AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

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September 14, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Sent electronically via regulations.gov

Re: CMS-1848-P [Medicare and Medicaid Programs; CY 2027 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 2027 Physician Fee Schedule and Quality Payment Program proposed rule published in the Federal Register on July 16, 2026.

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, including the 1 in 3 US adults with arthritis, a leading reversible cause of disability. Rheumatologists and rheumatology professionals provide ongoing care for Medicare beneficiaries with complex chronic and acute conditions that require specialized expertise.

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 specialists in treating their patients.

The ACR's comments address the following areas:

1) Comments regarding proposed changes to the CY 26 Physician Fee Schedule:
    a. Conversion factor update
    b. E/M payments for same-day services
    c. E/M visit complexity modifier
    d. Changes to practice expense methodology calculations
    e. Changes to remote monitoring codes
2) Comments regarding proposed changes to the Quality Payment Program:
    a. The promoting interoperability performance category
    b. RFI on MVP scoring methodology

c. RFI on the transition to FHIR-based digital quality reporting
d. Removal of the ACR-12 measure

Comments Re: Proposed Provisions in the CY26 Physician Fee Schedule

Conversion Factor

Nonsurgical physicians have experienced decades of erosion in Medicare reimbursement rates, particularly in demanding cognitive specialties like rheumatology. The proposed fee schedule represents an unusually dramatic decline in reimbursement. The proposed non-APM conversion factor of $32.84 is a decline of 1.68% from the current conversion factor ($33.40). For APM payments, the conversion factor of $33.17 is a decrease of 1.19% from the current conversion factor amid marked US inflation.

These cuts to the conversion factor come at a time when the cost of practicing medicine is rising rapidly – with the Medicare Economic Index (MEI) increasing by 2.7% in 2026 alone and the overall U.S. inflation rate rising by 29% since 2020. [1] [2] At the same time, physicians are confronting new, costly regulatory and administrative burdens with declining gains. [3] The decline in the conversion factor will threaten the viability of independent physician practices and lead to physicians exiting the Medicare program.

Cognitive specialists, like rheumatologists, are particularly vulnerable to declines in reimbursement, as Medicare reimburses physicians more for procedural, than for cognitive care.[4] Rheumatology practices also face disproportionately high overhead due to the need for specialized staff, infusion services, costly drugs, and monitoring equipment. As financial strain increases, some rheumatologists will be 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 US rural and underserved areas where there is already a severe shortage of practicing rheumatologists.

The ACR urges CMS to work with Congress towards a permanent, inflation-adjusted system for Medicare physician reimbursement. Further decreases in the conversion factor are unsustainable.

E/M Payments for Same-Day Services

CMS proposes cutting payment in half for the less expensive service when an evaluation and management (E/M) visit is furnished on the same day as a 0-, 10- or 90-day global surgical procedure. This provision, if implemented, would create yet another reimbursement cut for rheumatologists, while introducing procedures for rheumatologists to schedule E/M services and procedures on separate days, potentially delaying care and creating additional barriers to accessing care for patients.

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[1] https://www.ncci.com/Articles/Pages/Insights-Medicare-Fee-Schedules-and-Workers-Compensation-in-2026.aspx
[2] https://data.bls.gov/timeseries/CUUR0000SA0L1E?output_view=pct_12mths
[3] https://www.acponline.org/advocacy/where-we-stand/2025-acp-priorities/reducing-administrative-burden-in-medicine
[4] https://pubmed.ncbi.nlm.nih.gov/23939411/

In rheumatology, patients with chronic autoimmune and musculoskeletal diseases frequently require comprehensive medical management of complex conditions while also needing an in-office procedure to treat acute manifestations of their disease or rule out dangerous infection. The cognitive work performed during these encounters extends far beyond deciding whether to perform an injection or other procedure. A typical visit includes assessment of disease activity, review of laboratory studies for medication efficacy and toxicity, evaluation of imaging, medication reconciliation, discussion of treatment risks and benefits, adjustment of immunosuppressive or biologic therapy, coordination of ongoing care, and shared decision-making regarding long-term disease management. The procedure itself generally represents only a small portion of the total physician work performed during the visit.

