February 27, 2026

Dr. Thomas Keane
Assistant Secretary for Technology Policy
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street, SW Floor 7
Washington, DC 20201

Re: MGMA Response to HHS Office of the Secretary NPRM, *Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity*

Dear Dr. Keane:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the *Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity* proposed rule, published in the Federal Register on December 29, 2025. With a membership of more than 70,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties.

MGMA values the leadership of the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC) in overseeing the Health IT Certification Program (Certification Program) to reduce burden, offer flexibility to both developers and providers, and support innovation through the removal and revisions of certain certification criteria and regulatory provisions. We recognize the Administration's leadership advancing policies that transition healthcare to a Fast Healthcare Interoperability Resource (FHIR)-based Application Programming Interface (API) ecosystem as a strategic imperative and an investment in the nation's interoperability future. We also recognize the value in removing certain redundant requirements of the Certification Program to benefit the health IT community overall.

These proposals extend beyond the removal of redundancies in the Certification Program to, as ASTP states, "aggressively reduce and remove long-standing functionality-oriented and non-FHIR-based certification criteria from the Certification Program".[i] While MGMA supports reducing unnecessary regulatory burden on health IT developers, we believe the proposed removal of 34 certification criteria and revision of certain certification requirements risks shifting technical, operational, direct and indirect costs, and compliance responsibilities downstream to medical groups. For example, these changes could lead to increased product variability, especially with new market entrants, and the potential loss of expected "out-of-the-box" functionality could necessitate medical groups reassessing and renegotiating electronic health record (EHR) acquisitions to maintain capabilities they have come to rely on.

MGMA recommends that if ASTP proceeds to remove many of the criteria as proposed, then it should establish a feasible, strategic, longer-term timeline from what is proposed. Extending the proposed timelines for non-redundant criteria to be removed will benefit medical groups as they prepare for changes to their current product capabilities and workflows. We believe the compressed, proposed effective dates (listed as either effective date of final rule or January 1, 2027) may lead to unnecessary disruption to care and operations for medical groups and introduce added complexity and burden. Extended timelines and market stability will not only help ensure less potential disruption for medical groups' daily operations and patient care but also support practice groups' health information technology investments and decisions that are aligned with Centers for Medicare & Medicaid Services (CMS) program participation and compliance expectations.

For well over a decade, the Certification Program has established the baseline federal standards and required functionality for certified health IT products, including electronic health records. In practice, these standards directly shape the health IT tools medical groups rely on to support clinical documentation, information exchange, reporting, compliance, decision-making, and day-to-day practice operations. If finalized as proposed, we anticipate both potential positive and negative unforeseen consequences for medical groups; accordingly, many of our comments involve considerations for practice implementation and for helping to ensure stability as well as innovation. With fewer guardrails offering vendors greater flexibility and supporting expanded data access and FHIR-enabled automation, we believe trust, governance, and consistency at scale will be essential to successful technology implementation and overall policy execution.

From recent feedback we received (January 2026) on regulatory administrative burden from nearly 250 MGMA members, of the top three factors contributing to physician burnout at practices, inefficient or overly complex electronic health record workflows and systems were ranked number three. Federal policies and investments must ensure health IT not only helps with administrative burden but also supports, rather than hinders, clinical care and operations, protects patient privacy, and relies on evidence and consensus-based, nationally recognized health IT data and administrative simplification standards.

We note that in addition to seeking input on this proposed rule, ASTP is also seeking input through a separate request for information on diagnostic imaging interoperability and on potential standards and certification criteria to adopt in the Certification Program. ASTP describes the diagnostic imaging interoperability current state as a fragmented ecosystem where exchange is manual, burdensome, and unreliable. [ii] In this instance, ASTP is inviting input on potential additions to the Certification Program as it works to help address shortcomings in market innovation and capabilities that are widely available for imaging interoperability. We look forward to future regulatory activities to build upon the Certification Program to help address these and other interoperability challenges.

