AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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September 12, 2025

**VIA E-MAIL FILING**

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

**RE: Medicare 2025 Physician Fee Schedule Proposed Rule**

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on its Medicare physician fee schedule (PFS) proposed rule for calendar year 2026 (hereinafter referred to as "CY 2026 PFS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 5,600 physicians with expertise in total joint arthroplasty (TJA) procedures. Many of our members conduct research in this area and are experts in using evidence based medicine to better define the risks and benefits of treatments for patients suffering from lower extremity joint conditions. In all of our comments, AAHKS is guided by four principles:

- Payment reform is most effective when physician-led;
- Reductions in physician reimbursement by public and private payers drives provider consolidation;
- The burden of excessive physician reporting on metrics detracts from care; and
- Patient access, especially for high-risk patients, and physician incentives must remain a focus.

Our comments focus on the 2026 PFS proposed rule follow, beginning with a summary:

## I. Summary of Comments

- The Proposed Rule Contains a Series of Breathtaking, Arbitrary Proposals, Not Based on Empiric Data, that Will Lead to Less Accurate RVUs and Will Accelerate Provider Consolidation
- Conversion Factor (CF) Increases are Insufficient to Reverse Falling Reimbursements
- Congress and CMS Should Enact Physician Payment Reforms to Rebalance Divergent Provider and Facility Reimbursement for the Same Procedure

- Congress and CMS Should Ensure that Such Physician Payment Reforms Adequately Account for Inflation by Adjusting Physician Payments to the Medicare Economic Index
- CMS Proposes Severe, Material Cuts to Physician Reimbursement in Response to a Suspected "Potential" that Some PE RVUs "May" Be Overstated
- CMS Mistakenly Conflates Physician Ownership/Employment Trends with Changes in Medical Practice
- CMS Lacks Authority to Adjust RVUs Based on Ownership/Employment Trends
- CMS' Proposed PE RVU Methodology is Arbitrary and Unrelated to Actual Resources Used in Furnishing a Service
- CMS Proposes Significant Material Across-the-Board Cuts Based on a Mere Suspicion that Work RVUs Might be Overvalued, Not Documentation of Overvaluation
- CMS' Assumptions in Favor of Across-the-Board, System-Wide Cuts are Based on Misreading and Mischaracterizing Limited Studies of a Few Individual Codes, All of Which Actually Emphasize the Need for Procedure-Specific Values
- By Characterizing Work RVUs as Overvalued, CMS Dismisses and Ignores Decades of Its Own Policy that CMS Previously Claimed Ensured Accurate RVUs
- CMS Misreads or Misrepresents the 2015 GAO Study of the AMA RUC Process and Specialty Society Surveys
- The Efficiency Adjustment is Counter to Statutory Requirements to Value Individual Services
- There are Numerous Policy Problems with the Efficiency Adjustment
- Recent OIG Reports on Physicians Under-Reporting Post-Operative Visits Undermines Persuasiveness of Earlier CMS Reports that Global Surgical Packages are Overvalued
- Improving Payment Accuracy Requires a Comprehensive Holistic Review of Physician Treatment and Management of Underlying Conditions, and a Move to Longitudinal Care, Not Merely Attempts to Cut Post-Operative Visit Values
- Advancing So Many Different Payment Cuts Simultaneously Will Accelerate Even More Provider Consolidation and the End of Many Independent Practices
- AAHKS Supports the Administration's Focus on Reshaping the Care Continuum to Better Prevent and Manage Chronic Disease and Improve Quality of Life for Beneficiaries
- When Clinically Appropriate, Hip and Knee Procedures are Part of This Continuum by Managing Osteoarthritis and Enabling Beneficiaries to Leverage One of the Most Potent and Cost-Effective Tools to Combat Chronic Disease—Physical Activity

## II. Calculation of the 2026 PFS Conversion Factor (Sec. I.C)

Consistent with the requirements of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS proposes to apply separate conversion factors for Qualifying Advanced Payment Model Participants (QPs) and for non-QP clinicians. Overall, for 2026, CMS proposes a 3.83% conversion factor increase for QPs and a 3.32% conversion factor increase for non-QPs.

***AAHKS Comment:***

*a. Conversion Factor (CF) Increases are Insufficient to Reverse Falling Reimbursements*

AAHKS welcomes CMS's proposal to increase the Medicare conversion factor for 2026. In accordance with the Medicare statute, CMS adjusts the overall conversion factor used for all procedure in the PFS to maintain "budget neutrality" when CMS's changes to certain RVUs increase Medicare PFS expenditures for the year by more than $20 million than the expected expenditures in the absence of such changes and if CMS has not otherwise offset the excess expenditures through other specific RVU decreases.

Notwithstanding AAHKS's overall support of the proposed CF Increase, we emphasize that the CF Increase represents short-term, limited, relief for only *some* providers and leaves the long-standing, structural deficiencies of Medicare's physician payment framework unresolved. Further, the CF increase is modest and inadequate compared to the sweeping changes CMS proposes for work RVU and practice expense RVU methodology which will led to significant cuts for many specialties in 2026. Even with the proposed increase to the conversion factor, reimbursement for arthroplasty will decline precipitously:

| **Medicare Payment Levels for Hip and Knee Arthroplasty** | | | | | |
|---|---|---|---|---|---|
| | **2025** | **2026 (Proposed)** | | | |
| | | **QP** | **% Change** | **Non-QP** | **% Change** |
| **CPT 27447** | $1,257 | $1,170 | −6.87% | $1,164 | −7.34% |
| **CPT 27130** | $1,259 | $1,173 | −6.86% | $1,167 | −7.32% |

*b. Not All CF Increases are Welcome*

Notably, the proposed CF Increase represents the culmination of three separate policies rather than a targeted increase by CMS. Specifically, the CF increase results from (1) the 0.75% increase to the QP conversion factor and the 0.25% increase to the non-QP conversion factor statutorily mandated to occur starting in 2026 under MACRA, (2) a one-time statutory increase of 2.5% for 2026 only, and (3) 0.55% increase that largely is paid for by the arbitrary and harmful work RVU "efficiency adjustment" that CMS proposes for many procedures.

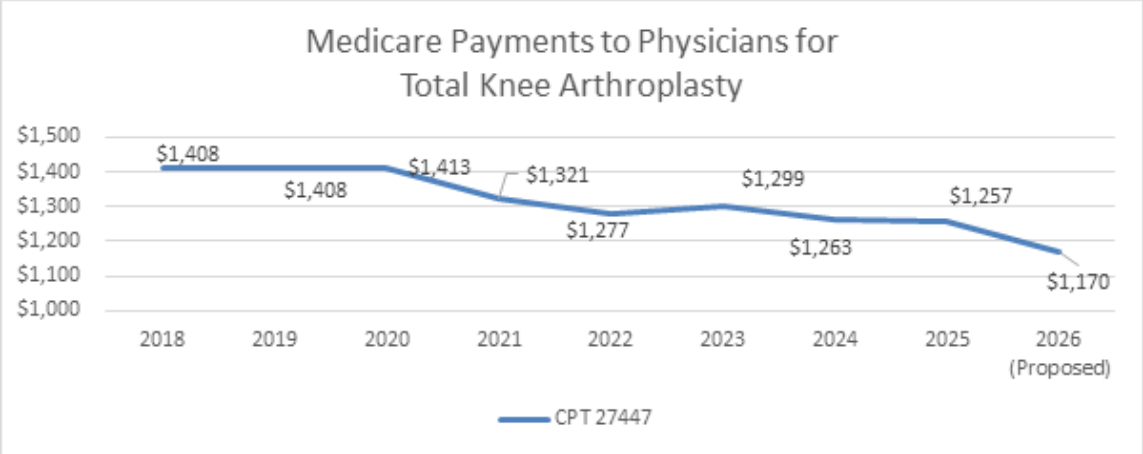
These increases are offset by the even greater decreases proposed with the work RVU adjustment and practice expense RVU reallocation. The 0.55% CF increase is not worth the lasting damages to doctors and the increasing consolidation that will be driven by the totality of PFS changes in the proposed rule. Rather, we believe CMS's proposed changes in the 2026 Proposed Rule reinforces the necessity of comprehensive and lasting Medicare physician reimbursement reform.

*c. Principles for Medicare PFS Reform*

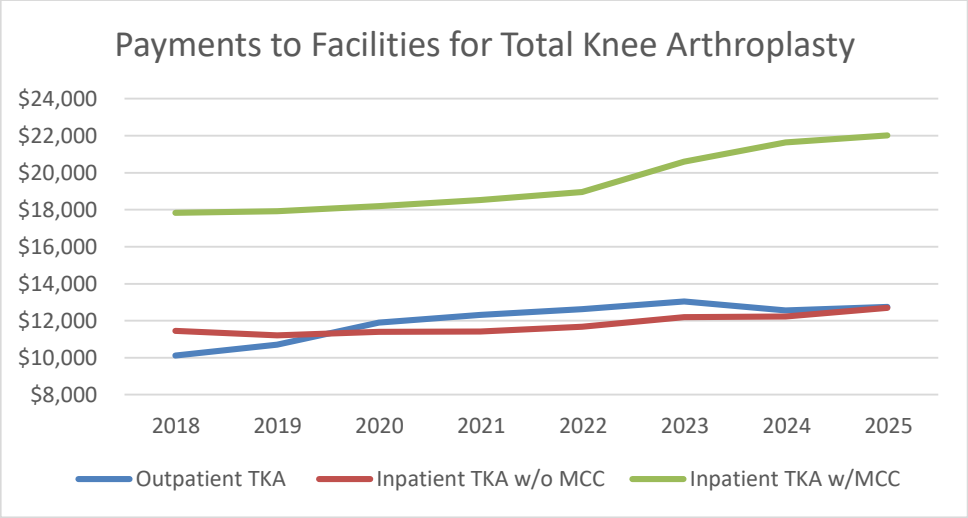
AAHKS urges CMS to work closely with Congress to advance comprehensive and long-term Medicare physician payment reforms that tackle current systemic deficiencies and improve what has become a broken process of perpetual cuts and end-of-year band-aids. Specifically:

i. <u>Ensure that Such Physician Payment Reforms Rebalance Divergent Provider and Facility Reimbursement for a Procedure</u>

