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The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8010
Baltimore, MD 21244-8010.

Submitted online via www.regulations.gov

RE: File Code CMS-1848-P Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule

Dear Administrator Oz:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) values its longstanding partnership with CMS and is excited to continue to collaborate with CMS to "Make America Healthy Again." Representing more than 9,000 oral and maxillofacial surgeons (OMSs) across the United States, AAOMS appreciates the opportunity to comment on the proposed CY 2027 Medicare Physician Fee Schedule.

Conversion Factor Updates

Medicare providers will face a payment cut beginning January 1, 2027. In the proposed rule, CMS estimates a CY 2027 conversion factor of $33.17 for qualifying providers and $32.84 for non-qualifying providers. These conversion factors represent payment decreases of 1.19 percent and 1.68 percent, respectively, from CY 2026.

After an increase in the conversion factor in CY 2026 stemming from the Working Families Tax Cuts legislation, this proposed payment reduction is a return to the recurring and significant payment cuts that undermine the financial stability of many healthcare practices year after year. These changes also follow already extensive payment cuts resulting from the efficiency adjustment and indirect practice expense methodology changes finalized for CY 2026. Policies that continue to reduce payment without sufficient granularity disproportionately harm specialty

care providers like OMSs. Unlike larger health systems, these providers often lack the financial resources necessary to absorb recurring payment reductions year after year, eroding the care networks upon which many Medicare beneficiaries rely.

CMS's proposal fails to account for worsening economic pressures that have substantially increased operational and practice costs for healthcare providers. Systemic issues within the Medicare payment system, such as the negative impact of budget neutrality requirements and the lack of an annual inflationary update, continue to generate instability for clinicians and ultimately threaten beneficiary access to essential healthcare services.

While AAOMS actively addresses these issues through support of legislation to address inflationary adjustments and budget neutrality, CMS may also address this matter through its rulemaking process. **AAOMS urges CMS to reconsider the proposed payment cuts and collaborate with Congress to fundamentally reform the Medicare payment system to ensure reimbursement stability for Medicare providers moving forward.**

Practice Expense RVU Methodology Changes

AAOMS acknowledges that practice expenses (PE) have changed significantly over the past two decades and appreciates CMS's efforts to recognize the growing economic pressures facing physicians. However, proposals to modify the underlying methodology for calculating practice expense require more granular data collection and specialty impact analysis. **As such, we urge CMS to postpone the implementation of the proposed PE methodology changes until a future rulemaking cycle where further data is collected and analyzed for each distinct proposed change to the PE methodology.**

CMS proposes four distinct changes to the indirect PE relative value unit (RVU) methodology: modifying the utilization formula to account for payment rules, altering the indirect allocator calculation, removing steps that rely on the Indirect Practice Cost Index (IPCI), and adding a stabilization adjustment factor. Given the intricacy of the PE RVU calculation, a change to any part of the methodology is significant; the proposal to introduce four changes at once is exceedingly complex. It is impossible for specialty providers to anticipate the full impact of these policy proposals without publicly available data modeling their impact.

As far as current data analysis allows, the proposed methodology changes would deeply impact reimbursement for specialties that rely on office-based procedures, imaging, diagnostic and technical services. CMS estimates that OMSs can expect a 1% reduction in PE RVUs in both facility and non-facility settings. OMSs may face significant variability in the reductions depending on the clinical family of a procedure and the proposed timeframe of implementation. Not only will physicians face unpredictable outcomes from the myriad of changes proposed, the proposals themselves may also produce uncertainties that change PE RVUs from year to year. Increased variability in payment undermines the ability of providers to maintain practices and deliver care.

Furthermore, aggregate specialty-level estimates may not adequately capture the variation within a specialty. OMS practices encompass a range of practice models and services, including office-based procedures, hospital-based procedures, ambulatory surgical center services, imaging, and other technical services. The impact of the proposed methodology may therefore vary substantially among OMS practices depending on their mix of services and practice setting. CMS should provide additional analysis of these variations before implementing changes that could have materially different effects on individual practices within the same specialty.

The proposed PE methodology changes are compounded by the proposed conversion factor reduction for CY 2027 as well as the CY 2026 efficiency adjustment and the indirect PE methodology changes. While we appreciate the proposed phase-in of the IPCI removal and the 5 percent cap for the stabilization factor, these transitory mechanisms only delay the full impact of reductions in PE RVUs and do not prevent future reductions or expansions of the policies to other procedures or parts of the physician payment calculation. For providers already operating on thin margins, cumulative payment reductions force providers out of the Medicare program, ultimately limiting patient access to care. When payment systems contract, specialty care providers, regardless of practice setting, bear a disproportionate share of the financial burden, particularly as shifting budgetary priorities redirect resources away from highly specialized clinical services.