In addition to the deregulatory certification-specific proposals in this rule, ASTP seeks input on which standards or implementation specifications it should retain for purposes of health IT alignment that involves support for acquiring, implementing, or upgrading health IT systems consistent with established policy in the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HHS Health IT Alignment Program that enables ASTP to work across HHS to promote greater alignment of health IT-related activities in support of its health IT and interoperability goals can help to eliminate data silos, reduce reporting burden, and further electronic health data exchange without dependency on proprietary solutions – these are all aims MGMA supports. Under this effort, standard health IT language is incorporated in federal applicable grants, cooperative agreements, contracts, and rulemaking/guidance to ensure alignment of HHS' health IT investments. We thank ASTP for inviting input on the standards and specifications for its alignment activities as we believe it provides a role for ensuring continuity of standards use and adoption across HHS grants, models, demonstrations, and related reporting requirements.

While we are not currently suggesting granular specification standards, we do believe there are opportunities to advance standards alignment policy to help improve current credentialing processes to reduce burden for medical groups, ensure access for patients, and minimize unnecessary revenue loss. As we recently heard from one MGMA member, "Credentialing woes have a hard impact on our practice as everything starts with credentialing. Delays continue to impact our revenue in significant ways and often we only know of a provider credentialing problem when it negatively affects a patient. For example, we first discover an issue when we hear from patients after they go to a pharmacy and cannot access their medication due to a credentialing problem". Multiple portals (including National Plan and Provider Enumeration System-NPPES, National Provider Identifier- NPI, and Provider Enrollment, Chain, and Ownership System- PECOS) necessitate data re-entry, separate log in access, may involve additional process requests for enabling provider delegation, and present practices with a lack of standardized data and timely notifications. The credentialing process is complicated, burdensome, and inefficient. We believe a standard alignment -based approach as part of policy agenda on this (and related issues) could help to reduce credentialing burden and enable a

seamless and efficient end user experience to benefit patients and practices. MGMA supports federally coordinated, HHS non-proprietary data standard use and adoption and looks forward to exploring further with ASTP how the Health IT Alignment Program can help to address the daily challenges of provider credentialing for medical groups.

We remain committed to working with ASTP to incorporate the daily realities of medical groups in implementing a final regulation that is expected to significantly reduce and remove long-standing functionality, and non-FHIR based certification criteria from the Certification Program. MGMA believes many of the proposed removals to the Certification Program warrant closer scrutiny and an extended, strategic implementation transition timeline to ensure continuity of care, preserve patient safety, and minimize workflow disruption for medical groups, especially for small and independent practices with limited capacity to compensate for these gaps in health IT functionality.

Health Data, Technology, and Interoperability ASTP/ONC Deregulatory Actions to Unleash Prosperity

We respectfully offer the following comments in response to this proposed rule. ASTP/ONC should:

Extend timelines for certain Consolidated Clinical Document Architecture (C-CDA) removal

As stated above, MGMA encourages ASTP to establish clear, phased transition expectations as certification shifts toward FHIR-based exchange and extend the timeline for non-redundant criteria removal should ASTP proceed to remove all the C-CDA criteria as proposed. An extended timeline for C-CDA criteria removal can help to enable both practice and market stability. Given that much of document-based exchange in healthcare interoperability today is based on the C-CDA, any retirement of the C-CDA functionality-oriented criteria should involve a phased implementation approach grounded in demonstrable readiness. We believe doing this effectively will involve conducting further analysis, including, but not limited to, FHIR readiness, focused comment review, and potential input from the Health IT Advisory Committee (HITAC) to inform sequencing, dependencies, and transition readiness before finalizing large-scale certification removals. Further, the HITAC is well-positioned to explore how document-based FHIR could work alongside API-based exchange and the value and feasibility for generating standardized FHIR document summaries as part of a transition away from C-CDA. Certification requirements have served as a critical safeguard, ensuring predictable and tested functionality. Eliminating C-CDA certification requirements without ensuring these functions remain reliably supported during a transition to FHIR risks increasing manual workflows and administrative burden while posing potential risk to clinicians and patients. Extending the timeline for criteria removal could help prevent any loss, disruption, degradation, or inconsistent

support of functionality and standards that medical groups depend on to deliver care and support daily operations.

