AMA
AMERICAN MEDICAL ASSOCIATION

John Whyte, MD, MPH
CEO, EXECUTIVE VICE PRESIDENT

john.whyte@ama-assn.org

February 25, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS Digital Quality Measure Request for Information (RFI)

Dear Administrator Oz:

On behalf of the physician and medical student members of the American Medical Association (AMA), I commend the Administration for focusing resources on interoperability and advancing measurement. Advancing to a standard based on Fast Healthcare Interoperability Resources (FHIR) represents an important step toward a more flexible and scalable measurement framework. If implemented thoughtfully, this transition has the potential to allow physicians, hospitals, and alternative payment model entities to incorporate additional and more clinically meaningful sources of data into quality reporting, which in turn could ease longstanding reporting burdens.

In particular, a FHIR-based approach will allow specialties such as radiology and gastroenterology, as well as other physician specialties, providers, and alternative payment model (APM) entities, to leverage digital data sources that historically have not been fully integrated into electronic health record workflows. We appreciate this early review of the draft FHIR-based digital quality measures (dQMs) but ask for clarity on whether this shift will allow physicians, hospitals, and others to leverage additional data sources beyond the electronic health record (EHR) system and if so, what the pathway and timeline will be for this transition. The re-specification of the existing electronic clinical quality measures (eCQMs) to the new standard is useful; however, we are concerned that rapid deployment of these new dQMs without sufficient testing, validation, and a clear pathway to implementation could result in increased reporting burden, particularly for small and rural practices and hospitals, and measure scores that are not accurate or representative of the true clinical care provided.

The glidepath to adoption MUST also include appropriate positive incentives to support providers and physician practices, particularly those that are small and rural, through the transition to FHIR adoption. In addition, the capabilities of the measure stewards and ongoing expense of working with measure developers also must be considered. Successful FHIR-based dQM development requires not only technical infrastructure but also sustained expertise in measure specifications, maintenance, and testing—resources that can be costly and are not uniformly available across organizations. **We are eager to assist the Centers for Medicare & Medicaid Services (CMS) in this move, and we welcome the opportunity to participate in its planning and execution.**

We offer feedback on the following questions within the RFI:

1. *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?*

To ensure the transition to FHIR is successful, objective criteria and deliverables must be established to determine whether the field (i.e., providers and technology developers) is ready to progress to the next stage of implementing FHIR dQMs:

- Demonstrated technical capability, such as successful end-to-end testing of FHIR dQM reporting;
- Sufficient adoption rates of FHIR-enabled systems across provider types;
- Training and technical support readiness for provider organizations;
- Evidence of data quality and completeness in reported dQMs; and
- Stakeholder consensus on burden, feasibility, and patient safety considerations.

By confirming readiness in this way, we can help the health care community adopt new standards with confidence, accelerate the availability of more timely and accurate information, and ultimately improve patient experiences of care and outcomes. Therefore, we urge CMS to release a transparent timeline and actively engage with the health care community for feedback (physicians, hospitals, APMs, health plans, patients, and EHR developers). Specifically, the process and timeline must outline when the technical requirements for FHIR-based reporting will be finalized and available with adequate time for developers to integrate them into their products, and when these requirements will be incorporated into federal certification requirements.

At the same time, CMS should build the internal capabilities needed to receive dQM data through FHIR-based application programming interfaces (APIs) and release guidance and education to assist the health care ecosystem in this transition. Subsequently, once CMS determines that developers are ready and certified to support this reporting and CMS can receive the data, a reasonable timeframe during which practices, hospitals, Accountable Care Organizations (ACO), and others must begin reporting these measures should be proposed.

Now that we have draft FHIR dQM specifications, we encourage CMS to work with practices, hospitals, ACOs, health information technology developers, and others to ensure that the data elements and logic now represented in FHIR and using a broader set of digital data are valid and produce the expected results. Real world implementation and assessments of feasibility of data collection across broader digital data sets and entities of varying sizes and locations will be imperative to ensure a seamless glidepath to these new measures in CMS quality programs. It is critical that any potential challenges or barriers to implementation are identified and resolved before practices are required to capture and report data beyond the EHRs and represented in FHIR.

2. *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?*

There appears to be an inherent assumption by CMS that if a physician or practice utilizes Certified Electronic Health Record Technology (CEHRT), the EHR can support all quality measures, which is typically not the case. CMS and the Office of the National Coordinator for Health Information Technology (ONC) need a process to ensure when a practice purchases an EHR that it can support the practice's quality reporting needs or a way for the practice to seamlessly build in the additional capabilities, without the vendor charging an additional cost to the practice. Frequently, when practices request that their EHR vendor make any change, including incorporating quality measures, this results in an additional cost. Therefore, **the transition to Bulk FHIR requires CMS and the Assistant Secretary**

for Technology Policy/ONC to re-look at CEHRT associated requirements so it can better support the needs of quality and provide assurances to practices that their CEHRT can support CMS quality reporting requirements.

