AAOS
American Association of Orthopaedic Surgeons

June 5, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1849-P
P.O. Box 8013
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Submitted via regulations.gov

Executive Summary: On behalf of the more than 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), and the orthopaedic specialty and state societies that agreed to sign on, I am writing to share our comments on the Fiscal Year (FY) 2027 Medicare Hospital Inpatient Prospective Payment System (IPPS) proposed rule (CMS-1849-P).

- **TEAM Updates:** AAOS reiterates our opposition to requiring mandatory participation in any alternative payment model, including TEAM. Instead, we encourage the Centers for Medicare & Medicaid Services (CMS) to create a voluntary model that ensures any set of surgeons, facilities, and providers can work in innovative ways to deliver high quality and well-coordinated care to their patients.
- **Request for Information: Inclusion of ASCs in TEAM:** AAOS appreciates the opportunity to provide input to CMS on the parameters under which Ambulatory Surgical Centers (ASCs) could be incorporated into TEAM. CMS should create a separate episode benchmark for procedures performed at the ASC and carefully analyze this data for several years before considering a benchmark combining ASC and HOPD procedures. Since ASCs are a lower-cost, high-quality option for patients who require minimal post-acute care, AAOS is concerned that there are minimal savings to be found by including ASCs in TEAM. AAOS opposes attempts by CMS to artificially create savings by using ASC inclusion to lower the target prices across the model.
- **Request for Information: Voluntary Participation in TEAM by Hospitals with Physician Ownership:** AAOS supports CMS providing the opportunity for POHs to voluntarily participate in TEAM. If CMS decides to proceed, AAOS encourages the CMS Innovation Center to evaluate data on these hospitals in their own category and to ensure that POHs are a distinct category in any CMS public reporting on the model.
- **Comprehensive Care for Joint Replacement-X (CJR-X):** AAOS appreciates that CMS is striving to continue improving the quality and value of care for seniors in need of lower extremity joint replacement surgeries. However, AAOS has serious concerns with the proposed mandatory national expansion CJR-X model, and we ask that CMS delay implementation of this model until our concerns and those submitted by other stakeholders are addressed in future notice and comment rulemaking.
- **Quality Improvement through Qualified Clinical Data Registry Participation:** AAOS recommends that TEAM and CJR-X participants be required to report data from total hip arthroplasty and total knee arthroplasty procedures to a national clinical data registry such as the American Joint Replacement

Registry (AJRR) run by AAOS. Hospitals should then be able to receive credit toward their quality scores for submitting this data.

- **Inpatient Prospective Payment System:** AAOS is pleased that CMS is making changes to reflect the resource intensiveness required to thoroughly treat periprosthetic joint infections (PJI) and appreciates that CMS continues to encourage the adoption of electronic prior authorization (PA) to streamline care decisions and reduce administrative burden. We are broadly supportive of CMS' proposal to add the Hospital Harm—Postoperative Venous Thromboembolism eCQM to the Hospital Inpatient Quality Reporting program beginning with the FY 2030 payment determination as an option for self-selection. However, to better strengthen the measure's alignment with our patient safety guidelines, we recommend refinement prior to adoption

Dear Administrator Oz:

On behalf of the more than 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), and the orthopaedic specialty and state societies that agreed to sign on, I am writing to share our comments on the Fiscal Year (FY) 2027 Medicare Hospital Inpatient Prospective Payment System (IPPS) proposed rule (CMS-1849-P).

Transforming Episode Accountability Model (TEAM) Proposed Updates

AAOS reiterates our opposition to requiring mandatory participation in any alternative payment model, including TEAM. Instead, we encourage the Centers for Medicare & Medicaid Services (CMS) to create a voluntary model that ensures any set of surgeons, facilities, and providers can work in innovative ways to deliver high quality and well-coordinated care to their patients.

Capturing APC and MS-DRG changes in preliminary target prices
AAOS appreciates CMS's efforts to address timing inconsistencies between preliminary target price construction and annual payment system updates to ensure that benchmarks and target prices more accurately reflect current coding, patient acuity, and resource utilization trends. As orthopaedic procedures continue to evolve across inpatient and outpatient settings, it is important that benchmark and target price methodologies remain responsive to current clinical and payment realities.

