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WHITE PAPER

The Digital Quality Future Is Now on the Calendar

ACOs Should Not Wait to Prepare

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EXECUTIVE SUMMARY

The Calendar Year (CY) 2027 Medicare Physician Fee Schedule proposed rule,[1] for the first time, puts a concrete timeline on the Accountability Care Organization (ACO) transition to Fast Healthcare Interoperability Resource (FHIR)-based digital quality measurement (dQM): optional reporting beginning CY2028 and mandatory reporting for applicable measures by CY2030. Two firm proposals in the rule function as a deliberate on-ramp, easing the near-term burden so ACOs can focus on building dQM capability. The transition dates themselves sit in a Request for Information rather than a proposal, but they provide the clearest signal the Centers for Medicare & Medicaid Services (CMS) have given and are best read as the roadmap.

The core message for ACOs is that dQM is not a new way to submit the same data. It requires computing quality measures directly from FHIR resources, a fundamentally different capability than the manual abstraction and portal entry most reporting rests on today. Standing up and validating that capability takes time, and the CY2028-to-CY2030 window is narrow. ACOs that begin during the optional period will have room to find and fix problems while existing reporting remains available as a fallback; those that wait for the mandate will not. The investment pays off well beyond the Medicare Shared Savings Program (MSSP): the same FHIR architecture can serve commercial and Medicare Advantage value-based contracts and, ultimately, inform care in real time rather than report on it retrospectively. Comments on the proposed rule are due September 14, 2026, giving ACOs a direct opportunity to shape whether the eventual mandate is workable.

[1] Centers for Medicare & Medicaid Services. CMS-1848-P. Available at: https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1848-p.

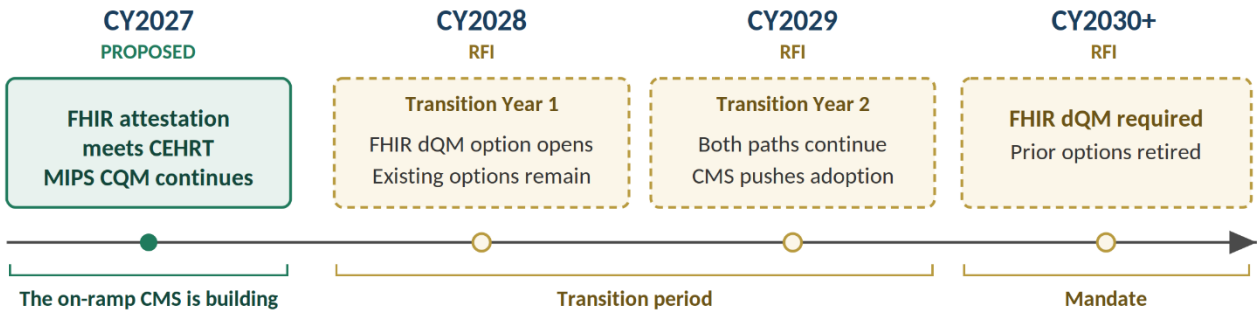
BACKGROUND

For years, the shift to FHIR-based dQM has been described as inevitable but distant. The CY2027 Medicare Physician Fee Schedule (CMS-1848-P) proposed rule changes that. For the first time, CMS has put a concrete timeline on the table for how Shared Savings Program ACOs will move to digital quality reporting, floating optional reporting in CY2028 and required reporting by CY2030. The window to prepare is short. Organizations that begin preparations now will be far better positioned than those that wait for the mandate.

This white paper lays out four things ACOs should take from the rule:

1. What CMS actually proposed versus what they asked about
2. What dQM readiness genuinely requires: a computation capability, not a reporting workflow
3. Why moving during the optional CY2028 window beats waiting for the mandate
4. Why the underlying investment pays for itself well beyond MSSP across an ACO's entire value-based book and, eventually, in care delivery itself

Figure 1. ACO Timeline: FHIR-Based Digital Quality Measurement, CY2027 to CY2030



Source: Adapted from CMS Figure C-C1, CY2027 PFS proposed rule. The CY2028–CY2030 transition and mandatory dates reflect CMS's Request for Information, not a proposal.