Security and Permission Set-Up: It should be noted that **security and permission setup is non-trivial and if done incorrectly, may result in vulnerability at either end of the FHIR transaction.** Organizations are becoming more risk adverse to moving patient level data across firewalls. While improved Bulk FHIR implementation makes that movement easier, additional regulatory attention around security and permitted use would be required to gain compliance from EHRs and health systems and practice. Health systems rely on internal quality teams to implement continuous quality improvement programs and small practices will likely not have many staffing and financial resources to allow them to quickly shift to this standard. Simply changing the reporting mechanism to Bulk FHIR for CMS quality measure reporting would not necessarily provide efficiency benefits or reduction in burdens to health systems and practices working to make quality changes at the point of care. Quality teams would still need to be engaged to determine how the data can be leveraged to improve programs and represent the quality of care provided. Therefore, **we recommend CMS develop solutions to the downsides of using Bulk FHIR data exports from EHRs to CMS to simplify clinical quality data submissions.**

In addition, how FHIR endpoints are built, maintained, and mapped vary between EHRs, requiring, at minimum, custom setup to connect to each practice or vendor system. The additional work required by the practices should not be minimized as it will take time and resources to ensure that the mapping is valid. Additional setup and complexities can arise depending on who maintains the FHIR endpoint, and how much support is dedicated to maintaining it. EHRs are currently not incentivized to support Bulk FHIR, increasing the prevalence of the issue. We believe that this issue could become even more complex as practices, hospitals, APM entities and others expand beyond the EHR to other digital data sources and CMS and ONC must be ready to facilitate these exports and endpoints as much as possible.

Cross-cutting informatics & data-quality issues: **"Clinical only" coding assumptions can break physician workflows and create measure friction**. Many physicians, particularly in outpatient and eligible clinician reporting contexts, rely on billing-adjacent artifacts such as Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, claim lines, and encounter-level billed services to operationalize quality reporting, even when clinical intent is documented using Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT) or Logical Observation Identifiers Names and Codes (LOINC).

If the dQM logic assumes only clinical terminologies will be present such as SNOMED CT or LOINC, you will see:

- false negatives when EHRs capture the billed service in CPT but not the equivalent SNOMED procedure;
- site/vendor variability (some store SNOMED in Procedure, others only CPT on charge capture/claim objects); and/or
- avoidable "documentation for measurement" burden on physicians.

CMS should ensure dQMs either: (a) natively support CPT/HCPCS coding paths where appropriate, or (b) formally specify a normative clinical to billing mapping approach so the industry does not reinvent mapping differently by vendor/payer/system.

Data Provenance & Attribution Gaps: "who did what" matters to physicians. Many physician measures depend on whether the eligible clinician personally performed, ordered, or documented a service, rather than the activity occurring elsewhere within the care team or organization. When

attribution is unclear or inaccurate, clinicians may feel they are being evaluated on events outside their control, leading to dissatisfaction and disputes over scoring. Common gaps to flag in dQM implementations:

- insufficient constraints around Performer/Author and organization/practitioner identity;
- ambiguity between "ordered" vs "performed" vs "resulted" events (e.g., orders, referrals, labs); and
- missing expectations for provenance (Provenance resource or clear "source of truth" policy) when combining EHR and other sources.

Measure implementability: missing "minimum data set" and conformance guidance. CMS asks if measure specs provide sufficient detail to support implementation. A recurring interoperability gap is the absence of a crisp, implementer friendly minimum required data elements section for each population criterion, including:

- required resources, required elements, and "must support" elements;
- required code systems/value sets and how they are expected to appear in FHIR and
- acceptable alternative data pathways (e.g., CPT in Procedure vs Claim).

CPT value sets must be explicitly supported for clinician reporting feasibility. Eligible clinician measures often rely on preventive services, counseling, screenings, procedures, and office visits that are more consistently and reliably captured through CPT codes than through purely clinical terminologies in ambulatory electronic health record data. For eligible clinician dQMs that require evidence of a service or procedure, explicitly support CPT-coded data by:

- including CPT codes within the relevant value sets, with licensing and access considerations clearly addressed; and/or
- establishing a clearly endorsed and technically supported mapping pathway from clinical concepts to CPT codes to ensure consistent and reliable implementation.

Conclusion

Thank you for considering our recommendations to improve the transition and adoption of dQMs. Please reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org if you have questions or need further information.

Sincerely,



John Whyte, MD, MPH