Accounting for uneven FHIR adoption and readiness will be important as part of any future effort to revisit proposed timelines. MGMA acknowledges FHIR as an important strategic direction and applauds the work of ASTP and CMS to advance an interoperable, person-centered ecosystem that leverages modern data standards for efficient, frictionless, accessible data exchange. At present, FHIR adoption and implementation are uneven across organizations, care settings, and use cases. Medical group practices, including smaller under-resourced practice groups, must operate within this reality and may support hybrid workflows and variable FHIR maturity. While FHIR offers important advantages for data sharing, implementation challenges persist, including interoperability with legacy systems, uneven adoption across organizations, ongoing maintenance demands, and inconsistent use of standardized terminologies and value sets. [iii] Certification program decisions could reflect actual practice costs and workflows, accounting for FHIR challenges, uneven adoption levels, and the lack of what is often described as the widespread use of "FHIR push capabilities" rather than assume an overall FHIR ecosystem readiness. Further, decisions could also consider future opportunities for standardized FHIR documents for summary-of-care exchange while transitioning away from C-CDA document summaries providers have familiarity with and depend upon.

Adopt appropriate safeguards, preserve real-world testing, and empower practice vendor due diligence

Program stability and predictability remain critical for medical group practices, making multi-year technology investments aligned with CMS program expectations. Removing certification requirements may, in certain instances, alter vendor development. In practice, it is possible certain vendors may prioritize investment in capabilities that are required, profitable, or contractually demanded, and may deprioritize document-based exchange and other functions no longer tied to certification. As certification requirements are reduced, medical group practices may face uneven FHIR implementation across products, and reduced support for established, widely used document-based interoperability workflows such as C-CDA.

We encourage ASTP to consider variable market responses and identify and advance appropriate and robust safeguards, such as maintaining expectations for end- to- end workflow reliability and encouraging continued testing and validations of interoperability functions in real-world settings if certification requirements involving C-CDA as part of real- world testing are removed. This will be impactful for medical groups navigating an altered landscape. Further, the uncertainty regarding whether new market entrants will reliably support functionality no longer tied to certification may pose risks to daily clinical workflows and interoperability goals. Medical groups depend on the knowledge that their certified product functions as intended in actual practice settings and not just successfully in a lab.

To help support and empower medical groups with related due diligence activities with their EHR vendor, we encourage ASTP to update and release a new version of the *EHR Contracts Untangled* guide from 2016[iv] and to consider developing other tools, such as an Informational Resource [v]for Medical Group Practices, in concert with stakeholders such as MGMA. As an MGMA member recently shared with us, if certification criteria are removed then having a standardized way to make sense of product capabilities in a visibly clear and usable manner (like online product comparison charts used today for other products) will be essential for understanding impact and to help with future purchases, contract negotiations, and planning. As this member further explained, for their small, under-resourced practice a change in vendor is highly unlikely given the cost and disruption it entails. Indeed, the process of finding and changing EHR vendors may take a medical group 12 to 18 months, can be costly (as noted by this example), and involves increased staff time dedicated to implementation, training, and associated due diligence activities.

Maintain privacy and security certification capabilities

Privacy and security certification criteria are important for sustaining and strengthening public and provider trust in technology systems, and are foundational infrastructure for safe, trusted interoperability, especially while granular data sharing and segmentation technical capabilities continue to advance. As pertains specifically to HIPAA Security, we appreciate ASTP's rationale in the NPRM that HIPAA Security Rule requirements apply independently of certification. We believe in balancing security requirements with the practical realties faced by medical groups, recognizing that new system updates, processes such as mandatory audits, and upstream changes impacting vendors can all impose significant costs. Policies should provide flexibility for medical groups in implementing cybersecurity measures avoiding requirements that add complexity without improving patient outcomes. The security certification requirements in the Certification Program can help medical groups rely on a baseline set of security capabilities that are relevant to, and supportive of, HIPAA Security Rule implementation, without implying or guaranteeing HIPAA compliance. We believe that these certification criteria have played a critical role in enabling medical group practices to rely on consistent, tested technical security functionality within certified health IT, and that eliminating these criteria risks shifting additional implementation responsibilities to practices even where underlying legal requirements remain unchanged. These concerns are heightened as future HIPAA Security Rule regulatory actions are currently unclear. Absent certification guardrails, medical groups may bear increased responsibility for independently assessing, validating, negotiating, and maintaining security functionality across their health IT products. MGMA recommends ASTP retain critical privacy and security criteria, such as auditable reports and events, access controls, authentication safeguards, and encryption-related capabilities, or at minimum establish a longer timeframe for preserving certified security capabilities so that practices can continue to rely on foundational protections already in place. Near term removal could result in costly, inconsistent, and error-

prone system customizations that shift operational risk, selection, and oversight responsibility more heavily on medical groups, particularly for small and independent practices with limited technical capacity.