The CMS proposed APC and MS-DRG update factors may help ensure that target prices more accurately reflect annual payment system updates under TEAM. At the same time, AAOS encourages CMS to maintain transparency regarding the methodology by addressing any changes in the IPPS Rule prior to the start of the performance year in which the methodology change would be applied. We also ask that CMS closely monitor the impact of this adjustment on target prices over time. It is important that updates to APC and MS-DRG calculations do not unintentionally create downward pressure on target prices or reduce predictability for participating hospitals and physicians. Stable and transparent payment methodologies are critical to maintaining provider engagement in episode-based payment models. Toward that end, we ask CMS to consider publishing the recalculated target price methodology with worked examples at a minimum of 90 days prior to the beginning of each performance year.

Request for Information: Inclusion of ASCs in TEAM
AAOS appreciates the opportunity to provide input to CMS on the parameters under which Ambulatory Surgical Centers (ASCs) could be incorporated into TEAM. AAOS also thanks CMS for stating that any future proposal to add ASCs to TEAM will go through the full notice and comment rulemaking process.

Advances in orthopaedic surgical techniques, new technology, and overall advancements in the practice of medicine have led to shifts in the site of service for orthopaedic procedures. CMS removed total knee arthroplasty from the Medicare Inpatient Only List (IPO) in 2018, then added it to the ASC Covered Procedures List (CPL) in 2020. Total hip arthroplasty was removed from the IPO List in 2020 and added to the ASC CPL in

2021. Total shoulder arthroplasty was removed from the IPO in 2021 and added to the ASC CPL in 2023. Since then, CMS has observed significant shifts in volume for these services away from the Hospital Outpatient Department (HOPD) and into the ASC. Many orthopaedic surgeons and patients prefer that ASCs are more streamlined and efficient than HOPDs and AAOS anticipates volume will continue to shift.

To date, CMS has not included ASCs in mandatory episode-based payment models, but the shift in site-of-service has prompted examination of this possibility. AAOS feels strongly that any future proposal to include ASCs in TEAM must not mandate ASC participation. ASCs should be given the option to participate in TEAM on a voluntary basis, and volunteers should be given a multi-year phase-in period before assuming downside risk.

Some of the structural features of ASCs that make them appealing, could also hinder the ability of ASCs to successfully participate in TEAM or the similarly designed Comprehensive Care for Joint Replacement-X (CJR-X) model. ASCs are efficiently optimized for orthopaedic surgeons to perform same-day total joint replacements. Patients tend to be healthier and able to be discharged to their home with prescriptions for physical therapy and medications. Elective arthroplasty performed in an ASC offers patients a physician-led experience in a setting where the orthopaedic surgeon is not only performing the procedure, but they are also arranging the pre-operative care, selecting the patient-specific site of service optimized for ideal outcomes, and coordinating the post-operative care. This stands in great contrast to a hip fracture patient who arrives to a hospital emergency department where the operating surgeon does not know the patient beforehand and cannot optimize them for the surgery. Post-operatively, a hospital case manager arranges rehab and holds the influence for patient outcomes and results variability. Historically, ASCs have not placed a strong emphasis on post-surgical care coordination, and this newly intensified focus could require significant operational adjustments. Should Medicare mandate the expansion of TEAM to the ASC setting, the administrative burden will increase the associated costs and therefore work counterproductively toward the Medicare program's stated goal of cost-savings.

CMS should create a separate episode benchmark for procedures performed at the ASC and carefully analyze this data for several years before considering a benchmark combining ASC and HOPD procedures. Since ASCs are a lower-cost, high-quality option for patients who require minimal post-acute care, AAOS is concerned that there are minimal savings to be found by including ASCs in TEAM. AAOS opposes attempts by CMS to artificially create savings by using ASC inclusion to lower the target prices across the model.

Many ASCs also face technological barriers to participation in longitudinal episode-based payment models. Currently, ASCs are not required to use electronic health records (EHR) systems, and ASCs were not provided financial incentives under CMS's meaningful use program to adopt EHRs. Independent ASCs not affiliated with a health system are less likely to have an EHR, and less likely to have the upfront capital required to purchase and implement an EHR. Though adoption is steadily increasing, these independent facilities in particular would benefit from CMS support to adopt EHRs. ASCs without EHRs will struggle to meet the reporting requirements of TEAM or other value-based care models.