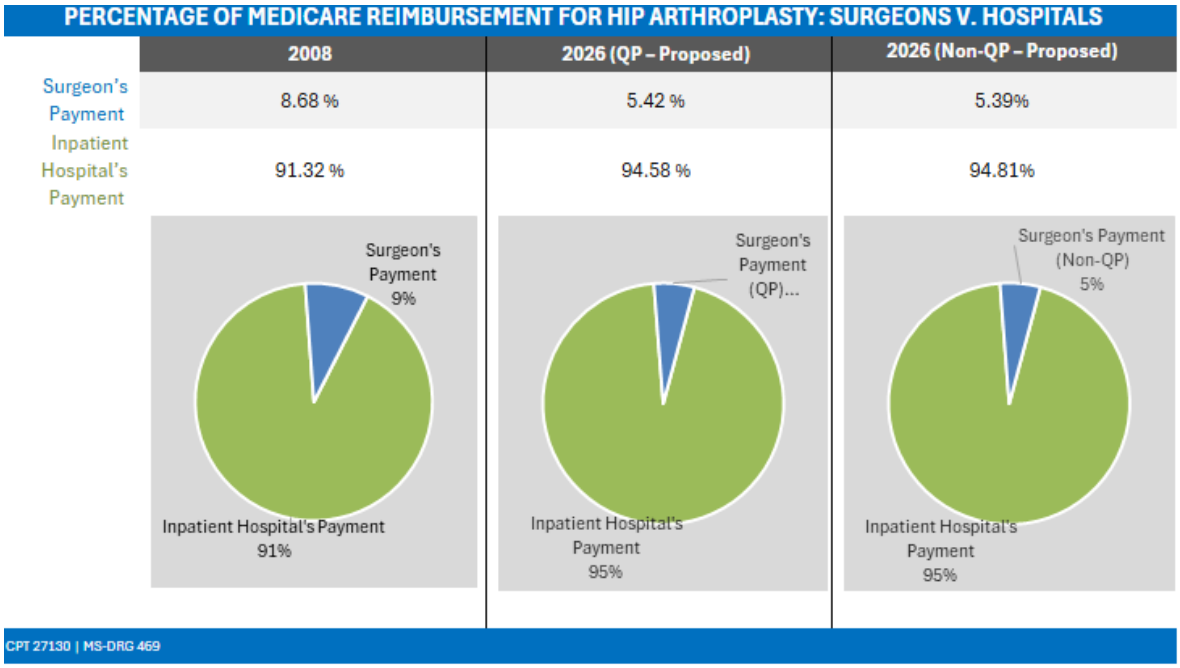
AAHKS acknowledges budget neutrality requirements and the need to manage federal expenditures. However, the federal government cannot derive health care savings solely from physicians. While payments under the IPPS, OPPS, and PFS may be calculated according to separate statutory formulas, AAHKS believes CMS and Congress should be alarmed at recent trends in facility and surgeon reimbursement for arthroplasty, which make the lack of coordination and consistency between Medicare payment systems evident. Medicare payment for the professional component of arthroplasty has been cut by [17%] since 2020, while Medicare payments to facilities for the same procedures over a similar timeframe have skyrocketed.




Although AAHKS generally supports increased payment rates to facilities for arthroplasty due to a variety of reasons—such as procedural complexity and innovations in care, among others—the ongoing annual increases in Medicare facility payments for arthroplasty present a stark contrast with severely decreasing Medicare physician payments for arthroplasty, as is illustrated as follows:

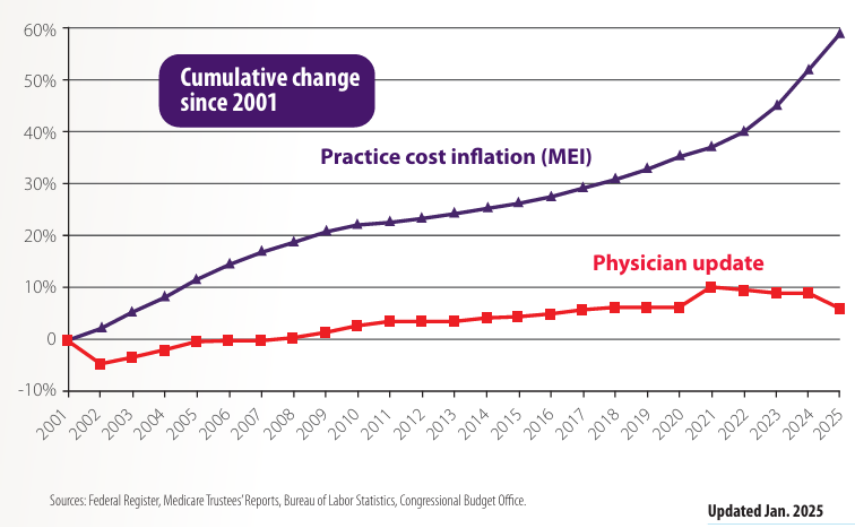



In effect, Medicare's payment formulas make the surgeons, whose reimbursement accounts for *less than six percent* of total Medicare payments to providers for TJA procedures, carry the burden of cost reductions while hospital payments continue to increase. We urge Congress and CMS to explicitly address whether Medicare beneficiaries and the health care system are best served by rapidly increasing reimbursement rates to facilities for arthroplasty procedures while, at the same time, making severe cuts to the reimbursement for professional services for those procedures. If so, we ask—why? If not, AAHKS urges CMS to articulate to Congress any necessary adjustments to statutory reimbursement formulas so that there may be a unified coordinated CMS policy towards the value of arthroplasty.



ii. Ensure that Such Physician Payment Reforms Adequately Account for Inflation by Adjusting Physician Payments to the Medicare Economic Index

Congress should add an inflationary adjustment factor for Medicare physician payments. The *Strengthening Medicare Patients and Providers Act*, which would adjust physician payments to the Medicare Economic Index, is one such way to ensure that Medicare payment rates keep up with the actual costs physicians encounter in real medical practice today.




Inadequate and ever declining reimbursement hinders surgeons' capacity to continue specializing in high-demand procedures critical to Medicare beneficiaries. AAHKS' members wish to remain in their field of choice. Unfortunately, the continued decline for Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA) has sadly led to surgeons shifting their focus to other procedures and conditions for which they have trained—despite the accelerating need for joint replacement in the Medicare age eligible population.

CMS's proposed changes in the 2026 Proposed Rule reinforce the necessity of comprehensive and lasting physician reimbursement reform. As such, AAHKS urges CMS to work with Congress to advance comprehensive and long-term physician payment reforms that tackle current systemic issues to ensure Medicare's physician reimbursement framework better reflects actual costs of physician encounters and services as medical practice continues to evolve and patients' demand for such services grow.

## III. Updates to Practice Expense Methodology – Site of Service Payment Differential (Sec. II.B.5.c)

CMS proposes to reduce the portion of the facility-based PE RVUs to half the amount allocated to non-facility PE RVUs. CMS states that practice expense (PE) RVU values, based on AMA surveys, are also unreliable. CMS points to "small sample sizes and sampling variation, low

response rates and representativeness, potential measurement error, and incomplete data submission" and therefore will not use the AMA submitted values.

Instead, CMS proposes a new PE methodology to "recognize greater indirect costs for practitioners in office-based settings compared to facility settings." CMS historically assumed that most physicians maintained a separate office even if they primarily practiced in a hospital. Now, CMS argues that because significantly more physicians are hospital employed, they are not maintaining separate offices and therefore have lower costs.

Specifically, 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 beginning in 2026.

**AAHKS Comment:**

*a. CMS Proposes Severe, Material Cuts to Physician Reimbursement in Response to a Suspected "Potential" that Some PE RVUs "May" Be Overstated*

It is disappointing to see a cavalier proposal to impose significant cuts to the indirect PE RVU values, based not on new, observed, quantifiable data on practice expense, but on a mere suspicion that a nation-wide trend regarding practice ownership across medicine "may" mean that all facility-based services are overvalued to exactly the same degree. Notably, CMS studiously avoids concluding that current PE RVUs valuations do not reflect real world practice patterns. CMS qualifies each proposition as follows:

- "These trends ***indicate*** a steady decline in the percentage of physicians working in private practice";
- "We believe that allocating the same amount of indirect practice expense based on work RVUs in both settings ***may overstate*** the range of indirect costs incurred by facility-based physicians";
- "Maintenance of that element of the methodology in the face of changing practice patterns ***likely represents*** an imbalance of the practice expense allocated to the facility relative to the nonfacility";
- "We share MedPAC's concerns regarding the ***potential*** for duplicative payment under the current PE methodology";
- "Allocating the same amount of indirect PE per work RVU for services furnished in the facility setting as the nonfacility setting ***may no longer*** reflect contemporary physician practice trends";
- "Data ***suggests*** that fewer than half of physicians currently own their practices".[1]

[1] All statements from 90 Fed.Reg. 32373 (July 16, 2025) (emphasis added).

*b. CMS Mistakenly Conflates Physician Ownership/Employment Trends with Changes in Medical Practice*

Statute permits CMS to periodically adjust RVUs based on "changes in medical practice, coding changes new data on relative value components, or the addition of new procedures."[2] Here, in support of reducing indirect PE RVUs, CMS looks to the "percentage of physicians in hospital-owned practices [that] has increased by over 47 percent, from 23.4 percent in 2012 to 34.5 percent in 2024."[3] CMS makes a leap to conclude "it is now less likely that [facility-based physicians] would maintain an office-based practice separate from their facility practice."[4]

There are three separate factors that CMS raises: (1) The ownership/employment of a physician practice; (2) the site of service of physician work; and (3) who bears financial risk for the indirect practice expenses of a physician office. These are all separate factors which may or may not be related to each other based on individual, specific circumstances.

Whether a physician is a member of an independent practice or practice owned by a hospital or is directly employed by a hospital does not in any way indicate the location of the physician's work. Rather, the physician's specialty and/or sub-specialty will most accurately suggest the amount of work performed in an office setting or facility setting.