WHAT WAS PROPOSED BY CMS, AND WHAT WAS ONLY ASKED ABOUT

It's important to be precise here. The rule mixes firm proposals with open questions, and the distinction matters.

On the proposed side, CMS is making real changes that will take effect soon. Setting aside the broader rule, two proposed changes bear directly on dQM readiness. Beginning in CY2027, an ACO could satisfy the Certified Electronic Health Record Technology (CEHRT) use requirement through FHIR by using FHIR-based data to support a single quality measure. CMS is signaling that reusing regulated FHIR endpoints is a valid demonstration of certified, interoperable health information technology. There is a quiet opportunity here for ACOs reporting Medicare CQMs. Unlike eCQMs, which remain bound to QRDA-based submission architecture, Medicare CQMs leave room to build on FHIR directly, and some ACOs are already doing exactly that. Under this proposed policy, that work would count toward satisfying the CEHRT requirement while building tomorrow's capability.

At the same time, CMS proposes to keep the MIPS CQM collection type available for CY2027 and beyond, rather than sunsetting it as current policy requires. CMS is explicit about why: continuity spares ACOs the burden of switching collection types in the interim and lets them focus their resources on the transition to dQM instead. Taken together, these two proposals form a deliberate on-ramp. The proposed policies are clearing the way for ACOs to redirect their resources toward the FHIR-based capability that will ultimately be required by dQM.

The transition timeline itself sits in a Request for Information, not a proposal. Through this Request, CMS floats a two-year transition period beginning in CY2028, during which existing reporting options would remain available while FHIR-based reporting would be introduced for available measures. Beginning in CY2030, FHIR-based reporting would become mandatory replacing the older reporting approaches for those measures.

While an RFI is not a commitment, it is the clearest signal CMS has given about where the program is headed. It is the roadmap.

Treating the RFI as merely hypothetical would be a mistake as the direction is unambiguous. Dates in a Request for Information can shift, and some of these likely will. But the destination is not in question, and neither is the sequence. ACOs that plan around the possibility of delay are betting on the one variable CMS has been most consistent about.