Below are examples of clinical scenarios often encountered by rheumatologists, differentiating the separately identifiable E/M work that may accompany a global surgical procedure:

Clinical Scenario	**Separately Identifiable E/M Work**	**Procedure(s)**
Rheumatoid arthritis with acute knee synovitis	Assessment of systemic disease activity, medication adjustment, review of inflammatory markers	20610 – Knee aspiration/injection (landmark-guided)
Psoriatic arthritis with De Quervain tenosynovitis	Assessment of peripheral arthritis, enthesitis, dactylitis, skin disease, review of biologic response, medication adjustment	20550 + 76942 – Ultrasound-guided tendon sheath injection
Chronic gout with acute first MTP flare	Urate-lowering therapy management, serum uric acid review, flare prevention, medication adjustment	20600 – Small joint aspiration/injection (landmark-guided)
Osteoarthritis with acute worsening of knee pain	Evaluation of acute change in symptoms, assessment of severe pain and new swelling/effusion, examination and evaluation of functional decline	20610 – Arthrocentesis/injection, major joint + 76881- Complete diagnostic ultrasound
Systemic lupus erythematosus with inflammatory shoulder arthritis	Lupus disease activity assessment, complement and anti-dsDNA review, immunosuppressive medication management	20610 – Shoulder injection (landmark-guided)
Sjögren syndrome with flexor tenosynovitis	Assessment of systemic manifestations, medication management, laboratory monitoring	20550 + 76942 – Ultrasound-guided flexor tendon sheath injection
Fibromyalgia with coexisting inflammatory arthritis	Distinguishing inflammatory pain from centralized pain, optimizing medication therapy, counseling regarding multimodal management	20552 – Trigger-point injection(s)
Rheumatoid arthritis with subacromial bursitis	Assessment of RA disease activity, medication efficacy, review of laboratory monitoring, adjustment of DMARD therapy	20611 – Ultrasound-guided subacromial bursa injection

Furthermore, rheumatologists are frequently required to perform biologic infusion procedures to treat rheumatoid arthritis and other autoimmune diseases. Infusion procedures tend to be accompanied by evaluation of disease activity, medication review and other separately identifiable E/M work. Procedures address distinct, acute issues, while the E/M service may involve management of underlying disease, reassessment of the treatment plan, medication changes or consideration of hospitalization. Payment for services should be determined based on medical necessity and the nature of the work required, not the location or timing of the service.

Though CMS claims that this policy would prevent duplicate reimbursement for the same services, existing valuation processes already account for any potential overlap. Further, no evidence supports a uniform 50% reduction in compensation. Modifier 25 exists precisely to distinguish separately identifiable physician work and as CMS itself acknowledges in the proposed rule, this process accounts for overlap when services are furnished together. No rationale or empirical data is provided by CMS for why any potential remaining overlap in services, after existing valuation adjustments to account for this overlap, would warrant a 50% reduction in payment.

CMS proposed a similar policy in the CY 2019 Medicare Physician Fee Schedule but eventually did not implement this policy due to similar stakeholder concerns about potential impact on beneficiary access. The concerns that led to the withdrawal of this policy during this earlier period of rulemaking remain today. As we have already illustrated, physicians face rising costs in their practice expenses and have seen Medicare reimbursement rates decline steeply over the last twenty years.

Independent practices cannot continue to absorb reductions in Medicare payment of this magnitude without consequences. This can mean reducing staff and services, closing locations or limiting access, consolidating with larger health systems or simply no longer accepting Medicare patients. Practice closures are especially significant in rural and underserved communities, where losing even one practice can mean drastically fewer options for Medicare beneficiaries.

To avoid reimbursement cuts, rheumatologists may also feel pressured to schedule procedures and E/M visits on different days. For patients already struggling with chronic autoimmune conditions and potentially required to travel long distances to access care, this can pose a significant added burden.

CMS should remove the proposed payment reduction for same-day E/M services and procedures, as the existing valuation process addresses any genuine overlap.

E/M Visit Complexity Modifier

The proposed rule would replace the current flat G2211 add-on payment for E/M visit complexity with a modifier that increases the payment associated with the E/M service by 16%. Practitioners participating in a Shared Savings Program ACO would receive a larger adjustment.

This methodology may provide a more accurate measure of visit complexity than the existing G2211 add-on code and would generally lead to higher reimbursement (compared to the present system) for high- and moderate-complexity visits.

While the G2211 code generates separate RVUs, the modifier, as presently described, simply scales up existing RVUs, which may lead to individual physicians experiencing a compensation disadvantage, even if the practice that employs them receives more dollars.

