December 15, 2025

Battelle, a certified consensus-based entity, released a request for information seeking public input on the impact of digital quality measures on the health care community, measure developers, and measure stewards to understand how digital measures may or may not require changes to measure endorsement and maintenance processes. Battelle convenes the [Partnership for Quality Measurement](#) (PQM) to ensure informed and thoughtful endorsement reviews of qualified measures for alternative payment models, clinical decision support, and quality improvement tools. The following responses were submitted by NAACOS through the [RFI portal](#).

RE: Digital Quality Measures RFI
Submitted electronically to: https://p4qm.org/form/digital-quality-measures

What opportunities and challenges are associated with developing and testing dQMs?

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to this request for information (RFI) on digital quality measurement. NAACOS is a member-led and member-governed nonprofit of nearly 500 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health care providers across the nation to improve the quality of care for patients and reduce health care costs. Collectively, our members are accountable for the care of more than 9.5 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH).

NAACOS and our members are actively engaged with the Centers for Medicare and Medicaid Services (CMS) to inform a seamless shift to digital quality measurement. Based on lessons learned from ACOs' current experiences with electronic clinical quality measures (eCQMs), shifting to digital quality measures (dQMs) will require new approaches to ensure success. Key areas to consider include expanding the current certification process overseen by the Assistant Secretary for Technology Policy (ASTP), prioritizing alignment of individual data elements specified in FHIR across measures, and requiring more robust testing than what is currently expected for endorsement and consideration of a dQM for a federal quality program.

Certification needs to expand from the current focus on specific functions of individual electronic health record (EHR) products to more broadly certifying the quality measure use case and confirming that data, regardless of the digital source (e.g., labs and health information exchange data), can be exchanged using FHIR endpoints. By broadening the certification process, we can achieve more consistency in structuring and mapping digital data to access and share quality measure information. This would offer the ideal approach for organizations like ACOs that leverage digital data sources outside of EHRs and must aggregate data across disparate EHR systems and care settings.

If dQMs are all specified in FHIR using the same specifications and definitions for each data element, this would also support alignment across quality measurement programs that currently use different measures to capture the same clinical concepts (e.g., diabetes control). To further facilitate alignment, developers should minimize variations in how these digital data sources are specified and the endorsement process should reinforce the importance of consistency.

The current eCQM requirements to assess feasibility and ensure reliability and validity will not be sufficient as we move to dQMs. It will be necessary to have additional guidance and detail describing how to determine which data to use for a dQM and an understanding of the feasibility of data collection across multiple vendor systems and other digital sources. Data element validity should be continuously assessed across several systems and sources rather than the current one-time assessment during the first endorsement review of a measure. The field must understand whether a group or ACO can produce the data required for a dQM and to what degree the resulting data will accurately and consistently represent true quality. This evaluation is not possible based on a single report of the feasibility and validity from one vendor system.

How will dQMs positively or negatively impact the health care community (patients, healthcare providers and organizations, payers, and others)?

NAACOS and its members applaud the vision of shifting to a dQM framework that supports multiple use cases. Our members seek to move to a quality measurement approach that leverages interoperable data sources that are seamlessly integrated and available at the point of care. This would increase efficiency, reduce administrative burden, and empower patients and providers to make informed care decisions. Transforming care delivery and improving quality are cornerstones of accountable care. ACOs and providers in accountable care regularly leverage data and technology, integrating claims and clinical data, to enhance clinical outcomes through innovative solutions and population health management. We believe that the data used for quality measurement should be a byproduct of care delivery – data that accurately and comprehensively represents the quality of care delivered by ACOs and their providers. Shifting to FHIR-based dQMs moves us closer toward that goal.

Implementing the FHIR standard for quality reporting would allow the same data to be used for multiple use cases, such as sharing data with a public health agency or health information exchange, or exchanging data with other health care entities to support comprehensive care across the continuum. In the long-term, shifting to dQMs will reduce administrative burden associated with quality reporting and enhance patient care.

What are the potential benefits, challenges, and unintended consequences associated with dQM implementation?

Implementation of eCQMs in the MSSP has created significant unintended challenges since these measures were developed and specified for individual clinicians and practices and then applied to ACOs with no modifications. It is critical that dQMs are designed for the appropriate audience and settings and when applied to ACOs, they must support population health. The shift to more appropriate ACO-level measures will require both vendor readiness and additional education and resources for those reporting to understand and implement what is required.

Based on feedback from our ACO members, vendors are not currently capable of supporting FHIR-based reporting. The majority of vendors do not support FHIR, and even fewer support Bulk FHIR, which will be necessary for the volume of data reported by ACOs. There is significant potential to reduce burden and costs using this standard; however, much work remains to ensure that the vendor community is ready to assist providers and ACOs in this effort.