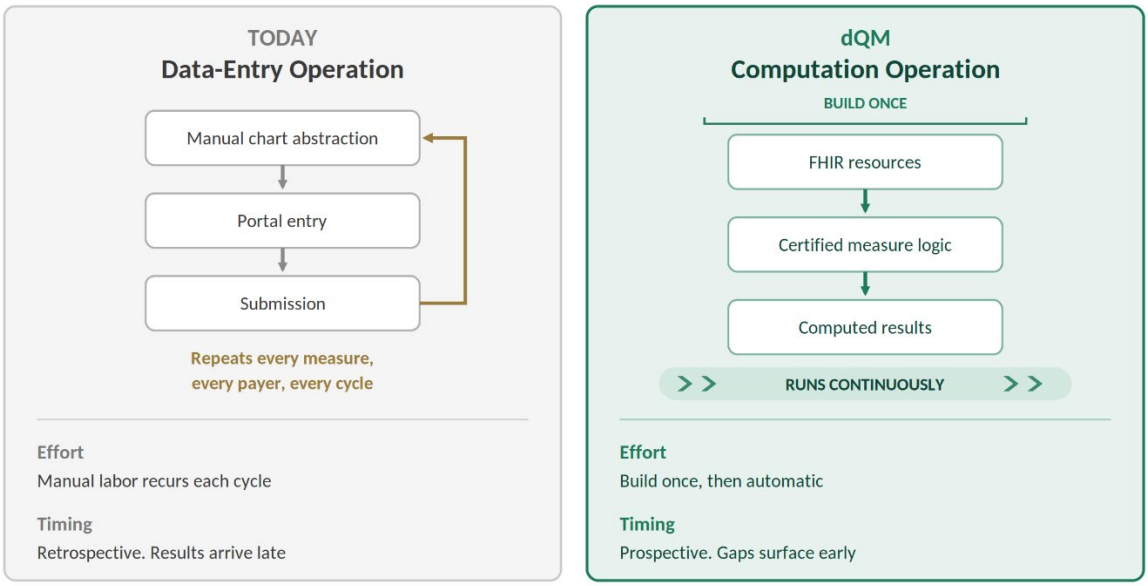
WHAT THIS MEANS FOR ACOS

The practical implication is that ACOs have a defined runway, roughly CY2028 through CY2030, to transition to a working FHIR-based quality reporting capability. That is not a long time to design, implement, and validate new infrastructure, particularly given the complexity of the work.

FHIR-based dQM is not a new way to submit the same data. It is a complete redesign of the end-to-end process.

FHIR-based dQM requires calculating measures directly from FHIR resources against certified module requirements. That is a fundamentally different engineering shop than most quality reporting operations today. Many organizations are built as data-entry operations around manual abstraction and portal entry. Moving from the first to the second is not a workflow tweak—it is a complete redesign of the end-to-end process.

Figure 2. Two Different Operations: Quality Reporting Today vs. FHIR-Based dQM



The readiness question is what matters, and it is the one to start on now. Assess your quality reporting partners directly by asking not, "Can they submit our measures?" but "Do they have a working FHIR-based computation pipeline that meets certified module requirements? And when will they be ready?" Many vendors that handle reporting today do not yet have this capability, creating a significant transition risk.

WHY MOVING EARLY BEATS WAITING

The CY2028 transition period is not when preparation begins; it is when the on-ramp opens. The organizations that arrive ready to use it will benefit the most.

It is tempting to treat CY2028 as the start date for planning. That would be too late. There are concrete reasons to begin preparation during the optional period early rather than waiting for the CY2030 mandate. FHIR-based reporting pipelines take time to build, test, and validate against real measure calculations. The gap between being connected and producing accurate, submittable results is where most of the work occurs. An ACO that starts testing during the optional window has room to find and fix problems while existing reporting options are still available as a fallback. An ACO that waits until FHIR reporting is mandatory has no such cushion. The narrow CY2028-to-CY2030 window leaves little room to switch approaches mid-transition if the first attempt does not work.

Early movers also gain something less tangible but real: experience. Organizations that pilot FHIR-based reporting while it is still optional will understand their own data, their vendors, and their gaps well before the stakes rise. That knowledge is difficult to acquire under a tight deadline.

One notable omission from the RFI is a financial incentive for the move toward dQM. The RFI left that piece undefined. This is where CMS is actively looking for ideas. This is not a reason to wait, but a reason to engage while the incentive design is still being written. CMS has a natural mechanism to tie dQM adoption to the Shared Savings Program, allowing early movers to benefit through their shared savings rate or quality performance standard rather than through a stand-alone reporting bonus. An incentive built into the shared savings mechanics would reward the ACOs doing the hard engineering work now, and it is exactly the kind of proposal the comment period is intended to answer.

