September 12, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically via http://www.regulations.gov

Executive Summary: On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we appreciate the opportunity to provide feedback on the CY2026 Medicare Physician Fee Schedule (CMS-1832-P).

- **Conversion Factor:** AAOS is pleased that CMS has proposed a positive conversion factor (CF) update for the first time in six years. However, the conversion factor is still historically low and not enough to relieve the significant financial pressures that have been building on physician practices for two decades, particularly after incurring 2.83% cut in 2025. These trends are especially problematic for independent physicians dedicated to providing high-quality care in their local communities. Ensuring stable and adequate reimbursement is essential for sustaining practice viability, investing in practice improvements, and ultimately ensuring that Medicare beneficiaries have access to the high-quality care they need.
- **Practice Expense RVUs:** AAOS asks that CMS not implement a 50% reduction to the indirect PE RVUs for facility-based services in CY2026. Instead, we encourage CMS to work with the AMA and other stakeholders to incorporate data from the 2024 PPI Survey into a new comprehensive MEI weighting update as discussed in more detail below.
- **Evaluation and Management Codes**: AAOS strongly urges CMS to revisit the budget neutrality assumption for G2211, making a prospective budget neutrality adjustment to the 2026 CF in the forthcoming PFS Final Rule for 2026 based on the claims data from 2024.
- **“Efficiency Adjustment”:** AAOS strongly opposes the proposed –2.5% “efficiency adjustment” as we disagree with CMS’ assumption that all services should automatically become more efficient over time. If CMS insists on finalizing the “efficiency adjustment” against the advice of AAOS, we ask that it not be applied to codes that have been newly created or revalued in the past five years as they have already undergone comprehensive study and review to account for efficiencies.

- **Ambulatory Specialty Model:** AAOS appreciates that CMMI has proposed a model that is specialist-led and seeks to incentivize better upstream care for patients with chronic conditions. However, AAOS believes the design of the model as it will apply to orthopaedic surgeons treating low back pain is deeply flawed and, therefore, cannot support its implementation as proposed. The issues are myriad and range from problems with the attribution and scoring methodologies to an inability to meaningfully impact care systems. While we wholeheartedly agree with the strategy of creating specialist led models for impactful change in musculoskeletal care across the population, starting with this model will be both unsuccessful in achieving CMS' goals and will likely sour future attempts to push these important goals forward. Accordingly, we respectfully request, that in light of the concerns outlined below, CMS withdraw the model from consideration in its current form and work with AAOS to improve the model's design.
- **Qualified Clinical Data Registries:** AAOS supports CMS' proposal to clarify that, beginning with the CY 2026 performance period, Qualified Clinical Data Registries (QCDRs) must be ready to support MVPs that are applicable to the MVP participant on whose behalf they submit data one year after finalization of the MVP.

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Dear Administrator Oz,

On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), and the orthopaedic specialty societies and state societies that agreed to sign on, we are pleased to provide comments in response to the Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS 1832-P) published in the Federal Register on July 16, 2025. AAOS appreciates the ongoing efforts of the Centers for Medicare & Medicaid Services (CMS) to create a health care system that results in better access to care, quality, affordability, and innovation.

CY2026 Conversion Factor Update

AAOS is pleased that CMS has proposed a positive conversion factor (CF) update for the first time in six years. CMS proposed that for CY2026, Advanced Alternative Payment Model (APM) Qualifying Participants (QPs) will receive a CF of $33.59, an increase of 3.83% from the current CF, while non-QP clinicians will receive a CF of $33.42, an increase of 3.30% from the current CF. However, these conversion factors are still historically low and not enough to relieve the significant financial pressures that have been building on physician practices for two decades. In CY2025, physicians absorbed a 2.83% cut to the conversion factor, the fifth year in a row of cuts. The small increase proposed for CY2026, which is substantially reliant on a 2.5% boost to the conversion factor formula from Congress that expires on December 30, 2026, does little to mitigate the financial pressures practices have felt because of Medicare's flawed physician annual update methodology.