The ACR urges CMS to introduce the new modifier through an incremental transition period, to monitor the impact on hospital-based clinicians. If the modifier results in a decline in payment for these clinicians, CMS should incorporate guardrails to prevent this unintended consequence.

Practice Expense Methodology

CMS proposes removing the Indirect Practice Cost Index (IPCI) and changing the indirect practice expense (PE) allocation methodology over a two-year transition period, with changes to the PE RVU code capped at ±5%. **The ACR is in support of modernizing practice expense methods but requests further information from CMS on how the change will impact different specialties. We also request that CMS engage physician stakeholders before finalizing the methodology and provide sufficient data to evaluate unintended consequences.**

Specifically, we would like to see specialty-level modeling of the new practice expense methodology demonstrating the projected impact on rheumatology practices and commonly billed rheumatology procedures. Special attention should be paid to office-based infusion practices and other settings that face substantial indirect practice costs for prior authorizations, care coordination, staff and facilities. Given the magnitude of the potential consequences of methodology changes, we also request that before finalizing the new method, CMS should conduct outreach to physician stakeholders and provide organized opportunities for input, through townhalls or interactive webinars.

Finally, given the paucity of details on the impact of the new methodology on the specialty level, we request that CMS consider extending the two-year transition period, so that physicians fully understand the impact of the new methodology before implementation begins.

Remote Monitoring Codes

CMS proposes limiting remote therapeutic monitoring (RTM) services to established patients and requiring that these services be furnished by staff employed by the practice, rather than contractors. While the ACR agrees that safeguards are needed to prevent inappropriate third-party billing for RTM services, we are concerned that the scale of the restrictions may create barriers to access for remote patients who could benefit most and reduce physician uptake of a promising evidence-based new clinical tools.

Rheumatologists frequently manage complex chronic illnesses and provide longitudinal care for their patients. RTM services can be very helpful in improving medication and treatment adherence and health outcomes, particularly in areas where patients must travel substantial distances to access a specialist.

Many rheumatologists and other cognitive specialists who would like to bill RTM codes do not have the infrastructure in place within their own offices to implement a workflow for these

services. Precluding practices from using third-party contractors to help with service delivery may restrict uptake of these codes. **The ACR requests that CMS include exceptions to the RTM restrictions proposed in the rule, particularly for patients who live in rural areas or areas with specialist shortages.**

Comments Regarding Transition to MIPS Value Pathways

The ACR supports CMS's continued investment in MIPS Value Pathways (MVPs) and appreciates the agency's efforts to create a more streamlined, clinically relevant approach to quality reporting. We recognize the potential of MVPs to improve alignment across quality measures, reduce reporting burden, and support value-based care.

At the same time, the ACR remains concerned that significant changes to reporting pathways could disproportionately affect small and independent rheumatology practices. Many practices have invested substantial resources in existing registry-based reporting workflows and may face considerable operational challenges as reporting requirements evolve. CMS itself notes that clinicians will require time to identify MVPs, establish workflows, and build the necessary reporting infrastructure, particularly as the program transitions toward digital quality measures.

Rheumatology remains a specialty in which nearly half (approximately 45%) of physicians practice in small or independent groups with limited administrative and information technology resources. New reporting requirements may necessitate EHR changes, staff training, workflow redesign, and vendor development efforts that create costs without corresponding benefits to patient care.

While we support CMS's continued investment in MVPs, we urge CMS to prioritize the continued advancement of specialty-specific MVPs. The Advancing Rheumatology Patient Care MVP must continue to evolve to reflect the breadth and complexity of rheumatologic care, as well as advances in treatment and disease management. Rheumatologists manage a diverse patient population with chronic and often lifelong conditions; therefore, a successful rheumatology MVP should support improvements in disease diagnosis, disease control, treatment safety, medication management, and patient-reported outcomes across these populations.

The ACR recommends that CMS:

- Offer targeted education and technical assistance to specialty practices transitioning to MVP participation.
- Assess the impact of policy changes on small and independent specialty practices to avoid unintended consequences and barriers to participation.
- Expand the measure inventory within the Advancing Rheumatology Patient Care MVP to better capture the full spectrum of rheumatic disease management.
- Increase opportunities to incorporate patient-reported outcomes and longitudinal measures that reflect the realities of chronic disease management.
- Collaborate with specialty societies and registries to ensure MVP measures remain clinically meaningful, actionable, and capable of improving patient outcomes.