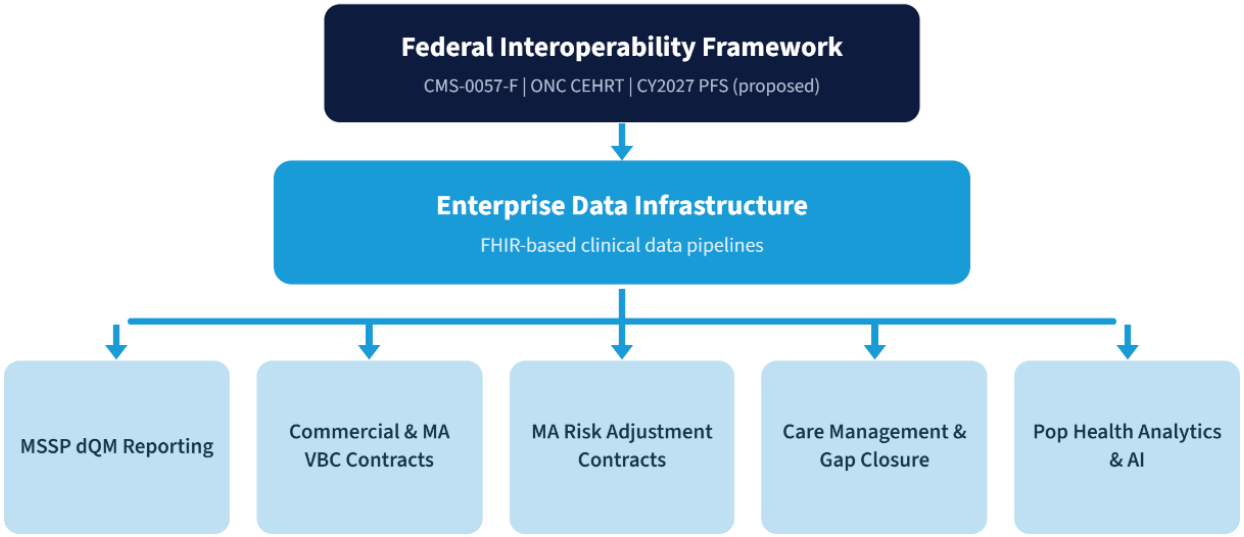
THE ARCHITECTURE PAYS FOR ITSELF BEYOND MSSP

Building a FHIR-based measure computation capability is an investment in reusable architecture, not single-purpose reporting machinery. The same FHIR endpoints and computation pipeline an ACO develops for MSSP dQM can be reused to meet quality and value-based care obligations with commercial and Medicare Advantage plans, which are moving toward FHIR-based measurement on the same timeline. Once the FHIR foundation is built and optimized, it will serve multiple payer contracts instead of maintaining a separate reporting apparatus for each.

The same FHIR pipeline built for MSSP can serve every value-based contract an ACO holds. Build it once, serve many.

Operational savings come from reuse. Manual abstraction and portal-based reporting carry a recurring labor cost that scales with every measure, payer, and reporting cycle. A computation pipeline shifts that burden from repeated manual effort to a built-once, run-often capability. The savings are not just in the CMS submission itself; they come from retiring the parallel, labor-intensive reporting an ACO would otherwise run across its entire book of value-based business.

Figure 3. Shared Infrastructure Dramatically Reduces dQM Cost



The final payoff is the one digital quality was meant to deliver all along. When measures are computed from live FHIR data rather than assembled retrospectively at reporting time, the same capability can inform care while outcomes can still change, surfacing gaps prospectively instead of confirming what was missed months later. That is the original promise of dQM: not faster retrospective reporting, but quality measurement that actually improves care.

SHAPE THE TRANSITION: RESPOND TO THE RFI

The transition timeline is not settled, presenting an opportunity. CMS is actively asking ACOs for input on the transition timeline, key milestones, implementation considerations, and the support small and rural practices will need. The proposals that make it into future rulemaking will be shaped by what stakeholders say now.

ACOs that have started thinking seriously about FHIR readiness are exactly the voices CMS needs to hear from, because they understand what the transition actually requires on the ground. Comments on the CY2027 PFS proposed rule are due September 14, 2026. Whether the eventual mandate is workable will depend in large part on whether the organizations that have to meet it weigh in while the timeline is still being written. We would encourage every ACO to respond, and we are happy to help develop a response.

LET'S TALK

The digital quality future now has dates attached. Wherever your organization is on the path, our experts can help you figure out next steps. Reach out to us to start the conversation.

MEET OUR EXPERTS

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