

### Fiscal Year 2026 Medicare Physician Fee Schedule Proposed Rule Summary

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) released the CY 2026 Medicare Physician Fee Schedule (MPFS) proposed rule. AAOS has prepared the summary below of key proposals in the rule and their potential impact on our members and patients. We will be submitting formal comments to the agency in response to the rule ahead of the September 12, 2025, deadline. **We welcome your feedback on any provisions below.**

Consistent with requirements established in the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), CMS proposes the following two conversion factors (CFs) for 2026:

- **\$33.5875** for items and services furnished by Qualifying APM Participants, which reflects a 3.84 percent increase relative to the 2025 CF
- **\$33.4209** for items and services furnished by all other providers (non-QP), which reflects a 3.32 percent increase relative to the 2025 CF

CMS continues to delay implementation of the 2017-based MEI cost share weights, citing concerns about redistributive effects and insufficient practice expense data from the AMA Physician Practice Information Surveys. CMS is proposing to phase in one-half of the geographic practice cost index (GPCI) adjustments in CY 2026 and the remaining half in CY 2027. CMS proposes to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs. CMS seeks comments on whether this is an appropriate reduction or whether it should consider a different percentage reduction for CY 2026 or in future years. CMS also seeks comment on the specific types and magnitude of indirect PE costs that are attributable to physicians who practice in part or exclusively in a facility setting, and any variables that affect whether and to what extent a practice would incur them.

CMS is also proposing to apply a –2.5% efficiency adjustment to the intraservice portion of physician time and work RVUs for all non-time-based codes for CY 2026. If CMS finalizes this proposal for CY 2026, they also intend to apply an efficiency adjustment every three years going forward with the next adjustment scheduled for CY 2029.

Under the Merit-Based Incentive Payment System (MIPS), the performance threshold will remain at 75 points for 2026 through 2028. Beginning with the CY 2026 MIPS performance period/2028 MIPS payment year, multispecialty groups will no longer be able to report MVPs as a single group. MIPS eligible clinicians in multispecialty groups must divide into and report as a subgroup or report as an individual to report an MVP. Alternatively, MIPS eligible clinicians in multispecialty groups may continue to participate in traditional MIPS reporting.

CMS is also proposing a new mandatory Ambulatory Specialty Care Model (ASM) focused on the care provided by select specialists to Medicare beneficiaries with heart failure and low back pain. The model would run from January 1, 2027 through December 31, 2031 and would evaluate whether linking specialist payments to performance on quality, cost, care coordination, and CEHRT use can improve chronic condition management. Participants would continue to bill FFS Medicare and would be exempt from reporting under MIPS.

CMS Proposal	Prior AAOS Comments	AAOS Relevance
<p><b>Conversion Factor (CF) Update</b></p> <p><i>CF for Advanced Alternative Payment Model (APM) Qualifying Providers (QPs): \$33.59</i></p> <p><b>This represents a projected increase of \$1.24 (3.83%) from the current CF</b></p> <p><i>CF for non-QP clinicians: \$33.42</i></p> <p><b>This represents a projected increase of \$1.17 (3.62%) from the current CF</b></p> <p><b>Both CFs also include a +2.50% update as statutorily mandated by the One Big Beautiful Bill Act and a +0.55% budget neutrality adjustment to account for proposed changes in work RVUs.</b></p>	<p>AAOS has consistently educated CMS that failing to appropriately compensate physicians will lead to access and quality issues for patients. The AMA estimates that Medicare physician payments will have decreased by approximately 20% between 2001 and 2021 due to the cumulative impact of practice cost inflation. This reduction is particularly concerning in light of the fact that, while Medicare spending on physician services per enrollee decreased by 1% between 2010 and 2020, spending on other components of Medicare increased by 3.6% to 42.1%.</p>	<p>CMS is proposing a positive update to the CF for the first time in six years.</p> <p>This is also the first year that CMS is proposing two separate conversion factors as statutorily required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Starting in CY 2026 Advanced Alternative Payment Model (APM) Qualifying Providers (QPs) will receive an annual 0.75% update to their CF while non-QP clinicians will receive a 0.25% update to their CF.</p>
<p><b>Adjusting RVUs To Match the PE Share of the Medicare Economic Index (MEI)</b></p>	<p>In CY 2025, AAOS supported CMS' decision to wait to rebase and revise the MEI until the AMA's data collection process was complete.</p>	<p>CMS believes that the MEI is the best measure available of the relative weights of the three components in payments under the PFS—work, practice expense (PE), and malpractice (MP). To ensure that the PFS payments reflect the relative resources in each of these PFS components, the RVUs used in developing rates should reflect the same weights in each component as the cost share weights in the Medicare Economic Index (MEI). CMS accomplishes this by holding the work RVUs constant and adjusting the PE RVUs, MP RVUs, and CF to produce the appropriate balance in RVUs among the three PFS components and payment rates for individual services, that is, that the total RVUs on the PFS are proportioned to approximately 51 percent</p>