AAOS and many other organizations representing physicians have come together to advocate for fundamental
reforms to the Medicare PFS including adoption of a mechanism for tying the conversion factor to underlying economic conditions such as the Medicare Economic Index (MEI). Until physician payments are automatically tied to inflation, as is already done in the facility prospective payment systems through market baskets, physicians will struggle to maintain access to care for Medicare beneficiaries. As acknowledged in the 2025 Medicare Trustees' Report:

> [P]hysician payment update amounts are specified for all future years. These amounts do not vary based on underlying economic conditions, and they are not expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. ...If the health sector cannot transition to more

> efficient care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries will, under current law, fall over time compared to that received by those with private health insurance.[1]

These trends are especially problematic for independent physicians dedicated to providing high-quality care in their local communities. Many independent physicians have already agreed to be acquired by larger hospital systems, health insurers, or private equity, and AAOS is committed to advancing policies that slow the rate of further consolidation. **Ensuring stable and adequate reimbursement that encourages competition is essential for sustaining practice viability, investing in practice improvements, and ultimately ensuring that Medicare beneficiaries have access to the high-quality care they need.**

Determination of PE RVUs

Adjusting RVUs To Match the PE Share of the MEI

CMS reiterated that to ensure PFS payments reflect the relative resources in each of the PFS components - work, practice expense (PE), and malpractice (MP) - the RVUs used in developing rates should reflect the same weights in each component as the cost share weights in the MEI. AAOS respects CMS' desire to rebase and revise the MEI to reflect current market conditions faced by physicians in furnishing physicians' services. To that end, AAOS supported the American Medical Association's (AMA) 2023 Physician Practice Information Survey (PPIS) to collect the most up to date and accurate data on physician practice costs and hours. We are disappointed that CMS chose not to incorporate this PPIS data in PFS rate setting in this proposed rule. We appreciate that CMS is willing to work with the AMA and other stakeholders to address the agency's concerns and strongly encourage the agency to do so. It is critically important that the real-world experiences of practicing physicians inform CMS policy to reimburse physicians for their work. AAOS agrees with CMS that other sources of data can and should complement the PPIS data, but AAOS feels strongly that excluding the PPIS data entirely when determining new MEI cost share weights would negatively impact physicians. **We ask that CMS delay any modification to the MEI cost share weights, and by extension, the indirect practice expense methodology until the 2024 PPI survey data can be included in said methodology.**

[1] https://www.cms.gov/oact/tr/2025 p.3

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

For CY2026, CMS is proposing to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs. AAOS opposes this change as currently proposed because it will dramatically and inappropriately reduce payments to orthopaedic surgeons for services delivered to Medicare beneficiaries while not achieving CMS' stated goals of protecting private practices and preventing duplicative payments.

CMS is correct to point out that the practice of medicine has shifted from most physicians fully or partially owning solo or group practices to a significant portion of physicians working as employees of health systems, insurance conglomerates, or private equity-backed entities. This trend is due to many factors including inadequate physician reimbursement due to the lack of an automatic inflation adjustment in the PFS as discussed above, consolidation of health systems, consolidation of insurance conglomerates, the impact of the COVID-19 pandemic on the practice of medicine, and many others.

AAOS is proud that despite these challenges, 54% of orthopedic surgeons are still in private practice, the second highest percentage of all physician specialties.[2] However, just because an orthopaedic surgeon is in private practice does not mean they perform a higher percentage of their work in an office setting. Due to the nature of orthopaedic surgery, most procedures cannot be performed in an office setting. By indiscriminately halving PE RVUs for all facility claims, rather than using a more refined and targeted approach, CMS is dramatically reducing reimbursement for orthopaedic surgeons, including those working to keep their private practices afloat. According to CMS' own calculations in Table 92, orthopaedic surgeons will see a -3% cut to total allowed charges which breaks down to a –9% cut to payments for services furnished in a facility and +5% increase to payments for services furnished in a non-facility (i.e., office) setting. Since orthopaedic procedures trend heavily toward facilities, the increase to non-facility payments will not be able to offset the facility cuts. CMS' Granular Specialty Impact Analysis (PFS) table shows that 66% of orthopaedic surgeons will see their RVUs reduced by at least –1%, with 30% of orthopaedic surgeons facing a cut of –5% or more. Only 17% of orthopaedic surgeons will see an increase greater than +1%. These cuts are not sustainable, will be extremely difficult for private practices to absorb, and will ultimately result in patients having less access to orthopaedic surgical care.

