February 25, 2026

Via electronic submission at

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Fast Healthcare Interoperability Resources® (FHIR®) Digital Quality Measures (dQMs)

Dear Dr. Oz,

As the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States, the Federation of American Hospitals (FAH) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) draft Fast Healthcare Interoperability Resources (FHIR)–based digital quality measures (dQMs) and accompanying test cases.

FAH supports CMS's long-term goal of modernizing quality measurement through interoperable digital standards. Properly implemented, FHIR-based dQMs have the potential to reduce reporting burden, improve clinical relevance, and allow more timely exchange of meaningful information.

Because the transition from electronic clinical quality measures (eCQMs) to FHIR-based dQMs involves a structural redesign of the quality reporting infrastructure, it is especially important that implementation be carefully sequenced, technically sound, and aligned with how hospitals operate in real-world clinical environments. Without clear milestones, operational readiness, and broad testing, the transition risks creating unnecessary disruption.
In reviewing the draft specifications and test cases, FAH encourages CMS to consider the following recommendations:

- Establish a clear, multi-year glide path that outlines specific milestones for specification finalization, vendor certification, CMS system readiness, voluntary reporting and any future mandatory adoption.
- Ensure that CMS infrastructure readiness and updated ONC Health IT certification requirements are fully operational before requiring hospitals to submit FHIR-based digital measures.
- Conduct broad, real-world testing across diverse hospital types, EHR vendors, and specialty systems to confirm feasibility before advancing to mandatory implementation.
- Recognize that the level of difficulty in transitioning to digital quality measures varies significantly across measures and should not be assumed to be uniform.
- Provide measure-specific guidance and piloting, particularly for complex inpatient, outpatient and clinician-level measures that rely on time-sensitive workflows or cross-system data integration.
- Account for workforce capacity, budgeting cycles and operational resource constraints when establishing implementation timelines.
- Avoid repeating implementation challenges experienced during prior quality reporting transitions by ensuring stable specifications, sufficient testing and transparent readiness criteria before finalizing requirements.

CMS Must Establish a Clear, Multi-Year Glide Path

CMS should publish a comprehensive implementation roadmap that clearly outlines the timing and sequencing of all major milestones related to FHIR-based dQMs. Hospitals and health systems must understand when draft technical specifications will be finalized, when those specifications will be incorporated into the Office of the National Coordinator for Health Information Technology (ONC Health IT) Certification Program requirements, when vendors must support production-ready functionality, and when CMS systems will be capable of receiving and validating FHIR-based submissions.

Importantly, hospitals cannot meaningfully assess implementation effort without finalizing specifications. At present, there is no defined baseline for comparison from an electronic health (EH) perspective. In the absence of final specifications and formalized requirements, hospitals and vendors are unable to conduct accurate uplift analyses to determine the scope of system changes, resource needs and operational impacts.

FAH recommends a stair-step approach to implementation. This approach would allow implementers to fully understand finalized dQM specifications and the associated data model before facilities are required to make significant changes to workflow or infrastructure. A phased approach would reduce the risk of premature investment based on evolving interpretation.

When implementation deadlines are established, CMS should provide ongoing technical support through recurring webinars, structured workgroups and real-time Q&A forums with the eCQM and informatics community to address emerging questions and interpretation challenges.

CMS Infrastructure Readiness and Vendor Certification Must Precede Mandates

The success of FHIR-based reporting depends equally on CMS readiness and vendor readiness. CMS must ensure that its internal systems can reliably receive large-scale FHIR API submissions, consistently validate measure logic, provide timely feedback to reporting entities, and maintain data collection stability.

From an implementation perspective, the burden may be significantly greater if initial reporting requires facilities to have FHIR servers and fully operational API enablement to replace existing extraction methodologies. Many hospitals currently rely on vendor-based extraction models. A shift requiring facility-level deployment of FHIR infrastructure would necessitate substantial investment in infrastructure, security configuration, interface development and workflow redesign.

Hospitals should not be required to submit FHIR-based dQMs until vendors are certified under updated ONC criteria that incorporate digital reporting functionality and CMS confirms its intake systems are fully operational and stable. Digital transformation should not proceed until the reporting ecosystem is demonstrably ready. Providers should not bear the operational risk associated with immature systems or undefined infrastructure expectations.

Real-World Testing Must Reflect the Diversity of U.S. Hospitals

Testing limited to a small number of electronic health records (EHR) platforms or large academic health systems does not reflect the diversity of hospitals nationwide. Before finalizing any mandatory reporting requirements, CMS should conduct broad testing across multiple EHR vendors, specialty systems, and hospital types.