In support of the contention of a "rise in physician employment by hospitals", CMS cites a MedPAC report showing the nine specialties in which at least 60 percent of the clinicians who billed Medicare furnished 90 percent or more of their services in facility settings. But a closer look at the MedPAC data reveals just a list of facility-based specialties, the top two being Hospitalist and Emergency medicine, presuming that facility-based specialists must be hospital-employed.

Further, whether a physician is in a hospital owned practice or directly employed by the hospital in no way indicates whether the physician maintains a separate office outside of the facility, where the office is located, and the degree to which the physician is economically at risk or responsible for the direct and indirect costs of maintaining the office. These are all subject to negotiation and variation between a physician and a hospital. The mere fact that a physician performs services in a facility or is employed by a hospital does not predict these factors with any accuracy.

*c. CMS Lacks Authority to Adjust RVUs Based on Ownership/Employment Trends*

As noted above, statute permits CMS to adjust RVUs based on "changes in medical practice."[5] That is, changes in clinical best practices applied by specific specialties to specific procedures. Statute does not grant CMS authority to adjust RVUs based on the economic model

[2] SSA § 1848(c)(2)(B)(ii).
[3] 90 Fed.Reg. 32373.
[4] Id.
[5] § 1848(c)(2)(B)(ii).

of the practice. PE RVUs are to be based on observed "resources used in furnishing the service that reflects the general categories of expenses . . . comprising practices expenses."[6]

*d. Wide Variation Exists in Ownership/Employment Trends Between Specialties*

Even if one accepts CMS' premise that the mere fact of some financial affiliation between a physician and a hospital means that the physicians indirect practice expense is half that of an office-based procedures, the data on financial affiliation varies widely, especially between specialties. CMS should also take into consideration data not specific to hip and knee surgeons that indicate private practice is still the dominant employment for physicians while hospital employment is only about a quarter of employed physicians.[7] The AMA's Physician Practice Benchmark Survey in 2024 indicates the two physician types which overwhelmingly remain in private practice are Ophthalmology with 70.4% of physicians in private practice in 2024 and Orthopedic Surgery with 54%.[8]

AAHKS members (orthopaedic surgeons who specialize in hip and knee arthroplasty) report similar rates of private practice with even signs that the rate of private practice is increasing. A formal published survey found 49 percent of AAHKS respondents in private practice at the end of 2022,[9] but another survey in late 2023 found that rate had increased to 53 percent.[10] Interestingly, 60 percent of respondents spent 50%-66% of their clinical time in the office, not the facility. This further suggests that indirect PE values should be based upon observed data specific to the procedure and not broad trends on ownership or site of service.

Finally, MedPAC states "there is not a definitive data source that shows whether a given clinician is financially affiliated" with a hospital.[11]

*e. CMS' Proposed Methodology is Arbitrary and Unrelated to Actual Resources Used in Furnishing a Service*

CMS declines to accept AMA's PPI and CPI Survey data for PE valuation, raising "substantive concerns about their accuracy, utility, and suitability."[12] But CMS' proposal is no more accurate or suitable to reflect actual resources furnished in a particular service as required by statute. The indirect PE reallocation is not based on data or analysis of the actual costs that

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[6] § 1848(c)(1)(B).

[7] Popover JL, Jones T, Kalathia C, Mackey A, King N, Sardzinski E, Oulton Z, Imam A, Al-Masri M, Toomey PG. *Physician Employment in America: Private Practices Dominate Despite Increased Hospital Employment*. JSLS. 2025 Apr-Jun;29(2):e2025.00012.

[8] Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties

[9] DeMik DE, Cohen-Rosenblum A, Landy DC, Kerr J, Deen JT, Ramkumar PN, Bernstein J. *The Practice Experience of an Adult Reconstruction Surgeon: A Cross-Sectional Analysis and Survey of the American Association of Hip and Knee Surgeons Membership*. Arthroplasty Today. 2024 Jun 27;27:101328.

[10] 2023 Annual Meeting Survey.

[11] MedPAC, June 2025 report to Congress (pg. 29).

[12] 90 Fed. Reg. 32369.

practices incur for specific service groups. CMS establishes a PR level it believes is appropriate for a hospital-employed physician and then imposes it on all services regardless of the actual employment/ownership status or the actual settings in which the physician practices.

In particular, independently owned and independently managed practice groups that employ practitioners to work in facility-based settings face all of the expected indirect PE costs associated with operating an office-based practitioner practice, as well as significant additional indirect PE costs that are unique to the need for these practices to operate within someone else's facility's EHR and workflow preferences.

*f. If Implemented, the Proposed PE Reallocation Will Speed Further Consolidation in Health Care*

While CMS calls this proposal a "refinement", in reality, a 24% cut in practice expense RVU, as proposed, is not a refinement but a radical reduction. This will materially impair the financial stabilities of our members' independent practices. CMS notes the trend in more physician employment by hospitals. CMS should be equally concerned about unintentionally incentivizing consolidation of providers. This trend will accelerate if this policy is finalized.

Consolidation and the overall decline in independent physician practices is primarily a result of declining Medicare rates over time. Without an inflation adjustment in the Medicare PFS, physician rates have dropped 60% in real dollars over 30 years and over 40% in nominal dollars. We remind CMS that consolidation leads to fewer choices for consumers across the care continuum, higher prices, and decreased access to care, particularly in rural and underserved areas.

The economic model of a practice (ownership/employment/independence, etc.) should be a choice for physicians. Physicians should not feel driven to become hospital employed out of necessity.

## IV. Work RVUs – Proposed Efficiency Adjustment (Sec. II.E.2.b)

CMS proposes to implement in 2026 a productivity adjustment (the "Efficiency Adjustment") to cut the intraservice time of the work relative value units (the wRVUs) for all non-time-based services by 2.5%. The 2.5% is derived from the Medicare Economic Index (MEI) productivity adjustment using a 5-year look-back period. CMS proposes to apply the Efficiency Adjustment every 3 years and proposes to permit the public to submit nominations (and supporting information) if they believe the efficiency adjustment will lead to inaccurate physician time and work RVUs for a particular code.

AAHKS strongly opposes CMS' proposed "productivity adjustment" that would arbitrarily and imprecisely make blanket cuts to carefully-determined procedure-specific reimbursement amounts in a manner that disregards statutory requirements and procedural nuances critical to

the practice of medicine. As a sweeping change that would apply to all non-time-based codes, the Efficiency Adjustment fails to align with the incremental and intentional approach CMS has taken since the "inception of the PFS" to refine its code valuation approach to better reflect procedure-specific nuances.[13]

*a. CMS Proposes Significant, Material Across-the-Board Cuts Based on a Mere Suspicion that Work RVUs Might be Overvalued, Not Documentation of Overvaluation*

CMS does not provide an evidence-based justification for sweeping, and arbitrary across-the-board cuts through the Efficiency Adjustment. CMS does not base its proposal on an evidence-based determination or any ***conclusion*** of over-valuation. Rather, CMS lists two areas of concern that CMS believes ***may*** have led to codes ***potentially*** being overvalued, stating in the Preamble:

> These changes in practitioner experience, operational workflows, and new technologies in totality represent large-scale, system-wide changes in medical practice . . . that ***may*** not have been previously accounted for in the valuation of non-time based codes . . . we are concerned that the RVUs we have established for codes paid under the PFS ***may*** not reflect these efficiencies accrued as practitioners gain experience, operational workflows improve, and new technology is adopted.[14]

Applying a sweeping cut to all non-time-based codes is too severe an action to make without even reaching a definitive conclusion that each of those codes has, in fact, been previously overvalued by CMS through the Valuation Process.

*b. CMS' Assumptions in Favor of Across-the-Board, System-Wide Cuts are Based on Misreading and Mischaracterizing Limited Studies of a Few Individual Codes, All of Which Actually Emphasize the Need for Procedure-Specific Values*

CMS fails to provide evidence of this system-wide change in medical practice that would apply equally to all impacted codes. Rather, CMS bases its conjecture on a variety of assumptions. The evidence CMS cites in support of its assumptions does support a wide-scale 2.5% Efficiency Adjustment across all non-time-based codes. In fact, the evidence CMS cites highlights the many procedure-specific factors and factors outside of intraservice time that impact a procedures' time and intensity. In fact, some of the cited studies suggest knee arthroplasty may be undervalued. That is why the statute requires service-specific valuation, as explained later in this comment.

CMS characterizes wRVU values recommended by the RUC as subjective, based on small unreliable surveys. Ironically, the studies CMS cites in support of its system-wide Efficiency

[13] Id. at 32398.
[14] Id. at 32401.

Adjustment are based on small surveys of low number of physician or facilities, focused on only a few procedures. Other problems with CMS assumptions are as follows:

i. Problems with Drawing Assumptions on Valuation from Urban Institute Study

CMS referenced a study conducted by the Urban Institute for a pilot project for CMS in 2016, stating the study "compared data obtained from electronic health records and direct observation, the ratios of fee schedule time to empirical time were often inflated, with the largest discrepancies in imaging and other test interpretations. In the study, the median ratio of PFS time to empiric intraservice physician time for CT and MRI scans was 2.13, for noninvasive cardiac testing was 4.00, and for mammography was 1.67."[15]

In fact, the Urban Institute study[16] regarding intra-service time has substantive shortcomings relative to the comparatively robust data from the RUC survey methodology. Data from only two facilities formed the basis of the Urban Institute analysis, which was significantly smaller than RUC survey data by specialty societies, which CMS criticizes for being too small. Important characteristics of the facilities and surgeons were not considered or addressed in the study. Together, these factors resulted in a clear selection bias and, as stated by the study's author, "these sites were very much a sample of convenience and should not necessarily be viewed as representative of other health systems."[17] Additionally, the Urban Institute report was designed as a feasibility study to obtain empirical time data and an author of the report explicitly stated not to rely on its results for procedure valuation.