ASCs that have already adopted EHRs may find the transition into value-based care models, including TEAM and CJR-X, easier with the help of a qualified clinical data registry. The ability to participate in a registry is a positive outgrowth of successful EHR adoption and can further reduce the burdens of data collection and

submission, including for quality measurement. Therefore, AAOS recommends that ASCs be required to report data from total hip arthroplasty and total knee arthroplasty procedures to a national clinical data registry such as the American Joint Replacement Registry (AJRR) operated by AAOS. ASCs should then be able to receive credit toward their quality scores in the form of bonus points for submitting this data. AJRR already has the capability to collect data for the CMS Inpatient Quality Reporting (IQR) THA/TKA Patient-reported Outcomes Performance Measure (PRO-PM) and other quality measures included in TEAM and CJR-X. A growing number of ASCs already participate in AJRR and find it helpful to demonstrate to patients, physicians and regulators that their quality is on par with their regional hospitals.

AAOS would be willing to share calculated metrics at the facility level or have metrics flow into a CMS calculated composite quality score to meet the model's requirement for public reporting. CMS could also use registry data on patient co-morbidities, Charlson Comorbidity Index, and other clinical items to help adapt the risk adjustment methodology to ensure appropriate outpatient site-of-service decisions. The AJRR team welcomes the opportunity to meet with CMS to discuss ways in which AJRR can advance the integration of ASCs into value-based care.

Request for Information: Voluntary Participation in TEAM by Hospitals with Physician Ownership
AAOS appreciates that the CMS Innovation Center recognizes the value and benefits of Physician-Owned Hospitals (POHs), especially as it relates to improving patient outcomes and preventing hospital consolidation. We are supportive of the CMS Innovation Center considering a voluntary opt-in for POHs located in core-based statistical areas (CBSA) not selected for inclusion in TEAM. Generally, AAOS believes that Physician-led hospitals are an important component of and competitive force within the American healthcare system that ensure patients receive the highest quality care at the lowest cost. If CMS decides to allow POHs to opt-in to TEAM, AAOS encourages the CMS Innovation Center to evaluate data on these hospitals in their own category and to ensure that POHs are a distinct category in any CMS public reporting on the model.

AAOS is hopeful that this objective data will add to the pool of evidence demonstrating that POHs provide high-quality, lower cost care and help persuade Congress to lift the current ban on physician ownership of hospitals. Lifting this ban can have an outsized impact by helping to keep hospitals open in rural areas while also improving competition in highly consolidated markets.

<u>Comprehensive Care for Joint Replacement-X (CJR-X)</u>

AAOS appreciates that CMS is striving to continue improving the quality and value of care for seniors in need of lower extremity joint replacement surgeries. However, AAOS has serious concerns with the proposed mandatory national expansion CJR-X model, and we ask that CMS delay implementation of this model until our concerns and those submitted by other stakeholders are addressed in future notice and comment rulemaking.

Mandatory Nature of Model
The AAOS supports voluntary bundled episode-of-care alternative payment models. However, as explained in our comment letter to the initial CJR proposed rule in September 2015 and all subsequent communication on this model, we ardently believe the proposal to mandate participation in the model for Lower Extremity Joint

Replacement (LEJR) episodes is flawed and should be replaced by a voluntary approach that allows providers and facilities to choose to be risk-bearing conveners.

