AMERICAN COLLEGE of RHEUMATOLOGY
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September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Submitted electronically via regulations.gov

RE: [CMS-1770-P] Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds concerning Discarded Amounts

Dear Administrator Brooks-LaSure,

The American College of Rheumatology (ACR), representing over 7,700 rheumatologists and rheumatology interprofessional team members, appreciates the opportunity to respond to the CY 2023 Physician Fee Schedule and Quality Payment Program proposed rule published in the *Federal Register* on July 7, 2022. We welcome the opportunity to share our comments regarding the impact of these policies on our ability to provide quality care to the 50 million Americans living with rheumatic diseases.

Rheumatologists and rheumatology healthcare professionals provide ongoing care for Medicare beneficiaries with complex chronic and acute conditions that require specialized expertise. They provide primarily non-procedure-based care to patients with severe conditions that can be difficult to diagnose and treat, including rheumatoid arthritis and other forms of inflammatory arthritis, vasculitis, systemic lupus erythematosus, and multiple other debilitating diseases. Rheumatologists and rheumatology professionals also work closely with physical and occupational therapists to maximize the ability of patients to achieve and maintain independence outside of healthcare settings. Early and appropriate treatment by rheumatologists and rheumatology professionals can control disease activity and prevent or slow disease progression, improve patient outcomes, and reduce the need for costly surgical or interventional procedures. The improved outcome enables our patients to continue to be more productive than they would have been without timely treatment.

The ACR thanks the Centers for Medicare and Medicaid Services (CMS) for its continued recognition of the value of complex medical decision-making provided by rheumatologists and other cognitive care specialists in treating their patients by continuing to operationalize and fine-tune the Evaluation and Management (E/M) code revaluation and documentation requirements. Our nation's healthcare system continues to navigate the challenges of a global pandemic that has strained resources, care teams, and healthcare professionals. We appreciate the policies and flexibilities set forth by CMS to help alleviate these challenges while we all work to provide quality patient care. In light of the ongoing volatility and unknowns in the healthcare system, the ACR offers the following comments on the policies regarding the decreased conversion factor, Medicare Economic Index, E/M split visits, telehealth flexibilities, and the Quality Payment Program (QPP).

Proposed Provisions in the CY23 Physician Fee Schedule

Conversion Factor

CMS proposes adjusting the CY2023 conversion factor (CF) to $33.08 from the current $34.61. This 4.4% decrease is detrimental to the stability of physicians and other healthcare professionals across the House of Medicine. We recognize the statutory limitations that impact the proposed CF for the upcoming calendar year. However, we must emphasize the strain healthcare professionals and teams face to continue caring for their patients. In another year of a public health emergency and facing staggering inflation costs and a significant workforce shortage, rheumatologists and rheumatology care teams struggle to continue providing care for their patients. **The ACR strongly urges CMS not to move forward with this damaging impact on an already strained system. We urge CMS to maintain the CF of $34.61 for CY2023. While our nation continues to adjust to life post public health emergency, the pandemic recovery is far from over. It will require continued consideration of the financial solvency of healthcare practices.**

Rebasing and Revising the Medicare Economic Index (MEI)

The Medical Economic Index (MEI) is an index that measures changes in the market price that accounts for the variable inputs used to furnish physician services. The current MEI used is primarily based on data from 2006. CMS proposes to rebase and revise the MEI based on a methodology and use publicly available data sources for input costs. Specifically, CMS is offering a new method for estimating base year expenses that rely on publicly available data from the 2017 U.S. Census Bureau's Services Annual Survey 2017 data from Table 5, Estimated Selected Expenses for Employer Firms for NAICS 6211 (Office of Physicians) to allow for the use of data that are "more reflective of current market conditions of physician ownership practices, rather than only reflecting costs for self-employed physicians, and will allow for the MEI to be updated on a more regular basis."