		<p>work RVUs, 45 percent PE RVUs, and 4 percent MP RVUs.</p> <p>In early 2025, the AMA submitted data from its Physician Practice Information (PPI) and Clinician Practice Information (CPI) Surveys to CMS for us to consider implementing the PE/HR data and cost shares in PFS ratesetting for CY 2026. CMS has substantive concerns about the accuracy and suitability of the PPI and CPI Survey data as an immediate replacement for the current PE/HR data and cost shares for use in CY 2026 PFS ratesetting.</p> <p>Therefore, CMS is NOT proposing to implement the PE/HR or cost shares from the AMA’s survey data at this time. Instead, we propose to maintain the current PE/HR and 2006-based MEI cost shares for CY 2026 PFS ratesetting.</p> <p>CMS included a detailed discussion of what it believes are the flaws with the AMA’s PPI and CPI surveys. CMS said it will continue to work with the AMA and other interested parties on ways to incorporate specialty-specific data into the ratesetting methodology.</p> <p>AAOS is disappointed that CMS chose NOT to accept the AMA’s new data. We are also concerned about the broader overarching theme in this rule of distrust of the AMA’s various processes, including these surveys and the RUC, for collecting input from practicing physicians to advise CMS on ratesetting and the current practice of medicine.</p>
<p><b>Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential</b></p>	<p>N/A</p>	<p>CMS is proposing a change to the methodology so that when work RVUs are used to allocate indirect PE to the facility RVUs, they are assigned at one-half the amount allocated to the non-facility PE RVUs for that same service.</p>

		<p>CMS seeks comment on the specific types and magnitude of indirect PE costs that are attributable to physicians who practice in part or exclusively in a facility setting, and any variables that affect whether and to what extent a practice would incur them. CMS also seeks comment on whether its proposal to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs is an appropriate reduction or whether it should consider a different percentage reduction for CY 2026 or in future years.</p> <p>At the individual code level, cuts to a sampling of common orthopaedic surgeries performed in ASCs or hospitals range from –1% to –11%. Some common orthopaedic procedures that can be performed in the non-facility setting will see increases of around +10%.</p> <p>This proposal is particularly problematic for most orthopaedic surgeons that perform high volumes of procedures in facilities. The cuts will make it harder for orthopaedic surgeons to remain in private practice, further driving consolidation.</p>
<p><b>Work RVUs: Application of –2.5% efficiency adjustment</b></p>	<p>N/A</p>	<p>CMS believes that the current process for valuing physician services via the RUC is inaccurate, biased, error prone and overly dependent on unreliable survey data. Specifically, CMS feels that non-time-based codes should become more efficient as they become more common, professionals gain more experience, technology is improved, and other operational improvements are implemented, but that the current RUC methodology does not reflect these efficiencies.</p>

		<p>To remedy this, CMS is proposing to apply a – 2.5% efficiency adjustment to the intraservice portion of physician time and work RVUs for all non-time based codes for CY2026. To arrive at this number, CMS added the MEI productivity adjustment percentages for the past five calendar years.</p> <p>If CMS finalizes this proposal for CY2026, they also intend to apply an efficiency adjustment every three years going forward, with the next adjustment scheduled for CY2029.</p>
<p><b>Payment for Medicare Telehealth Services</b></p>	<p>N/A</p>	<p>To simplify the process for adding services to the telehealth list, CMS is revising the 5-step review process implemented in 2025.</p> <p>CMS is also proposing to permanently remove frequency limitations on telehealth for Subsequent Inpatient and Nursing Facility Visits, and Critical Care Consultation Service.</p> <p>CMS is proposing that the presence of the physician required for direct supervision can include virtual presence through audio/video real-time communications technology for services without a 010 or 090 global surgery indicator.</p> <p>These policies will make the use of telehealth easier and more accessible for physicians and patients.</p>
<p><b>Valuation of Specific Codes - <i>Limb Lengthening-Shortening, Femur</i> (Codes 27465, 27466, 27468, 27XX0)</b></p>	<p>N/A</p>	<p>CMS is proposing the RUC-recommended work RVUS of 26.65 for code 27XX0 which was created at the May 2024 CPT Editorial Panel Meeting. CMS is also proposing the RUC-recommended work RVUs for family codes 27465 (21.13) and 27466 (22.65). CMS is recommending the direct PE inputs for all three codes without refinement.</p> <p>For code 27468, CMS disagrees with contractor</p>

		pricing as recommended by the RUC. CMS believes that the code is valued appropriately and should not be paid under contractor pricing based on the survey results. CMS is proposing to maintain the current work RVU of 19.97.
<b>Valuation of Specific Codes - <i>Limb Lengthening – Shortening (Codes 27715, 27XX1)</i></b>	N/A	CMS is proposing the RUC-recommended work RVU of 28.00 for CPT code 27XX1 which was created at the May 2024 CPT Editorial Panel Meeting. CMS is also proposing the RUC-recommended work RVU of 28.00 for code 27XX1 and 22.50 for code 27715. They are also proposing the direct PE inputs for both codes without refinement.
<b>Valuation of Specific Codes - <i>Great Toe Arthrodesis (Codes 28750, 28755)</i></b>	N/A	<p>Code 28750 was identified by the 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. Additionally, code 28755 was added as a family code having never been surveyed as it was Harvard valued code.</p> <p>CMS is proposing the RUC-recommended work RVU of 8.75 for code 28750. However, CMS disagreed with the RUC-recommended RVU of 7.50 for code 28755 and instead proposed a work RVU of 6.76. CMS states that RUC-recommended valuation would place 28755 above the median range when compared to other 90-day codes with similar work times. CMS has based their proposed work RVU on a crosswalk to code 28122 which shares the same intraservice work time and similar total time.</p> <p>CMS proposes the RUC-recommended direct PE inputs for all codes in this family.</p>

