AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

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September 10, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Submitted electronically via regulations.gov

RE: [CMS-1832-P] Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

The American College of Rheumatology (ACR), representing over 10,400 rheumatologists and rheumatology interprofessional team members, appreciates the opportunity to respond to the CY 2026 Physician Fee Schedule and Quality Payment Program proposed rule published in the Federal Register on July 16, 2025. We welcome the chance to share our comments regarding the impact of these policies on rheumatologists' ability to provide quality care to the 53.2 million Americans living with rheumatic diseases.

Rheumatologists and rheumatology 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 that entail complex diagnoses and treatments. 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. These improved outcomes enable our patients to be more productive than they would have been without timely, effective, specialized 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 specialties in treating their patients. We appreciate the policies set forth by CMS to help alleviate these challenges amid challenging environments for providing high quality healthcare. The ACR offers the following comments on policies regarding physician reimbursement for Part B services and drugs, telehealth flexibilities, code valuations, and the Quality Payment Program (QPP).

Proposed Provisions in the CY26 Physician Fee Schedule

Conversion Factor

The ACR appreciates CMS's proposed increase to the conversion factor from $32.35 to $33.42 (non-Alternative Payment Model (APM) participants) and $33.59 (qualifying APM participants). However, while this represents a nominal increase, it is insufficient to address decades of Medicare reimbursement erosion for cognitive, chronic-care specialties like rheumatology. According to the American Medical Association (AMA), Medicare physician payments declined 33% from 2001 to 2024 when adjusted for inflation in practice costs.[1]

On top of this, the U.S. inflation rate has risen nearly 25% since 2020. This has had grave effects on consumer prices, healthcare labor costs, prescription drug costs, supply procurement, and other healthcare practice expenses.[2] In particular, the cost of practicing medicine has risen by nearly an estimated 25% over the past two decades with CMS estimating that the Medicare Economic Index (MEI) increased by 3.5% in 2025 alone.

While the increase to the conversion factor is certainly a positive step, it is largely due to the 2.5% increase signed into law in early July. This increase is a temporary measure, only affecting reimbursements from January 1, 2026, through December 31, 2026. Without further congressional action, the conversion factor for 2027 will drop to the previous rate. Further, this underwhelming increase from CMS comes despite predictions that the MEI will increase by 2.3% percent in 2026, thus confirming that inflationary costs associated with running a practice will continue to rise and increase the divide between expense and income for Medicare providers.

The lack of an inflationary update continues to threaten the viability of physician practices, adds considerable burden to the practice of medicine, and stifles innovation. Rheumatology practices face disproportionately high overhead due to the need for specialized staff, infusion services, costly drugs, and monitoring equipment. As financial strain increases, some rheumatologists are forced to limit the number of Medicare patients they see, consolidate with larger systems, or in some cases close their practices. This further limits access for patients with chronic rheumatic diseases, particularly in rural and underserved areas where there is already a severe shortage of practicing rheumatologists.

In addition to limiting the number of Medicare patients, practices are increasing the total volume of patients they see to compensate for decreasing reimbursement. Many commercial insurers follow Medicare rates, so a decrease in Medicare reimbursement translates to a decrease from all payers. Overextending physicians' patient volumes is a driver of burnout that leads to physicians

[1] https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-physician-pay-has-plummeted-2001-find-out-why?utm_source=chatgpt.com

[2] https://www.mckinsey.com/industries/healthcare/our-insights/the-gathering-storm-the-transformative-impact-of-inflation-on-the-healthcare-sector

choosing to leave their practice.[3] This trend is particularly concerning for rheumatology, which is already facing a workforce shortage.[4]

Additionally, rheumatologists are being asked to invest in care coordination, quality reporting, and practice modernization. However, with stagnant reimbursements eroded by inflation, practices lack the resources to invest in practice updates, undermining CMS's own goals for value-based care. With the number of Medicare beneficiaries expected to increase to over 80 million patients by 2030, coupled with a corresponding increase in the frequency of rheumatic disease in this patient population, many beneficiaries will be unable to access the specialized care they need.