Further, although the Urban Institute interpreted the results to conclude "that the fee schedule's time assumptions were often high relative to the empirical time captured in their study,"[18] the study was based only on intraservice time, the time the clinician spends on treatment/therapy and documentation of services. The Urban Institute analysis did not consider or capture preservice time (the time "preparing to see the patient, reviewing records, and communicating with other professionals") or the postservice time (the time spent "arranging for further services and communicating (written or verbal) with the patient, family, and other professionals. As such, the report specifically stated, "Since this project only captured intraservice time, we were unable to directly analyze total work and intensity."[19]

As the study could not "directly analyze total work and intensity", components required by statute to be the basis of the RVU "work component", it is inappropriate to use this study to conclude non-time-based codes have been sweepingly overvalued by CMS. Also, the study

[15] Id.
[16] Zuckerman, S., K. Merrell, R. Berenson, et al. *Collecting empirical physician time data: Piloting an approach for validating work relative value units. Report prepared for the Centers for Medicare & Medicaid Services*. The Urban Institute (Dec. 2016).
[17] Id. at pg. 5.
[18] Id. at pg. 38.
[19] Id. at pg. 21.

reports that the largest discrepancies in time were observed in imaging and other test interpretation codes. This highlights the importance of ***procedure-specific valuations***, as the study found that the discrepancies in the overvaluation varied between services and was service specific. Therefore, even if the codes were overvalued, the findings of this study still make evident that sweeping cuts fail to adequately address procedure-specific differences in code values.

ii. CMS Cites a Study on Estimated Procedure Times that Actually Suggests Arthroplasty Services are Undervalued

CMS referenced a study published in JAMA, that it says "compared estimated procedure time from anesthesia claims and the PFS time, and found that the mean estimated procedure time was 27 percent lower than the time used for PFS valuation."[20] Significantly, the study itself stated, "[t]here were notable exceptions, for which the mean estimated procedure time equaled or exceeded the valuation time […]."[21]

The study actually found:

- Differences between estimated procedure time and PFS valued time varied by procedure. Some procedures had estimated times that were equal to or over the PFS values
- For instance, total hip arthroplasty took 5% longer than the PFS valued time, while total knee arthroplasty had an equal duration
- Patient health led to variation in procedure time. Noting that "[w]ithin a given code, older patients and those with more illness had longer procedure times"
- Differences in specialties: "There was substantial variation across specialties in the percent difference between mean estimated and valuation procedure times ranging from gastroenterology (36% shorter) and ophthalmology (35% shorter) to cardiac surgery (2% longer) and thoracic surgery (7% longer)"

If anything, the study in JAMA highlights that a variety of factors can lead to differences between estimated procedure time and PFS valued time, reiterating that across-the-board cuts lack the adequate precision necessary for evaluating individual services as required by statute and as required to ensure appropriate reimbursement of medical procedures furnished to patients. Notably lacking from the Preamble was discussion of CMS's consideration of patients when contemplating the Efficiency Adjustment proposal.

iii. Problems with CMS Assumptions on Automation and Personnel Substitution

CMS states that "Expert reviewers have attributed some of the discrepancies [between observed or estimated time and PFS values] to automation and personnel substitution that has

[20] 90 Fed. Reg. 32401.

[21] Crespin, Daniel, Teague Ruder, Andrew Mulcahy, Ateev Mehotra. "*Variation in Estimated Surgical Procedure Times Across Patient Characteristics and Surgeon Specialties*." JAMA Surg. 2022 May 1;157(5):e220099.

become prevalent in the time between when CMS adopted many codes and when those codes are revalued."[22]

However, the study CMS cites for this statement found that, of the services reviewed (including noninvasive cardiac testing, gastroenterology, ophthalmology, orthopaedics, radiology, and urology), the impact of automation was generally only observed with respect to the noninvasive cardiac testing services.[23] This again highlights how ineffective a blanket-adjustment, based on potential impacts, could be at ensuring procedures have accurate values.

iv. CMS Cites a Study on Operative Time Efficiency that Actually Finds Significant Variation in Efficiency Between Specialties and Significant Variation in efficiency Over the Course of a Surgeon's Career

CMS assumes that intraservice portion of physician time and the work intensity (including mental effort, technical effort, physical effort, and risk of patient complications) would decrease as experience, learning and confidence "accumulate across the entire health care system" leading to "changes in medical practice such as enhancements in operation flows or technology advancements."[24] In support of this, CMS cites a study published in BMJ of which CMS says "one cross-specialty observational study found that increased surgical experience was associated with significant reductions in operative time for coronary artery bypass grafting, total knee replacement, and bilateral reduction mammoplasty."[25]

Notably, CMS did not refer to the study's findings, which undercut the concept that across-the-board cuts can accurately value services with wide variation in efficiency and experience.

> First, in contrast to the notion that efficiency is optimised within a fairly narrow temporal window following the start of clinical practice, our data suggest that operative learning curves, ***for some procedures***, exhibit ongoing improvement in efficiency over the course of a surgeon's career, with time courses much longer than previously anticipated. This emphasises the necessity to draw equitable comparisons between surgeons at similar stages of the learning curve, and supports proposals for continual monitoring, training and behavioural interventions aiming to accelerate operative maturation.

[22] 90 Fed. Reg. 32401.
[23] Zuckerman, S., K. Merrell, R. Berenson, et al. *Collecting empirical physician time data: Piloting an approach for validating work relative value units. Report prepared for the Centers for Medicare & Medicaid Services*. The Urban Institute pg. 31 (Dec. 2016).
[24] 90 Fed Reg 32401.
[25] Id.

> Second, our results demonstrate the ***different learning curve dynamics that exist between procedures***. BRM is typified by an initial phase of variability, followed by a period of rapid improvement, followed by a relative plateau phase. TKR and CABG, on the other hand, demonstrate a more linear improvement over time. Such findings suggest that certain procedures may demonstrate characteristic learning curves, with some achieving maturation more ***rapidly than others. The factors contributing to these characteristics should be the subject of further investigation***.[26]

The BMJ study therefore supports our position that RVUs should be assigned only on observed data specific to individual procedures and not through across-the-board, one-size-fits all arbitrary cuts when "the magnitude of improvements in efficiency over time varies from procedure to procedure."[27]

v. CMS Cites a Studies on Increased Operational Efficiency Over Time that In Reality Simply Documents the Learning Curve of New Surgeons

CMS states that one study found "for clinicians newly introduced to robotic thoracic surgery, a reduction in operating time based on the increasing number of cases performed."[28] With respect to a similar study, CMS states that the study "concluded that for robotic thoracic procedures, the hourly productivity increase for experienced and proficient surgeons ranged from 11.4 [wRVUs]/hour (+26%) for lobectomy to 17.0 [wRVUs]/hour (+50%) for segmentectomy.[29]

While both studies in question focus on robotic thoracic surgery, the studies highlighted additional factors that impact the level of efficiency increases with experience. The first study was a review of 12 prior observational studies focused on the learning curves of new surgeons, not increased efficiency over time. The authors did find wide differences among procedures, noting "[a] steep learning curve was described for thymectomy, with a decrease in operating room time in the first 15 cases ***and a plateau after 15–20 cases***. For anatomic lung resection, the number of cases to achieve a plateau in operative time ranged between 15–20 cases and 40–60 cases."[30] Achieving a plateau of efficiency when first performing a new procedure, contra to CMS, does not represent "changes in practitioner experience [that] represent large-scale, system-wide

[26] Maruthappu, Mahiben, Antoine Duclos, Stuart Lipsitz, Dennis Orgill, Matthew Carty. *''Surgical Learning Curves and Operational Efficiency: A Cross-Specialty Observational Study*.'' BMJ Open. (pg. 3) 2015 Mar 13. (emphasis added).
[27] Id.
[28] 90 Fed. Reg. 32401.
[29] Id.
[30] Power, Alexandra, Desmond D'Souza, Susan Moffatt-Bruce, Robert Merritt, Peter Kneuertz. "*Defining the Learning Curve of Robotic Thoracic Surgery: What Does it Take*?" Surg Endosc. (Dec.33, 2019). (emphasis added).

changes in medical practice"[31] upon which CMS is allowed to make service-specific RVU adjustments. Only some of the observational studies reviewed showed continued gradual improvements in operating room time for some procedures.

The second study noted that "[s]urgeon experience level, dual console use, system model, and robotic stapler use were factors independently associated with console time for robotic lobectomy."[32] Further, the study's ultimate and narrow conclusion was that "[t]he aggregate learning curve for robotic thoracic surgeons in the United States varies significantly by procedure type and demonstrate continued improvements in efficiency beyond 100 cases for lobectomy and esophagectomy."[33]

vi. CMS Obfuscates How Frequently It Already Reviews High Volume and High Value Codes

In support of its proposal to implement the Efficiency Adjustment, CMS states that "given the relative infrequency of service revaluation under the PFS […], we are concerned that the RVUs we have established for codes paid under the PFS may not reflect these efficiencies accrued as practitioners gain experience, operational workflows improve, and new technology is adopted."[34] CMS states the following with respect to the frequency of code revaluations:

> [T]here are often many years between a code's introduction and revaluation within the RUC process, with only a few hundred out of the more than 9,000 codes paid under the PFS considered for revaluation annually by the RUC. While there is significant variability in how often codes are reviewed by the RUC, on average, CMS estimates that there are 25.49 years since a code valuation has been reviewed by the RUC (this includes 5382 out of 9970 codes which were never reviewed). When we exclude from the average those codes that have never been reviewed, the average is 17.69 years since the last review of a code by the RUC.[35]

CMS does not explain how it came to its estimation of 17.69 years. However, it noted "that these numbers weight each code equally and the PFS itself is heavily weighted by utilization towards a much smaller number of often utilized codes."[36] CMS still considers using this estimate as a basis for challenging the accuracy of current codes and in considering the lookback period.

[31] 32401 citing SSA 18048(c)(2)(B)(ii)(I).
[32] Ammu Vijayakumar, et al, *National learning curves among robotic thoracic surgeons in the United States: Quantifying the impact of procedural experience on efficiency and productivity gains*, J. Thorac Cardiovasc Surg (Mar. 2024), https://pubmed.ncbi.nlm.nih.gov/37562675/.
[33] Id.
[34] 90 Fed. Reg. 32401.
[35] Id. at 32400.
[36] Id.