<p><b>Valuation of Specific Codes - Percutaneous Interlaminar Lumbar Decompression (Codes 62XX0, 62XX1)</b></p>	<p>N/A</p>	<p>Two new codes were created at the September 2024 CPT Editorial Panel Meeting, replacing existing Category III code 0275T.</p> <p>CMS is proposing the RUC-recommended work RVUs for CPT codes 62XX0 (8.00) and 62XX1 (4.25). CMS is also proposing the RUC-recommended direct PE inputs without refinement for both codes.</p> <p>Code 62287 (decompression, percutaneous) was not surveyed as part of the code family due to low utilization. AAOS and relevant specialty societies requested deletion of this code which will take place for 2026 CPT.</p>
<p><b>Valuation of Specific Codes - Percutaneous Decompression of the Median Nerve (Code 647XX)</b></p>	<p>N/A</p>	<p>A new code for reporting percutaneous decompression of the median nerve at the carpal tunnel using ultrasound guidance and a balloon dilation device while transecting the transcarpal ligament was created for 2026.</p> <p>CMS is proposing the RUC-recommended work RVU (2.70) and direct PE inputs for code 647XX.</p>
<p><b>Valuation of Specific Codes Laminotomy Repair of Disc Defect (Code 6XX13)</b></p>	<p>N/A</p>	<p>A new code was created at the September 2024 CPT Editorial Panel Meeting for repair of an annular defect by implantation of a bone anchored annular closure device after a laminotomy (hemilaminectomy).</p> <p>CMS is proposing the RUC-recommended work RVU of 2.50 for code 6XX13. There are no direct PE inputs for this code.</p>
<p><b>Evaluation &amp; Management</b></p>	<p>Last year, AAOS continued to oppose the implementation of HCPCS code G2211, arguing that it results in overpayments and necessitates reductions in the Medicare conversion factor. We urged CMS to rescind this code, as</p>	<p>CMS is proposing to allow HCPCS code G2211 to be reported as an add-on code with the home or residence evaluation and management visit codes (99341-99350). CMS is also updating the parenthetical note to the descriptor to reflect this change: (Add-on code, list separately in addition to</p>

	<p>the current E/M coding structure already sufficiently addresses patient care complexities.</p>	<p>home or residence or office/outpatient evaluation and management service, new or established)</p>
<p><b>Enhanced Care Management</b></p>		<p>CMS is soliciting comments on software-based technologies as software as a service (SaaS) such as what factors should the Agency consider when paying for Saas.</p> <p>CMS is also seeking comments on user experience of incorporating SaaS, alternative pricing strategies, valuation of physician work associated with utilizing Fand interpreting the clinical outputs associated with SaaS and AI devices, etc as well as any additional suggestions that would help CMS provide consistent payment for procedures incorporating SaaS.</p> <p>“Establishing the President’s Make American Healthy Again Commission” executive order directs CMS’ focus to understanding and lowering chronic disease rates. CMS is seeking feedback on how they could enhance their support management for prevention and management of chronic disease.</p>
<p><b>Remote Patient Monitoring (RPM) &amp; Valuation for Remote Therapeutic Monitoring (RTM)</b></p>	<p>N/A</p>	<p>CPT code 98XX5 Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, 2-15 days in a 30-day period</p> <p>CPT code 98977 Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of</p>

		<p>musculoskeletal system, 16-30 days in a 30-day period</p>
<p><b>Payment for Skin Substitutes</b></p>	<p>CMS proposes to treat skin substitutes (including skin substitutes) as incident-to supplies as described under section 1861(s)(2)(A) of the Act when furnished in a non-facility setting. CMS is also proposing to include the costs of these products as resource inputs in establishing practice expense RVUs for associated physician’s services effective January 1, 2024. AAOS strongly opposes this proposal and urges CMS not to include skin substitute products as incident-to CPT codes. (AAOS CY 23 MPFS Comments)</p>	<p>CMS is proposing, effective January 1, 2026, to separately pay for the provision of certain skin substitute products as incident-to supplies when used during a covered application procedure paid under the PFS (non-facility setting) or OPPS. This does not apply to biological products licensed under section 351 of the PHS Act, which will continue to be paid under the ASP methodology.</p> <p>Under the PFS, CMS proposes to separately pay for non-biological skin substitutes as incident-to supplies in the non-facility setting, in accordance with section 1861(s)(2)(A). These products are necessary supplies for surgical repair procedures described by CPT codes 15271–15278.</p> <p>CMS is seeking comment on both the proposal to separately pay for these products and its application across both non-facility and hospital outpatient settings.</p> <p>CMS seeks comments on how to properly recognize innovative products through payment policy under the PFS as CMS continues to assess how best to identify and value innovative products under the PFS. For example, CMS seeks comments on whether skin substitutes with active pass-through payment status under the OPPS and/or those receiving new technology add-on payments (NTAP) under the IPPS should be paid separately from their FDA category under the PFS. CMS seeks comments on whether these products should meet a substantial clinical improvement standard or whether, consistent with current pass-through policy, a device that has received marketing authorization for an indication covered by FDA’s Breakthrough</p>