Ensure information blocking exception and definition changes do not increase compliance risk

MGMA cautions that revisions to the information blocking exceptions, including those narrowing the infeasibility and manner (and removal of Trusted Exchange Framework and Common Agreement -TEFCA- manner) exceptions, should not increase compliance risk or operational uncertainty for medical group practices acting in good faith. ASTP should ensure that revised exceptions appropriately reflect real-world implementation constraints and do not potentially penalize practices for interoperability limitations that are beyond their control. We believe ASTP and the HHS Inspector General should focus enforcement on egregious violations and provide updated, practical technical assistance and education to help providers comply. As pertains to the proposal to revise information blocking definitions to emphasize that they include automated means of access, exchange, or use of electronic health information (EHI) including, without limitation, autonomous Artificial Intelligence (AI) systems, we believe it is important to fully explore the potential impact this holds for medical practices. While the expanded definitions are intended to support innovation, medical groups remain regulated actors under information blocking policies including when automated or AI-enabled data access capabilities are embedded in a system that practices do not design. The inclusion of AI-enabled access to EHI raises additional potential concerns for practices related to patient consent, secondary data use, transparency, and additional cybersecurity risk. Enabling responsible AI use involves access to high quality data coupled with adequate guidance and having precautions in place for providers and patients. MGMA believes additional clarification is needed to ensure that revised definitions and exceptions do not unintentionally increase compliance risk for medical groups. Expanded definitions could inadvertently shift liability and oversight responsibilities to practices without providing commensurate tools or protections, increasing administrative burden and uncertainty.

Avoid leaving medical groups accountable to CMS requirements without certified tools and strategies to support them

Regulatory streamlining of the Certification Program should not weaken certified health IT capabilities in ways that could potentially increase reporting risk or operational burden for medical groups participating in HHS programs such as the CMS Merit-based Incentive Payment System (MIPS). The proposed certification removals and modifications have direct implications for medical groups' MIPS Promoting Interoperability (PI) participation and other critical models or reporting requirements. ASTP and CMS should coordinate closely to ensure certification changes do not undermine program integrity or shift compliance and performance risk to practices leaving them without adequate capabilities in place to support performance and

reporting in the future. This may involve extending flexibility for reporting and enforcement discretion during transition years.

In certain instances, certification criteria proposed for removal or modification underpin workflows that medical group practices must still operationalize to meet CMS program requirements, even if the formal certification mandate is eliminated. As a result, practices may face misalignment between CMS expectations and the capabilities that are assured through certification. Although CMS may not explicitly require C-CDA–based exchange, in practice many PI measures depend on the availability of reliable, standardized exchange capabilities across diverse trading partners. Even in an environment where certification criteria remain constant but there are changes to MIPS, as one practice administrator of a small medical group recently shared with us, "any change to a MIPS category involves more cost, more upgrades, staff training, and is disruptive to our workflow and patient care". As pertains to advanced payment models (APM), while we continue to advocate for CMS to rescind burdensome Certified Electronic Health Record Technology (CEHRT) requirements and further incentivize the transition to value-based care arrangements by reducing reporting burdens for APM participants, we do not believe, at this time, that the removal of certification criteria contained within CEHRT as proposed will lessen reporting burden for medical groups.

Medical groups remain accountable for CMS requirements even as certification criteria change and are removed. MGMA is concerned with the potential impact these proposed policies have on the base EHR and CEHRT definitions and with the absence, at present, of an implementation-focused, technically feasible and coordinated ASTP/CMS timeline-transition strategy to ensure stability for medical operations. As example, without an aligned programmatic strategy in place, CMS may need to rely more frequently on discretionary tools such as measure- suppression if technical readiness lags policy expectations rather than on a predictable transition framework additionally useful for medical group operations and planning. The development of a programmatic strategic framework could be further informed by the Health IT Advisory Committee with input from additional stakeholders such as MGMA.

