February 25, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Submitted electronically to: https://oncprojectracking.healthit.gov/support/browse/CQM-8399

RE: FHIR Public Comment Period for Draft CMS Digital Quality Measures (dQMs) and Test Cases for Eligible Clinicians

Dear Administrator Oz:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to Draft CMS Digital Quality Measures (dQMs) and Test Cases for Eligible Clinicians. NAACOS is a member-led and member-governed nonprofit of nearly 500 accountable care organizations (ACOs) and value-based care entities 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 cost. Collectively, our members are accountable for the care of more than 10 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model. NAACOS applauds the vision of shifting quality reporting to a digital framework that supports multiple use cases, increases efficiency, reduces administrative burden, and empowers patients and providers to make informed care decisions. Our comments below reflect concerns of our members and our shared goals to move to a quality measurement approach that leverages interoperable data sources that are seamlessly integrated and available at the point of care.

General

9. What challenges do you anticipate when transitioning to FHIR, including data quality, implementing new systems, and managing transition timelines? How might these challenges impact overall project success and stakeholder readiness?

10. To what extent have the organizations you're familiar with adopted and integrated FHIR APIs and the associated workflows that enable data reporting from EHR systems? What challenges or successes have they encountered in this process?

NAACOS supports the Centers for Medicare and Medicaid Services' (CMS) overall goal of transitioning to a dQM approach that leverages interoperable data sources integrated at the point of care, which will reduce administrative burden and enhance patient care. 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 provided by ACOs and their providers – and shifting to FHIR-based dQMs moves us closer to that goal.

Implementing the FHIR standard for quality reporting would allow the same data to be used for multiple purposes, such as sharing data with a public health agency or health information exchange (HIE) or exchanging data with other health care entities to support comprehensive care across the continuum. However, shifting to the FHIR standard will require both vendor readiness and additional education and resources for those reporting to understand what is required. Feedback from our ACO members who are attempting to work with their vendors on FHIR-based solutions highlights that many members of the vendor community 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. Of those that currently support FHIR, our members identified significant challenges with the data's validity. Current Bulk FHIR technical limitations include system crashes, scheduled processing windows often requiring weeks to extract data, and duplication issues that make real-time reporting impossible. There is significant potential to reduce burden and costs using this standard; yet, much work remains to ensure that the industry is ready to assist providers and ACOs in this effort.

We urge CMS not to limit FHIR-based quality reporting to data extracted from electronic health record (EHR) systems. Value-based care organizations have different approaches to making data available to clinicians, including through an EHR or custom platforms or products that are integrated with the EHR. It is critical that data are stored where they are most appropriate and most useful, which may vary by clinician and practice. The purpose of quality reporting should not dictate where and how data are stored and displayed. As such, organizations should not be required to force other data sources into an EHR solely for the purpose of quality reporting. Additionally, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) has proposed eliminating a significant portion of the criteria for certified EHR technology (CEHRT), which could exacerbate challenges with generating needed data from vendor systems and jeopardize ACOs' ability to meet CMS' quality and promoting interoperability (PI) requirements. NAACOS encourages CMS and ASTP/ONC to collaborate on certification criteria that support value-based care programs and reduce regulatory burden.

To ensure a smooth transition to FHIR-based reporting, we urge CMS 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. A sufficient runway should include time for providers to adopt workflow changes and capture meaningful data prospectively before FHIR-based dQM reporting becomes mandatory.

Based on lessons learned from ACOs' current experiences with electronic clinical quality measures (eCQMs), shifting to dQMs will require new approaches to ensure success. Certification needs to expand from the current focus on specific functions of individual EHR products to more broadly certifying the quality measure use case and confirming that data, regardless of the digital source (e.g., labs and HIE 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. Our members have identified major concerns with minimal testing requirements for eCQMs. 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.

If dQMs are 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 CMS must ensure that the data required for the measures in the APM Performance Pathway (APP) Plus set are aligned and represented consistently. If the data are not represented using the same logic and value sets across measures, then we will not achieve the desired gains in efficiency.

The ability to support standardized FHIR APIs, including Bulk FHIR, which allows 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.

Value-based care entities develop relationships with practices, hospitals, other care providers, and vendors to support population health and ACOs are uniquely positioned to lead approaches to piloting and scaling FHIR-based dQMs. 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 would be able to save time and money during this transition as many of the costs and requirements would have been identified and possibly resolved.

Within the context of CMS' goal to engage more small, rural, and independent providers in accountable care, additional considerations are necessary in the transition to dQMs:

1. Shift to a learning framework, rather than threatening compliance action and penalties, when organizations make mistakes. This should include a multi-year grace period before compliance actions are taken, beginning with performance year 2025, the first year ACOs were required to shift away from the straightforward Web Interface reporting method. CMS should also implement an on-ramp for new ACOs to adopt digital quality approaches that goes beyond the currently available pay-for-reporting in the first performance year. Otherwise, this shift will act as a barrier for new ACOs, especially small physician-led organizations.

2. Create flexibility in data completeness requirements. All-patient, all-payer reporting results in a massive increase in the volume of patients on which ACOs must report quality measures on, sometimes over 1,000% increases. This exacerbates the challenges described above and skews results when comparing ACO quality to individual clinicians reporting on their patient panels (i.e., the current MSSP quality benchmarking process). CMS must define data completeness requirements differently for ACOs, such as by a percentage of practices or providers in the ACO, and create clear guidance on acceptable exclusions.

3. Tailor measure attribution approaches for use in ACOs. Because ACOs span the full care continuum, measure specifications designed for individual clinicians and groups lead to overly

broad inclusion of patients and specialties, contributing to the significant denominator volume issues described above. This leads to the inclusion of patients who have no primary care relationship with the ACO and specialties for whom the measures are not clinically relevant. CMS should either (1) limit measure attribution to ACO-assigned patients or (2) modify the attribution approach for each of the ACO measures to exclude specific specialties and require a higher number of visits for inclusion rather than the current one visit requirement.

CONCLUSION

Thank you for the opportunity to provide feedback on the draft CMS dQMs and test cases for eligible clinicians. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on the transition to FHIR-based digital quality measurement approaches. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,

Emily D. Brower
President and CEO
NAACOS