		<p>Devices Program would generally represent clinically-relevant innovation sufficient to qualify for a product-specific payment rate. Finally, CMS seeks comments on using either a product’s ASP or invoice pricing, similar to how devices with pass-through status are paid in ambulatory surgical centers, or adding a set percentage, similar to the NTAP add-on, to the applicable FDA category’s base rate to set payment limits during the period of time that the product is covered by the passthrough and/or NTAP programs.</p>
<p><b>Strategies for Improving Global Surgery Payment Accuracy</b></p>	<p>From 2025 Summary: AAOS opposes CMS’s refusal to apply RUC-recommended work and time increases to global surgical codes. We recommend that CMS adopt these changes to ensure Fee Schedule relativity.</p>	<p>CMS is seeking comments on a new methodology for allocating procedure shares within the global bundles.</p> <p>CMS proposes to calculate procedures’ work RVUs by subtracting the work RVUs for postoperative visits provided as part of global surgical packages. To do so, we would multiply the number of post-operative visits typically provided for the global procedure HCPCS code (defined as the median count of post-operative visits reported to CMS using no-pay code 99024 among procedures without overlapping global periods with other global surgical services) by the average valuation per post-operative visit calculated for the mix (that is, number and level) of post-operative visits for the global procedure HCPCS code as listed in the Physician Time File.</p> <p>CMS believes this approach (using postoperative visit counts from claims-based reporting) reflects real-world, observed patterns of postoperative care and that it allows for routine, transparent updating of procedure shares over time.</p>

<p><b>Determination of Malpractice Relative Value Units (RVUs)</b></p>	<p>N/A</p>	<p>For CY 2026, CMS is proposing an MP RVU of 0.01 for skin substitute supplies, consistent with the PFS rounding convention that assigns a minimum of 0.01 MP RVUs to all codes except add-on codes (75 FR 73276). CMS believes the malpractice resources are already reflected in the MP RVUs associated with the CPT application codes (15271–15278).</p> <p>CMS calculated the proposed MP RVUs using updated malpractice premium data obtained from state insurance rate filings, reflecting rates effective no later than December 31, 2023, from insurers with the largest market share in each state.</p> <p>CMS is not proposing any major methodological refinements to MP RVU development for CY 2026 but has refined the universe of specialties subject to imputation and the sources of imputation for each specialty.</p> <p>CMS is also soliciting public comment on the list of expected specialties used in these calculations.</p>
<p><b>Geographic Practice Cost Indices (GPCIs)</b></p>	<p>The AMA has pointed out that in addition to significant specialty redistribution, geographic redistribution would also occur, as CMS proposes to modify weights of the expense categories (employee compensation, office rent, purchased services and equipment/supplies/other) within the practice expense Geographic Practice Cost Index (GPCI). The changes in the MEI that CMS is proposing are almost entirely related to the category weights. A change in the price proxy is</p>	<p>For CY 2026, CMS is proposing to phase in 1/2 of the proposed GPCI adjustments and apply the remaining 1/2 in CY 2027, since more than one year has passed since the previous update in CY 2023 and 2024. As required by statute, CMS developed GPCIs to measure relative cost differences among payment localities compared to the national average for the work, PE, and MP components of the fee schedule.</p> <p>The CY 2026 work GPCIs and summarized GAFs do not reflect the 1.0 work floor, consistent with statute. However, the 1.5 work GPCI floor for Alaska and the 1.0 PE GPCI floor for</p>

recommended for just one of the cost categories which accounts for only 2% of the index. CMS is not proposing a change to the productivity adjustment. The Census Bureau's 2017 SAS for the "Offices of Physicians" industry was not designed with the purpose of updating the MEI. As a result, there are key areas (physician work, nonphysician compensation and medical supplies) where CMS must use data from other sources to update the weights appropriately. CMS has relied on AMA physician cost data for 50 years in updating the MEI and 30 years in updating the resource-based relative value scale (RBRVS). The current MEI weights are based on data obtained from the AMA's Physician Practice Information (PPI) Survey. This survey was last conducted in 2007/2008 and collected 2006 data. Hence, we fully agree with CMS that the MEI weights must be updated. However, the AMA is currently engaged in a process to collect this data again. It is expected that the new data collection efforts will be completed by 2023 and will be based on 2022 cost data. We, therefore, ask CMS to collaborate with AMA and national specialty societies like us and postpone updating the MEI data updates until the AMA survey is complete.

Frontier States are permanent and are reflected in the proposed GPCIs.

To update the GPCIs:

- Work and PE GPCIs use updated BLS OEWS data (2020–2023), replacing 2017–2020 data.
- The PE office rent index uses 2018–2022 ACS 5-year estimates, replacing 2015–2019 data.
- The CY 2026 MP GPCI update reflects premium data presumed in effect by December 31, 2023.

CMS is proposing to continue using the current 2006-based MEI cost share weights for determining proposed PE GPCI values. Although CMS received data from the AMA's PPI and CPI Surveys, it states the data lack the specific breakdown needed to weight components of the PE GPCI, such as Office Rent and Purchased Services.