In short, failure to provide an appropriate inflationary update results in cumulative pay cuts for rheumatologists, threatens practice sustainability, and worsens patient access to timely, specialized care. **The ACR urges CMS to increase the conversion factor beyond the proposed amount to at least keep pace with the MEI and to collaborate with Congress to enact a permanent inflationary update for physician payments.**

Efficiency Adjustment

CMS is proposing a -2.5% efficiency adjustment to the Medicare Physician Fee Schedule (MPFS) for CY 2026. This adjustment aims to account for productivity gains over time that are not reflected in current reimbursement rates. While the adjustment is intended to apply to non-time-based services, the ACR has significant concerns regarding its potential impact.

CMS's proposal to decrease the work Relative Value Units (RVU) and physician intraservice time for approximately 7,000 physician services due to efficiencies is arbitrary and does not justify a decrease in payment every three years. This adjustment will likely nullify the small increase in the conversion factor and aggravate the payment reductions physicians endured for over 20 years, thus adding to the financial pressure on practices that are already coping with increasing costs and stagnant payments. It will also threaten beneficiary access to care and jeopardize our healthcare system's sustainability.

Secondly, the proposed across-the-board adjustment is not being appropriately applied and does not reflect the time and effort physicians use in providing thousands of services. The ACR agrees with CMS that "accruing efficiencies does not apply to all services equally" and we believe the agency should not apply this adjustment arbitrarily. CMS should instead work with us to address the impact on Medicare beneficiaries living with complex, chronic autoimmune and inflammatory diseases.

CMS has taken important steps in recent years to strengthen access to cognitive specialists, including improvements to office and outpatient E/M codes, creation of new codes for prolonged and chronic care management, and expanded use of telehealth. These actions have supported specialties such as rheumatology, which play a vital role in treating patients with conditions that require ongoing, comprehensive management. However, the proposed efficiency adjustment

[3] https://www.mgma.com/mgma-stat/physician-burnout-still-major-factor-even-as-unexpected-turnover-eases
[4] https://acrjournals.onlinelibrary.wiley.com/doi/epdf/10.1002/art.42833

would significantly erode these gains. **The ACR strongly urges CMS to rescind this proposal and explore alternatives to blunt, across-the-board efficiency adjustments that unintentionally penalize cognitive specialties. We also welcome the opportunity to contribute clinical expertise to help shape an alternative solution that will be fair to both physicians and their patients.**

Practice Expense Methodology

CMS proposes revising the methodology for allocating indirect practice expense (PE) costs for facility-based services. Beginning in CY 2026, CMS proposes to reduce the portion of PE RVU allocated based on work RVU in the facility setting to half the amount used in the non-facility setting. CMS's proposed shift in reimbursement away from services provided in the facility setting will create a redistribution of value for facility-based services and reduce the indirect PE RVU component formula. This will be a substantial change and will significantly lower reimbursement for practices in the facility setting.

The ACR is concerned that the proposed revision to the practice expense methodology will exacerbate already insufficient Medicare reimbursement for rheumatology services. Insufficient reimbursement across the board has led many independent practices to sell to hospital systems to remain financially viable. Under the proposed methodology, payments would be cut even further, which will have the opposite effect and will create higher costs, new cuts, and fewer options for patient access to care. The ACR strongly encourages CMS to rescind this proposal and instead work on a methodology that accounts for the real costs associated with providing care, so the growing number of patients with rheumatic diseases can access affordable, high-quality care that they need.

Prevention and Management of Chronic Disease – Request for information (RFI)

The ACR commends CMS for seeking a better understanding of how it could enhance its support management for prevention and management of chronic disease. We have the following feedback:

1. *How could we better support prevention and management, including self-management, of chronic disease?*

   Rheumatology patients often present with complex, multi-system autoimmune conditions requiring ongoing medication monitoring, comorbidity management, and frequent coordination between specialists, primary care, and ancillary services. Although CMS currently reimburses Chronic Care Management (CCM), Principal Care Management (PCM), and Complex CCM codes, uptake among specialists remains limited due to complicated billing requirements, prohibitions on concurrent billing with certain services, and administrative burden that disproportionately affects small and rural practices.