As CMS advances the Quality Payment Program through MVPs, it is also essential to preserve the role of Qualified Clinical Data Registry (QCDR) measures. Specialty-developed measures

provide meaningful insight into care processes and outcomes that are often not captured by broadly applicable quality measures. For rheumatology, QCDR measures address critical aspects of care, including disease activity assessment, medication safety, monitoring of high-risk therapies, and management of chronic autoimmune conditions. Developed through extensive clinical expertise and real-world testing, these measures are often more meaningful and impactful for improving rheumatologic care than more generic measures.

QCDRs have historically served as an important source of specialty-specific quality measurement innovation. As CMS transitions from traditional MIPS reporting to MVPs, the agency should clarify the future role of QCDRs and specialty-specific QCDR measures to ensure that the transition does not unintentionally limit opportunities for the development, testing, approval, implementation, and adoption of clinically meaningful specialty measures.

Many of the concepts central to high-quality rheumatology care are currently captured through rheumatology-specific QCDR measures available through the RISE Registry. As CMS develops a process and timeline for incorporating QCDR measures into MVP measure sets, we encourage the agency to establish clear, objective, and publicly available criteria for evaluating measures and determining their eligibility for inclusion. Transparent standards and a defined review process will help ensure that high-value specialty measures are consistently incorporated into MVPs and that specialty-specific MVPs continue to evolve alongside advances in clinical practice and patient care.

As MVPs become the primary reporting pathway, CMS has not clearly articulated:

- How specialty-specific QCDR measures will continue to enter the program.
- How MVPs will incorporate new and existing QCDR measures.
- How measure developers should prioritize resources for new QCDR measure development during the MVP transition, given the lack of a defined future pathway.
- Whether specialty registries will have sufficient opportunities to propose measures for inclusion in MVPs.
- The process and timeline for transitioning new or existing QCDR measures into MVP measure sets.

The ACR recommends that CMS:

- Continue allowing specialty-developed QCDR measures to serve as foundational measures within MVPs.
- Establish a transparent pathway for incorporating existing and future QCDR measures into MVPs and future digital quality measurement frameworks.
- Create clear, objective, and publicly available criteria for reviewing and incorporating specialty-specific QCDR measures into MVPs.
- Ensure specialty registries have ongoing opportunities to develop and propose innovative measures that address emerging clinical priorities and gaps in care.

Promoting Interoperability Performance Category: Proposals

We appreciate CMS's ongoing efforts to modernize the Promoting Interoperability (PI) performance category while reducing unnecessary administrative burden on clinicians. We support policies that advance the secure, standardized exchange of health information and

encourage the use of interoperable technology to improve patient care. We are particularly encouraged by CMS's stated goal of updating the PI measure inventory in a manner that promotes meaningful interoperability while reducing reporting burden.

As CMS continues to evolve the Quality Payment Program and transition toward MVP-focused participation, we encourage the agency to prioritize measures that reflect successful information exchange and clinical utility rather than process-oriented attestations that do not directly demonstrate improved patient care or interoperability outcomes. Below are the ACR's comments and recommendations on each of the specific changes proposed to the PI performance category.

Removal of the Security Risk Analysis Measure

We support CMS's proposal to remove the Security Risk Analysis measure from the PI performance category. The Security Risk Analysis requirement is already embedded within broader HIPAA compliance obligations, and its inclusion within MIPS has created duplicative reporting requirements without necessarily providing meaningful insight into interoperability performance. At the same time, we recognize the critical importance of cybersecurity as healthcare becomes increasingly interconnected. Therefore, we encourage CMS to clearly communicate that removal of the measure should not be interpreted as a reduction in cybersecurity expectations.

Electronic Prior Authorization Measure

We support CMS's continued efforts to promote electronic prior authorization and reduce delays in patient care. Prior authorization remains a significant source of administrative burden for practices and can contribute to treatment delays, staff workload, and clinician burnout. CMS's focus on modernization in this area is well founded. However, successful electronic prior authorization transactions depend not only on clinicians and EHR systems but also on payer readiness, technology capabilities, and documented compliance. Clinicians should not be penalized for circumstances outside their control, including limited payer adoption, incomplete implementation of standards, system outages, or inconsistent transaction requirements across health plans.