Criteria Specific Comments

Consistent with the overarching recommendations and implementation considerations outlined above, below we offer additional comments on a select number of specific certification criteria from the 34 that are proposed for removal and 7 for revision. We believe these criteria, essential to medical group health operations and care delivery, provide valuable examples for reconsideration of the proposed timeline and removal approaches.

TOPIC/ISSUE: Care Coordination- Transitions of Care and Clinical Reconciliation

ASTP/ONC proposal: ASTP proposes to revise and simplify the transitions of care certification criterion by removing requirements to "send" and "create" clinical documents while retaining a

requirement to "receive" a C-CDA document. The proposal is intended to position this criterion for future evolution to receive data via FHIR. ASTP also proposes to revise and scale back clinical reconciliation functionality.

MGMA comment: MGMA is concerned that the proposed scaling back of transitions of care and clinical reconciliation requirements weakens testing of foundational capabilities relied upon by medical groups to support safe, coordinated care. Clinical reconciliation is closely tied to transitions of care. Together, these certification criteria help enable effective referrals, care coordination, and enable the ability to meaningfully incorporate external data into clinical workflows. Without robust reconciliation capabilities, burden will likely shift further on to clinicians and staff to manually review and reconcile information across systems which can lead to further administrative burden. In practice, weakened transitions of care workflows may also exacerbate patient matching and data linkage challenges at the point of care. The inclusion of patient matching criteria within the continuity of care document (CCD) improves patient safety and security by reducing instances of patient misidentification. Difficulty matching and linking patient data can limit a practice's ability to obtain a comprehensive view of a patient's health record, undermining critical care delivery functions such as care coordination, safe transitions, utilization tracking, and follow-up care.

MGMA believes these proposed changes warrant closer scrutiny and a more deliberate transition timeline to ensure continuity of care, preserve patient safety, and minimize workflow disruption for medical groups, especially for small and independent practices with limited capacity to compensate for these gaps in health IT functionality.

TOPIC/ISSUE: Public Health Reporting Related Criteria

ASTP/ONC proposal: ASTP proposes removing public health criteria tied to transmission to cancer registries, antimicrobial use, and health care surveys and revising criteria for electronic case reporting. ASTP indicates that cancer registry reporting is moving from C-CDA to FHIR through the HL7 FHIR Accelerator Helios and that health care survey capabilities are already widely implemented and used.

MGMA comment: State public health data reporting policies and practices vary widely. [vi] Removing standardized EHR functionality that supports medical groups with public health reporting increases the risk that medical groups will face inconsistent workflows and added operational burden while detracting in the near term from federal efforts to standardize public health data exchange if removals outpace availability of replacement FHIR standards. Moreover, even as FHIR readiness may come in place, migrating to these standards is costly for small practices. Scaling back certification and testing requirements for electronic case reporting may lead to greater variability in this functionality across vendors increasing manual oversight, configuration, and troubleshooting for medical practices. Further, it may also unintentionally compromise the integrity of public health reporting. We recommend ASTP reconsider the

proposed removals and revisions to electronic case reporting and, at minimum, extend the associated timelines to ensure an adequate period for adoption and implementation of FHIR based approaches from current C-CDA-based public health-related certification criteria.

TOPIC/ISSUE: Privacy and Security Certification Criteria

ASTP/ONC proposal: ASTP/ONC proposes to remove Privacy and Security certification criteria and the associated Privacy and Security Certification Framework, asserting that HIPAA Security Rule requirements apply independently of ONC certification and that certification has not been a primary driver of privacy and security compliance. ASTP further states that certification does not guarantee HIPAA compliance or provide an affirmative defense and seeks to reduce duplicative regulatory burden. ASTP indicates intent to prioritize the adoption of privacy and security capabilities that are fit for purpose, use case specific, and deliver technical consistency paired with specific conformance requirements.