   Proactive care coordination for rheumatologic disease patients is associated with a reduction in emergency room visits. However, the current CCM/PCM payment structure does not reflect the intensity of coordination required in subspecialty care. CMS should streamline

documentation and reporting requirements for these codes, permit shared management arrangements between rheumatologists and primary care providers, and provide targeted education to specialty practices on billing and compliance. This approach would ensure that beneficiaries with rheumatic diseases can benefit from timely, coordinated care that prevents costly disease exacerbations.

Additionally, CMS must increase reimbursement for evaluation and management (E/M) visits. Medicare payment policies have long undervalued these visits relative to procedural services. Rheumatology is a largely cognitive specialty, relying heavily on E/M services rather than procedural revenue. When Medicare reimbursement for E/M visits does not keep pace with inflation or practice costs, rheumatology practices, especially small or independent ones, face increased financial strain. This makes it more difficult to sustain operations, retain staff, and invest in infrastructure such as infusion suites or electronic health record (EHR) systems that optimize patient care and provide interoperability.

If E/M reimbursement rates continue to decline, some rheumatologists may limit the number of Medicare patients they accept, shorten visit lengths, or in some cases withdraw from Medicare entirely. This is particularly concerning because rheumatology already faces a significant workforce shortage, and reduced participation could worsen wait times and access barriers for older adults with arthritis, lupus, and other rheumatic diseases

2. *Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set?*

   There are a few notable examples of rheumatology services that are not adequately captured by the current fee schedule code set. First, teaching patients self-injection techniques and safe medication use are bundled by current E/M codes into counseling time, but do not reflect the structured, team-based education needed for effective self-administered treatments and medication adherence. No specific code covers self-injection training or medication device education.

   Second, existing infusion administration codes (96365+) only capture the technical infusion service, not the cognitive/coordination work of therapy management, patient safety protocols, and adherence follow-up. This negatively impacts risk assessment before infusion, infusion reaction management, and coordination with specialty pharmacies.

   Lastly, CMS must remove the restriction on reporting modifier –25 when G2211 is billed. Rheumatology patients often require comprehensive management of chronic, systemic diseases alongside medication safety monitoring and comorbidity management. G2211 was intended to account for this added complexity. By restricting its use when modifier -25 is applied (i.e., when an E/M visit occurs on the same day as a procedure, such as a joint injection or infusion service), CMS is essentially removing payment for the longitudinal complexity of the encounter, even though that complexity still exists.

Telehealth

The ACR appreciates CMS's proposals in the CY 2026 PFS to expand and improve telehealth, including:

- Permanent removal of frequency limits for inpatient, Skilled Nursing Facilities, and critical care telehealth visits;
- Streamlined addition of services to the telehealth list; and
- Permanent allowance for real-time virtual direct supervision.

These changes will directly benefit patients with complex rheumatic diseases by enabling timely follow-up, continuity of care, and practice efficiency.

However, we are deeply concerned about the impending expiration of the originating site and geographic restrictions on October 1, 2025. Many rheumatologic patients, particularly those who are immunocompromised, mobility-impaired, or living in rural areas, depend on the flexibility to connect with their providers from home. Reinstating location limits will create significant access barriers, delay care, and undermine the very intent of telehealth expansion. By preserving broad telehealth access and adapting services to specialty needs, CMS can strengthen equitable care delivery for Medicare beneficiaries with rheumatic diseases. **The ACR encourages CMS to work with Congress to permanently extend all regulatory flexibilities on telehealth reimbursement. We also call for CMS to remove all restrictions on payment parity and remove any barriers to interstate licensure that bar providers from treating beneficiaries across state lines.**

Average Sales Price: Price Concessions and Bona Fide Service Fees

The December 2022 Office of Inspector General (OIG) report titled, "Manufacturers May Need Additional Guidance to Ensure Consistent Calculations of Average Sales Prices," recommended that CMS determine whether additional guidance would ensure more accurate and consistent Average Sales Price (ASP) calculations. CMS is thus proposing new regulatory text and definitions related to price concessions and bona fide service fees intended to provide further clarification to manufacturers and improve the accuracy of ASP, which is used to determine Medicare Part B drug payment limits. The ACR applauds CMS's efforts to "reduce the opportunity for improper manipulation of the ASP calculation," and increase certainty in the "integrity of the submitted ASP." Ensuring integrity of the ASP calculation is key to better aligning reimbursement for Part B drugs with the actual prices paid by rheumatology practices.