We recommend that CMS:

- Establish robust exclusions or hardship accommodations when payers do not actively implement these electronic transactions.
- Monitor implementation performance and make scoring adjustments if widespread limitations are identified.

New Electronic Prior Authorization for Prescription Drugs Measure

We support the overall goal of extending electronic prior authorization capabilities to prescription drugs and agree that improved automation has the potential to reduce administrative burden and improve patient access to therapies. Implementation success will depend heavily on the readiness of EHR vendors, pharmacy systems, intermediaries, and health plans. Introducing a new measure before these stakeholders have broadly implemented consistent workflows could create reporting challenges and unintended administrative burden.

We recommend that CMS:

- Implement the measure through a phased approach with defined implementation milestones and timelines.
- Consider an initial reporting period focused on performance monitoring rather than accountability scoring.
- Align technical specifications with existing industry standards to minimize workflow disruption.
- Collect information on real-world implementation, including clinician adoption, EHR and pharmacy system readiness, data availability, workflow impacts, and reporting challenges. This evaluation period would help identify technical or operational barriers and allow refinements to the measure specifications before organizations are subject to full performance scoring, payment implications, or other accountability measures.

CEHRT Definition and Technology Transition Requirements

We understand CMS's proposal to align the definition of Certified Electronic Health Record Technology (CEHRT) with related ONC policies and support efforts to maintain consistency across federal interoperability initiatives. However, clinicians frequently experience delays in receiving software upgrades due to vendor development schedules, implementation timelines, organizational approval processes, and resource constraints. Practices should not face adverse consequences when they have made good-faith efforts to adopt required technology but remain dependent on vendor deployment timelines.

RFI: MVP Scoring Methodology

Support for Exploring MVP-Specific Score Normalization

The ACR appreciates CMS's efforts to ensure fair and meaningful comparisons among clinicians participating in MIPS Value Pathways (MVPs). As MVPs become the primary reporting mechanism under The Quality Payment Program, scoring methodologies must account for the fact that clinicians participating in different MVPs report on distinct measure sets, patient populations, and clinical activities. CMS has proposed sunsetting traditional MIPS after the 2028 performance year, making it increasingly important that scoring methodologies accurately reflect performance within a clinician's specialty or practice setting.

The ACR believes that comparing clinicians within the same MVP may provide a more equitable assessment of performance than comparing clinicians across fundamentally different specialties and measure sets. Rheumatology clinicians treat complex chronic diseases that differ substantially from the management of procedure-based or acute clinical conditions, outcomes, and care processes represented in other MVPs. A scoring methodology that recognizes these differences could improve fairness and strengthen clinician confidence in the program.

Preference for Category-Level Normalization

If CMS chooses to pursue MVP score normalization, the ACR recommends that normalization occurs at the performance category level rather than solely at the final score level.

Normalizing at the category level would provide greater transparency into how performance is evaluated and would better account for differences in measure availability, benchmark distributions, and reporting opportunities within each MVP. Category-level normalization would also allow CMS to identify specific areas where scoring disparities exist and make targeted adjustments over time.

By contrast, normalizing only the final MVP score may obscure important differences across Quality, Improvement Activities, Promoting Interoperability, and Cost performance categories and make it more difficult for clinicians to understand how their results were calculated.

Ensure Specialty Measure Performance Is Not Penalized

Regardless of the methodology selected, CMS should ensure that normalization does not disadvantage clinicians reporting specialty-specific measures, including QCDR measures.

Many rheumatology measures focus on complex patient populations, longitudinal disease management, treatment safety, and outcomes that may not achieve the same performance distributions as measures used in other specialties. Normalization methodologies should recognize these differences and avoid creating incentives for clinicians to choose reporting pathways based on scoring advantages rather than clinical relevance.

The ACR encourages CMS to evaluate whether proposed normalization approaches:

- Preserve incentives for specialty-specific quality measurement.
- Maintain the value of specialty-specific QCDR measures.
- Avoid penalizing clinicians caring for medically complex patients with chronic conditions.
- Promote meaningful quality improvement rather than pathway selection strategies.

The ACR supports testing a revised MVP scoring methodology prior to full implementation. Given the significance of this change, CMS should consider a voluntary pilot or informational "shadow scoring" period before applying normalized scores to payment adjustments. This approach would allow clinicians, registries, and specialty societies to better understand the methodology, evaluate unintended consequences, and provide operational feedback.