AAOMS supports CMS's efforts to modernize the practice expense methodology and recognizes that reliance on historical practice cost data may no longer accurately reflect current physician practice patterns. To this end, **AAOMS encourages CMS to incorporate the AMA's Physician Practice Information (PPI) Survey conducted in 2024 into future rulemaking on the PE methodology**. The PPI survey was a multi-year effort to collect updated physician practice data at the specialty level. CMS did not adopt this data, but it remains the most recent and comprehensive data on physician practice costs and hours. AAOMS recognizes CMS's concerns regarding the response rate and representativeness of the PPI survey. However, these limitations should not be viewed as a reason to proceed without updated data. Instead, they demonstrate the need for CMS to work with the AMA and specialty societies to improve future data collection. CMS should identify the specific limitations that prevented adoption of the 2024 PPI data and develop a plan to address those limitations before implementing a new PE methodology that will affect every physician specialty. CMS should also consider working with the AMA and specialty societies to simplify the survey methodology or modify the survey population to obtain more robust results from a larger share of physicians. **Until more robust, specialty specific data can be produced to understand the impact of each of these proposals, AAOMS strongly urges CMS to delay the proposed PE methodology changes. During this delay, we also encourage CMS to engage the AMA and specialty societies on data collection methods to better inform future rulemaking on PE methodology.**

Indirect Practice Expense Methodology Site of Service Payment Differential

We also remain concerned that future reductions in indirect practice expense for hospital-employed or facility-based physicians could disproportionately affect academic oral and maxillofacial surgery programs, which incur substantial clinical, teaching, administrative, and research-related expenses not reflected in traditional private-practice cost structures. **We urge CMS to repeal its CY 2026 implementation of the 50 percent work adjustment to the indirect PE methodology for January 1, 2027.**

Prior to implementing any policy that differentiates facility-employed and independent physicians, CMS should analyze the impact on academic faculty practice plans and hospital-based specialty programs. Data driven approaches are needed to assess whether current PE allocation methodologies adequately account for hospital-employed and integrated delivery system practice models where practice expenses may not be fully reflected in existing calculations. Empirical analysis will aid in addressing potential duplications of indirect expense payment between the MPFS and hospital payment systems are necessary to ensure that independently practicing physicians are not unintentionally harmed.

If CMS elects to proceed with any portion of the proposed PE methodology changes, AAOMS urges CMS to adopt additional safeguards to mitigate unintended disruptions in physician payment. **At a minimum, CMS should consider a longer phase-in period and limits on annual reductions in PE RVUs while additional specialty-specific data are collected and analyzed**. CMS should also commit to reevaluating the methodology once more robust data is available and provide stakeholders with an opportunity to review and comment on that analysis before further implementation.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

AAOMS strongly opposes CMS's proposal to introduce a payment reduction when a separately identified office or outpatient evaluation and management (E/M) visit is furnished by the same physician, or physician in a group practice, on the same day as a 0-, 010-, or 090- day global procedure. We also oppose expansions of this policy to include E/M visits furnished on an inpatient basis.

As proposed, this policy creates significant uncertainties about application and impact. The proposed rule indicates that claims with modifier -25 would be subject to this policy change if finalized; but AAOMS is concerned that the rationale articulated by the agency and the broad proposal language could provide a framework for future expansion of the policy to other circumstances involving E/M services furnished in conjunction with major procedures, such as those with modifier -57. **AAOMS requests confirmation this proposal would be applicable only to scenarios where modifier -25 applies.**

CMS has historically recognized these E/M visits as separately identifiable, permitting the usage of modifiers -25 and -57 where appropriate. The usage of these modifiers to support separately identifiable E/M services and the decision for surgery following an E/M visit already requires

significant documentation to ensure that payment abuses and overpayments do not occur. The proposed policy is a radical departure from existing and widely accepted policy that will create drastic consequences for physician payment and practice as well as patient access to and choice of care and treatment.

Moreover, the introduction of an additional payment reduction where the RUC valuation process already accounts for duplicative physician work and practice expense further undermines independent, office-based practices. This proposal directly contradicts CMS's stated goals of improving access to continuous, coordinated, and comprehensive care. If finalized, this policy would only exacerbate the financial challenges facing independent practices, pushing them towards alternative practice models and methods.

Additionally, the proposed 50% reduction – as well as the consideration of a more severe 75% reduction – are arbitrary and unsupported by empirical data. The proposed across-the-board payment reductions fail to capture the nuances of clinical practice and medical decision-making. A more appropriate course of action would be a detailed review of specific procedures that CMS identifies as having overpayments and resource overlap with E/M visits. Then, based on objective analysis, an appropriate adjustment can be made using already existing valuation mechanisms such as the RUC process, if warranted. Without this detailed data analysis, it is impossible to fully anticipate the impact of this policy and to make necessary adjustments for specialty-specific considerations. If there is genuine overlap or duplication of payment between the E/M services already paid for during the surgical package and any additional E/M services billed for through the use modifier -25, CMS should publicly provide the data indicating as such prior to implementing this proposal. Doing so will give specialty societies sufficient information to understand coding and billing patterns and provide additional details that may account for observed aberrations. Additionally, if CMS were to pursue a payment reduction for these E/M services, following the publication of data, the agency should engage the RUC to formally revalue specific services in accordance with the resource-based valuation processes to ensure transparency and objectivity.