The ACR appreciates the agency's proposal to update the MEI to reflect current economic considerations better. We note that while the new MEI cost weights to set PFS rates would not change overall spending on PFS services; the changes will likely result in significant changes to payments among PFS services. **We encourage CMS to collaborate with stakeholders during sub-regulatory guidance to ensure payment accuracy and stability for rheumatology practices.**

Evaluation and Management (E/M)

As part of the ongoing updates and coding guidelines to the E/M services, CMS will adopt significant coding updates for other E/M visits, including inpatient, observation, emergency department, nursing facility, and home/residence service visits. The American Medical Association CPT Editorial Panel extended the framework created for code selection of office/outpatient to the new set of codes aligned with the structure used for all future updates. The ACR appreciates the ongoing review and refinement of codes to ensure accuracy in billing and coding to reflect the healthcare professional's work.

Split/Shared Services

In the CY 2022 PFS final rule, CMS finalized their policy to allow payment where a physician and Non-physician providers (NPP) deliver service together for a split/shared facility-based visit (including prolonged visits.) The policy calls for the provider to deliver more than half of the care provided during a shared/split visit to bill for the services. The new policy does not consider the role of medical decision-

making as a primary determining factor in the successful outcome of the visit. This policy raises concerns about negative implications on collaborative care and the critical role of medical decision-making in patient care. Cognitive-based physicians are experts in making clinical decisions based on years of training to ensure the highest quality care for their patients. CMS must maintain the reimbursement structure to appropriately recognize the expertise associated with the physician's medical decision-making expertise.

With the changing landscape in healthcare and the prominent role of NPPs in care delivery, the ACR appreciates CMS's proposal to delay their split/shared visit policy and extend flexibilities to permit split/shared E/M visits to be billed based on one of three components (history, exam, or medical decision making) or time until 2024. This delay will allow physicians and NPPs to establish a more collaborative cadence in their split/shared visits that emphasizes the cognitive skills needed to provide the best care for their patients.

Telehealth Services

Following statutory guidance, CMS proposes to continue all telehealth flexibilities five months following the expiration of the public health emergency. The ACR appreciates the telehealth flexibility extension. This will allow our rheumatology care teams time to readjust their practices to account for a more limited telehealth role in their care delivery.

However, the ACR notes that removing many of the flexibilities that will expire will negatively impact rheumatology practices as patients have become accustomed to many of the roles of telehealth in care delivery. These services include telephone E/M visits, audio-only visits, and real-time audio/video technology, as direct supervision requirements are set to expire five months following the expiration of the public health emergency. These services will revert to a physical presence requirement.

Telehealth services filled a crucial gap during the COVID pandemic and have remained an essential element in the future health care needs in the United States. Many of our patients travel long distances to get the care they need to manage their rheumatic diseases. These chronic, debilitating diseases require continuous follow-up with the rheumatic care team. Telehealth has allowed patients to receive the care they need without traveling long distances for a brief follow-up. Audio-only telehealth has provided necessary care and non-inferior satisfaction to video visits for our patients without the need for complex audio-visual capabilities. Further, patients with low technological literacy or those with limited or no internet connections can benefit from continuous care by audio-only telehealth, without worrying about finding ways to satisfy the visual component of telehealth services. **The ACR firmly believes a more comprehensive telehealth service will be a permanent fixture in the future of healthcare but should serve as a supplemental method of care and not a substitute for in-person care. These expanded telehealth services are vital for our patients, and the ACR encourages discussion and policies that allow for appropriate reimbursement rates for these services.**

Musculoskeletal Ultrasound Work RVU and Practice Expense Valuation

Under the proposed valuation for CPT code 76881, CMS drastically cut the work RVU recommended by the AMA RUC. **The ACR strongly opposes these cuts and urges CMS not to proceed with this proposal.** Arbitrarily reducing work RVUs, despite a valid survey, is not justified and devalues the work of the AMA and the specialty societies involved in the process. Removing the pre-time and post-time, citing overlap, is inappropriate as we have demonstrated that the ultrasound service is a separate and identifiable visit from the E/M visit. Thus, the rendering physician still requires time to review prior

imaging for comparison, patient clinical information, and provide consent and patient education. The technical skill needed to review, interpret, and provide conclusive findings for ultrasound images is beyond the technical skill related to management decisions associated with the E/M visit. Therefore, the history and pertinent clinical information must be reviewed, in addition to any prior applicable imaging studies, to optimize the examination.