But CMS does not demonstrate that an alleged low frequency of review is indeed the case for all the non-time-based codes to which CMS plans to apply the Efficiency Adjustment.

We believe this argument is an attempt to obfuscate and distract from the fact that "[o]verall, the RUC has reviewed approximately 95% of the *Medicare Physician Payment Schedule allowed charges.* Codes that have not been reviewed are low volume and represent a minimal amount of allowed charges."[37] CMS further ignores the work it has done itself to frequently revalue codes based on value or volume. The primary codes billed by AAHKS members, 27130 and 27447, are revalued by CMS every 5-6 years, consistent with statute.

If CMS wishes to revalue a large number of low-volume, low value codes that have never before been revalued, CMS is free to do so. If CMS has failed to do so up to now, that in no way justifies applying a new 2.5% "efficiency" cut to services CMS has recently revalued.

*c. By Characterizing Work RVUs as Overvalued, CMS Dismisses and Ignores Decades of Its Own Policy that CMS Previously Claimed Ensured Accurate RVUs*

CMS has a suspicion that "changes in practitioner experience, operational workflows, and new technologies" it cited in the studies above "may not have been previously accounted or in the valuation of non-time based codes"[38] and therefore CMS surprisingly concludes that all non-time based codes should be cut by 2.5%. This is surprising because of the lack of confidence CMS seems to have in the extensive process it currently uses for code valuation (herein, the "Valuation Process").

The process includes the nearly unlimited scope of information CMS may consider under the statute for individual code valuation, how CMS sets coding values, the extent of discretion CMS has to consider information when evaluating codes (including specialty society surveys), and public feedback through notice and comment rulemaking. Rather than continuing to consider these criteria on a procedure-specific basis as required by statute, and without presenting firm conclusory evidence of misvaluation, CMS proposes broad, arbitrary cuts based on an arbitrary methodology and applies these cuts in an arbitrary way that disregards procedure-specific nuances critical to accurate code valuations and the practice of medicine.

While AAHKS acknowledges both the Valuation Process and aspects of the American Medical Association (AMA)/Specialty Society Relative Value Scale (RVS) Update Committee (the RUC) recommendation process could be strengthened through further refinements, AAHKS strongly urges CMS to decline from finalizing its Efficiency Adjustment proposal, and instead encourages CMS to address the concerns through targeted, evidence-based adjustments to the Valuation Process, such as by prioritizing consideration of and reliance on actual peer-reviewed observations of time when establishing base values, or by working with Congress to advance

[37] American Medical Association, *AMA/Specialty RVS Update Committee, An Overview of the RUC Process,* pg. 7 (2025).
[38] 90 Fed. Reg. 32401.

more comprehensive provider payment reforms to correct fundamental deficiencies of the PFS, such as the lack of a positive inflation adjustment such as is applied under all other Medicare payment formulas.

i. The Current, Extensive RVU Valuation Process Gives CMS All the Tools Its Needs

CMS's own description of the Valuation Process proves that CMS already has, and already exercises, the tools and authority necessary to account for limitations of specialty society surveys when determining reimbursement rates. When CMS receives wRVU recommendations from the RUC (which remains *the only comprehensive source of information* regarding physician work), CMS also receives the RUC's survey data. CMS then has the tools and authority to review the RUC recommendation, to assess the RUC recommendation, and to adjust and refine the RUC recommendation. Additionally, CMS is not bound to accept the RUC recommendation and may consider various other sources.

CMS starts by providing an extensive background of the Valuation Process and the rulemaking related to its development. CMS then provides an in-depth overview of the Valuation Process, including how it determines code values. Specifically, CMS notes that for each code, CMS "conduct[s] a review that includes the current work RVU (if any), RUC-recommended work RVU, intensity, time to furnish the preservice, intraservice, and postservice activities, as well as other components of the service that contribute to the value."[39]

CMS next describes its approach to reviewing RUC recommendations and developing proposed values for specific codes. CMS states it "*assess[es] the methodology and data used to develop the recommendations submitted […] by the RUC and other public commenters and the rationale for the recommendations*"—in effect, highlighting CMS' acknowledgement that it does not accept RUC recommendations at face value. Notably, CMS concedes that it "has historically had to rely on survey data *due to a lack of other more reliable sources of information,"* as the RUC and specialty societies provide the nation's only uniform comprehensive valuation of procedures.[40]

ii. RUC Recommendation as Only a Starting Reference

CMS states that after its assessment of the RUC recommendation: "rather than ignoring the RUC-recommended value, we used the recommended values as a starting reference and then applied one of these several methodologies to account for the reductions in time that we believe were not otherwise reflected in the RUC-recommended value. If we believe that such changes in time are already accounted for in the RUC's recommendation, then we do not make such adjustments[.]"[41]

[39] Id. at 32399.
[40] Id.
[41] Id.

CMS also lists examples of "the many methodological approaches CMS employed to identify potential values that reconcile the RUC-recommended work RVUs with the recommended time values when the RUC-recommended work RVUs did not appear to account for significant changes in time."[42] In the Preamble alone, CMS describes such methods as including a building block approach, an incremental methodology, magnitude estimation, standardized preservice time packages, and crosswalks.

iii. CMS' Earlier Solutions to Concerns Over RUC Valuations

CMS also cites several specific concerns it has previously raised with RUC recommendations and then details CMS' corresponding action to refine the RUC-recommended values to address those concerns, as summarized as follows:

A. Service the Same Day as E/M Service

CMS notes "In cases where a service is typically furnished to a beneficiary on the same day as an E/M service, we believe that there is overlap between the two services in some of the activities furnished during the preservice evaluation and postservice time. Our longstanding adjustments have reflected a broad assumption that at least one-third of the work time in both the preservice evaluation and postservice period is duplicative of work furnished during the E/M visit."[43]

CMS's Own Solution to Refine the Code: "Accordingly, in cases where we believe that the RUC has not adequately accounted for the overlapping activities in the recommended work RVU and/or times, we adjust the work RVU and/or times to account for the overlap."[44]

B. Accounting for Significant Changes in Time

CMS states that it had "observed that for many codes reviewed by the RUC, recommended work RVUs have appeared to be incongruous with recommended assumptions regarding the resource costs in time."[45]

CMS's Own Solution to Refine the Code: CMS details its existing solution and the many options CMS has available to consider when refining the value, stating: "When we adjusted work RVUs to account for significant changes in time, we started by looking at the change in the time in the context of the RUC-recommended work RVU. When the recommended work RVUs do not appear to account for significant changes in time, we employed the different approaches to identify potential values that reconcile the recommended work RVUs with the recommended time values. Many of these methodologies, such as survey data, building block, crosswalks to key

[42] Id.
[43] Id at 32398.
[44] Id.
[45] Id. at 32399.

reference or similar codes, and magnitude estimation have long been used in developing work RVUs under the PFS. In addition to these, we sometimes use the relationship between the old-time values and the new time values for particular services to identify alternative work RVUs based on changes in time components."[46]

C. Using Other Methodologies

CMS notes circumstances in which "the RUC's recommendation has appeared to disregard or dismiss the changes in time, without a persuasive explanation of why such a change should not be accounted for in the overall work of the service […]."[47]

CMS's Own Solution to Refine the Code: CMS stated that it would "generally use[/] one of the aforementioned methodologies to identify potential work RVUs, including the methodologies intended to account for the changes in the resources involved in furnishing the procedure[…]."[48]

iv. CMS Does Not Rely Soley on RUC Recommendations in the Valuation Process

CMS emphasizes that it does not solely rely on the RUC recommendation in the Valuation Process, noting that its "reviews of recommended work RVUs and time inputs generally include, but have not been limited to, a review of information provided by the RUC, the HCPAC, and other public commenters, medical literature, and comparative databases, as well as a comparison with other codes within the PFS, consultation with other physicians and health care professionals within CMS and the Federal Government, as well as Medicare claims data."[50] CMS also references instances in previous rulemaking when CMS "reminded commenters that we do not exclusively rely on RUC recommendations and can receive data and recommendations from other outside sources as well."[49] In fact, CMS states:

> As part of our obligation to establish RVUs for the PFS, we thoroughly review and consider available information including recommendations and supporting information from the RUC, the Health Care Professionals Advisory Committee (HCPAC), public commenters, medical literature, Medicare claims data, comparative databases, comparison with other codes within the PFS, as well as consultation with other physicians and healthcare professionals within CMS and the Federal Government as part of our process for establishing valuations. Where we concur that the RUC's recommendations, or recommendations from other commenters, are reasonable and appropriate and are consistent

[46] Id.
[47] Id.
[48] Id.
[49] Id. at 32400.

> with the time and intensity paradigm of physician work, we proposed those values as recommended. Additionally, we continually engage with interested parties, including the RUC, regarding our approach for accurately valuing codes, and as we prioritize our obligation to value new, revised, and potentially misvalued codes.[50]

The percentage of wRVUs CMS sets at or above the RUC's recommendation each year is illustrative of the RUC recommendation's role and weight in the Valuation Process.[51] While CMS sets the majority of codes at or above the RUC's recommendation, which we believe shows the tendency towards accuracy of the RUC's recommendation, the variations in the percentages over the years highlights that the RUC's recommendation would not be considered determinative in CMS's evaluation.

| Year/Review | Recommendations Submitted (# of CPT Codes) | Work RVs at/above RUC recs (%) |
|---|---|---|
| CPT 2020 | 301 | 79 |
| CPT 2021 | 154 | 77 |
| CPT 2022 | 185 | 77 |
| CPT 2023 | 206 | 80 |
| CPT 2024 | 87 | 97 |
| CPT 2025 | 127 | 91 |

v. Conclusion: CMS Concerns Over One Part of the Complex Valuation Process Does Not Justify Applying an Arbitrary Across-the-Board 2.5% Cut to All Non-Time-Based Codes

Despite the safeguards available to CMS to address suspected deficiencies of a particular specialty society survey in the Valuation Process, and the fact that CMS is not bound to the RUC recommendation and may use other available information, CMS still cites the specialty society surveys as part of its justification for going outside of statutory requirements to assign values to individual codes. While specialty society surveys used in RUC recommendations have limitations and we agree that the Valuation Process could benefit from further improvement, CMS fails to show that the entire Valuation Process failed so systematically in capturing such large-scale, system-wide changes that the proposed Efficiency Adjustment for all non-time-based codes constitutes an appropriate remedy over targeted, evidence-based adjustments. If CMS truly seeks to reconsider how it weighs the RUC recommendations due to its concerns about specialty society survey reliability, CMS should do so in a manner that more directly incorporates actual peer-reviewed observations of time from clinical experts in the field. AAHKS would stand ready to assist CMS.