The proposal to include LEJR episodes across all eligible acute care hospitals nationwide will severely disadvantage those surgeons, non-physician providers, and facilities that either do not have the proper infrastructure to optimize patient care under episodes-of-care payment models and/or lack adequate patient volumes to create sufficient economies of scale. A voluntary program that allows surgeons, facilities, and non-surgical providers to tailor their episode-of-care models to their unique patient population would lead to far better patient care as well as more accurate and efficient payments. In fact, the evidence reflects that BPCI-A physician group conveners produced larger Medicare savings than hospital conveners. As it relates to the proposals made here, we ask the CMS to consider the essential role that orthopedic surgeons play in leading these innovative cost-savings solutions.[1]

We strongly urge CMS to revise the mandatory nature of the proposal and instead create incentives for interested participants that would reward innovation and high-quality patient care. We believe the program should be voluntary and on a nationwide basis for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to bring higher quality, improved care coordination, and to lower costs for musculoskeletal care and who have the infrastructure necessary to carry out an episode of care approach to payment and delivery. Specifically, we recommend that CMS require that any participating entity has verifiable interoperability and infrastructure agreements between all necessary entities.

Impact of savings going to hospital and gainsharing implications
Orthopaedic surgeons, who are at the center of the care teams providing the services in CJR-X, should be able to share the savings. The orthopaedic surgeon holds the accountability and clinical decision-making authority for the procedure, and with this, the levers that drive episode cost. For example, the operating surgeon decides the most appropriate implant for the patient based on unique clinical factors, length of stay, post-acute disposition, and follow-up cadence. Each of these choices plays a key role in quality outcomes and overall cost. However, many orthopaedic surgeons are not being given the opportunity to enter into gainsharing agreements with the hospitals that control the bundled payment arrangements with the CMS Innovation Center.

Per our comments to the original CJR proposed rule, the AAOS recommends revising the proposal to give operating surgeons and physician groups the ability to oversee the bundle, including collecting payments and accepting two-sided risk across the spectrum of care. Alternatively, CMS should provide greater incentives for CJR-X participating hospitals to exercise CMS' proposed CJR-X Collaborator Policies to engage individual surgeons or physician group practices to participate in managing the CJR-X episode. AAOS is concerned that under the current optional collaborator process, hospitals do not have sufficient impetus to take on the extra burden required to engage physicians even though physicians are at the core of delivering care to LEJR patients.

Risk Adjustment

[1] https://www.cms.gov/priorities/innovation/data-and-reports/2023/bpci-adv-ar4-appendices

Hospitals serving disadvantaged populations may be disproportionately impacted by penalties. An analysis of CJR Year 2 data showed hospitals with a high percentage of dual-eligible beneficiaries (patients with both Medicare and Medicaid insurance) were more likely than low-dual hospitals to be penalized (24.3% vs 13.7%).[2] CMS' "CJR Seventh Evaluation Report Executive Summary"[3] showed 27 of the 32 hospitals that owed the highest repayment amounts were safety net hospitals. The report also noted that safety net hospitals performed fewer LEJR procedures, but that a higher proportion of those procedures were due to fractures which are far more difficult to preoptimize.

The majority of savings in Medicare Part A spending for the CJR model has been a result of the reduction in post-acute care, specifically the use of inpatient rehabilitation facilities (IRF). Yet, individuals with disabilities and those belonging to economically disadvantaged groups are more likely to need higher intensity institutional post-acute care because of their health status. In addition, a study found that in the CJR model, hospitals with a higher percentage of Medicare-Medicaid dual-eligible patients must reduce spending at a higher rate than others to obtain a positive bonus despite their high share of patients with complex social and clinical needs.[4] Assuming that the same trends hold from CJR to CJR-X, then hospitals with higher proportions of low-income patients will perform worse than their peers, leading to lower shared savings and/or higher repayment obligations. Financial penalties as a result of caring for more complex patients further reinforce a system that provides fewer resources to safety-net hospitals and worsens healthcare outcome disparities.

Target Pricing

AAOS appreciates that CMS acknowledges concerns surrounding the "ratchet effect", where lowering spending could lead to lower future target prices and effectively penalize efficiency. However, the proposed target pricing methodology proposed by CMS for CJR-X does not eliminate this "ratchet effect." Under CJR-X, episode target prices are adjusted every year based on actual spending in prior years. Even if a hospital is able to reduce spending in one year, it could be penalized the following year if it does not reduce spending even further. In other words, successfully achieving the model's goal of saving costs could ultimately harm hospitals by driving target prices to a level that is unsustainably low over the course of the model. This is especially problematic since CJR-X does not have an end date.