However, the ACR remains concerned about rebates between manufacturers and pharmacy benefit managers (PBM) that are reflected in manufacturers' quarterly ASP reporting. These rebates have artificially lowered the ASP for certain biosimilar drugs to the point that many providers' acquisition costs substantially exceed Medicare and other private health plan reimbursement. This scenario puts rheumatology practices in an untenable position and threatens patients' access to critical treatments which may lead to suboptimal outcomes including disease worsening.

The ACR encourages CMS to work with Congress to pursue the following legislative updates to the Social Security Act (SSA) to help ensure appropriate reimbursement and access to biosimilar drugs:

- **Amend Section 1847A(b) of the SSA to temporarily provide an 8% add-on to the providers' acquisition cost of all biosimilar products.**
- **Amend Section 1847A(c)(4) of the SSA to extend the Secretary's authority to use wholesale acquisition cost (WAC) + 3% until ASP reaches sustainable levels, as determined by the Secretary; or**
- **Amend Section 1847A(c)(3) of the SSA to permanently remove manufacturer rebates from the ASP methodology for biosimilars.**

Average Sales Price: Units Sold at Maximum Fair Price

The Inflation Reduction Act (IRA) empowers Medicare to negotiate maximum fair prices (MFPs) for high-cost prescription drugs under Part D, beginning in 2026. These MFPs establish price ceilings below traditional list prices. Starting January 1, 2026, CMS is proposing that units of selected drugs sold at the MFPs—as negotiated under the IRA—will be included in the calculation of the manufacturer's ASP. As CMS knows, Part B drugs will be included in the Medicare Drug Price Negotiation Program's third round of negotiations, with prices taking effect in 2028. As such, this proposal will have several negative implications for rheumatologists.

First, MFPs are likely to be lower than current ASPs for Part B drugs, which are currently calculated as a manufacturer's ASP across a number of eligible entities, including providers, commercial insurers, and Medicare Advantage plans. Inclusion of MFPs in the calculation of ASP is likely to pull ASPs downward. Currently, a significant share of provider reimbursement by commercial insurers for medicines is based on ASP. A recent survey of commercial insurers showed that over 60% of commercial and Medicare Advantage insurers reference ASP for reimbursing Part B drugs.[5] If CMS moves forward with including MFPs in the calculation of ASP for selected drugs, research suggests providers could face add-on payment decreases of up to $37 billion across Medicare and the commercial market. [6] CMS's decision comes at a time when providers, particularly independent, community-based providers, are already feeling significant financial pressure from historical Medicare payment cuts.

Second, CMS' decision is likely to cause patient access issues, and lead to practice closures and consolidation. The increased financial pressure on rheumatologists that often accompanies rising infusion costs frequently requires them to make difficult decisions when it comes to patient care. This is particularly the case for small and rural rheumatology practices, which typically operate on slim margins and would be least able to absorb the reimbursement cuts triggered by the inclusion of MFPs in the calculation of ASP. If reimbursement does not cover acquisition and

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[5] Avalere Health. (January 2025). Estimating the Spillover Impact of IRA Part B Negotiation. Available at: https://advisory.avalerehealth.com/insights/estimating-the-spillover-impact-of-ira-part-b-negotiation

[6] Avalere Health. (September 2024). Commercial Spillover Impact of Part B Negotiations on Physicians. Available at: https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians.

administration costs, some rheumatologists might limit offering certain therapies or shift prescribing patterns. They may also decide to refer patients to an offsite infusion center, which tends to be more costly for the patient, or switch the patient to a less expensive but potentially less effective treatment. These cost necessities would disrupt the continuity of patient care and could negatively impact patient outcome. CMS should also note that many of these practices are already underwater in prescribing a number of biologic medications – meaning acquisition costs are greater than reimbursement due to PBM/manufacturer rebates.