Similarly, because it is an imaging code, the post-service time is required because the physician must still perform the following: dictate, discuss, and explain findings of the examination to the patient as needed, separate from the E/M encounter, review and sign an imaging specific final report for the medical record, and communicate findings to referring clinician, as required. An accurate comparison is essential in assessing disease severity activity and changes to therapeutic interventions made since the previous ultrasound. Then the report must be dictated (or typed) and made available in the patient's chart.

Additionally, it is questionable that the complete study 76881, requiring many more captured images and evaluation time, has a lesser RVU value change than the study 76882. **Thus, for 76881, we respectfully request upholding the 2 minutes of clinical labor time for CA006, the 1 minute of clinical labor time for CA007, and the 2 minutes for CA011 instead of the elimination of these elements as is currently proposed.**

The valuation method looks at all service elements and preserves relativity within the relative value scale for a code family. The AM RUC and CMS have held a longstanding position that treating all components of physician time (pre-service, intra-service, post-service, and post-operative visits) as having identical intensity is incorrect. This is even more evident when 76881 describes the physician's work involved in a complete evaluation of a specific joint in an extremity. At the same time, 76882 represents a limited evaluation of a joint or focal evaluation of a structure(s) in an extremity other than a joint (e.g., soft-tissue mass, fluid collection, or nerve[s]). CPT code 76881 requires ultrasound examination of all the following joint elements: joint space (e.g., effusion), peri-articular soft-tissue structures that surround the joint (i.e., muscles, tendons, other soft-tissue structures), and any identifiable abnormality. In some circumstances, additional evaluations such as dynamic imaging or stress maneuvers may be performed as part of the complete evaluation. CPT code 76882 does not assess all the elements included in 76881 and should not have a lower work value. The proposal to assign 0.54 work RVUs to 76881 and 0.59 work RVUs to 76882 creates a rank order anomaly.

Along with the AMA, we do not agree with the reverse building block methodology to reduce the work RVU for this service as it is inconsistent based on the current RUC process. **The proposed policy is based on discordant methods, including practice expenses and the lack of recognition of the pre-and post-time work required. Therefore, we strongly urge CMS not to proceed with the proposed cuts. Instead, CMS must maintain pre- and post-time and allow for greater stakeholder engagement in determining the appropriate practice expenses to allow accurate reimbursement for this important diagnostic service.**

The tables below reflect the impact of the conversion factor reduction with RVU and PE changes on 76881.

Table I Recommended RVU Table

Code	Descriptor	**CMS Proposed wRVU**	**RUC Recommended wRVU**

76881	Ultrasound, complete joint, real-time with image documentation	0.54	0.90
76882	Ultrasound, limited joint, real-time with image documentation	0.59	0.69
76XX0	Ultrasound, nerves comprehensive, real-time cine imaging with image documentation, per extremity	0.99	1.21

Table II Proposed 2023 Medicare National Physician Fee Schedule

Code	Descriptor	Non-facility Fees			Facility Fees		
		2022	2023		2022	2023	
76881		$59.70	$34.05	-58%			
76881-26		$30.37	$8.91	-70.7%	$30.37	$8.91	-70.7%
76881-TC		$29.33	$25.14	-14.7%			
76882		$57.61	$36.03	-37.5%			
76882-26		$23.45	$8.25	-54.7%	$23.45	$8.25	$54.7%
76882-TC		$34.16	$27.78	-23.0%			

Practice Expense (PE) Data Collection and Calculations Methodology

In the CY23 proposed rule, CMS proposes refinements to the direct practice expense inputs for specific codes. CMS intends to move to a standardized and routine approach to the valuation of indirect PE. **While the ACR welcomes the concept for updates to indirect practice expense (PE) data collection and methodology, we feel it is prudent to work within the structure currently in place with the AMA RUC.**

As CMS plans to move forward to a standardized and routine approach to the valuation of indirect PE, as stakeholders, we believe this is important because the indirect expenses for practice are significant and must be accounted for. The ACR believes that it is essential that CMS be more transparent in identifying misvaluation of services.