[50] Id. at 32398.

[51] See American Medical Association, *AMA/Specialty RVS Update Committee, An overview of the RUC Process* (2025).

*d. CMS Misreads or Misrepresents the 2015 GAO Study of the AMA RUC Process and Specialty Society Surveys*

In attempting to justify the Efficiency Adjustment, CMS notes its concerns with the reliability of specialty society surveys, stating that "[g]iven the… limitations of reliance on survey data, we are concerned that the RVUs we have established for codes paid under the PFS may not reflect these efficiencies accrued as practitioners gain experience, operational workflows improve, and new technology is adopted."[52] Specifically, CMS cited concerns such as potential biases and conflicts of interest and low response rates, low total number of responses, and the large range in responses. CMS' concerns are largely based on a 2015 report of the Government Accountability Office (GAO).[53] However, as noted below, the GAO report itself does not indicate that specialty society surveys are unreliable—particularly to a degree to justify the proposed Efficiency Adjustment.

i. Alleged Conflict of Interest of Survey Respondents

CMS states that, "the GAO report noted that the RUC has undertaken steps to mitigate the effects of possible biases; however, the report goes on to describe the potential conflicts of interest survey respondents may have, as those that serve Medicare beneficiaries would benefit from an increase in the relative values for the services they perform."[54]

In reality, GAO stated the following: "We and others have concluded that physicians who serve Medicare beneficiaries may have conflicts of interest when making relative value recommendations. *The RUC has taken steps, though, to mitigate any possible biases that RUC members or specialty societies involved in the recommendation process may have from affecting the RUC's work relative value and DPEI recommendations*."[55]

GAO acknowledges that "each individual physician who serves Medicare beneficiaries would nonetheless benefit from an increase in the relative values for the services they perform" but highlights that, "[g]iven this potential conflict of interest and other potential conflicts that individual physicians involved in the recommendation process may have, *the RUC takes steps to mitigate any possible bias from affecting its recommendations to CMS*."[56] Additionally, GAO notes that while "survey results may be undermined by the individuals who complete the survey, […] *the RUC has made efforts to address these issues*."[57] The GAO provided examples of the RUC's actions to mitigate potential bias:

[52] 90 Fed. Reg. 32401.
[53] See GAO, *Medicare Physician Payment Rates, Better Data and Greater Transparency Could Improve Accuracy* (May 2015).
[54] 90 Fed. Reg. 32400.
[55] GAO, pg. 24 (emphasis added).
[56] Id. (emphasis added).
[57] Id. (emphasis added).

- Does not assign members to prereview recommendations developed by their own specialty societies
- Prohibits "its members from participating in deliberations and voting on services in which they or a family member have a direct financial interest"
- Provides "RUC members have the opportunity to question the different specialty societies' proposed recommendations" during the deliberation process
- Designs the "survey instrument to ask respondents to disclose any direct financial interests they or a family member have in the surveyed service"
- Asks [s]urvey respondents to complete surveys for services that apply to them and to indicate how many times they have performed the services in the past year"

The GAO explains that "while the survey data are ***the beginning of the process*** to establish work relative value recommendations, the RUC relies on magnitude estimation and the clinical expertise of its members to develop the RUC's final recommendations." [58] GAO further notes that "[t]he RUC ***provides CMS with its survey data*** when it submits its recommendations, ***which may help CMS to draw independent conclusions about the reliability of the RUC's recommendations*** and thus how services should be valued."[59]

It is worth placing specialty society input in its appropriate context in valuing physician work time and intensity. Regardless of perceptions of conflict of interest, no other stakeholder is better equipped to provide expertise to inform the RUC recommendation process. Congress clearly recognized this when enacting the PFS methodology in statute, as emphasized in the requirement for the Secretary to "consult with the Medicare Payment Advisory Commission and organizations representing physicians," when making adjustments to relative values.[60]

ii. CMS Refers to Low Response Rates Under the Old Process that Was Ended More than 10 Years Ago

In discussing concerns with surveys' low response rates, CMS cites GAO's finding "that the median number of responses to surveys administered by the RUC for payment year 2015 was 52, the median response rate was only 2.2 percent, and 23 of the 231 surveys had under 30 respondents."[61] CMS studiously avoids also mentioning GAO's reporting that the RUC subsequently implemented minimum survey thresholds, more than ten years ago, specifically "to further mitigate possible bias."[62] GAO explained that the 23 services CMS referenced as having fewer than 30 respondents did not satisfy the RUC's threshold requirements, and in accordance with the RUC's threshold requirements, the specialty societies were required to "conduct new surveys and present revised recommendations to the RUC at the next RUC meeting."[63]

[58] Id. at pg. 25.
[59] Id. (emphasis added).
[60] 42 U.S.C. § 1395x.
[61] 90 Fed. Reg. 32400.
[62] GAO at Note 52.
[63] Id.

iii. CMS Implies the RUC Recommends Reductions a Minority of the Cases When in Fact the RUC Recommends Reductions in a Plurality of All Cases

In the Preamble, CMS notes that "even when recommendations have been submitted by the RUC to CMS as potentially misvalued codes from 2009 to 2025, the RUC only recommended a decrease in the physician time and resources for the codes 39 percent of the time."[64] However, that 39% cited by CMS represents the largest category of possible RUC recommendations for the 2,924 codes it reviewed during that time frame.[65] In fact, in 2025, the AMA noted that only 26% of codes were reaffirmed, 19% were deleted, 11% were increased, and 6% were still under review.[66]

iv. GAO Recommended CMS Rely More on Physician Groups for Data

The Report focused primarily on how CMS could improve its own Valuation Process. The GAO recommended to CMS that "[t]o help improve CMS's process for establishing relative values for Medicare physicians' services, the Administrator of ***CMS should incorporate data and expertise from physicians*** and other relevant stakeholders into the process."[67] While GAO "acknowledge[d] that CMS has made progress towards meeting [its] recommendation by beginning to use PAMA funds to assist with valuing global services and exploring avenues for collecting practice expense data," GAO also stated that "[it would] need documentation that CMS has started to incorporate data more broadly into its process for establishing relative values."[68] Now 10 years later, GAO has noted that "[a]s of January 2025, [GAO] received this documentation, but CMS reported that it was in the process of determining implementation."[69]

The GAO recommending that CMS rely more on data from physician groups for valuing individual services does not justify CMS applying an arbitrary across-the-board cut to all non-time-based codes. The RUC improved its processes 10 years ago following GAO's study and recommendations. CMS did not.

*e. Efficiency Adjustment is Counter to Statutory Requirements to Value Individual Services*

Section 1848(c) of the Social Security Act unambiguously requires the determination of relative values for physicians' services be service-specific. Section 1848(c) states~~,~~ that "the Secretary of the U.S. Department of Health & Humans Services (the "Secretary") shall develop a methodology for combining the work, practice expense, and malpractice relative value units, […] for ***each*** service in a manner to produce a single relative value for ***that*** service […]."[70]

[64] 90 Fed. Reg. 32400.
[65] American Medical Association, AMA/Specialty RVS Update Committee, An overview of the RUC Process (2025).
[66] Id.
[67] GAO, Highlights, GAP-15-434, https://www.gao.gov/products/gao-15-434. (emphasis added)
[68] Id.
[69] Id.
[70] Emphasis added.

i. Statute and Regulations Reiterate Requirement for Service-Specific Determinations

- The Medicare program defines "physicians' services" as "professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls […]."[71]

- To divide physicians' services into components for *the* relative value *determination*, the status states that "with respect to *a physicians' service*: […] The term "work component" means the portion of the resources used in furnishing *the service* that reflects physician time and intensity in furnishing *the service*. Such portion shall—(i) include activities before and after direct patient contact, and (ii) be defined, with respect to surgical procedures, to reflect a global definition including *pre-operative* and *post-operative physicians' services*."[72]

- To compute "work relative value units," the statute specifies that "for *each physicians' service* […] [t]he Secretary shall determine a number of work relative value units for *the service* or group of services based on the relative resources incorporating physician time and intensity required in furnishing the service or group of services."[73]

- Regulations state that "[p]hysician work RVUs are established using a relative value scale in which the value of physician work for *a particular* service is rated relative to the value of work for other physician services."[74]

- The Secretary must also "determine a work percentage […] for *each physician's service*."[75] The statute specifies that the "work percentage for a service (or class of services) is equal to the sum most (for all physician specialties) of (I) the average percentage division for the work component for each physician specialty […], multiplied by the proportion […] of such service (or services) performed by physicians in that specialty."[76]

CMS' proposed Efficiency Adjustment, which applies sweepingly to all non-time-based codes, does not align with the unambiguous statutory language that indicates codes must be determined on a procedure-specific basis. CMS attempts to indicate that the adjustment captures "changes in medical practice." However, historically, when CMS has made adjustments to capture changes to "medical practice," it has generally done so based to reflect specific changes in medical practice for particular codes determined to be misvalued.