The ACR strongly encourages CMS to not move forward with this provision. If CMS chooses to move forward with it, the ACR recommends that CMS create a reimbursement floor so that ASP reductions from MFPs do not push reimbursement below drug acquisition and administration costs. We also request monitoring and reporting requirements from CMS on whether access disruptions (i.e., site-of-care shifts, drug shortages) occur after the ASP declines.

MVP Group Reporting

The ACR is deeply engaged in helping our members with quality reporting and improvement through our own Qualified Clinical Data Registry (QCDR). As such, we would like to express our concerns regarding the proposed requirement that, beginning with the CY 2026 Merit-based Incentive Payment System (MIPS) performance period (2028 payment year), multispecialty groups must report MIPS Value Pathways (MVPs) either as subgroups or as individuals, rather than as a single group entity.

While we understand CMS's intent to align reporting more closely with specialty-specific care, this proposal introduces significant operational and technical burdens for multispecialty practices, particularly those leveraging QCDRs for MIPS reporting. Our concerns are as follows:

1. **Increased Administrative Burden**
   Subgroup formation, registration, and management introduces new layers of complexity. Practices will need to invest in additional resources to manage subgroup configurations, ensure accurate attribution, and maintain compliance with evolving MVPs requirements. This is particularly burdensome for large multispecialty groups with diverse clinical services that would be required to report through multiple MVPs.

2. **Disruption to Established Reporting Workflows**
   Many multispecialty practices have invested heavily in QCDR-based workflows that are optimized for group-level reporting. The proposed change would necessitate significant reengineering of these workflows, potentially disrupting data integrity and continuity in performance measurement.

3. **Limited Practice and QCDR Support for Multiple MVPs**
   Not all QCDRs are equipped to support multiple MVPs simultaneously. This limitation means that multispecialty practices may be forced to engage with multiple QCDRs or alternative reporting mechanisms to accommodate the diverse specialties within their group.

This fragmentation increases administrative complexity and costs and may lead to inconsistent data capture and reporting.

4. **Loss of Aggregated Quality Insights**
   One of the key advantages of group-level reporting is the ability to aggregate data across specialties for comprehensive quality improvement initiatives. Requiring subgroup or individual reporting undermines this capability, making it difficult for organizations to identify system-wide trends, benchmark performance, and implement coordinated quality improvement strategies.

The ACR urges CMS to reconsider this proposal. Additionally, maintaining the option for group-level MVP reporting, particularly for practices that can demonstrate meaningful quality improvement through aggregated data, would preserve flexibility and reduce unnecessary burden.

Core Elements RFI

While the ACR supports CMS's goal of simplifying measure selection and enhancing the relevance of quality reporting, we have several concerns and recommendations regarding the current proposal.

1. **Patient Understanding and Transparency**
   If one of the primary goals of Core Elements is to provide patients with meaningful information to compare clinician performance, the current approach may fall short. Patients generally do not understand the technical nuances of quality measures. To truly empower patients, CMS must simplify and translate these measures into language and concepts that are accessible and relevant to the public. Without this, CMS's goal for transparency will not be achieved.

2. **Core Elements Do Not Reduce Complexity as Proposed**
   As written, the Core Elements policy and mandating of a core element could risk inadvertently penalizing clinicians whose patient populations or practice settings do not align with the selected metric. Such misalignment may result in inaccurate performance evaluations and negative payment adjustments, especially for smaller or subspecialized practices. Additionally, if a Core Element is a QCDR measure that requires licensing it could place significant burden on Qualified Registries (QRs) and QCDRs. If only QPP measures are included as Core Elements, it may negatively impact the specialty nature of the MVP.