CMS is inviting comments on:

- The potential use of 2017-based MEI cost share weights or PPI/CPI data for future GPCI or PFS ratesetting,
- Whether to incorporate updated cost share weights in CY 2027, and
- The appropriateness of a multi-year transition for adopting updated cost share weights for the PE GPCI.

<p><b>Drugs and Biological Products Paid Under Medicare Part B</b></p>	<p>N/A</p>	<p>For CMS is proposing policies to provide additional guidance on two aspects of the calculation of manufacturer’s ASP:</p> <p>Price Concessions &amp; Bundled Arrangements: CMS proposes regulatory text clarifying when fees are considered price concessions and how manufacturers should allocate pricing for drugs sold under bundled arrangements.</p> <p>CMS proposes to define “Bundled Arrangement: An arrangement, regardless of physical packaging, under which the rebate, discount, or other price concession is conditioned upon the purchase of the same drug or biological, other drugs or biologicals, another product, or performance requirements (e.g., market share, formulary placement, purchasing patterns), or where the resulting discounts are greater than had the products been purchased separately.”</p> <p>Value-Based Arrangements: CMS is not proposing to adopt Medicaid’s treatment of value-based purchasing arrangements as bundled sales but is soliciting comments on how discounts across time periods (e.g., outcomes-based contracts) could be accounted for in the ASP calculation.</p>
<p><b>Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)</b></p>	<p>N/A</p>	<p>Effective January 1, 2026, CMS is proposing to require RHCs and FQHCs to report the individual codes that make up CoCM HCPCS code G0512 and HCPCS code G0071. Payment for these services would be based on the national non-facility PFS rate, whether billed alone or with other payable services, and updated annually.</p> <p>CMS proposes to reflect payment of CTBS and remote evaluation services and to adopt services designated as care management under the PFS for separate payment under</p>

		<p>RHC and FQHC care coordination. Services and supplies furnished incident to TCM and care coordination may be furnished under general supervision.</p> <p>CMS seeks comment on:</p> <ul style="list-style-type: none"><li>• Whether aligning care coordination services with PFS care management services is sustainable;</li><li>• More effective approaches for adopting new care coordination codes in RHCs and FQHCs.</li></ul> <p>CMS is proposing to permanently adopt virtual direct supervision via real-time audio/video technology in RHCs and FQHCs, consistent with section II.D.2 of the rule. CMS proposes to define “direct supervision” to include virtual presence, excluding audio-only. CMS also reaffirms that global billing codes are not accepted for RHC or FQHC payment. In the event Congress no longer authorizes payment for telehealth services via a telecommunications system using PFS-equivalent rates, CMS is proposing a temporary approach to pay for non-behavioral health (“medical visit”) services furnished via telecommunications technology. RHCs and FQHCs would continue to bill HCPCS code G2025, with payment based on the volume-weighted average of PFS telehealth services.</p> <p>CMS proposes to continue this temporary payment methodology through December 31, 2026, to preserve access, citing the same rationale finalized in CY 2025.</p> <p>CMS did not propose an alternative capitated payment approach based on the RHC AIR or FQHC PPS per-visit rates due to unintended consequences but is soliciting comment on</p>
--	--	---

		defining a visit to include interactive, real-time audio/video telehealth for future use.
<b>Ambulatory Specialty Model (ASM)</b>	N/A	<p>ASM would be established as a mandatory model focused on the care provided by select specialists to Medicare beneficiaries with the chronic conditions of heart failure and <b>low back pain</b>. The proposed model, which would begin January 1, 2027 and end December 31, 2031, would evaluate whether linking specialist payments to performance on measures related to quality, cost, care coordination, and meaningful use of certified electronic health record technology (CEHRT) can lead to more effective upstream chronic condition management. Participants will continue to bill FFS Medicare and be exempt from reporting under MIPS.</p> <p>CMS would measure the performance of participating orthopaedic surgeons treating low back pain against all other model participants treating low back pain (but not the heart failure cohort or physicians outside the model). Based on performance, clinicians would see all their Medicare Part B payments adjusted by +/- 9% in year 1 scaling up to +/- 12% in year 5.</p> <p><b>See more detailed summary below</b></p>

**Quality Payment Program Proposed Updates**

<b>CMS Proposal</b>	<b>Prior AAOS Comments</b>	<b>AAOS Relevance</b>
---------------------	----------------------------	-----------------------

***MVP subgroup reporting: Beginning with the CY 2026 MIPS performance period/2028***

**MIPS payment year, multispecialty groups will no longer be able to report MVP as a single group. Thus, if a multispecialty group would like to report an MVP, beginning with the CY 2026 MIPS performance period/2028 MIPS payment year, MIPS eligible clinicians in multispecialty groups must divide into and report as subgroup or report as an individual to report an MVP. Alternatively, MIPS eligible clinicians in multispecialty groups may continue to**

**participate in traditional MIPS reporting.**

***Reporting for small practices:***

**Multispecialty groups that meet the requirements of a small practice may be MVP participants. MVP Participant means an individual MIPS eligible clinician, single-specialty group, multispecialty group that meets the requirements of a small practice (15 or fewer clinicians), subgroup, or APM Entity that is assessed on an MVP for all MIPS performance categories.**

**In lieu of using the claims data for designating a group as either a single specialty or a multispecialty group, CMS proposes that to report an MVP, a group practice which is either a single-specialty group or a multispecialty group that meets the requirements of a small practice, would be required to**

To best balance the increased burden of subgroup reporting with the need for comprehensive reporting on the diverse range of services provided by clinicians within a group, AAOS believes it is critical that CMS maintain flexibility. This includes allowing group practices to determine and inform CMS of their specialty composition and the most appropriate subgroup reporting strategy for their unique practice.