[71] 42 U.S.C. § 1395x.
[72] Id. (emphasis added).
[73] Id. (emphasis added).
[74] 42 C.F.R. § 414.22. (emphasis added).
[75] § 1395x (emphasis added).
[76] Id.

ii. Statute Creates Separate, Distinct Process to Identify and Correct Potentially Misvalued Codes

To ensure that wRVUs accurately reflect physician work time and intensity over the years, the statute requires the Secretary to "periodically identify *services as being potentially misvalued*" and to "review and make appropriate adjustments to the relative values established under [the PFS Statute] for *services identified as being potentially misvalued*."[77] Notably, the statute requires the Secretary to "examine *codes (and families of codes as appropriate*) based on" certain criteria.[78]

Further, the statute enumerated the scope of activities Secretary may use to "review and make appropriate adjustments to the relative values […] for services identified as being potentially misvalued.,"[79] This includes:

- Using existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services
- Conducting surveys, other data collection activities, studies, or other analyses, as appropriate, to facilitate the review and appropriate adjustment
- Using analytic contractors to identify and analyze services, conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services
- Coordinating the review and appropriate adjustment with CMS' periodic review
- Making appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule

iii. Efficiency Adjustment Does Not Follow Requirement for CMS to Identify Which Specific Codes are Potentially Misvalued

As noted above, CMS did not identify any particular codes or families of codes as being potentially misvalued. Further, CMS does not ever conclusively determine that each or any of the non-time-based codes subject to the Efficiency Adjustment has actually been misvalued. In fact, CMS does not indicate any service-specific assessment that would have, or even could have, led to a determination that the non-time-based codes were overvalued. CMS does not indicate it performed any assessment regarding the underlying reason the non-time-based codes may have allegedly been overvalued or any assessment of the proposed adjustment to each code.

[77] Id. (emphasis added).
[78] Id. (emphasis added).
[79] Id.

*f. Numerous Problems with Efficiency Adjustment*

i. RVU Accuracy Requires Procedure Specific Valuations

Although CMS is concerned that current work RVUs are vague, imprecise estimates of codes' relative value, CMS proposes an arbitrary cut, unrelated to data on intraservice time that will be even more disconnected from actual intraservice time data than any current work RVUs could be. While we do not dispute that the Valuation Process could benefit from further refinement, CMS has not shown that the entire Valuation Process failed so systematically in capturing such large-scale, system-wide changes to necessitate the Efficiency Adjustment for all non-time-based codes as preferred over targeted, evidence-based adjustments.

ii. CMS Would Apply the Efficiency Adjustment from an Inflationary Update Formula, Without Applying the Underlying Inflationary Update

CMS develops its Efficiency Adjustment proposal by using the last five years of the Medicare Economic Index (MEI) productivity adjustment percentage. The MEI is a measure of practice cost ***inflation*** used to estimate changes in physicians' operating costs and to help determine annual Medicare physician payment updates. It accounts for changes in two major components: physician practice costs (including staff salaries, office rent, supplies, and malpractice insurance) and physician compensation. The MEI is adjusted by a factor for economy-wide labor productivity and has been updated periodically, which is called the productivity adjustment, which would be the basis for CMS' Efficiency Adjustment.

It is mind-boggling that CMS would propose to apply the efficiency adjustment from an inflation adjustment formula when there is no inflation factory increase in the PFS. MEI's productivity adjustment was designed to work with the inflation update, not to stand on its own to be applied as a perpetual deflationary adjustment. Further, it is highly doubtful that the MEI' economy-wide labor productivity adjustment when applied to physicians' procedure intraservice time would lead to more accurate reflections of physician work time than exist today.

CMS notes "[t]he MEI productivity adjustment is substantively similar to the productivity adjustment required for the hospital inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS)." This fails as a reassurance because, unlike the PFS, both the IPPS and OPPS already have inflation adjustments.

Finally, CMS characterizes its proposal as "a modified version" of MedPAC's 2018 recommendation to impose "an across-the-board reduction to all fee schedule services other than ambulatory E&M services." Notably, the MedPAC recommendations CMS references come from its proposal for a one-time adjustment to "offset the increase in fee schedule payment for ambulatory E&M services in a budget-neutral manner." CMS already significantly increased E/M code rates in 2021, paid for by slashing the PFS Conversion Factor. The cuts were so large that Congress intervened to phase-them in over several years.

We note that MedPAC also has clearly recommended that an inflation update be added to the PFS.

iii. A 5-year Look-back Period is Punitive and Arbitrary

CMS states it will implement this efficiency adjustment by reducing intraservice physician time for codes describing non-time-based services by a factor equal to the MEI productivity adjustment, equivalent to if this factor had been applied every year over the past 5 years. CMS assessed only two options for look-back period: 17 years (based on its own unweighted assessment) and 5 years. These are strikingly divergent timeframes when presented with only two options, particularly when taking into account CMS's concern with precision and accuracy under the current Valuation Process.

iv. Regularly Applying the Efficiency Adjustment in the Future Produces Perpetual Cuts that Do Not Reflect Actual Intraservice Time and Effort

AAHKS opposes CMS's proposal to apply the Efficiency Adjustment on a regular basis in the future. It is nonsensical that CMS would apply on an ongoing basis the efficiency adjustment from an inflation update with no plans to eventually add an inflation update to the PFS. Therefore, with no inflation updates, and with wRVUs decreasing by approximately 2.5% every three years, physicians can expect perpetually falling reimbursement rates indefinitely. Such a continuous and arbitrary adjustment would eventually lead to wRVU values of near zero.

A better question would be to ask CMS how long the Efficiency Adjustment can be applied before wRVUs become in no way related to actual physician intraservice time? Does CMS believe that physicians should reduce their intraservice time spent working on patients by 2.5% every three years regardless of the clinical scenario?

v. CMS Abdicates Its Statutory Obligation to Set Accurate Procedure Specific Values by Imposing a One-Size-Fits-All Cut and Placing the Burden on Physicians to Set Accurate Work RVUs

CMS says that, going forward, the public may submit nominations via the ''Potentially Misvalued Codes'' process if they believe the efficiency adjustment will lead to inaccurate physician time and work RVUs for a particular code. CMS says it will place greater emphasis on nominations based on empiric data, including "electronic health record logs, operating room logs, and time-motion data and should be robust enough to achieve a high degree of assuredness as to accuracy and be inclusive of multiple types of practices (for example, inclusive of academic, health centers, and private practices wherever possible)."[80]

Whereas statute requires CMS to assign RVUs to capture actual physician work for each individual service, CMS imposes through the Efficiency Adjustment an arbitrary across-the-board

[80] 90 Fed. Reg. 32403.

cut, not based on empiric data of intraservice time, leaving wRVUs in place that are inaccurate for innumerable procedures. Then physicians have the burden to justify an accurate time with empiric data. That is not the system envisioned or required by Congress. CMS has the resources and responsibility to begin with setting RVUs that it can justify as accurate and based on empiric data and informed by physicians and stakeholders.

*g. CMS Should Instead Observe How AMA RUC Actions May Change If an MEI Adjustment is Added to PFS*

There is widespread agreement in Congress that the PFS is broken. The proposed Efficiency Adjustment will make the problem worse. A more sensible approach is for CMS to work with Congress to enact an inflation adjustment for the PFS. CMS should then observe and track the trends in RUC recommendations following enactment.

## V. Strategies to Address 90-day Global Package Valuation (Sec. II.L.2)

For many years, CMS has been working to improve the valuation of postoperative care within global surgical package codes, based on CMS' belief that surgical code values overestimate the number of postoperative visits actually provided. CMS states that its own analysis and several published studies by RAND find that "only fraction of the 'expected' post-operative visits are provided."[81]

CMS earlier proposed "to transition all globals with 10-day and 90-day global periods to have 0-day global periods…[allowing] practitioners to bill separately for any post-operative visits (or other care related to the procedure, for example, care for complications) furnished after the day of the procedure to be billed as standalone services."[82] This year, CMS is soliciting public comments on (1) Strategies to improve the accuracy of payment for global surgical packages, specifically those related to the procedure shares, (2) What the procedure shares should be based on for the 90-day global packages, and (3) Input on current practice standards and division of work between surgeons and providers of postoperative care.

***AAHKS Comment:***

*a. Recent OIG Reports on Physicians Under-Reporting Post-Operative Visits Undermines Persuasiveness of Earlier CMS Reports that Global Surgical Packages are Overvalued*

For its claim that global surgery codes are overvalued, CMS relies on several studies by CMS and RAND that analyze claims data. But recent reports from the HHS Office of the Inspector General (OIG) argue that Medicare claims data on post-operative visits is inaccurate

[81] Id. at 32523.
[82] Id. at 32522.

because of underreporting by physicians. In one report, OIG found that "[o]f the 105 sampled global surgeries (97 major and 8 minor surgeries), 42 major surgeries had a total of 94 unreported postoperative visits."[83] Furthermore, "these errors occurred because some practitioners and the practices' staff were either unaware that certain practitioners were required to report their postoperative visits to CMS, or they did not understand which visits were considered postoperative visits under Medicare's global surgery policy."[84]

A second recent report by OIG reviewing global surgical code claims "estimated that for 22,713 of the global surgeries in our sampling frame, there were 60,568 postoperative visits that were supported by the patients' medical records, but the practitioners did not report the postoperative visits to CMS." [85] OIG concludes that underreporting occurs because "practitioners did not understand CMS's global surgery policy, their billing systems were not properly designed to always submit CPT code 99024 on claims to CMS, [and] they lacked access to medical records associated with postoperative visits performed outside of the practice location."[86]

Therefore, allegations that global surgical codes are overvalued should be based on much more than analysis of claims data since OIG finds that claims data underreports post-operative visits actually provided. As OIG recommends, significant improvements are needed in provider education and post-operative visit reporting capacity before claims data is valid for post-operative value analysis. Given the high stakes of potentially changing 90-day global surgical codes valuation, CMS should prioritize accurate data first.

*b. Improving Payment Accuracy Requires a Comprehensive Holistic Review of Physician Treatment and Management of Underlying Conditions, and a Move to Longitudinal Care, Not Merely Attempts to Cut Post-Operative Visit Values*

If CMS wishes to "improve the accuracy of payment for the global surgical packages" it can assign procedure wRVUs based upon a consistent percentile level from physician surveys. For instance, regarding the valuation for CPT 27447, when the RUC and CMS have actual physician work survey data, they use wildly varying percentiles to set value. The arbitrary nature of the valuation (median amount for some procedures, 25$^{th}$ percentile for some procedures, below 20$^{th}$ percentile for others), suggests that CMS is motivated, not by standards for payment accuracy, but by reducing program expenditures.