3. **Need for Stakeholder Collaboration**
   We strongly recommend that CMS convene working groups with stakeholders from all areas of the QPP program—including clinicians, registry staff, specialty societies and informatics experts—to collaboratively define the "core concepts" that should underpin MVPs. From there, CMS can develop Core Elements that are both clinically meaningful and understandable to patients. This collaborative approach will ensure that Core Elements reflect real-world practice and support both quality improvement and transparency.

4. **Timeline Concerns**
   Implementing a Core Elements policy by the 2027 MIPS payment year is premature if CMS intends to make a meaningful and lasting impact. Developing truly representative, actionable, and patient-friendly Core Elements will require thoughtful design, stakeholder engagement, and system-wide readiness. We urge CMS to take the necessary time to do this right, rather than rushing implementation on an aggressive timeline that could compromise effectiveness and increase burden.

5. **Requirement to Tying MVPs to Procedural Billing**
   While we recognize potential positives to this proposal, we have two concerns with the concept of requiring clinicians to report a specific MVP based on the procedural codes that they bill.
   - This requirement may limit a clinician's ability to select the most appropriate MVP for the scope of their practice.
   - While using Medicare Part B claims data is a useful starting point, it may not fully capture the complexity of a clinician's practice.
   - As an alternative, the ACR recommends that CMS use clinical support tools within the QPP portal that guide MVP selection based on billing codes and show how similar clinicians/peers report data.

Well-being and Nutrition Measures RFI

The ACR commends CMS for recognizing the importance of a comprehensive approach to disease prevention and health promotion. We offer the following comments and recommendations.

First, we strongly support the inclusion of validated patient-reported outcome measures (PROMs). Patient-Reported Outcome (PRO) assessments are rigorously developed and widely used to assess physical, mental, and social health across a variety of conditions and populations offer a standardized way to capture the patient's voice and provide actionable insights into overall well-being. However, CMS should be aware that PROs are typically not captured as structured data elements in the EHR and are difficult to collect. If CMS moves forward with this policy, it needs to address implementation concerns such as:

- Identifying which PROs are relevant for each specific quality measure.
- Access to licensed PRO instruments.
- Ensuring PRO access to clinicians, hospitals, patients, and that surveys are available in multiple languages.
- Patient education.
- Provider education.
- Ensuring results are in a structured data field or results are interoperable.

Secondly, if CMS intends to use well-being measures to inform patient choice and transparency, it is critical that these measures be presented in a way that is understandable to the public. Concepts like "emotional well-being" or "life satisfaction" must be translated into plain language and supported by clear, relatable examples. Without simplification, patients may struggle to interpret the data meaningfully, undermining the goal of informed decision-making.

The ACR recommends that CMS convene expert panels knowledgeable about PROMs to collaboratively define the core concepts of well-being and nutrition measures and implement a robust framework that will ensure long-term success and adoption.

Third Party Intermediaries Support of MVPs

We thank CMS for the proposed modification that QCDRs and qualified registries must support MVPs that are applicable to the MVP participant on whose behalf they submit MIPS data no later than one year after finalization of the MVP in accordance with the current requirement. The ACR agrees with this modification.

Toward Digital Quality Measurement in CMS Quality Programs – Request for Information

While the ACR supports the long-term vision of interoperability and real-time data exchange to improve care quality and outcomes, we would like to highlight several concerns regarding the practical implications of this transition—particularly for clinicians with limited EHR capabilities.

1. **Small and Rural Practices Face Infrastructure Gaps**
   Many small and rural practices operate with limited EHR systems that lack the advanced functionality required to support structured data capture or Fast Healthcare Interoperability Resources (FHIR)-based interoperability. These practices may not have the financial or technical resources to upgrade their systems in the near term, making it difficult for them to comply with new digital reporting requirements without significant support.

2. **Widespread Use of Unstructured Documentation**
   Even in larger or more technologically advanced settings, many clinicians continue to document key clinical information in unstructured notes fields. These data are often not captured in discrete, reportable formats, which poses a major challenge for automated digital quality measurement. Without robust natural language processing or manual abstraction, critical information may be excluded from quality reporting, leading to incomplete or inaccurate performance assessments.