Clinical Labor Pricing Update

CY 2022 was the final year of a multi-year phased update for practice expense (PE) for supplies and equipment and the first year of a four-year phase-in to update PE clinical labor pricing, as previous data for this component was nearly 20 years old. FY 2023 will be the second of the four years for the phased-in update. While the clinical labor pricing has the potential to address the current staffing challenges for physician practices, the ACR believes there is an imbalance in the direct practice expense pool, and any proposal moving forward would disproportionately impact rheumatology practice negatively with the proposed changes. **The ACR recommends an additional review of overall clinical labor costs and the conversion factor to appropriately compensate healthcare professionals in future years.**

Geographic Practice Cost Indices (GPCI)

As required by law, CMS proposes to update the GPCIs using more recent wage, office rent, and malpractice premium data. The adjustment will be phased over calendar years (CYs) 2023 and 2024.

For the CY 2023 GPCIs, CMS proposes to continue to use the current 2006-based MEI cost share weights rather than the rebased and revised MEI cost share weights discussed elsewhere in the proposed rule. The ACR appreciates the agency's recognition of the need to use more up-to-date information to depict better the actual costs of delivering quality care.

Dental and Oral Health Services

Following input from interested parties on the lack of clarity in current policies related to dental coverage for Medicare beneficiaries, CMS also recognizes that there may be other clinical situations in which dental care coverage is inextricably linked to the success of other medical services. Rheumatic diseases require long-term management with immunosuppressant medications. The intensity and duration of immunosuppressant therapies affect the level of risk for severe complications from local and systemic spread of dentally sourced pathogens.

Many patients require medications that suppress their immune systems to control their rheumatic disease, and the combination of secondary health issues and potential side effects from the medications increases the likelihood of dental problems. **Therefore, the ACR urges CMS to include dental coverage for patients suffering from rheumatic diseases, particularly immunocompromised patients.**

Proposed Revisions to the Quality Payment Program (QPP)

MIPS Value Pathway (MVP)

QCDRs/QRs/Health IT Vendors Supporting All Measures in MVPs

In the proposed rule, CMS seeks comments on whether third-party intermediaries should have the flexibility to choose which measures they will support in an MVP. **The ACR encourages CMS to require qualified registries (QRs) and Health IT Vendors to support all non-QCDR measures within an MVP.** The ACR's RISE registry welcomes the opportunity to work with groups interested in licensing our QCDR measures. However, the RISE Registry must retain the final determination of how those measures are used within the QPP. Requiring groups to support other measures in the MVP will allow for more options for clinicians, groups, and subgroups.

CME Organizations Submitting Improvement Activities for MVPs

CMS is considering allowing Continuing Medical Education (CME) organizations to submit improvement activities on behalf of the physician following the completion of a CME or Maintenance of Certification course to be counted toward an improvement activity within an MVP. **The ACR supports this proposal.**

Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in the QPP

Recognizing the importance of digital data to achieve greater interoperability and burden reduction, CMS is soliciting comments on refining policies surrounding digital quality measures (dQM), including refining the definition of dQM, data standardization, and approaches to achieve fast healthcare interoperability resources in electronic clinical quality measures (eCQM). The ACR believes that interoperability is paramount in transforming our healthcare system. **The ACR supports recommendations on refining the definition of a digital quality measure (dQM) and its interest in**

accelerating data standardization and interoperability. However, we urge CMS to address concerns related to this initiative.

While implementing these initiatives, the ACR encourages CMS to consider the impact on physicians and other healthcare professionals who participate in MIPS/MVPs but may choose to use EHR systems that do not meet ONC's certification requirements. If EHRs do not meet data standards, the self-contained dQM QMls may not be sufficient to measure implementation. We encourage CMS to consider how it would build its policies to address this issue for healthcare professionals and the organizations (e.g., QCDRs, QRs) that support them. We also strongly encourage CMS to consider how their vision of data interoperability could extend to allow individual dQMs to access and use data from multiple sources, such as registries, administrative data (including Medicare claims), patient applications, etc. The ACR continues to have concerns that there will be critical areas where data standards and formats are not set and will continue to require additional mapping efforts beyond what is included in the dQM package.

Further, we encourage CMS to continue monitoring the updates ONC makes to the standards defined in the USCDI and how ONC's timelines for requiring that Health IT vendors incorporate updated versions of the UCSDI impact the standards needed to implement dQMs will be in place. The ACR would also be interested in hearing more from CMS regarding what infrastructure they and other government agencies would be able to put into place to support TQM development and maintenance, such as a dQM authoring tool, data exchange platforms, value set resources, education on how specialty-specific data fits within the FHIR standard, etc. We suggest that CMS consider developing guides for measure developers, particularly QCDRs, to help them understand the resources available and pathways for requesting standards for critical data relevant to their work if none exist.