AAOS members who participate in quality reporting via MVPs will have greater flexibility to determine their group composition.

<p>attest to its designation as a group that meets the requirements of a single specialty group, or a multispecialty group that meets the requirements of a small practice, respectively.</p>		
<p><b>LEJR MVP: CMS proposes to remove 1 quality measure (Q487-Screening for Social Drivers of Health) and 2 improvement activities (IA_AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols and IA_PM_6: Vaccine Achievement for Practice Staff: COVID-19, Flu, and Hepatitis B).</b></p>	<p>AAOS supports the use of meaningful measures that can be captured via the AAOS Family of Clinical Registries.</p>	<p>The LEJR MVP includes quality reporting measures relevant for AAOS members performing joint arthroplasty in the hospital setting.</p>
<p><b>Podiatry MVP: The proposed Podiatry MVP focuses on assessing meaningful outcomes in foot and ankle care for patients with chronic conditions, wound/ulcers, and general care for the podiatry patient. It targets podiatrists and NPs and PAs.</b></p>	<p>N/A</p>	<p>AAOS supports the most appropriate and skilled medical team members providing the right care at the right time for foot and ankle surgery.</p>
<p><b>Medicare Procedural Codes RFI: CMS seeks feedback on the consideration to identify Medicare Part B procedural billing codes that align with each MVP, and to encourage, or potentially require, specialists to report the relevant MVP based on their use of the procedural billing codes.</b></p> <p><b>CMS would prioritize linking MVPs with high-utilization and high-cost procedures—for example, connect the hip replacement surgery procedural codes to the Improving Care for Lower Extremity Joint Repair MVP.</b></p>	<p>AAOS has previously stated that MVPs do not address many of the underlying challenges associated with MIPS, including siloed performance categories, the lack of incentives for the development and use of more specialized and robust measures (e.g., patient-reported outcome measures), and the ongoing misalignment between MIPS cost and quality measures.</p>	<p>MVPs may become mandatory in the future and AAOS is closely monitoring the development and implementation of new APMs that capture quality reporting and payment for specialty care.</p>

<p><b>Core Elements RFI: CMS is considering a policy to require an MVP Participant to select one quality measure from a subset of quality measures in each MVP, referred to as “Core Elements.” MVP Participants would select the other three required quality measures and would still have to meet existing MVP reporting requirements. This policy aims to emphasize and increase reporting on select quality measures that are most important to clinicians and patients and reflect care that is at the crux of the MVP’s applicable specialty, medical condition, or episode of care. Core Elements could be, but would not necessarily be, outcomes measures. Core Elements would highlight measures that represent the foundation and essence of an MVP. CMS is considering proposing the Core Elements policy in the CY 2027 PFS proposed rule and proposing the policy for implementation prior to the sunset of traditional MIPS.</b></p>	<p>N/A</p>	
<p><b>QCDRs: Beginning with the CY 2026 performance period/2028 MIPS payment year, 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. This proposed modification will provide QCDRs and qualified registries with one year following the effective date of the final</b></p>	<p>AAOS has previously advocated for this change to allow for improved participation by our QCDRs.</p>	<p>AAOS QCDRs support MIPS and MVP reporting, but the abbreviated window between when MVPs are finalized as part of the final rule in November and implementation in January leaves little time to update the quality measurements from the registry perspective and therefore limit possibilities for supporting this avenue of quality reporting.</p>

<p>rule for programming and system preparation for MVP reporting success and reduce potential of withdrawal or termination.</p>		
<p><b>New MIPS Improvement Activity: Patient Safety Use of Artificial Intelligence “would include events where actual harm was caused to a patient because AI technology was used, as well as near misses. Once a MIPS-eligible clinician has identified an event, a process to identify the cause and plan for future mitigation would be documented.”</b></p>	<p>AAOS has closely monitored the use of AI in the practice of medicine, most recently through the release of our <a href="#">position statement</a>.</p>	<p>This proposed new Improvement Activity measure would support tracking the negative impact of AI on patient care.</p>
<p><b>CMS is proposing that measure 350: Total Knee or Hip Replacement: Shared Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation</b></p> <p><b>Decision-Making: Trial of Conservative (Non-surgical) Therapy and Measure 351: Total Knee or Hip Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation as topped out.</b></p>	<p>N/A</p>	<p>AAOS follows measures that are relevant to orthopaedic surgery and encourages CMS to maintain a robust measure set.</p>
<p><b>Beginning with the 2026 performance period, CMS proposes to revise the MIPS Total Per Capita Cost (TPCC) measure so that 1) clinicians are only attributed costs for beneficiaries that have had at least two qualifying services from their clinician group, and where both services were provided by a clinician that is not excluded from measure attribution due to the specialty exclusion; and 2) so that advanced care practitioners are excluded from</b></p>	<p>N/A</p>	<p>AAOS follows measures that are relevant to orthopaedic surgery and encourages CMS to maintain a robust measure set.</p>