A pilot period conducted while traditional MIPS remains available would provide valuable implementation experience and help CMS refine the model before it becomes the basis for payment adjustments across all MVP participants.

RFI: Transition to FHIR-Based Digital Quality Reporting

The ACR appreciates CMS's efforts to advance interoperable, standards-based quality measurement through the adoption of Fast Healthcare Interoperability Resources (FHIR). We support the long-term goal of reducing reporting burden through more automated and standardized data exchange and recognize the potential for FHIR-based reporting to improve

data quality, consistency, and timeliness. As a CMS-approved Qualified Clinical Data Registry (QCDR) that relies extensively on electronic health record (EHR) data to support quality measurement and reporting, the ACR strongly supports modernization efforts that improve interoperability and facilitate more efficient reporting workflows.

The ACR supports CMS's proposal to establish a transition period beginning with the CY 2028 performance period that allows existing reporting mechanisms to remain available while FHIR-based reporting capabilities mature. A phased implementation approach will provide clinicians, specialty societies, EHR vendors, and registries the opportunity to test workflows, validate data quality, identify operational challenges, and educate physicians and other health professionals on documentation and workflow changes necessary for successful adoption before FHIR-based reporting becomes mandatory. Maintaining existing reporting options during the transition period will help ensure continued participation in quality reporting while stakeholders work toward broader adoption of FHIR standards.

Given the diversity of EHR systems used within rheumatology practices, significant variability remains in the maturity of FHIR implementation across vendors and healthcare organizations. Based on the ACR's experience supporting FHIR-based data ingestion across numerous EHR systems, we have found that a vendor's claim of being "FHIR-enabled," "USCDI-conformant," or "ONC-certified" is a necessary but insufficient indicator that the data required for quality reporting will be available in a complete, consistent, and computable format. Certification confirms the existence of standardized APIs but does not guarantee that required quality measure data elements are populated, semantically consistent across organizations, or accessible without additional technical development, licensing costs, or vendor intervention.

In practice, substantial variability exists both across and within EHR platforms. Organizations using the same certified EHR product may expose different FHIR capabilities based on local configuration, implementation choices, licensing arrangements, and adoption of optional resources and profiles. While patient-level USCDI-based read access is increasingly mature, the data required for digital quality measurement often extends beyond the USCDI floor and includes specialty-specific clinical data, administrative and billing information, patient-reported outcomes, disease activity assessments, medication monitoring data, and laboratory results that may not be consistently available through FHIR APIs.

Challenges

The ACR's implementation experience highlights several practical challenges that certification alone does not address. For example:

- A widely used ambulatory EHR advertised FHIR API connectivity, but the specific resource needed to support quality reporting returned repeated errors and required multiple vendor-side product updates before data could be reliably retrieved.
- A specialty-focused EHR could not expose the billing and administrative codes necessary to calculate measure denominators through its FHIR interface, requiring the registry to establish a separate data acquisition pathway to obtain the information needed for accurate quality measurement.
- Several practices experienced prolonged delays in establishing data exchange despite the availability of certified FHIR capabilities because of environment-access constraints,

implementation issues, and vendor readiness challenges that required substantial remediation before connections could be activated.

These experiences demonstrate that successful API connectivity does not necessarily translate into successful quality measurement. Required clinical data elements may be inconsistently documented, stored in unstructured formats, unavailable through standard FHIR endpoints, or require significant normalization, mapping, and validation before they become suitable for quality reporting.

While the ACR supports the ultimate transition to FHIR-based reporting, we encourage CMS to modify implementation timelines by demonstrated ecosystem readiness rather than a fixed date alone.

Successful adoption will require:

- Consistent FHIR implementation across EHR vendors and healthcare organizations.
- Reliable support for specialty-specific clinical data elements and QPP reporting requirements.
- Adequate testing and validation of data completeness, accuracy, and computability.
- Inclusion of QCDR and specialty measure requirements within FHIR implementation guides and digital quality measure specifications.
- Sufficient time for registry, vendor, and health system development activities.
- Significant modernization and alignment of existing Quality Payment Program measures for digital reporting.
- Comprehensive education and training for health professionals regarding documentation expectations and workflow changes needed to support digital quality measurement.
- Demonstrated vendor readiness and sufficient operational support for active production-scale implementation.