CMS itself acknowledges in the proposed rule that spending on LEJR episodes has been declining over time and "may reach a point where further decreases in spending could compromise quality and patient safety." CMS further notes that spending has stabilized in recent years, "suggesting that there may no longer be as much of an opportunity for participant savings as there was in the early years of CJR." This raises serious questions about the long-term viability and fairness of the proposed target pricing methodology.
LEJR episodes have been tested by the CMS Innovation Center for more than a decade. In this time, orthopedic surgeons have complied with multiple iterations of mandatory and voluntary models aimed at

[2] Kim, H., Meath, T.H., Dobbertin, K., Quinones, A.R., Ibrahim, S.A., & McConnell, K.J. (2019). Association of the Mandatory Medicare Bundled Payment With Joint Replacement Outcomes in Hospitals With Disadvantaged Patients. *JAMA network open, 2(*11*),* e1914696-e1914696

[3] https://www.cms.gov/priorities/innovation/data-and-reports/2025/cjr-py7-ar-exec-sum

[4] Kim, H., Meath, T.H., Dobbertin, K., Quinones, A.R., Ibrahim, S.A., & McConnell, K.J. (2019). Association of the Mandatory Medicare Bundled Payment With Joint Replacement Outcomes in Hospitals With Disadvantaged Patients. *JAMA network open, 2(*11*),* e1914696-e1914696

reducing costs to the lowest possible denominator. Through innovation, optimization, and a commitment to excellence in patient care, these musculoskeletal care teams led by orthopedic surgeons have achieved historic savings for the Medicare program.

AAOS members are deeply troubled that CMS continues to focus almost exclusively on extracting savings from LEJR procedures after these procedures have already been targeted by several value-based care models over the past ten years. Particularly as it relates to the impacts of the proposed CJR-X model, we are concerned that the only savings left to glean are within the post-acute care space, and that these savings are now minimal, as CMS acknowledges in the proposed rule. CMS' "CJR Seventh Evaluation Report Executive Summary"[5] showed that most of the savings in performance years 6 and 7 came from reductions in spending on inpatient rehabilitation facilities. Since PY7 concluded on December 31, 2023, orthopaedic surgeons have continued to decrease post-acute care spending through patient pre-optimization efforts. IRF and skilled nursing facilities (SNF) placement after LEJR is already almost completely reserved for the most complex patients who cannot safely conduct rehabilitation in their home and outpatient settings. Patients with hip fractures are more likely to need post-acute care. These procedures are not elective; therefore, the patients are not able to be preoptimized. By placing additional downward pressure on the post-acute component within the 90-day episode, Medicare is diminishing the care of the neediest patients it is designed to serve. As CMS acknowledges in the proposed rule, we may have now reached a point where "further decreases in spending could compromise quality and patient safety."

These policies, combined with the arbitrary 2% discount factor that is newly applied each year, exacerbate the already difficult economic situation that musculoskeletal teams face in their day-to-day practice. By forcing orthopedic surgeons to do the work of minimizing costs but giving them no control over the bundle and no guarantee of gainsharing, it creates a dynamic that complicates the goal of streamlining care and improving access. AAOS urges CMS to reconsider the CJR-X episode and instead look to other sources of Medicare spending to garner meaningful savings *and* quality improvements.

Recommended Improvements to TEAM and CJR-X

Allow Voluntary Participation by Physician Practice Groups
We ask that CMS allow physician practice groups to voluntarily opt-in as TEAM or CJR-X participants, taking clinical and administrative responsibility for convening the episode bundles and financial responsibility for two-sided risk. Many orthopaedic practices voluntarily participated in Bundled Payments for Care Improvement Advanced (BPCI-A) before it was terminated on December 31, 2025. These practices adapted their business and clinical workstreams to successfully improve quality and produce savings for CMS, and physician groups ultimately performed better than hospitals in this model. Now these physician groups are left with systems in place to support value-based episode bundled payments, but there is no opportunity to continue providing this same type of care since they are excluded from TEAM and CJR-X. We urge CMS to open TEAM and CJR-X to these practices and others interested in providing value-based care to seniors.