<p>attribution in specific specialty settings (i.e., groups where all physicians are excluded based on the specialty exclusion criteria).</p>		
<p><b>Advanced APMs: CMS proposes to add an individual level calculation to Qualifying APM Participant (QP) determinations, for all eligible clinicians participating in an Advanced APM, such that each eligible clinician would receive both APM Entity level calculation and an individual level calculation. CMS is also re-proposing to expand the scope of the services in the sixth criterion of the definition of “attribution-eligible beneficiary” to use covered professional services. CMS believes that, together, these proposals would modernize and improve the QP determination approach across Advanced APMs.</b></p>	<p>AAOS recognizes the complexity of making QP determinations within APM entities and has encouraged policy changes that support specialist eligibility for the QP track of the QPP.</p>	<p>These determinations impact participation requirements and payment for Advanced APM participation.</p>

### Ambulatory Specialty Model (ASM)

CMMI proposed to establish the ASM as a mandatory model focused on the care provided by select specialists to Medicare beneficiaries with the chronic conditions of heart failure and **low back pain**. The model follows the MIPS/MVP framework in terms of categories that must be reported, and performance-based adjustments to Medicare Part B payments for professional services.

Under the model, clinicians who treat low back pain would be required to report a uniform set of clinically relevant measures and activities to assess quality, cost, interoperability, and care coordination practices. CMS would assess the clinician’s performance on those measures and activities relative to their peers and then apply a positive or negative adjustment to the clinician’s Medicare Part B payments. Participation in ASM would replace participation in MIPS. **This is a five-year demonstration with performance years from January 1, 2027 to December 31, 2031 and payment years from January 1, 2029 to December 31, 2033.**

**Participant Selection:** CMMI will use a sampling methodology to select approximately 25% of Core Based Statistical Areas (CBSAs). CMMI will then look at all providers in the CBSA at the TIN/NPI level. Participation will be limited to individual physicians – no groups and no non-physician providers.

- The ASM low back pain cohort will include clinicians with a specialty type of anesthesiology, interventional pain management, neurosurgery, **orthopedic surgery**, pain management, and physical medicine and rehabilitation to which CMMI can attribute 20 or more episodes using the **Low Back Pain Episode Based Cost Measure** finalized in MIPS as part of the Rehabilitative Support for Musculoskeletal Care MVP.
- CMS estimates that approximately 5,200 ASM low back pain participants billing under 2,400 TINs would participate in the model.
- Preliminary participant notices will be delivered by the end of CY2025, and final notices will be sent by July 2026. Participation status will then be verified before the start of each subsequent performance year.

CMS estimates that the administrative costs of adjusting to and complying with the measure reporting requirements for ASM to be approximately \$3,077 per ASM participant per year.

**Quality Measures**

- The Low Back Pain track includes five quality measures, and participants must submit data for each measure. CMMI is setting a 75% data completeness requirement for each measure and if this minimum is not met, the provider will receive zero achievement points for the measure.

<b>Low Back Pain</b>			
Excess Utilization	Risk reduction/absence of disease	MRI Lumbar Spine for LBP (measure in development)	Claims
Evidence-based Care and Outcomes	Adverse events and acute utilization	Use of High-Risk Medications in Older Adults (MIPS Q238)	eCQM MIPS CQM
Evidence-based Care and Outcomes	Risk reduction/absence of disease	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (MIPS Q134)	eCQM MIPS CQM
Evidence-based Care and Outcomes	Risk reduction/absence of disease	Preventive Care and Screening: BMI Screening and Follow-Up Plan (MIPS Q128)	eCQM MIPS CQM
Patient Reported Outcomes and Experience	Function/health status/wellbeing	Functional Status Change for Patients with Low Back Impairments (MIPS Q220)	MIPS CQM

- The MRI Lumbar Spine for LBP measure is based on Hospital Outpatient Quality Reporting Program measure OP-8. This facility measure is being reconfigured to measure individual providers and possibly getting a new denominator. CMS would propose the measure's specifications through notice-and-comment rulemaking.
- When describing the Functional Status Change for Patients with Low Back Impairments PROM (MIPS Q220), CMMI noted that AAOS recommends the use of the Oswestry Disability Index, which can be used to fulfill this measure, as one of its preferred tools for spine care.

**Cost Measure:**

- CMMI is proposing to utilize the low back pain Episode Based Cost Measure (EBCM) that is finalized as part of the Rehabilitative Support for Musculoskeletal Care MVP. The low back pain EBCM evaluates a participant's risk adjusted and specialty-adjusted cost to Medicare for patients receiving medical care to manage and treat low back pain.