Before mandatory implementation, CMS should verify that FHIR-based reporting can support clinically meaningful specialty data elements at a level comparable to existing QPP reporting methods. Digital quality measurement depends not only on the existence of FHIR APIs, but also on the availability of complete, accurate, and computable data across diverse care settings.

As CMS advances digital quality measurement, the ACR encourages the agency to ensure that specialty registries and QCDRs remain integral participants in the reporting ecosystem. Registries have served as an important bridge between EHR systems and federal quality programs by enabling automated data extraction, benchmarking, quality improvement, and reporting across diverse clinical environments. Future FHIR-based reporting policies should leverage, rather than replace, the infrastructure, expertise, and data validation capabilities developed by specialty registries.

Recommendations

CMS should specifically ensure that:

- Quality measures can be supported through FHIR-based reporting approaches across the diverse EHR landscape, including both small community-based practices and large academic health systems.

- QCDR-developed measures are incorporated into digital quality measure development efforts.
- Registries have access to technical guidance, implementation resources, and testing opportunities throughout the transition period.
- Specialty-specific clinical concepts are adequately represented within FHIR standards, implementation guides, and certification requirements.
- Certification and interoperability requirements evolve to better align with the real-world data needs of quality measurement and reporting programs.

Further Considerations

Therefore, the ACR recommends that CMS implement a robust piloting, testing, and validation strategy prior to mandatory adoption. Specifically, CMS should consider:

- Voluntary reporting periods before mandatory implementation.
- Parallel reporting pathways that allow comparison of FHIR-derived and existing reporting results.
- Vendor readiness and implementation assessments.
- QCDR participation in testing and validation initiatives.
- Public reporting of implementation findings, lessons learned and identified barriers.
- Ongoing evaluation of clinician burden, workflow impacts, and data quality outcomes.

This approach would allow stakeholders to identify discrepancies, improve data quality, address implementation barriers, and reduce the risk of unintended consequences before FHIR-based reporting directly affects performance scores or payment adjustments. By prioritizing demonstrated readiness, robust testing, health professional education, and continued engagement with specialty registries and QCDRs, CMS can accelerate the successful adoption of digital quality measurement while maintaining the integrity, accuracy, and clinical relevance of quality reporting programs.

Removal of ACR12 Measure

The American College of Rheumatology (ACR) strongly opposes the proposed removal of ACR12 from the Rheumatology Care MVP.

First, removing ACR12 further reduces the already limited number of specialty-relevant measure options available to rheumatologists participating in MIPS Value Pathways. The MVP framework was intended to streamline reporting while preserving meaningful opportunities for specialists to demonstrate the quality of care they provide. Eliminating ACR12 removes the only psoriatic arthritis measure and narrows measure choice and places rheumatologists at a disadvantage by limiting their ability to select measures that best align with their patient populations, clinical workflows, and quality improvement priorities. In a specialty such as rheumatology, where the number of applicable quality measures remains relatively small and the diseases treated vary considerably in their clinical manifestations and management approaches, maintaining a robust portfolio of measure options is particularly important.

Second, we believe the proposed removal is premature. The ACR communicated all MVP measure changes to CMS in April and did not receive feedback indicating concerns with ACR12

prior to publication of the proposed rule. Had the concerns regarding the measure's specifications or implementation been communicated to us earlier, the ACR would have been well-positioned to update and strengthen the measure. As the measure steward, the ACR remains committed to continuous improvement and can make the necessary modifications for future performance years to address CMS concerns while preserving an important rheumatology-specific quality measure. Removing the measure eliminates an opportunity for iterative improvement and creates unnecessary disruption for clinicians who have incorporated the measure into their quality reporting programs.

We respectfully request that CMS retain ACR12 in the Rheumatology Care MVP for the upcoming performance year and work collaboratively with the ACR on refinements for future rulemaking. Preserving measures while updates are developed would support clinician participation, maintain specialty-relevant measure choice, and help ensure that quality assessment within rheumatology reflects the breadth and complexity of the conditions that rheumatologists treat.

Please contact Sweta Haldar, MSPH, ACR Manager of Regulatory Affairs, at shaldar@rheumatology.org or (202) 807-5262 should you have any questions or if we can provide additional assistance.

Sincerely,

William F. Harvey, MD, MSc, FACR
President, American College of Rheumatology