Community hospitals, rural hospitals, safety-net providers, and specialty hospitals must be included in testing. Many facilities operate separate systems for obstetrics, radiology, oncology, behavioral health, or emergency departments. Integrating FHIR-based extraction across these disparate systems requires new interfaces and technical resources that are not uniformly available.

Small and rural hospitals, in particular, may require additional time and potentially financial support to implement FHIR-based reporting. A uniform timeline that fails to account for these differences could unintentionally disadvantage the very providers serving vulnerable communities.

Complexity of Transitioning to dQMs

CMS should recognize that the effort required to transition to the dQM data model will be significant. The work required to understand the changes in the extraction methodology will likely involve substantial crosswalk mapping

between the current eCQM model and the new dQM data model. Data element mapping, validation logic alignment and recalibration of internal reporting systems will require coordinated technical effort at both the facility and vendor levels.

In addition to facility-level mapping, vendors will face internal burdens related to reprogramming measure logic, recalculating outcomes under the new specification, and updating reporting interfaces for their clients. These vendor-side changes will undoubtedly cascade to hospitals, creating layered implementation demands.

Measures that rely primarily on structured, discrete data elements may be more readily adaptable to automated FHIR extraction, provided vendor logic is standardized. However, measures dependent on time-sensitive workflows, narrative documentation, cross-setting coordination, imaging interpretation data or social determinants of health information will require deeper workflow redesign and documentation adjustments.

CMS should avoid assuming uniform feasibility across all 18 measures. A tailored, phased approach that acknowledges varying levels of technical and operational complexity will be more realistic and sustainable.

Measure-Specific Considerations

Hospital-Level Inpatient Measures

Sepsis-related measures that rely on time-stamped interventions and laboratory results present particular complexity. Documentation timing varies across systems, and the measure logic is often intricate. Extensive piloting will be necessary before any mandatory conversion.

Maternal health and obstetric measures present additional challenges. Obstetric documentation frequently resides in specialty modules that are not fully integrated with enterprise EHR systems. CMS should ensure that specialty vendors are included in testing and that integration challenges are addressed.

Outcome-based and readmission measures that depend on linkage between clinical and claims data require clear guidance on how FHIR-based submissions will interact with existing claims infrastructure. Duplicate or parallel reporting pathways should be avoided.

Safety and complication measures that rely on coded diagnoses may transition more smoothly if coding logic remains stable. However, vendor variability in implementation must be minimized.

Hospital Outpatient Measures

Emergency department measures often depend on systems that function semi-independently from inpatient platforms. Standardization of triage and throughput documentation will be necessary to ensure reliable extraction.

Imaging efficiency measures rely on radiology information systems and imaging platforms that may not integrate seamlessly with enterprise APIs. CMS should confirm specialty vendor readiness prior to widespread implementation.

Clinician-Level Measures

Chronic disease management measures that rely on structured ambulatory data may transition more readily, although variability across independent practices remains a concern.

Care coordination measures assume interoperability across settings that is not yet uniformly achieved nationwide. CMS should be cautious about relying on real-time cross-entity data exchange without confirming infrastructure readiness.

Behavioral health measures often depend on narrative documentation. Additional validation and structured documentation standards may be required to ensure accuracy.

Workforce and Budget Implications

Transitioning to FHIR-based dQMs will require hospitals to upgrade IT infrastructure, potentially deploy or expand FHIR servers and API frameworks, conduct extensive data element crosswalk mapping, train clinical informatics staff, update data governance processes, and redesign documentation workflows.

These changes occur in the context of ongoing workforce shortages in health IT and quality reporting. Hospitals must incorporate these costs into multi-year capital planning cycles. Without finalized specifications and sufficient implementation runway, organizations cannot accurately forecast budget impact or staffing requirements.

A phased, stair-step implementation strategy with defined technical support from CMS will be essential to mitigate these constraints.

Avoid Repeating Prior Implementation Challenges

FAH previously raised concerns during the implementation of the hybrid measures, regarding unstable technical specifications, limited vendor testing, and compressed timelines. CMS should ensure that final specifications are stable, that vendors are certified and operationally ready, that large-scale testing has demonstrated feasibility, and that CMS intake systems are functioning effectively before advancing to mandatory reporting.

Transparent readiness benchmarks and ongoing technical engagement with the eCQM community will help prevent avoidable disruption.

FAH appreciates the opportunity to comment and stands ready to work with CMS to ensure that digital measurement achieves its intended goals.

Sincerely,