Finally, we see an opportunity for CMS to take advantage of foundational architecture already in place among QCDRs and QRs, allowing them to serve as data aggregators for their users. QCDRs and QRs already have the expertise and resources required to populate dQMs that rely on multiple data sources and support the wide variety of use cases CMS references in their RFI. QCDRs, especially those associated with medical specialty societies, would be good partners in contemplating the required infrastructure to support dQMs with multiple data sources as they sit at the intersection of data aggregation, measure development, measure use, and provider support, provider advocacy, and action based on federal regulations. Perhaps working collaboratively with QCDRs would be a way for CMS to continue working towards dQMs while also developing more complex use cases for how TEFCA could advance the goals of CMS programs.

RFI on aligning MVPs and APMs

In the proposed rule, CMS is requesting feedback on ways MVPs can be used to obtain more meaningful performance data. **The ACR encourages CMS to develop incentivizes for healthcare professionals to report measures relevant to the APM goals, such as patient-reported outcome measures.** One option could be to provide bonus points for those who report on such measures, regardless of the program in which they are participating (MIPS vs. MVP vs. APM). This encourages physicians and care professionals to become more familiar with the measures likely to be part of the payment program for years to come, which would ease the transition from one pathway to the next. The incentive would also reduce the burden on measure developers when introducing new measures into the program that better align with the program's ultimate goals.

Addition of Q134 to Advancing Rheumatology MVP (Appendix 3)

The ACR appreciates CMS' continued support of the Advancing Rheumatology Patient Care MVP**. We ask CMS to reconsider adding quality measure Q134 to this MVP and removing Improvement Activity IA_BMH_4: Depression screening.** The RISE registry, a rheumatology-specific QCDR, has offered this measure to our users for many years. None of our users are actively tracking their performance on that measure. The other steps included in the MVP are commonly used and more relevant to rheumatology practice. CMS will likely receive little to no data on Q134 from rheumatologists if it remains in the MVP.

Changes to MVP Based on Public Comments

Overall, the ACR supports CMS' proposal to obtain public comment on MVPs. As proposed, we understand the value of hearing public comments on MVP elements for MVP candidates and existing MVPs. However, to help ensure the appropriateness of changes to MVPs, **we encourage CMS to build in time for review of those comments by those organizations creating MVPs and the medical specialty societies directly impacted by the MVP.** As experts on the specific MVP and the specialty represented by the MVP, these groups are in the best position to evaluate the comments received and assess the feasibility and relevance of suggested changes to the MVP. We request, at minimum, to consult with CMS on any planned changes based on public comment ahead of the proposed rule.

Identifying Clinician Specialty

CMS proposes identifying clinician specialty based on Medicare Part B claims. **We understand the decision to move from PECOS to Part B Claims; however, we remain concerned with the differentiation between "ordering provider" and "servicing provider."** For example, if a rheumatologist is the "ordering provider" for a Part B drug and sends the patient to an outside infusion center, where there is a non-rheumatology clinician in the infusion center who is the "servicing clinician," would each clinician be appropriately recognized as rheumatologist and non-rheumatologist, or would both be identified as rheumatologists? The scenario could also easily be reversed – a non-specialist "ordering provider" and specialist "servicing provider." Additionally, specialists such as rheumatologists may not be appropriately identified if Part D claims are not also used to identify specialty.

Scoring for Subgroups that Register but Do Not Report

CMS included a proposal not to score those subgroups who register but who choose not to report during these initial years when subgroup reporting is optional. **The ACR supports this proposal and encourages CMS to leave this in place until traditional MIPS is sunset.**

Merit-based Incentive Payment System (MIPS)

MIPS Quality Performance Category Health Equity

In the proposed rule, CMS solicits feedback on essential considerations for developing and including additional health equity measures in MIPS. Successful processes and implementation for a health equity measure development and similar equity initiatives will: 1) encourage providers to collect relevant data, 2) allow providers to collect measure data more consistently, and 3) use the data gathered to develop an evidence-based, risk-adjusted outcome measure. The ACR recognizes that social determinants of health may vary based on the patient population and health care setting. **Therefore, we encourage CMS to ensure a pathway for other measure development organizations, such as QCDRs, to build health equity measures that are particularly relevant for their stakeholders.**