Quality Measurement

[5] https://www.cms.gov/priorities/innovation/data-and-reports/2025/cjr-py7-ar-exec-sum

As we have done in past comments, AAOS continues to support the use of the Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient Reported Outcome -Based Performance Measure (PRO-PM) (CMIT ID #1618). However, we are concerned that this measure is not ready for inclusion in mandatory alternative payment models. CMS is currently administering the first mandatory reporting cycle of this measure in the Hospital Inpatient Quality Reporting (IQR) program – the final data submission deadline is not until September 30, 2026, and CMS does not expect to publicly release results of the cycle until 2027. Similar to data released from the voluntary reporting period, AAOS is concerned that this new data will show the threshold for reporting a matched pre- and post-operative PRO-PM survey for 50% of individual patients is too high in a real-world setting. Accordingly, we ask that CMS make this measure "pay-for-reporting" only and not "pay-for-performance" until the FY2030 Hospital IQR payment determination period. This will provide CMS with adequate time to analyze and publicly release the data from the first several mandatory reporting periods and adjust the reporting threshold. It will also provide hospitals, physicians, and their staff with additional time to make the workflow and technology changes necessary to effectively and efficiently collect PRO-PM data from patients. AAOS strongly believes that PRO-PMs can meaningfully inform clinical decision making and improve patient care, but the measure's specifications must be realistic and achievable for the measure to have these intended positive impacts.

Maintaining Access to Fracture Liaison Services
AAOS is concerned that the bundled payment model's coverage of all Medicare Part A and Part B services provided under either the 30-day TEAM episode post-discharge window or the 90-day CJR-X post-discharge window would disincentivize the uptake of Fracture Liaison Services (FLS) for osteoporotic patients. Despite their demonstrated value in reducing secondary fractures among osteoporotic patients, FLS are widely underutilized and therefore largely absent from the historical spending data used in setting target prices for LEJR episodes under TEAM and CJR-X. To address this and ensure that the majority of hip fracture patients who are diagnosed with osteoporosis or osteopenia maintain access to FLS, we recommend that CMS exclude these costs from the bundles all together and continue to pay them separately. Without this exclusion hospitals may be disincentivized from referring patients to these services or could be inclined to delay the start of services to outside the bundle period, thus resulting in potential patient harm and fragments in the continuity of care.

If CMS is not willing to exclude these costs, we ask that the agency consider working with appropriate stakeholders to develop flexibilities or a pathway that encourages FLS adoption. Likewise, we encourage CMS to actively monitor hospitals to ensure that FLS uptake is not discouraged or delayed due to financial pressures imposed by the TEAM or CJR-X bundle target price.

Quality Improvement through Qualified Clinical Data Registry Participation
AAOS recommends that TEAM and CJR-X participants be required to report data from total hip arthroplasty and total knee arthroplasty procedures to a national clinical data registry such as the American Joint Replacement Registry (AJRR) run by AAOS. Hospitals should then be able to receive credit toward their quality scores for submitting this data. AJRR already has the capability to collect data for the Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618) required in the TEAM and CJR-X quality measure sets.

Since TEAM and CJR-X are mandatory models, they include hospitals that have never participated in a value-based care model prior to January 1, 2026. Registry reporting could make it easier for hospitals new to value-based care to meet the requirements of TEAM and CJR-X by reducing the administrative burden associated with collecting and submitting data to CMS. Registry participation can also generally improve the quality and safety of care being provided to patients, patient outcomes, and measurement of these metrics, all long-standing priorities of CMS. For these reasons, multiple accreditation and certification bodies have registry participation requirements for advanced certifications in orthopaedics generally and LEJR specifically.

For these CMS Innovation Center models, AAOS would be willing to share calculated metrics at the facility level or have metrics flow into a CMS calculated composite quality score to meet the requirements for public reporting. Additionally, AJRR already contains functionality to allow for benchmarking between participating facilities, a capability that could help CMS improve the design of these models over time. **The AJRR team welcomes the opportunity to meet with CMS to discuss ways in which AJRR can advance value-based care for hospitals of all sizes in all regions.**

Inpatient Prospective Payment System

Changes to MS-DRGs for Prosthetic Joint Infection
AAOS is pleased that CMS is making changes to reflect 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] Given the wide variability of resource use among cases assigned to the current MS-DRGs, we appreciate that CMS has now proposed to assign these cases to a set of narrow, better defined 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 change to the MS-DRG structure for these cases is a significant positive step in that direction.