3. **Data Blocking**
   Despite ongoing efforts to improve interoperability, EHRs continue to pose significant challenges for providers participating in the QPP particularly due to data blocking practices. Although the 21st Century Cures Act and subsequent regulations have aimed to curb information blocking, many EHR vendors and health systems still engage in behaviors that restrict the access, exchange, or use of electronic health information. These practices can include excessive fees for data sharing, technical limitations, or refusal to integrate with other systems. This not only jeopardizes performance scores but also undermines the broader goals of care coordination and patient-centered care. The lack of seamless data exchange continues to frustrate providers, hinder quality reporting, and ultimately impact reimbursement and patient outcomes.

4. **Need for Technical and Financial Support**
   To ensure equitable adoption of Digital Quality Measures (dQMs), CMS should consider providing technical assistance, financial incentives, and phased implementation timelines for practices with limited infrastructure. This support could include grants for EHR upgrades, training on structured documentation, and access to centralized tools for FHIR conversion.

5. **Impact on QCDRs and Specialty Reporting**
   QCDRs play a vital role in supporting specialty-specific quality measurement. Requiring all QCDR-developed measures to be specified in FHIR may limit innovation and create barriers for registries that serve niche clinical areas. CMS should consider allowing flexibility in existing measure formats during the transition period to avoid significant burden and use of resources. The ACR urges CMS to work closely with QCDRs and other stakeholders to ensure alignment with specialty needs.

Proposal to Adopt a Two Year Informational Only Feedback Period for New MIPS Cost Measures

The ACR fully supports this approach and commends CMS for taking a thoughtful and measured step toward improving cost measure implementation. A two-year feedback period will provide clinicians and groups with the necessary time to evaluate their performance without the pressure of financial implications, identify data or attribution issues and provide meaningful feedback to CMS for refinement or improvement. This approach promotes transparency, encourages engagement, and supports a more accurate and equitable rollout of cost measures. It also aligns with the broader goals of value-based care by ensuring that cost measures are both clinically relevant and methodologically sound before they impact payment.

Promoting Interoperability

The ACR acknowledges CMS's proposal to modify the Security Risk Analysis measure under the Promoting Interoperability performance category to include a second component: an affirmative attestation of having conducted security risk management in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule.

This enhancement reinforces the importance of safeguarding electronic protected health information (ePHI) and aligns with existing HIPAA requirements. By requiring clinicians to affirm that they have conducted a security risk analysis and implemented necessary updates, CMS is promoting accountability and strengthening data protection practices.

While the measure remains a "Yes/No" attestation, it is critical that CMS provide clear guidance and accessible tools—such as the Security Risk Assessment Tool developed by ONC and OCR—to support clinicians in meeting this requirement. **The ACR strongly urges CMS to ensure that the programmatic requirements of the QPP do not become burdensome for clinicians and practices.**

RFI Regarding the Query of Prescription Drug Monitoring Program (PDMP) Measure

The ACR appreciates CMS's efforts to enhance the Promoting Interoperability performance category through the PDMP measure that tracks controlled substance prescriptions. However, we continue to ask that CMS consider the burden new requirements will put on clinicians and practices as the QPP program continues to evolve. We believe adopting a performance-based approach could improve accountability and data quality, however the measure must be carefully designed to reflect clinical relevance and workflow feasibility. PDMP queries can be time-consuming, especially when systems are not integrated into the EHR. This can cause workflow disruptions for busy clinicians.

We urge CMS to consider the following regarding this proposed measure:

- Allow flexible implementation timelines.
- Provide technical assistance and funding for Certified EHR Technology (CEHRT) upgrades.
- Offer hardship exemptions for providers lacking PDMP integration or facing state level access restrictions.
- Allow group reporting to reduce burden.
- Exclude providers who do not prescribe controlled substances.

RFI on the Modification of the Query of PDMP Measure to Include All Schedule II Drugs

The ACR supports the proposed expansion of the Query of PDMP measure to include all Schedule II drugs. This broader scope will enhance patient safety and improve monitoring of controlled substance prescribing.