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[2] https://www.ama-assn.org/practice-management/private-practices/smaller-share-doctors-private-practice-ever

CMS also states a goal of this policy is to prevent duplicative payments for indirect costs in facilities. First, physicians are still responsible for many costs, whether independent or employed by hospital systems, including scheduling and coding. Additionally, even for employed physicians, hospitals often charge back indirect costs to physicians via their departments. When that is not the case, however, CMS does not provide any evidence that when the hospital is the billing entity for the professional services of an employed surgeon that it does not incur the indirect costs simply because the surgeon is employed. Cases must still be scheduled. Coding experts in physician services must still be hired. Billing staff must still be employed. These are costs that might be borne by a different entity when a physician becomes employed, but the incremental costs that surround the services provided by the physician do not disappear (as evidenced by the example above where some hospitals charge back the indirect costs to the physician). Therefore, it is important that the payment for professional services delivered by physicians continue to reflect adequate indirect cost reimbursements and paying at 50% of the current rate as CMS proposes is not sufficient.

AAOS asks that CMS not implement a 50% reduction to the indirect PE RVUs for facility-based services in CY2026. Instead, we encourage CMS to work with the AMA and other stakeholders to incorporate data from the 2024 PPI Survey into a new comprehensive MEI weighting update as discussed above. If CMS insists on proceeding with this new indirect PE RVU methodology in CY2026, we ask that CMS increase the allocator from the currently proposed 50% to at least 75%, and that this new methodology be phased in over at least four years, keeping with CMS' thoughtful history of phasing in other major changes to the PE methodology. Simultaneously, we urge CMS to work with relevant stakeholders including AAOS and other physician organizations to develop a more appropriate methodology for evaluating and properly reimbursing the indirect PE expenses of employed physicians.

Valuation of Specific Codes

Methodology for Establishing Work RVUs - Proposed "Efficiency Adjustment"

CMS is proposing to apply a –2.5% "efficiency adjustment" to the work RVUs and physician intraservice time for most codes representing non-time-based-services based on the assumption that physicians should get more efficient at performing these procedures over time. CMS arrived at –2.5% by adding the productivity adjustments in the MEI over the past five years, even though physician payments are not tied to MEI like hospital payments. According to Table 92, this adjustment will result in a –1% cut to the allowed charges for orthopaedic surgeons and many other specialists.

AAOS strongly opposes this proposed "efficiency adjustment" as we disagree with CMS' assumption that all services become more efficient over time. In fact, a recently released study from

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the American College of Surgeons[3] found that from 2019 to 2023 operative times have been increasing, measures of patient complexity have been increasing, and operative mortality has remained steady. ACS used the National Surgical Quality Improvement Program (NSQIP) registry to analyze about 1.7 million operations across 249 CPT codes with at least 1,000 underlying cases across 11 surgical specialties in 2019 and 2023. The study concluded that, "Overall, operative times increased by 3.1% (CI 3.0-3.3%, p<0.001) in 2023 compared to 2019, or 0.8%/year (CI 0.7-0.8%/year, p<0.001). At the procedure level, 90% of CPT codes had longer or similar operative times in 2023 compared to 2019." This study, using empirical non-survey data, directly refutes CMS' assumption that non-time-based-services are gaining significant efficiencies over time. Rather, operative times are increasing as patients become more complex, which technological advances and mastery of procedures cannot easily alter.

AAOS is also concerned that this proposed "efficiency adjustment" will have unintended consequences. Under the assumption that these non-time-based-services will continue to gain efficiencies, CMS proposes to update and apply an efficiency adjustment every three years in perpetuity. As these adjustments compound, payment cuts will become larger and more untenable, leading to more, not less physician consolidation when private practices struggle to absorb the cuts. These cuts will also be felt by employed physicians as many of their contracts with health systems are based in whole or in part on work RVUs. Physicians are already struggling with the past several years of cuts to the conversion factor and lack of an inflation adjustment, and the "efficiency adjustment" will further destabilize this already fragile payment system.