Instead of considering different approaches of using claims-based reporting of postoperative visits to realign shares within the global surgical packages, CMS should look at the entire global surgical package and not post-operative visits alone. The shift to value-based care

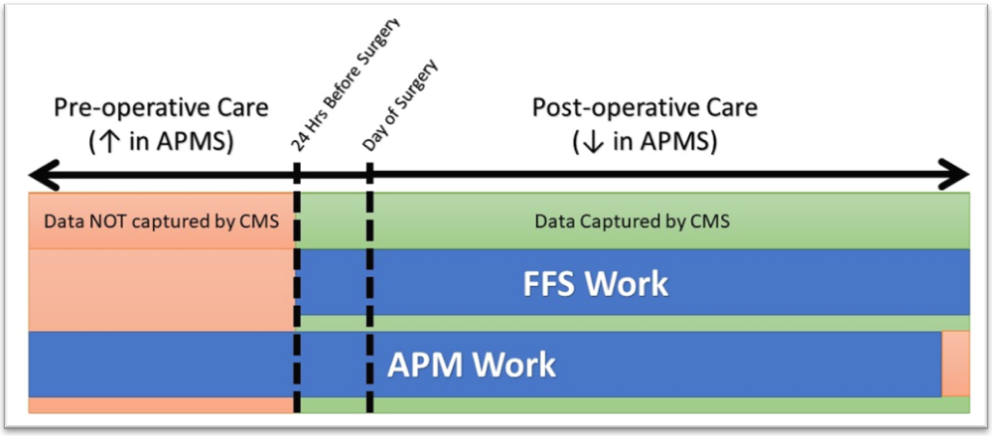
[83] OIG, *CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries*, A-05-20-00021, pg. 8 (June 2025).
[84] Id. at pg. 10.
[85] OIG, *CMS Should Confirm It Is Receiving Medicare Postoperative Visit Data on Global Surgeries When Reporting Is Required*, A-05-20-00027, pg. 10 (Aug. 26, 2025).
[86] Id. at pg. 8.

in the last decade has led to evolutions in how many surgical procedures are managed which requires a new comprehensive consideration on assessing value.

Orthopaedic surgeons, and THA and TKA procedures specifically, have been at the forefront of the transition to value-based care as high-volume, high-value procedures present significant opportunities for improvements in quality and efficiency. Hip and knee surgeon participation in alternative payment models (APMs) is approaching 50%, the highest rate of any subspecialty. Our members' work within CJR and BPCI-A models has improved outcomes, reduced patient time spent in the hospital, and subsequently saved Medicare hundreds of millions of dollars.

Much of the effectiveness of these programs, however, has come from the shift from reactive, hospital-based postoperative work to proactive, office-based preoperative work. Our members and associated qualified health professionals, and clinical staff have experienced significant increases in preservice work to optimize patients through screening, education, and coordination of care with other health care providers (patients' primary care physicians, medical specialist consultants, physical therapists, post-acute care, and others), and from other activities required to ensure the best outcome for a patient's surgery. However, these activities on behalf of the patient and family fall outside of the global surgical bundle because they are not included in the traditional RUC survey definition of "pre-service activities," nor the time clinical staff spent providing certain pre-service activities for the patient and family.

**Arthroplasty Preservice Optimization Time Not Captured**




Evidence has made clear that the additional time spent on these preoperative activities has resulted in improved clinical quality for patients and significant savings by reducing patients' post-operative lengths of stay, readmissions, and other complications. An April 2019 New England Journal of Medicine article estimated that 42% of TKA and THA procedures over a two-year period were performed under the CJR and resulted in a 3.1% reduction in Medicare spending for Total Knee Replacement and Total Hip Replacement.[87] It is important to note that it is the

[87] Michael L Barnett, et al., *Two year Evaluation of Mandatory Bundled Payments for Joint Replacement*, 380 NEW ENGLAND J. OF MED., 252-262, (Jan. 17, 2019), https://www.nejm.org/doi/full/10.1056/NEJMsa1809010.

increased work by surgeons, managing the patient experience and optimization, that leads to arthroplasty savings realized in reduced spending by the facility and post-acute care.

Penalizing surgeons for this successful collaboration, by reducing valuation for post-operative visits while not reimbursing preservice optimization time, does not lead to more accurate payments. We encourage CMS to evaluate whether current global surgical bundles are capturing all pre- and post-operative work and consider whether CPT codes exist for work performed outside the bundles.

We wish to echo the previous comments of our colleagues at the Bone Health and Osteoporosis Foundation and the American Society for Bone and Mineral Research who have argued that Medicare's global payment structures contribute to the osteoporosis care gap as orthopedic surgeons treating an acute conditions like fracture are not compensated for the time and services required to address the underlying chronic condition of osteoporosis. We therefore encourage CMS to accelerate the pace to making available Medicare longitudinal care models to unite orthopedic surgeons with other providers to care for beneficiaries with orthopedic needs, such as fracture care management and osteoarthritis.

*c. Advancing So Many Different Payment Cuts Simultaneously Will Accelerate Even More Provider Consolidation and the End of Many Independent Practices*

CMS must be realistic about the impact on providers and access to services from all of its significant proposed reforms proposed simultaneously. Many physicians are already facing rate cuts of 5%, 10%, or more in 2026 due to CMS' proposed wRVU "efficiency adjustment" and PE RVU reallocation. Facing such sweeping and arbitrary cuts which will accelerate consolidation makes it impossible to meaningfully focus on various methodologies related to post-operative visit valuation and shares.

## VI. Quality Measures - Proposed Changes to the 2025 MIPS MVP Pathway: Improving Care for Lower Extremity Joint Repair

CMS proposes to make several modifications to the Improving Care for Lower Extremity Joint Repair Merit-based Incentive Payment System Value Pathway (MIPS-MVP), including to revise Q376: Functional Status Assessment for Total Hip Replacement such that the timing of the encounter aligns with the post-surgical assessment timeframe of 300-425 days following the original THA surgery.

***AAHKS Comment:***

AAHKS supports finalizing this revision as proposed to align the Q376 timeframe with that of other quality reporting programs (e.g., the Hospital-Level THA/TKA Patient Reported Outcome-Based Performance Measure).

Additionally, with regards to Q470: Functional Status After Primary Total Knee Replacement, AAHKS supports CMS' proposal to clarify that if a tool other than the Oxford Knee Score (OKS) or Knee injury/Osteoarthritis Outcome Score Joint Replacement (KOOS, JR.) is used to assess a patient's functional status, this should result in a performance not met. This revised clarification is consistent with current report practices for outcomes and, therefore, AAHKS supports finalizing as proposed.

## VII. Prevention and Management of Chronic Disease RFI (Sec.II.I.2.)

The Trump Administration has set the laudable goal of lowering chronic disease rates through a variety of clinical and lifestyle interventions, including improved physical activity.[88] Accordingly, CMS issues a Request for Information (RFI) on strategies to leverage the Fee Schedule to better prevent and manage chronic disease.

***AAHKS Comment***:

AAHKS supports the Administration's focus on reshaping the care continuum to better prevent and manage chronic disease and improve quality of life for beneficiaries. When clinically appropriate, hip and knee procedures are part of this continuum by managing osteoarthritis (OA) and enabling beneficiaries to leverage one of the most potent and cost-effective tools to combat chronic disease—physical activity. At the same time, expanded coverage and payment of additional care to prevent and manage chronic disease would support hip and knee surgeons' efforts to counsel patients on chronic disease management (e.g., weight reduction). As CMS considers additional resources to support this goal, it is imperative that reimbursement for hip and knee arthroplasty procedures not be reduced in exchange.

*a. Topics and Questions Posed for Public Comment*

i. How could CMS better support prevention and management, including self-management, of chronic disease?

CMS could work with AAHKS and other specialty societies to establish clinical practice guidelines concerning non operative management of OA (i.e., weight management, activity modification, NSAIDs, cortisone). If these evidence-based measures are not effective, then coverage and reimbursement for TKR or THR becomes increasingly critical, as both have been demonstrated to offer significant gains in quality of life—particularly for beneficiaries with advanced OA.[89]

[88] EO 14212**,** *Establishing the President's Make America Healthy Again Commission*, 90 Fed. Reg. 9833 (Feb. 19, 2025).

[89] *See, e.g.*, Michele Palazzuolo et al., *Total Knee Arthroplasty Improves the Quality-Adjusted Life Years in Patients Who Exceeded Their Estimated Life Expectancy*, 45 INT'L ORTHOPAEDICS 635 (2021).

In addition, CMS could support specialist-led, longitudinal care models that integrate the expertise of beneficiaries' full clinical care team (e.g., primary care practitioners, dietitians, etc.) Multiple AAHKS members have independently implemented such models with great success.

ii. Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, please provide specific examples

Provider-patient communication through EMR platforms is increasingly used for substantive care management. This is an effective and convenient tool for beneficiaries to manage chronic conditions and, to support utilization going forward, CMS should ensure the Fee Schedule accounts for the time and resources spent by physicians on these platforms.

iii. How should CMS consider provider assessment of physical activity, exercise prescription, supervised exercise programs, and referral, given the accelerating use of wearable devices and advances in remote monitoring technology?

AAHKS is generally supportive of integrating data from credible wearable device vendors into the care continuum for chronic disease management. Wearable devices offer insight into the degree of disability caused by progressive arthritis. They also can objectively demonstrate improvement in activity with conservative and operative interventions. Additionally, they offer more granular information than many Patient-Reported Outcome Measures, which can be more subjective.

iv. Should CMS consider creating separate coding and payment for intensive lifestyle interventions, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set, and how should these interventions be prioritized? If so, what evidence has supported these services, and what do the services entail?

Among all the interventions that exist for advanced hip / knee arthritis, the only intervention that has been shown to be successful to improve QALYs is a total hip and knee arthroplasty when non operative measures have been deemed not effective. Intensive lifestyle modifications can delay the timing of the surgery but do not address the underlying pain generator. For this same reason, expanded coverage of motivational interviewing and services by health coaches are not sufficient to care for beneficiaries who satisfy the clinical criteria for hip or knee arthroplasty.

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AAHKS appreciates your consideration of our comments. If you have any questions, you can reach Mike Zarski at mzarski@aahks.org or Joshua Kerr at jkerr@aahks.org.

Sincerely,

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