MGMA comment: As discussed in greater detail above, MGMA believes it is important to retain certification-based privacy and security capabilities to secure patient and practice data and ensure technology systems deliver effective protections. These criteria provide medical groups with confidence that baseline security capabilities exist and function as tested - not that HIPAA compliance is guaranteed. While underlying legal requirements may remain unchanged, removal of these criteria risks shifting the burden onto medical groups (particularly small and independent practices) by eliminating a consistent certification baseline for critical security capabilities. Such a shift could increase operational risk, complexity, and variability for practices handling sensitive patient data, as practices also remain responsible for meeting HIPAA Security Rule obligations. We appreciate the future intent to, as we understand, prioritize embedded privacy and security capabilities, but believe greater information is needed by ASTP on this proposed approach and, as such, these criteria should remain in place or, at a minimum, ASTP should finalize a later date for their removal to ensure critical protections remain available.

TOPIC/ISSUE: Decision Support Interventions

ASTP/ONC proposal: ASTP proposes to revise and remove parts of the decision support interventions (DSI) certification criterion that helps to ensure users can leverage health IT for clinical decision making and enables users access to transparent information about DSI performance and quality. This would remove certain requirements related to source attributes that enable transparency regarding how a predictive or generative AI application was designed, developed, tested, evaluated, and should be used in practice.

MGMA comment: MGMA is concerned that this proposal involving DSI certification criteria removes certain source attributes and transparency requirements routinely available via certified health IT modules to medical practices for clinical artificial intelligence and machine-learning tools. Without these requirements, practices will have significantly less visibility into how

predictive or generative AI applications are designed, developed, tested, evaluated, and intended to be used in clinical workflows.

The potential loss of standardized transparency could make it more difficult for practices, especially smaller and community-based medical groups, to evaluate AI tools for adoption, support informed provider use, and train staff appropriately. In practice, medical groups may rely on vendor-provided information (including model cards) to assess the safety, performance, and limitations of AI-enabled clinical decision support. Changing DSI requirements in this way reduces the availability and consistency of this information at the point of purchase and implementation, potentially shifting evaluation and liability risk onto practices without providing an alternative framework. Practices would be left independently assessing vendor AI tools and managing associated clinical and legal risk without access to standardized information on how those tools were developed, validated, and evaluated for real-world use. This creates a gap at a time when guardrails, governance, and trust in AI-enabled decision support are increasingly important.

MGMA believes these requirements remain valuable to purchasers and implementers of health IT and are premature to change as proposed absent a clear replacement. Transparency and knowledge about AI use directly support provider trust, appropriate adoption, and safer use at scale enabling medical groups to make informed decisions about AI deployment in clinical practice.

TOPIC/ISSUE: Real-World Testing

ASTP/ONC proposal: ASTP proposes narrowing real-world testing reporting to specific API focused certification criteria and to de-scope broader real-world testing conditions and maintenance of certification requirements.

MGMA response: As discussed in detail above, real-world testing of certified health IT products provides practices with assurance that the technologies they use are functioning as intended in clinical practice without adverse impact on patient care. For medical groups, real-world testing provides insight into how capabilities perform outside of a controlled laboratory, testing environment. Limiting real-world testing to specific API criteria risks reducing transparency into system performance, reliability, functionality degradation, increased vendor dependency, and could result in further unintended downstream effects on practices and patient care during real-world use. These risks are very concerning for small and independent practices that have limited resources to validate vendor performance on their own.

MGMA urges ASTP to adopt a measured approach that preserves real-world testing expectations while transitioning certification policy toward FHIR overall so that health IT for medical groups continues to enable safe, reliable care in clinical practice settings.

TOPIC/ISSUE: Direct Project and Direct Project, Edge Protocol, and XDR/XDM

ASTP/ONC proposal: ASTP proposes to remove certification requirements tied to Direct Project and associated C-CDA content standards, indicating this functionality has been widely adopted and there is no longer added benefit to include it as part of conformance testing in the Certification Program. ASTP proposes to retain Direct Project as an available transport standard for use by vendors and providers recognizing that doing so is important for continuity and that many groups still rely on it.