AAOS also highly questions CMS' decision to make no accommodations in this policy for new codes or recently revalued codes. CMS goes so far as to accept new values for codes in the CY 2026 proposed rule and *then* still apply the so called "efficiency adjustment" to something that CMS has approved a new value for with new intraservice times. We are perplexed as to why CMS would not exclude those codes from the "efficiency adjustment" if it were truly interested in accuracy. While AAOS opposes the premise of the "efficiency adjustment" altogether, if CMS were to proceed with it, AAOS asks CMS to exclude codes that have recently been revalued or newly created. As CMS is aware, the RUC will be reviewing several high-volume codes in September 2025 due to site-of-service changes from inpatient to

[3] Childers, Christopher P MD, PhD; Foe, Lauren M MPH; Mujumdar, Vinita JD; Mabry, Charles D. MD, FACS; Selzer, Don J MD, MS, FACS; Senkowski, Christopher K MD, FACS; Ko, Clifford Y MD, MS, MSHS, FACS, FASCRS; Tsai, Thomas C MD, MPH, FACS. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. Journal of the American College of Surgeons ():10.1097/XCS.0000000000001588, August 13, 2025. | DOI: 10.1097/XCS.0000000000001588

outpatient facilities, including total hip, knee and shoulder replacement procedures. AAOS has been working closely with the appropriate subspecialty societies in the House of Orthopaedics to ensure the integrity and accuracy of all data that will be considered in this revaluation process. The effort organizations expend on these efforts is tremendous. Yet by virtue of CMS' proposal to apply this "efficiency adjustment" to newly valued codes (and to do so in perpetuity) is essentially CMS saying, "It doesn't matter what you believe is an accurate value or what you come up with. Even if we agree with you, we are going to cut you by approximately 1.5% every 3 years." **If CMS insists on finalizing the "efficiency adjustment" against the advice of AAOS, we ask that the "efficiency adjustment" not be applied to codes that have been newly created or revalued in the past five years as they have already undergone comprehensive study and review to account for efficiencies.**

Proposed Valuation of Specific Codes for 2026

Great Toe Arthrodesis (Codes 28750, 28755)
Code 28750 was identified by the AMA Relativity Assessment Workgroup for "different performing specialty from survey screen" where the top specialty performing over 50% of the Medicare claims did not participate in the original survey. Code 28755 *(Arthrodesis, great toe; interphalangeal joint)* was added as a family code having never been surveyed as it was a Harvard valued code.

AAOS appreciates CMS accepting the RUC-recommended RVUs and practice expense inputs for code 28750. However, CMS disagrees with the RUC-recommended RVU of 7.50 for code 28755 and instead proposes a work RVU of 6.76 using a crosswalk to code 28122 *(Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus).*

CMS states that the RUC-recommended valuation would place 28755 above the median range when compared to other 90-day codes with similar work times. As such, code 28122 was used as a crosswalk as it shares the same intraservice work time and has similar total time.

AAOS disagrees with CMS' recommendation for code 28755 as well as the crosswalk to code 28122. Code 28755 is a more intense and complex procedure which requires significantly more complex intraoperative work than code 28122. Code 28122 is an excision procedure where portions of bone are excised. Whereas code 28755 is an arthrodesis procedure which requires meticulous exposure of the articular surfaces for fusion. The physician must carefully remove all the joint cartilage. Congruent apposition needs to be achieved with stable fixation placed to provide compression. At the completion of the procedure, the physician must assure that there is good opposition of the bone surfaces and proper

alignment of the long axis of the toe. The time, technique and degree of accuracy required for this procedure far exceeds the complexity of the exostectomy described by code 28122.

