AAOS
American Association of Orthopaedic Surgeons

June 6, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1833-P
P.O. Box 8013
Baltimore, MD 21244-1850

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

Subject: CMS-1833-P

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

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 (CMS-1833-P) FY 2026 Hospital Inpatient Prospective Payment System proposed rule.

- **TEAM Model**: AAOS strongly urges CMS to revise the mandatory, geographically limited nature of TEAM and instead create incentives for voluntary participation by any interested set of surgeons, facilities, and other providers who seek to collaborate in innovative ways to deliver high quality and well-coordinated care to their patients.
- **IQR– RSCR Following Primary Elective THA/TKA**: AAOS supports the technical update to transition the RSCR risk adjustment methodology from Hierarchical Condition Categories (HCCs) to International Classification of Diseases (ICD)-10 codes as well as the addition of Medicare Advantage beneficiaries to the measure cohort.
- **VBP – THA/TKA RSCR & Complication Measures**: AAOS supports the proposed technical updates to the measure and encourages CMS to publish updated performance standards in a timely and transparent manner.
- **MS-DRG – Periprosthetic Joint Infection (PJI)**: AAOS supports CMS's proposal to assign PJI cases to new MS-DRGs centered around a principal diagnosis of periprosthetic joint infection, recognizing this as a significant positive step toward more accurate and appropriate reimbursement.
- **NTAP – Alternative Pathway**: AAOS supports the continued availability of the alternative pathway for medical devices designated under the FDA's Breakthrough Devices Program and urges CMS to apply the "substantial similarity" criteria consistently and transparently, particularly when evaluating novel orthopaedic biologics.

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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, we are pleased to provide comments in response to the Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes (CMS-1833-P) published in the Federal Register on April 11, 2025.[1]

Transforming Episode Accountability Model (TEAM)

AAOS reiterates our opposition to requiring mandatory participation in any alternative payment model, including TEAM. While we strongly support the development and implementation of voluntary models, we believe that mandatory participation by acute care hospitals in CMS-selected Core-Based Statistical Areas (CBSAs) is flawed and should be replaced by a voluntary approach that includes acute care hospitals as well as physicians. A voluntary approach, including the option of surgeons as conveners of risk, allows physicians to tailor their episode-of-care models to their unique patient populations leading to improved patient care and more accurate, efficient payments. Many of the hospitals in the CBSAs are in economic distress and lack the economies of scale and infrastructure needed to succeed in a competitive bundled program. We strongly urge CMS to revise the mandatory, geographically focused nature of TEAM and instead create incentives for voluntary participation by any interested set of surgeons, facilities, and other providers who seek to collaborate in innovative ways to deliver high quality and well-coordinated care to their patients.

AAOS appreciates that the Lower Extremity Joint Replacement (LEJR) category will include both inpatient and outpatient procedures. The LEJR category includes total ankle, knee, and hip arthroplasty. Likewise, we appreciate that CMS has updated the Spinal Fusion category to reflect the changes in the related MS-DRGs.

Concerns with the Surgical Hip and Femur Fracture Episode

While we believe the LEJR and Spinal Fusion episodes hold promise under TEAM, we remain concerned about the viability of participants being able to produce savings under the Surgical Hip and Femur Fractures episode. These cases are unplanned and are primarily performed on elderly patients who have multiple comorbidities. It is impossible to pre-optimize the patient for surgery and significantly reduce post-acute care costs to meet target prices and achieve success under this model; it risks inappropriate care. Moreover, we believe that the 30-day episode window further limits the ability of participants to be successful under the model given that fracture care involves lengthy and intense post-acute care which spans the course of months. We ask that CMS reconsider the inclusion of this episode category. Should CMS move forward with this episode category, we ask that changes to

[1] https://www.federalregister.gov/documents/2025/04/30/2025-06271/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

the target price or episode length be made to account for the higher co-morbidity and urgency related to patients undergoing these procedures.