Cost Improvement Scoring

CMS proposes establishing a maximum cost improvement score beginning with the CY24 MIPS payment year. **While we appreciate the agency's ongoing refinement of the cost category, we urge CMS to provide greater clarity on this proposal, including the timeframe on which these scores will be assessed and distinct scenarios that will add or subtract from the overall score.** Specifically, the ACR seeks clarification as to whether this policy will allow for the addition of one percentage point if a practice or clinician shows improved cost scores over time or, conversely, the deduction of a percentage point if a practice or clinician shows no change or a decline in the cost score over time.

Sunset Traditional MIPS

For several years, CMS has reiterated its plan to transition the QPP from traditional MIPS toward MVPs and APMs. **While the ACR supports a more integrated payment system that emphasizes quality patient care, we encourage CMS to delay setting a deadline for sunsetting traditional MIPS until the successful implementation of MVPs and more APM opportunities are materialized.** Important details related to the MVP and APM programs have yet to be addressed through the rule-making process. Without the specifics of these programs finalized, CMS must not set an unattainable timeline for sunsetting MIPS.

QCDR Requirements

Updates to Measure Specification Posting Requirements

CMS proposes updates to clarify the requirements for specific measure specification information that QCDRs must make publicly available. **While we support this proposal, the ACR respectfully requests that CMS remove "risk adjustment algorithms" from the list of specifications that must be posted publicly.** We recognize it is essential to share information on the variables used in risk adjustment; however, we believe that public sharing of the risk adjustment algorithms raises two critical concerns based on our experiences: 1) it leads to more significant confusion among healthcare professionals if they are trying to understand the algorithm without direct interaction with an expert from the measure development team; and 2) given the importance of the risk-adjustment algorithm to properly implementing the measure, we believe that sharing the actual algorithm should be restricted to registry users who wish to better understand how the measure calculation impacts them, and to other organizations that have the QCDR's approval to implement the measure in their systems.

Delaying QCDR Measure Testing

Recognizing the continued impact of COVID-19 on QCDR measure testing, CMS proposes to delay the requirement that QCDR measures must be fully developed and tested until CY24. **The ACR appreciates the agency's recognition of the ongoing challenges related to the pandemic and supports this proposal.**

Proposed Changes to Rheumatology Measure Set/Removal of 110 and 111

The ACR supports the CMS proposal to include the Screening for Social Drivers of health in the rheumatology measure set. However, we oppose removing measures 110: Preventive Care and Screening: Influenza Immunization and 111: Pneumococcal Vaccination Status for Older Adults from the MIPS

program and the rheumatology measure set and replacing them with the Adult Immunization Status measure. While we understand the desire to combine immunizations and checks for immunizations into one measure, the proposed replacement measure includes immunizations for issues that are not relevant to the field of rheumatology, such as Td, Tdap, and zoster. Our focus on including immunization measures has been around those necessary for rheumatology patients to receive, given their immunocompromised state. With this in mind, the different measures 110 and 111 for influenza and pneumococcal have served rheumatology care teams and their patients very well. **We strongly urge CMS not to move forward with its proposal to remove 110 and 111 and replace them with the immunization status measure in the rheumatology measure set.**

The ACR is dedicated to working with CMS to ensure that rheumatologists and rheumatology interprofessional team members are equipped to provide patients with quality care. As we transition to a health care system beyond the public health emergency, we urge CMS to recognize the value of telehealth in chronic care management, the importance of appropriate reimbursement for our members and the services they provide, and streamlining programs designed to advance quality care. We look forward to serving as a resource to you and working with the agency to explore changes and improvements needed to ensure patients with rheumatic diseases have access to quality care. Please contact Amanda Grimm Wiegrefe, MScHSRA, Director of Regulatory Affairs, at awiegrefe@rheumatology.org or (202) 991-1127 if we can be of assistance or if you have questions.

Sincerely,

Kenneth G. Saag, MD, MSc
President, American College of Rheumatology