Lastly, the post-op care is much more intensive to ensure bony union. Code 28755 requires more immediate post-operative time and a higher level of post-operative visits. For these reasons, **AAOS urges CMS to accept the RUC recommended work RVU of 7.50 for CPT code 28755.**

Evaluation and Management (E/M) Visits

AAOS remains concerned that use of HCPCS code G2211 (office/outpatient evaluation and management (E/M visit complexity add-on code) results in overpayments and has necessitated reductions in the Medicare conversion factor to maintain budget neutrality under the MPFS. AAOS urges CMS to revisit the utilization assumption for G2211.

In CY2024, CMS finalized code G2211, which provides an add-on payment for complex patients with existing office/outpatient evaluation and management (E/M) visits. AAOS opposed implementation of the code despite CMS' proposal to refine its policy on its use and payment allowance of the O/O E/M visit complexity add-on code when the O/O E/M base code is reported on the same day as an Annual Wellness Visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting. While AAOS appreciated CMS' efforts, concerns were raised regarding the Modifier -25 restriction, complicating billing for complex cases involving preventive services.

Furthermore, the CMS assumption used for the budget neutrality adjustment is at 38%. According to 2024 Medicare utilization data, the utilization assumption is 11.2% which is far below the CMS assumption. The result of this overestimate is an unwarranted cut to the Medicare Conversation Factor as CMS implemented G2211 in a budget neutral manner as it expected there would be increased Medicare spending. The budget neutrality adjustment in the CY2024 Final Rule resulted in a 2.18% decline to the 2024 CF, but the actual 2024 claims data suggest this should have been a 0.79% decline. Therefore, the 2024 budget neutrality adjustment cut was three times as large as it should have been, unnecessarily removing $1 billion from the PFS.

AAOS strongly urges CMS to revisit the budget neutrality assumption for G2211, making a prospective budget neutrality adjustment to the 2026 CF in the forthcoming PFS Final Rule based on the claims data from 2024.

Strategies for Improving Global Surgery Payment Accuracy

CMS continues to express concerns about the accuracy of 10 day and 90 day global surgical bundles and is seeking comments on strategies to improve these payments, including through the transfer of care policies finalized in the CY2025 PFS. CMS has proposed three alternative methods for determining procedure shares of global bundles when the surgeon who performed the procedure does not perform the follow-up visits. The first approach is premised on CMS' data collection effort involving the use of reporting CPT 99024 that the HHS OIG called "inaccurate and cannot assist in improving global surgery valuation as Congress intended." AAOS is perplexed as to why CMS would even include that approach in the proposed rule given that the effort clearly failed when subjected to audit. One of the other methods would base the calculations on work RVUs and the last method would base the calculations on physician time. AAOS does not believe any of these three alternative methods are appropriate. AAOS continues to support the current procedure share ratios triggered by the use of modifier –54.

AAOS continues to oppose CMS's failure to incorporate the RUC-recommended work and time incremental increases for the inpatient hospital and observation care visit codes (99231-99233, 99238, 99239) and office/outpatient visit E/M codes (99202-99215) into all global surgical codes. Again, we strongly urge CMS to apply the RUC-recommended changes to the E/M component of the global codes to maintain the relativity of the Fee Schedule. CMS' failure to do this has made the files on which it relies for its "time" and "work RVU" approaches to re-assessing the "procedure shares" of the global surgical package fraught with inconsistencies and a poor source of information to utilize for this purpose.

Ambulatory Specialty Model

AAOS appreciates that CMMI has proposed a model that is specialist-led and seeks to incentivize better upstream care for patients with chronic conditions. However, AAOS believes the design of the model as it will apply to orthopaedic surgeons treating low back pain is deeply flawed and, therefore, cannot support its implementation as proposed. The issues are myriad and range from problems with the attribution and scoring methodologies to an inability to meaningfully impact care systems. While we wholeheartedly agree with the strategy of creating specialist led models for impactful change in musculoskeletal care across the population, starting with this model will be both unsuccessful in achieving CMS' goals and will likely sour future attempts to push these important goals forward. Accordingly, we respectfully request, that in light of the concerns outlined below, CMS withdraw the model from consideration in its current form and work with AAOS to improve the model's design.