We urge policymakers to create and release a detailed timeline with milestones, build internal capabilities to receive data through FHIR-based APIs, pilot these solutions with vendors and providers, and release guidance and education to assist practices and ACOs in this transition – including support for working with their vendors. The timeline should also include the potential pathway and requirements for endorsement and provide opportunities for the field to provide input, particularly for ACOs and others with experience leveraging digital data.

Currently, there is wide variation in documentation practices. Standardization and alignment will be critical for achieving seamless dQM reporting. Policymakers must work with measure stewards to ensure that data elements are aligned across their specifications. We are at significant risk of replicating the ongoing challenges of measures and data elements that appear to be aligned but the detailed specifications are distinctly different and require additional mapping and data collection – all for the same clinical concept and intent. This is especially important for value-based care organizations that enter into risk arrangements with other payers. For example, one ACO reported that they are responsible for over 1,300 measures across value-based contracts and such variations in data elements adds significant burden to their quality reporting efforts. Additionally, practices should be afforded sufficient time to adopt new workflows and input data in discrete fields. While smaller practices may be able to change behavior more quickly, larger groups may require longer to implement such changes, and practices should not be expected to backfill information. Therefore, a sufficient runway should include time for providers to adopt workflow changes and capture meaningful data prospectively before FHIR-based dQM reporting is mandatory.

Value-based care entities develop relationships with practices, hospitals, other care providers, and vendors to support population health. As such, ACOs are uniquely positioned to lead approaches to piloting and scaling FHIR-based dQMs. ACOs that are at the forefront of the digital quality transition could be tapped to help identify vendors that are working to implement FHIR capabilities to partner with to participate in a pilot. Because ACOs integrate data from multiple sources and across the continuum of care, they are arguably the most complex implementation environment for FHIR-based dQMs. By demonstrating success in an ACO pilot, the health care ecosystem will be able to save time and money during this transition as many of the costs and requirements will be identified and possibly resolved.

What processes or outcomes will be measurable using FHIR-based dQMs that are not currently measurable?

If developed and implemented thoughtfully, FHIR-based dQMs have the potential to meaningfully measure population health outcomes, which has not been achieved in current quality measurement programs.

What support can Battelle, as a CBE, provide to measure developers and stewards as dQMs become more widely adopted?

Our members have identified major concerns with minimal testing requirements. Battelle has the opportunity to ensure the minimum criteria for endorsed measures includes evidence of how a dQM may or may not operate widely. We know from current experiences with eCQMs that approving endorsement based on testing in one vendor system is not sufficient.

Additionally, measure developers should be encouraged to align on how individual data elements are specified.

How should CBE endorsement and maintenance criteria and submission requirements evolve to accommodate FHIR-based dQMs? Are there differences between new dQMs and dQMs that are respecified versions of existing eCQMs?

As noted in response to the first question, we believe there needs to be a shift to validating FHIR endpoints across many vendor systems with multiple data sources. Regardless of where data are derived from, certification needs to be expanded beyond EHR vendors and focus on the individual endpoints regardless of data source. Specifically, all data sources used for quality measurement should be mapped to a FHIR endpoint and validated.

The ability to support standardized FHIR APIs, including Bulk FHIR, that allow consistent access to patient-level and population-level data must be part of vendor certification for FHIR-based reporting to become feasible. Robust validation and mapping processes should ensure that data extracted from various sources are complete and trustworthy. Certification should also include requirements for interoperability testing across vendors and workflows to reduce provider burden and make quality reporting more automated and reliable. For interoperability purposes, APIs should be open source and there should be limited use of proprietary APIs. Any proprietary APIs should not require additional fees or costs to health care providers and organizations. Vendors need to be able to quickly adapt their APIs to add additional data elements if a new measure requires it.

We should not encourage respecifying eCQMs as dQMs, as eCQMs are inherently limiting to value-based care organizations like ACOs that have access to multiple data sources to inform population health improvement. Current eCQM specifications create challenges and unintended consequences for ACOs that span the full continuum of care. These have led to ACOs removing specialists and smaller, under-resourced practices that lack the vendor capabilities to extract and report all-payer, all-patient EHR data for eCQM reporting. With the shift to dQMs, there is an opportunity to leverage new data and new clinical concepts with a broader array of data sources. Both new dQMs or respecified dQMs must meet the same high-level standard of testing described above. There should be an assumption that adding additional data sources will require additional feasibility and validity testing.

NAACOS and its members look forward to working with Battelle and policymakers to ensure certification and testing criteria support seamless, technology-enabled quality measure reporting that leverages interoperable data sources seamlessly integrated at the point of care.