RFI Regarding Data Quality

The ACR appreciates CMS's focus on improving data quality across the healthcare continuum. High-quality data is essential for accurate performance measurement, care coordination, and patient safety. Below are responses to the specific questions posed in the RFI:

1. What data quality challenges does your organization experience? How are you addressing them? What challenges persist longitudinally?

QCDRs encounter several data quality challenges:

- Inconsistent data capture across EMR systems - Variability in how clinical concepts are documented (e.g., disease activity scores, medication adherence) leading to gaps in completeness and reliability.
- Missing or incomplete data fields - Key data elements such as lab results, imaging, or patient-reported outcomes are often absent, inconsistently structured, or captured outside of the EMR.
- Lack of standardization - Differences in coding practices. For example, medication data may be recorded using different formats—some systems use National Drug Codes (NDC), others use RxNorm, and some rely on free-text entries. This inconsistency complicates efforts to aggregate and analyze data across practices.

To address these issues, we urge CMS to do the following:

- **Work closely with EMR vendors to improve structured data capture and improve the capture of specialty-specific and disease-specific data elements in structured data fields.**
- **Provide data validation tools and dashboards to help clinicians identify and correct gaps.**
- **Promote use of standardized terminologies and templates.**
- **Encourage practices to integrate patient-reported outcomes and longitudinal tracking tools.**

2. What are the primary barriers to collecting high-quality data? What resources could help?

Key barriers include:

- EMR limitations - Many systems lack the flexibility to capture specialty-specific data in structured formats.
- Workflow burden - Clinicians face time constraints that limit detailed documentation.
- Lack of interoperability - Data exchange between systems is often fragmented or delayed.
- Limited technical support - Smaller practices may lack IT resources to optimize data capture and reporting.

The ACR recommends that CMS create the following resources:

- **Funding for EMR enhancements and integration.**
- **Technical assistance programs for small and rural practices.**
- **Incentives for adopting standardized data models and Application Programming Interfaces (APIs).**
- **Continued support for QCDRs to serve as intermediaries in data quality improvement.**

3. What solutions have MIPS eligible clinicians found most effective to address data quality?

Clinicians have found success with:

- Using QCDR dashboards to monitor data completeness and performance.
- Implementing structured templates for documentation of disease activity and treatment plans.
- Participating in peer benchmarking to identify and address data gaps.
- Engaging in quality improvement collaboratives that focus on data-driven care.

These strategies improve both clinical outcomes and reporting accuracy.

4. What steps should CMS consider to drive further improvement in data quality and usability?

CMS can support data quality improvement by:

- Promoting interoperability standards such as Fast Healthcare Interoperability Resources (FHIR) and United States Core Data for Interoperability (USCDI).
- Expanding support and funding for QCDRs to develop and validate specialty-specific measures and define specialty-specific data elements to be implemented in EMR systems.

- Encouraging alignment across federal programs to reduce duplication and streamline data requirements.
- Facilitating partnerships between clinicians, vendors, measure developers and agencies to co-develop solutions.

5. What methods should CMS and partners explore to rectify data quality issues?

The ACR recommends:
- Real-time data validation tools embedded in CEHRT.
- Standardized data dictionaries/templates for specialty care.
- Pilot programs to test innovative data capture and exchange models.
- Public-private partnerships to advance data quality research and implementation.

Conclusion

The ACR is dedicated to working with CMS to ensure rheumatologists and rheumatology interprofessional team members are equipped to provide patients with quality care. As costs for providing high quality care continue to increase, we urge CMS to ensure reimbursement policies reflect the complexity and longitudinal value of rheumatologic care and to consider workforce shortages in rheumatology and the impact of reimbursement on patient access.

Rheumatologists are vital to the health and independence of Medicare beneficiaries living with chronic rheumatic diseases. Continued support from CMS will help sustain access to these highly specialized services, prevent avoidable complications, and improve the quality of life for millions of patients. 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 Colby Tiner, MA, Manager of Regulatory Affairs, at ctiner@rheumatology.org if the ACR can be of assistance or if you have questions.

Sincerely,

Carol A. Langford, MD, MHS
President, American College of Rheumatology