AAOS believes that participation in value-based care should be voluntary, and we are disappointed that a subset of orthopaedic surgeons who treat low back pain will be mandated to participate in this model. Specifically, a geographic subset of orthopaedic surgeons who are attributed at least 20 episodes of care under the MIPS Low Back Pain Episode Based Cost Measure (LBP EBCM) will be required to participate in the model. CMS noted in its proposal that 35% of specialists who would be required to participate in ASM would only be attributed 20-29 low back pain episodes. We believe this may be due to CMS including specialists in the model who are not typically attributed under the LBP EBCM. For example, the measure generally attributes patients to providers such as chiropractors and physical therapists, who are excluded from the model. As a result, very few orthopaedic surgeons are likely to meet the case minimum for the LBP EBCM, and those who do would still treat only a small number of relevant patients. By using the LBP ECBM to assign physicians to the ASM low back pain cohort, CMMI is targeting a very small number of orthopaedic surgeons treating a very small number of patients, yet putting the entirety of the orthopaedic surgeon's Medicare Part B payments at risk of a 9-12% reduction. Because low patient volumes can create volatility in performance results, a single abnormally high-cost case could disproportionally penalize a participant. If CMS proceeds with using the LBP EBCM, AAOS recommends that the attachment threshold be increased to 50 attributed patients under the LBP EBCM. AAOS also recommends that the model be open to physicians in all CBSAs to ensure that there is a fair evaluation and comparison on performance of quality measures for a larger group of model participants. Finally, we ask that CMS consider excluding from ASM CBSAs in New Jersey, Ohio, Oklahoma, Texas, Arizona and Washington as these states will also be subject to CMS' new Wasteful and Inappropriate Service Reduction (WISeR) Model. WISeR is also heavily focused on items and services used to treat low back pain and we are concerned that requiring physicians to participate in two new models simultaneously could significantly increase financial and administrative burden, especially for physicians in small private practices or in rural areas.

Additionally, the LBP EBCM is initially attributed to a group practice based on taxpayer identification number (TIN) and then further attributed to individual clinicians who provide at least 30% of the total number of qualifying services during the episode based on national provider identifier number (NPI). This means that even though specialists are required to participate in ASM at the individual level, they could be held financially responsible for patients primarily treated by other physicians or non-physician providers in their practice. Therefore, we believe it is appropriate for physicians to have the option of participating in ASM as a group with other physicians in the same TIN, as is permitted in MIPS and MVPs, for all of the patients that are attributed to the TIN.

In reviewing Table 37, CMS states that an analysis of 2023 data for the Low Back Pain EBCM found that 90% of patients treated for low back pain by orthopaedic surgeons did not undergo spine surgery as treatment. Such data highlights the deliberate efforts already undertaken by orthopaedic surgeons to

thoughtfully treat low back pain in a way that maximizes quality and savings. We are concerned that this proposed model continues to look at narrow aspects of the care for chronic conditions instead of assessing the entire scope of care across clinician types and interventions. For example, by requiring orthopaedic surgeons to participate but not primary care providers or physical therapists, significant portions of the care and services ordered and expensed to treat low back pain are omitted from the model's window of care. We are curious as to why CMS would recognize this distinction in the heart failure episode where proceduralists are excluded, but not in the low back pain episode. As evidenced, proceduralists are limited contributors to the overall costs of managing these chronic conditions. Toward that end, we suggest that for there to be meaningful assessment of the full spectrum of care, any model must include financial incentives for primary care providers to partner with cross-functional teams of specialists responsible for treating the symptoms and causes of low back pain. ASM as currently designed is too narrow to meaningfully improve quality and reduce costs of treating low back pain.

We are also concerned that significant confusion may be caused by certain policies related to quality reporting requirements. These include the required reporting on the Promoting Interoperability (PI) for hospital-based clinicians who would otherwise be exempt from this under traditional MIPS and would likely lead to a negative impact. Similarly, the requirement to report on more quality measures than what is required of MVP participants seems like an undue burden in light of the mandatory nature of the model and the limited applicability of the measures to orthopaedic surgeons in the low back pain cohort. Moreover, we are concerned the quality measures selected for the Low Back Pain cohort are not measures included in the orthopaedic specialty set. This misalignment is likely to create unnecessary burden and confusion among participating orthopaedic surgeons who may be unfamiliar with these measures. It further underscores why the model, in its current design, is not appropriate for including orthopaedic surgeons as mandatory participants.