Measure additions and updates
AAOS is broadly supportive of CMS' proposal to add the Hospital Harm—Postoperative Venous Thromboembolism eCQM to the Hospital Inpatient Quality Reporting program beginning with the FY 2030 payment determination as an option for self-selection. However, to better strengthen the measure's alignment with our patient safety guidelines, we recommend refinement prior to adoption. Specifically, we request that additional clinically appropriate exclusions be made (for example, pending surgery); incorporate specialty-specific workflows, particularly for orthopaedic trauma; and conduct further testing/validation to ensure that the measure does not incentivize care that delays surgery or limits appropriate anesthesia. Furthermore, we encourage CMS to align measures with evidence-based guidelines and real-world care pathways to ensure the unintended tradeoffs are avoided. Current AAOS guidelines state that VTE prophylaxis

is recommended for hip fracture patients, *but* surgery should occur within 24-48 hours of admission for optimal outcomes (i.e., surgery timing or anesthesia should not be compromised).[6,7]

Electronic Prior Authorization Measure
AAOS appreciates that CMS continues to encourage the adoption of electronic prior authorization (PA) to streamline care decisions and reduce administrative burden. Consistent with our comments on prior authorization across the various Medicare programs[8], we encourage use of PA to be deliberate and concise while minimizing clinician burden and patient delays in care. If this proposal is finalized, we ask that CMS expand this measure to also include drugs, consistent with the recently released Fiscal Year (FY) 2027 Interoperability Standards and Prior Authorization for Drugs proposed rule (CMS–0062–P)

Unique Device Identifiers for Implantable Medical Devices Measure
AAOS is supportive of CMS' proposal to adopt a unique device identification measure under the Public Health and Clinical Data Exchange objective beginning with the CY 2027 Electronic Health Record (EHR) reporting period. Should this proposal be implemented with care for accuracy and consistency, it would make the identification of component information easily accessible for integration into our clinical data registries and therefore strengthening our device surveillance capabilities.

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 2027 Hospital Inpatient Prospective Payment System (IPPS) 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,

Joel Mayerson, MD, FAAOS
AAOS Council on Advocacy Chair

cc: Wilford K. Gibson, MD, FAAOS, AAOS President
Michael L. Parks, MD, FAAOS, AAOS First Vice President
Elizabeth G. Matzkin, MD, FAAOS, AAOS Second Vice President
Thomas E. Arend, Jr., Esq., CAE, AAOS Chief Executive Officer

[6] https://www.orthoguidelines.org/topic?id=1024
[7] https://ashpublications.org/bloodadvances/article/3/23/3898/429211
[8] https://www.aaos.org/globalassets/advocacy/issues/aaos-comments-on-cy-2027-ma-tech-rule-1.26.26.pdf

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
American Orthopaedic Foot & Ankle Society
American Shoulder and Elbow Surgeons
American Society for Surgery of the Hand Professional Organization
Cervical Spine Research Society
J. Robert Gladden Orthopaedic Society
Musculoskeletal Infection Society
Orthopaedic Trauma Association
Ruth Jackson Orthopaedic Society

Alabama Orthopaedic Society
Arkansas Orthopaedic Society
Connecticut Orthopaedic Society
Delaware Society of Orthopaedic Surgeons
Florida Orthopaedic Society
Georgia Orthopaedic Society
Illinois Association of Orthopaedic Surgeons
Massachusetts Orthopaedic Association
Michigan Orthopaedic Society
Minnesota Orthopaedic Society
Missouri State Orthopaedic Association
Nebraska Orthopaedic Society
New Jersey Orthopaedic Society
North Carolina Orthopaedic Association
North Dakota Orthopaedic Society
Ohio Orthopaedic Society
Pennsylvania Orthopaedic Society
South Carolina Orthopaedic Association
South Dakota State Orthopaedic Society
Tennessee Orthopaedic Society
Texas Orthopaedic Association
Virginia Orthopaedic Society
West Virginia Orthopaedic Society