**Practice Improvement Activities:**

- Providers will attest to completing activity IA-1 and IA-2.
- IA-1: Connecting to Primary Care and Ensuring Completion of Health-Related Social Needs Screening
  - ASM participants must have evidence of processes, workflows, and/or technology that require the ASM participant to: (1) confirm the ASM beneficiary has access to primary care services and, if not, assist the ASM beneficiary in finding a clinician who provides primary care services, (2) communicate relevant information back to the ASM beneficiary's primary care provider following the ASM beneficiary's visit with the ASM participant, and (3) determine whether the ASM beneficiary has received an annual HRSN screening in the primary care setting and, if not, encourage the primary care services provider to conduct the screening or allow the ASM participant to conduct the HRSN screening
- 1A-2: Establishing Communication and Collaboration Expectations with Primary Care Practices using Collaborative Care Arrangements (CCAs)
  - The ASM participant must enter into at least one CCA with a primary care practice that includes at least three of the following five following collaborative elements: data sharing, co-management, transitions in care planning, closed-loop connections, and care coordination integration.
  - ASM participants must ensure the CCA is with a primary care practice with whom they share at least one ASM beneficiary. ASM participants should seek to enter into an CCA with another primary care practice with which they share the largest number of ASM beneficiaries.

- As currently defined, a collaborative care arrangement is exclusively between an ASM participant and a primary care practice. CMS acknowledges this will be burdensome to both clinicians.

**Promoting Interoperability:**

- To earn a performance category score for the Promoting Interoperability Performance category for inclusion in the final score, an ASM participant must attest to being a meaningful EHR user as currently defined in MIPS. CMMI will not include additional provisions related to information blocking.

**ASM Performance Category Weights and Scoring Adjustments:**

- To create a final score from 0 to 100 based on the individual ASM performance category scores, we propose to:
  - Assign an ASM performance category weight of 50 percent to each of the quality and cost ASM performance categories, resulting in a combined score of 0-100 points.
  - Apply neutral or negative adjustments to the final score above based on scores in the improvement activities and Promoting Interoperability ASM performance categories.
- This system is designed to achieve one of CMMI's stated goals of ASM which is to increase two-sided risk and create payment adjustments of a higher magnitude to incentivize performance improvements.

**TABLE 42: ASM PERFORMANCE CATEGORY SCORING WEIGHTS AND ADJUSTMENTS BY ASM PERFORMANCE CATEGORY**

<b>ASM Performance Category</b>	<b>Weight or Scoring Adjustment in Final Score</b>
Quality	50 percent weight
Cost	50 percent weight
Improvement Activity	Scoring adjustment of zero, -10, or -20 points
Promoting Interoperability	Scoring adjustment of zero to -10 points

- CMMI proposes to calculate and apply a Complex Patient Scoring Adjustment for each ASM provider using two risk indicators, Hierarchical Condition Category (HCC) risk scores and the proportion of patients with dual eligible status, “dual eligible proportion.”

- CMS also proposes a small practice scoring adjustment - this will add 10 points to the final score of an ASM participant if the participant is a small practice (15 or fewer clinicians) and 15 points to the final score of an ASM participant if the participant is a solo practitioner.
- Each ASM participant will receive a performance report with (1) individual measure-level scores for each of the measures required under each ASM performance category; (2) ASM performance category-level scores; (3) complex patient scoring adjustment, as applicable; (4) small practice or solo practitioner scoring adjustment, as applicable; (5) final score, and (6) the applicable ASM payment adjustment factor and (7) ASM payment multiplier for the applicable ASM payment year as discussed in section
  - ASM will include its own unique appeals process to ensure participants can challenge and have their report corrected in a timely manner – participants must submit their appeal within 30 days of receiving their report.

**Payment:**

- CMS proposes a performance-based payment methodology for the ASM model, in which a portion of Medicare Part B payments made to ASM participants for covered professional services during a performance year would be redistributed as scaled payment adjustments during the corresponding ASM payment year.
- Rather than withholding payments prospectively, CMS proposes to create virtual incentive pools based on actual Medicare spending during the ASM performance year. These pools would then serve as the basis for calculating the scaled payment adjustments distributed to participants.
- CMS proposes an ASM redistribution percentage of 85 percent beginning with the 2029 ASM payment year, meaning 85% of payments would be distributed to ASM participants and 15% would be retained in the Medicare Trust Fund.
- CMS proposes to establish the ASM risk level as the maximum downside or upside risk to which an ASM participant would be subject to during an ASM payment year. CMS proposes the following risk levels:
  - Year 1: +/- 9%
  - Year 2: +/- 9%
  - Year 3: +/- 10%
  - Year 4: +/- 11%
  - Year 5: +/- 12%

**Waivers:**



AMERICAN ASSOCIATION OF  
ORTHOPAEDIC SURGEONS

CMMI proposes to:

- Waive ASM participants from MIPS reporting and payment adjustments.
- Waive certain telehealth restrictions to encourage greater flexibility with the use of telehealth services by ASM participants – this would align with the current COVID PHE waivers even if Congress fails to act to extend them this fall.
- Allow ASM participants the option of providing in-kind patient engagement incentives
  - CMMI envisions this could take the form of remote patient monitoring devices such as blood pressure monitors or scales with or without the capability to send data to their providers, vouchers for healthier food options or meal planning, and promotions for regular physical activity such as gym memberships or classes.
- Permit ASM to overlap with other CMS Innovation Center models and CMS programs, except for MIPS, but including Advanced APM Qualified Providers.