The ASM scoring methodology is also cause for serious concern. Physicians can only receive positive points for the cost and quality categories, while practice improvement and meaningful use are at best neutral and at worst a 20% negative adjustment. This is highly problematic when considering the burden participants will face to achieve the improvement activities requirement of entering into a formal collaborative care arrangement with a primary care physician. Additionally, since there is no performance threshold, and participants are scored only on how they compare to the other physicians in their cohort, physicians will not be able to gauge where they will land. This methodology also means the goalposts move every performance year, so even if a physician improves from year one to year two, the physician may still receive a penalty if others in the cohort improve more. This is unfair to the physicians, and will make multi-year strategic planning difficult, especially for independent practices. The scoring equation will also push participants toward extremes at the ends of the range +/- 9% to +/- 12% two-sided risk range, higher than the maximum penalty under MIPS, rather than using a mean

methodology that clusters toward the center of the scoring range which is different than other CMMI models. Lastly, CMS proposes to withhold 15% of the incentive pool for Medicare savings which further reduces payments to physicians already struggling with prior cuts and lack of an annual inflation adjustment in the PFS. These methodological decisions will harm all physicians mandated to participate in ASM without improving the quality of care patients receive.

In sum, our vast concerns with the proposed implementation of the Ambulatory Specialty Model lead us to request that CMS withdraw this model in its current form and work with us to improve the model design in ways that will more effectively improve the quality and reduce the cost of treating low back pain.

AAOS has developed and previously discussed with CMMI a specialty-care focused model that is intended to incentivize the uptake of surgeon-led, condition-based bundled payments for comprehensive musculoskeletal care. The model proposes a mechanism for interaction between primary care providers and musculoskeletal multi-specialist teams that we believe will help support more comprehensive musculoskeletal care earlier in patients' disease or condition progression by including bundle triggers that occur prior to the need for surgical interventions. We believe our proposal aligns with CMMI's principles of improving outcomes, decreasing costs, and empowering patients and physicians to collaborate for better health. This model envisions a healthcare system that is proactive, patient-centered, and driven by evidence-based best practices. It emphasizes prevention, effective care through delivery of high-value services, and aligning incentives to optimize outcomes and control costs. Unlike ASM, AAOS' proposal will engage all necessary medical professionals to manage chronic musculoskeletal conditions and evaluate them using quality and cost metrics that reflect their expertise and effectiveness in providing this care.

Updates to the Quality Payment Program

MVP Subgroup Reporting

AAOS appreciates that CMS is proposing, beginning with the CY 2026 MIPS performance year, to increase flexibilities for multispecialty group practices that also meet the requirement to be small group practices. With this proposal, these groups would not be required to divide and report as subgroups. We believe that this change would increase the reporting options and thus improve participation among small multi-specialty groups. Likewise, we appreciate that CMS is proposing to offer self-attestation for multi-specialty groups instead of relying on claims data.

Third-Party Intermediaries

AAOS supports CMS' proposal to clarify that, beginning with the CY 2026 performance period, Qualified Clinical Data Registries (QCDRs) must be ready to support MVPs that are applicable to the MVP participant on whose behalf they submit data one year after finalization of the MVP. This change will allow time for QCDRs to substantially support their MIPS participants and improve their role as a meaningful quality reporting partner.

Core Elements Request for Information

While we understand and support CMS' goal of creating a meaningful quality reporting system that allows patients to select the best quality providers and make informed decisions, we must caution against the proposed implementation of core elements in the MVP program. We urge CMS to consider improving the robustness of the measures available within the specialty tailored MVPs. Though cross-cutting measures sound appealing as one solution to limiting the burden of measure inventory, the use of these measures with broad applicability means that physicians will spend valuable time collecting information not relevant to the specialized care they provide and patients will have an insufficient amount of substantive data on which to base their decisions.