MGMA comment: MGMA cautions against the proposed timeline for removing certification criteria tied to standardized C-CDA content and testing which would no longer ensure through the Certification Program the availability of standardized content transmitted via Direct Project. We believe these proposed changes warrant closer timeline scrutiny to ensure continuity and minimize workflow disruption for practices. During a transitional period toward FHIR-based interoperability, document-based push exchange remains foundational for enabling practice referrals, consults, public health reporting, electronic case reporting, and care coordination. Direct Secure Messaging, as ASTP acknowledges, is widely adopted. [vii]According to industry reporting, in the last quarter of 2025, over 484 million Direct Secure Messages were exchanged, meaning that over 6.5 billion messages cumulatively have been exchanged since the start of tracking message volume in 2014. [viii] Many medical groups use Direct-enabled secure messaging workflows, including within patient portals, to support secure information exchange. Ensuring stability of these workflows is important for patient access and practice operations. Removing Direct-related criteria does not eliminate Direct Secure Messaging but would remove the assurance that vendors continue to support standardized, reliable content exchange in ways medical groups and their patients depend on. Certification has played a significant role in promoting Direct Secure Messaging's uniform implementation, broad accessibility, and cost-effective use across the ecosystem.

Conclusion

MGMA recognizes FHIR as an important strategic direction and supports ASTP's efforts to advance a more interoperable, person-centered ecosystem built on modern data standards. We believe many of the proposed certification changes warrant closer review and a more deliberate and feasible transition timeline to ensure continuity of care, preserve patient safety, and minimize workflow disruption for medical groups, especially for small and independent practices with limited capacity to compensate for gaps in health IT functionality.

MGMA remains committed to working with ASTP to align health IT policy modernization with the operational realities of medical groups and welcomes continued collaboration to inform future policies and resources, so that medical groups can effectively navigate changes to the Certification Program and benefit from innovation without disruption or instability to their practices. We appreciate HHS's leadership in seeking to reduce burden and to provide flexibility to both developers and providers while supporting innovation through the removal and revisions

of certain certification criteria and regulatory provisions. Changes to the Certification Program and to information-blocking policies that reflect and are informed by the operational realities of medical groups will help achieve the aims of these proposed policies for better health and impactful innovation enabled by technology. If you have any questions, please contact Samantha Meklir, Associate Director of Government Affairs, at smeklir@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders M. Gilberg
Senior Vice President, Government Affairs

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[i] U.S. Department of Health and Human Services, Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology, *Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity* (proposed rule), 90 Fed. Reg. 60972 (December 29, 2025)

[ii] U.S. Department of Health and Human Services, Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology, *Request for Information: Diagnostic Imaging Interoperability Standards and Certification,* 91 Fed. Reg. 4056 (January 30, 2026)

[iii] Raof Nopour, "Using FHIR for Data Sharing: A Scoping Review of Challenges and Facilitators in Healthcare Settings," International Journal of Medical Informatics 205 (2026): 106128, https://doi.org/10.1016/j.ijmedinf.2025.106128.

[iv] Office of the National Coordinator for Health Information Technology. *EHR Contracts Untangled: Selecting Wisely, Negotiating Terms, and Understanding the Fine Print.* September 2016.

[v] Examples of ASTP Informational Resources that identify health IT certification criteria and standards to support multiple care and practice settings can be accessed at https://healthit.gov/maternal-and-pediatric-care/

[vi] The Pew Charitable Trusts. State Public Health Data Reporting Policies and Practices Vary Widely: Nationwide analysis outlines opportunities to improve data for disease detection and prevention. 2024. Available at: https://www.pewtrusts.org/en/research-and-analysis/reports/2024/10/state-public-health-data-reporting-policies-and-practices-vary-widely. Accessed [January 22, 2026].

[vii] Everson J, Andriesen B. *Achieving Widespread Use of Direct Secure Messaging by US Hospitals.* Assistant Secretary for Technology Policy (ASTP) Blog. July 15, 2025. Available at: https://www.healthit.gov/blog/interoperability/achieving-widespread-use-of-direct-secure-messaging-by-us-hospitals/. Accessed January 20, 2026.

[viii] DirectTrust. (2025). *DirectTrust enabled transactions by quarter: Number of send and receive transactions to/from trusted endpoints.* Powerpoint slides.
https://directtrust.app.box.com/s/0iomf8gnt5qvvd8v5k3ap0zy1sxlk4pf