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The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1834-P
P.O. Box 8010
Baltimore, MD 21244-8010.

Submitted online via www.regulatons.gov

RE: File Code CMS-1832-P MIPS Value Pathways (MVPs) outlined in the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule

Dear Administrator Dr. Oz:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) appreciates the opportunity to comment on the CMS' RFI relating to the transition to MIPS Value Pathways (MVPs) and the future direction of the Merit-based Incentive Payment System (MIPS) as outlined in the 2026 Medicare Physician Fee Schedule Proposed Rule. As the national professional association representing oral and maxillofacial surgeons (OMSs), AAOMS is committed to advancing high-quality, patient-centered care and ensuring that federal quality reporting programs reflect the unique clinical realities of our specialty.

We recognize CMS's efforts to streamline MIPS through the MVP framework and the overarching goals of improving care coordination, reducing administrative burden, and enhancing the relevance of performance measurement. However, we remain concerned that the current MVP structure may not adequately accommodate the diverse practice environments and specialized services provided by OMSs.

While MVP participation remains optional at this time, CMS has signaled future changes to the program structure, including subgroup reporting requirements for multispecialty groups beginning in the 2026 performance year. CMS has also indicated that traditional MIPS may eventually be phased out, though no formal timeline has been proposed. In light of this uncertainty, AAOMS urges CMS to provide clear guidance and sufficient lead time for any future transition to MVPs, particularly for specialties with unique clinical and operational characteristics.

The current MVP framework presents several challenges for oral and maxillofacial surgeons (OMSs):

- **Limited Measure Relevance**: The measures included in proposed and existing MVPs do not correspond to the procedures and patient populations typically managed by OMSs. As a result, participation could yield artificially low performance scores due to irrelevant or inapplicable metrics, undermining the intent of value-based care.

- **Case Minimums and Scoring Limitations**: OMS practices may struggle to meet case minimums for certain measures, leading to unscored or excluded metrics. This not only distorts performance evaluations but also creates uncertainty in payment adjustments.

- **Administrative Burden for Small Practices**: The requirement to form subgroups for MVP participation adds significant complexity, particularly for small and solo OMS practices. The infrastructure needed to support subgroup formation and reporting may be cost-prohibitive and operationally burdensome.

- **Technology Limitations and EHR Certification**: Most OMS practices utilize specialty-specific practice management software that does not meet the certification requirements for electronic health records (EHRs). This technological gap places OMSs at a disadvantage in meeting MVP reporting requirements and further exacerbates the administrative burden, especially when certified EHR adoption is not feasible or clinically justified for the specialty.

Although the goals of MIPS, APMs, and MVPs may be well-intentioned, the reality for many practices is that the programs remain overly complicated, resource-intensive, and difficult to navigate. Many practices lack certified technology, technology with FHIR capabilities, and/or the financial resources to continuously upgrade EHR systems to meet these demands.

Staff shortages across the healthcare industry have only exacerbated these challenges. In many cases, practices do not have the personnel to manage MIPS/APM participation tasks such as data collection, performance tracking, and reporting. In smaller or rural practices, these responsibilities often fall to clinical staff who are already stretched thin—diverting time and attention away from direct patient care. Even understanding the nuances of MIPS scoring, category weighting, and measure selection requires expertise that many practices cannot afford to maintain in-house.

These challenges—combined with the threat of financial penalties—discourage participation, despite clinicians' commitment to value-based care, ultimately undermining the intent of the program.

Moreover, many OMSs do not meet the MIPS eligibility thresholds—seeing fewer than 200 Medicare Part B patients annually or billing less than $90,000 in covered services—yet may still be swept into mandatory MVP participation if CMS does not account for these structural limitations. Without certified EHRs and sufficient patient volume, OMSs face significant barriers to meaningful participation and risk being unfairly penalized under a system that does not reflect their practice realities. This disconnect between program design and specialty-specific practice patterns places OMSs at a disadvantage, particularly when they are held to standards that assume access to infrastructure and patient volume more typical of primary care or large integrated health systems.

Further compounding this burden are the complex and resource-intensive MIPS submission methods, which include Qualified Registries, Qualified Clinical Data Registries (QCDRs), EHRs, and the CMS Web Interface. These reporting mechanisms often require costly infrastructure, technical expertise, and administrative support—resources that many OMS practices, especially smaller or independent ones, may not have. The lack of interoperability with specialty-specific systems and the absence of certified EHRs in many OMS settings make compliance even more challenging.

As a result, the MIPS framework not only fails to accommodate the unique structure of OMS practices but also risks diverting valuable clinical resources away from patient care—further reinforcing the misalignment between program expectations and specialty realities.

AAOMS urges CMS to ensure that any future MVPs developed for mandatory participation include measures that are clinically relevant and appropriately tailored to the unique specialty. We also recommend that CMS allow sufficient flexibility for clinicians whose scope of practice does not align with existing MVPs. Additionally, CMS should consider the unique technological landscape of OMS practices and offer exemptions for specialties that do not or cannot utilize certified EHR systems or meet MIPS eligibility thresholds.

Finally, we urge CMS to consider eliminating or, at a minimum, significantly streamlining MIPS, APM, and MVP requirements to reduce reporting burdens and promote meaningful engagement. We recommend expanding technical support and educational resources and offering greater flexibility for practices facing staffing and infrastructure constraints. Simplifying the program and aligning with the realities of specialty care would go a long way in helping providers focus on what matters most: Caring for their patients.

We welcome continued dialogue with CMS to ensure that the transition to MVPs supports meaningful quality improvement without disadvantaging specialties with unique clinical profiles. Please contact Patricia Serpico, AAOMS Director of Health Policy, Quality, and Reimbursement with any questions at 800-822-6637, ext. 4394, or pserpico@aaoms.org.

Sincerely,

J. David Morrison, DMD
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