Instead, if CMS chooses to continue with the shift to MVPs, the agency should look to expand the number of MVPs that are relevant to specialists and subspecialists and use meaningful measures to generate the volume of quality data necessary for improvement and decision-making. From the physician perspective, the measures that are reported should be highly relevant to the specialty and the MVP should be based on these tailored measures as opposed to creating MVPs by piecing together irrelevant measures from across medicine. For example, AAOS supports the Improving Care for Lower Extremity Joint Repair MVP as a highly-tailored, meaningful option for orthopaedic surgeons subspecializing in hip and knee surgery. In contrast, we do not feel the Surgical Care MVP is properly designed to meet the needs of orthopaedic surgeons subspecializing in spine surgery. A more robust measure set would improve the overall experience for physicians and reduce burden by creating more relevant and meaningful reporting choices at the specialty and subspecialty levels.

Procedural Codes Request for Information

AAOS is concerned that CMS is considering assigning physicians to specific MVPs based on Part B claims data will hinder progress in developing meaningful quality measures that appropriately assess the value a physician brings to the patient. Particularly when there are so few MVPs that meet the needs of specialists and subspecialists, using claims data to pigeonhole physicians into an existing MVP that most closely matches their practice while the underlying measures still remain disconnected from the work they actually do will offer even less value than allowing physicians to self-select an MVP that they can report on and achieve some level of positive outcome, particularly when it comes to cost measures. By

way of example, in the ASM which is essentially testing this concept, CMS is proposing to base the Low Back Pain cohort which will apply to orthopaedic surgeons on the measures used in the Rehabilitative Support for Musculoskeletal Care MVP even though this MVP is designed for physical therapists and other non-surgeon clinicians. Importantly, the measures chosen from this MVP for inclusion in ASM are not included in the orthopaedic specialty set. This type of disjointed episode creation will only lead to greater difficulty if physicians are mandatorily assigned to these episodes or MVPs based on claims data.

Particularly as it relates to musculoskeletal care, which has an outsized impact on activities of daily living and productivity, measuring quality from the perspective of the appropriate surgical and nonsurgical treatments at the right time is preferable to forcing surgeons to be assigned based on claims data to a haphazardly selected set of quality measures that does not reflect the full scope of their work. Toward that end, we believe that in addition to claims data where appropriate, the best measures of a specialist's quality come from measures that are risk-adjusted and focus on outcomes that substantively improve a patient's quality of life.

Thank you for your time and attention to the concerns of the American Association of Orthopaedic Surgeons (AAOS) on the significant proposals made in the CY 2026 MPFS proposed rule (CMS-1832-P). AAOS looks forward to working closely with CMS on further improving the payment system, and to enhancing the care of musculoskeletal patients in the United States. Should you have questions on any of the above comments, please do not hesitate to contact Lori Shoaf, JD, MA, Vice President, AAOS Office of Government Relations at shoaf@aaos.org.

Sincerely,

Adam Bruggeman, MD, MHA, FAAOS, FAOrthoA
Chair, AAOS Council on Advocacy

This letter has received sign-on from the following orthopaedic societies:

American Osteopathic Academy of Orthopedics (AOAO)
American Orthopaedic Foot & Ankle Society (AOFAS)
American Orthopaedic Society for Sports Medicine (AOSSM)
American Shoulder and Elbow Surgeons (ASES)
American Society for Surgery of the Hand Professional Organization (ASSH)
North American Spine Society (NASS)

Florida Orthopaedic Society
Georgia Orthopaedic Society
Illinois Association of Orthopedic Surgeons
Massachusetts Orthopaedic Association
Minnesota Orthopaedic Society
Missouri State Orthopaedic Association
North Dakota Orthopaedic Society
Ohio Orthopaedic Society
Oregon Association of Orthopaedic Surgeons
Pennsylvania Orthopaedic Society
South Carolina Orthopaedic Association
Tennessee Orthopaedic Society
Texas Orthopaedic Association
West Virginia Orthopaedic Society
Wisconsin Orthopaedic Society