Concerns with Inadequate Pre-Implementation Resources to Ensure Surgeon Integration under TEAM

Similarly, we are concerned that the hospitals that are required to participate have not had enough time to work with their surgeon leaders to prepare for the model's implementation. Successful implementation requires planning, team reorganization, and a systems-level approach to reducing costs across the entire perioperative time. We ask that CMS ensure that hospitals and their physician leaders have the resources necessary to successfully enter into participation ahead of the January 1, 2026, model start date. These may include education on the model's specifications and requirements, meaningful data to inform practice changes that would produce successful outcomes within the model's framework, and funding to ensure that physicians have the necessary digital and human resources necessary to maintain perioperative efficiency.

Support for Patient-Reported Outcome Measures in Orthopaedic Surgery

AAOS remains supportive of the use of the Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Measure (PROM) for LEJR episodes. This measure is consistent with our view that PROMs are crucial to improving quality and ensuring positive patient outcomes that add value. We encourage CMS to consider additional PROMs for the musculoskeletal episode categories that have been developed with the input of orthopaedic surgeon experts. Similarly, we are supportive of the proposal to add the Information Transfer PRO-PM to the LEJR and Spinal Fusion quality measure sets for the model.

Support for Methodology Changes Supporting Statistical Integrity of Episode Cost Calculations

We also applaud the proposed standard, three-step approach to account for MS-DRG and HCPCS/APC changes by remapping and adjusting relevant MS-DRG/HCPCS episode types during the baseline period to estimate performance year costs. We see this as a pragmatic approach for ensuring that target prices keep pace with coding changes over the lifetime of the model.

We are also pleased that CMS has proposed to conduct a 180-day lookback for each beneficiary to determine assignment of HCC variables (or flags), as previously requested by AAOS. The lookback period is essential to understanding a patient's chronic conditions and their subsequent impact on the episode's outcomes. This will lead to improved data collection and quality improvement.

Hospital Inpatient Quality Reporting (IQR) Program

The Centers for Medicare & Medicaid Services (CMS) is proposing several changes to the Hospital IQR Program. One of these proposals is to make updates to the Hospital-Level, Risk Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) beginning with the April 1, 2023 – March 20, 2025, Reporting Period/2027 Payment Determination.[1]

AAOS supports the technical update to transition the RSCR risk adjustment methodology from Hierarchical Condition Categories (HCCs) to International Classification of Diseases (ICD)-10 codes. We believe this change may enhance clinical specificity, improve alignment with orthopaedic care documentation, and provide greater granularity. However, the impact of the model's predictive accuracy must be validated, particularly in terms of concordance statistics.

We also acknowledge CMS's update to the THA/TKA Complications measure to include patients with a principal or secondary diagnosis of COVID-19 in both the numerator and denominator. However, we caution that COVID-19 remains a clinically complex and variable factor in patient recovery, and we urge CMS to monitor for any unintended consequences related to its inclusion in outcome measures, particularly for hospitals still experiencing pandemic-related patient risk disparities.

AAOS also supports the addition of Medicare Advantage (MA) patients to the measure's cohort, as it reflects the growing proportion of beneficiaries in MA plans. However, we urge CMS to ensure the MA data sets are consistent across payers and comparable to fee-for-service Medicare to ensure appropriate integration, risk adjustment, and comparison. Outcomes and care delivery patterns for MA enrollees can differ significantly from those in traditional Medicare, and differences in coverage, care management, and health status must be accounted for to avoid skewing performance data. To account for these potential differences, we concur with the Pre-Rulemaking Measure Review Hospital Committee's recommend that CMS provide stratified data by fee-for-service and MA beneficiaries to hospitals as part of their confidential reports.

Finally, AAOS continues to urge CMS to analyze THA and TKA outcomes separately. While both procedures improve patient quality of life, they differ in recovery timelines, patient satisfaction, and functional improvement. Distinct reporting pathways would yield more accurate data and allow clinicians to make better-informed decisions that are tailored to each procedure type.[2]

Hospital Value-Based Purchasing (VBP) Program

CMS is proposing modifications to the Hospital-Level-Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure beginning with FY 2033 program year. AAOS appreciates CMS's efforts to refine the Hospital-Level RSCR Following Elective Primary THA/TKA measure and align it with corresponding updates proposed in the Hospital Inpatient Quality Reporting (IQR) Program, including the changes to the risk adjustment methodology discussed above.[1] These updates reflect ongoing work to improve the accuracy and applicability of musculoskeletal quality measures within the Medicare payment framework.

