures – filter* assesses the ability of CEHRT to filter quality data at the patient and aggregate levels based on a set of standardized data elements for provider identification, patient demographics and the problem list. Removal of this certification criteria could result in inconsistent CEHRT performance adversely impacting patient attribution for MSSP ACOs and commercial payers.

The Security Risk Analysis measure, aligned with the parameters of the HIPAA Security Rule at 45 CFR 164.308(a)(1), requires the clinician to attest that they have evaluated all three categories of HIPAA safeguards: administrative, physical, and technical. CMS' justification for removing this measure from the Promoting Interoperability Program objectives and measures is that the measure is duplicative with the HIPAA Security Rule and overly burdensome for clinicians to comply with. Analysis of data breaches in 2025 by the HIPAA Journal indicates that 57.5% of breaches occurred among healthcare providers, 61.5% involved exposed and stolen protected health information stored on network servers with improperly secured databases, 24.9% involved compromised email accounts and 64% of healthcare data breaches were relatively small, impacting less than 10,000 individuals, confirming that the majority of data breaches occur in smaller practices.

In addition, 76% of all HHS OCR enforcement actions included a penalty for a risk analysis failure.[4] This data tells us that clinicians would benefit from greater awareness of security risks and there an advantage in including more effective measures of assessment in the Promoting Interoperability Program, not eliminating them.

MHDC notes that CMS and the ONC have a history of collaboration, utilizing the Promoting Interoperability Program as a feedback mechanism to alert the ONC when increased surveillance activities for CEHRT should be considered. With the removal of these requirements that potentially present a risk to patient safety or the security of healthcare data, this feedback mechanism is lost.

MHDC therefore recommends that CMS and the ONC consider developing an alternative mechanism for eligible clinicians to report variations in expected operation of CEHRT to perform secure health information exchange, especially in the absence of ONC health IT certification criteria that validate functionality critical to CEHRT.

Conclusion

MHDC appreciates CMS' leadership in modernizing quality measurement across CMS payment programs through a thoughtful transition to FHIR-based quality measurement, and reorienting the Meaningful Use of CEHRT towards electronic prior authorization within the Promoting Interoperability Program. At the same time, MHDC urges CMS to pursue a measured implementation strategy founded in stakeholder collaboration, realistic timelines, and robust real-world testing to ensure that measure reporting for quality and electronic prior authorization is both achievable and meaningful. CMS should also account for the operational realities of interoperability within Meaningful Use so that program changes maintain trust and minimize burden shifting to providers. MHDC looks forward to continued collaboration with CMS and other stakeholders to strengthen and expand the digital health ecosystem and advance the shared goal of interoperability.

Sincerely yours,

Denny Brennan
Executive Director

[4] https://www.hipaajournal.com/2025-healthcare-data-breach-report/