We encourage CMS to publish updated performance standards in a transparent and timely manner to allow orthopaedic providers to prepare for upcoming changes across the FY 2027-2031 program years.

MCD 08 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Hip or Knee Procedures with Periprosthetic Joint Infection (PJI)

AAOS is pleased that CMS is taking note of the resource intensiveness required to thoroughly treat periprosthetic joint infections (PJI). PJIs have become more prevalent in recent years and are now the leading cause of revision surgery in both Total Knee Arthroplasty (TKA) and Total Hip Arthroplasty (THA). According to the American Joint Replacement Registry, PJIs account for over 20% of Hip Revisions and 28% of Knee Revisions annually.[1] As CMS states in the proposed rule, there are multiple MS-DRGs to which these cases are assigned dependent on treatment type. Given the wide variability of cost among these MS-DRGs, we appreciate that CMS has now proposed to assign these cases to new MS-DRGs that center around a principal diagnosis of PJI. We believe these new MS-DRGs will provide more accurate and appropriate reimbursement for treatment of PJI commensurate with the complexity of these cases. As this epidemic of PJI is growing, we want to ensure that individuals facing challenges with treatment of PJI have access to a quality health care system which is primarily based on a set of organizational structures to ensure rapid diagnosis and appropriate treatment, and this coding change is a significant positive step in that direction.

New Technology Add-on Payment (NTAP): Alternative Pathway Policy

AAOS supports CMS's continued commitment to expanding beneficiary access to innovative technologies through the NTAP program. We appreciate the continued availability of the alternative pathway for medical devices designated under the FDA's Breakthrough Devices Program**.** While AAOS has not previously commented on the proposal to waive the substantial clinical improvement requirement for these devices, we do not oppose this approach, provided all other eligibility criteria are met.

We request that CMS apply the "substantial similarity" criteria consistently and transparently, particularly when evaluating novel orthopaedic biologics. Given the complexity of these technologies, we recommend that CMS carefully evaluate these technologies based on their specific clinical applications to avoid comparisons that may not accurately reflect their value or use in musculoskeletal care.

AAOS continues to recommend that NTAP-eligible technologies be supported by peer-reviewed evidence and allow for independent evaluation. We also continue to recommend clinical data registry integration to enable long-term outcome tracking and accountability. Finally, we encourage CMS to maintain transparency around cost thresholds and recognize that orthopaedic technologies may span multiple MS-DRGs.

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 FY 2026 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule. Should you have questions on any

of the above comments, please do not hesitate to contact Lori Shoaf, JD, MA, AAOS Office of Government Relations at shoaf@aaos.org.

Sincerely,

Ned Amendola, MD, FAAOS
AAOS President

cc: Wilford K. Gibson, MD, FAAOS, AAOS First Vice President
Michael L. Parks, MD, FAAOS, AAOS Second Vice President
Thomas E. Arend, Jr., Esq., CAE, AAOS Chief Executive Officer
Nathan Glusenkamp, MA, AAOS Chief Quality and Registries Officer

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

American Association for Hand Surgery (AAHS)
Arthroscopy Association of North America (AANA)
American Orthopaedic Foot & Ankle Society (AOFAS)
American Orthopaedic Society for Sports Medicine (AOSSM)
American Osteopathic Academy of Orthopedics (AOAO)
American Shoulder and Elbow Surgeons (ASES)
American Society for Surgery of the Hand Professional Organization (ASSH)
Atlantic Orthopaedic Specialist (AOS)
Cervical Spine Research Society (CSRS)
J. Robert Gladden Orthopaedic Society (JRGOS)
Limb Lengthening and Reconstruction Society (LLRS)
Musculoskeletal Tumor Society (MSTS)
North America Spine Society (NASS)
Orthopaedic Trauma Association (OTA)

Illinois Association of Orthopedic Surgeons
Iowa Orthopaedic Society
Massachusetts Orthopaedic Association
Minnesota Orthopaedic Society
Missouri State Orthopaedic Association
New York State Society of Orthopaedic Surgeons
Nebraska Orthopedic Society
North Dakota Orthopaedic Society
Ohio Orthopaedic Society
West Virginia Orthopaedic Society