We strongly oppose the introduction of a payment reduction for separately identifiable office or outpatient E/M visits furnished on the same day as a 0-, 010-, or 090- global procedure. Instead, we respectfully request CMS to engage with the RUC on formal valuation processes to understand the scope and scale of modifier -25 usage prior to policymaking.

<u>Global Surgical Payment Accuracy</u>

We appreciate CMS's ongoing efforts to improve transparency and accuracy in the valuation of global surgical packages. **We support the proposal to pause collection of CPT code 99024 and would urge CMS to not expand the reporting requirement to all providers.** This will alleviate administrative burden for providers and allow CMS to engage with more accurate and physician-informed data sources for global surgical payment methodology.

The current data collection creates undue burdens for providers. Practice management systems often do not allow entry of codes with a zero-dollar charge, further complicating compliance with reporting requirements while increasing burden on providers and their administrative staff. Additionally, claims data may not accurately reflect the number or complexity of post-operative visits, especially when providers are not incentivized or equipped to report zero-dollar services.

While we understand CMS's rationale in using claims-based reporting to refine the allocation of payment shares among pre-operative, operative, and post-operative components, AAOMS does not agree with the assertion that the data collected is reliable and sufficient to understand the provision of post-operative visits in the global period. The RAND analyses of CPT code 99024 reporting have been widely criticized. The longstanding concerns about the reliability of the underlying data and methodology for reporting of CPT code 99024 underscores the need to pause data collection. Additionally, if CMS intends to use this data to reassess global surgical values, there are potential concerns with using flawed historical reporting data to justify future downward revaluation of surgical packages. Without accounting for the inaccuracies in the data and reporting methodology, future valuation decisions will not reflect clinical practice realities.

We strongly urge the agency to continue to rely on the physician-led AMA Relative Value Update Committee (RUC) for valuation recommendations. We support RUC's prior recommendation that the full increase of work and physician time for the inpatient hospital and observation care visits (CPT codes 99231-99233, 99238 and 99239) and office visits (99202-99215) be incorporated into the surgical global periods for CPT codes with 010- and 090- day global periods. We further support the RUC's recommendation that practice expense inputs should be modified for the inpatient hospital and observation care visits and office visits within the global periods.

AAOMS recommends that CMS maintain alignment with RUC recommendations and avoid relying solely on claims-based data for valuation decisions and also engage with specialty societies and practice management experts to ensure that any reporting requirements are feasible and meaningful.

Office/Outpatient Evaluation and Management (E/M) Complexity Code Replacement

AAOMS appreciates CMS's continued efforts to properly value ongoing, longitudinal patient care in office or outpatient visits. While AAOMS has historically supported the termination of the G2211 code, the proposal to replace HCPCS code G2211 with a two-digit modifier that is a percentage of the associated evaluation and management visit requires additional information to ensure suitability for clinical practice patterns and billing procedures.

We would request clarification regarding the operational implementation of this proposal, to include details about appropriate usage and reporting requirements. If finalized, we also urge the

agency to provide extensive education for providers to avoid coding and billing inaccuracies. CMS should also consider lengthening the implementation timeframe of this proposal to ensure that providers are sufficiently aware of changes.

To support understanding the full impact of this proposal, we would further encourage CMS to conduct analysis of the specialties that currently bill G2211. Understanding the current usage and billing patterns of G2211 by specialty will support ongoing refinement of the complexity add-on payment while also supporting specialty-led education efforts to aid in promotion and adherence to the policy. AAOMS also supports ensuring that the new modifier structure remains budget-neutral to affected specialties and would oppose any reductions in payment for longitudinal care management currently recognized through G2211. More analysis into G2211 usage will ensure that the valuation of proposed modifiers is based on empirical evidence.

We support continued analysis into add-on complexity payment methodologies in alignment with specialty-level practice data and extensive provider education for proposed reporting changes.

Quality Payment Program (QPP) and MVP Transition

AAOMS appreciates CMS's goal of advancing value-based care through the Merit-based Incentive Payment System (MIPS), Alternative Payment Models (APMs), and MIPS Value Pathways (MVPs). However, for many OMS practices, these programs remain overly complex, resource-intensive, and difficult to navigate.

OMS practices have long faced barriers to meaningful participation in MIPS, including low Medicare patient volume, a lack of clinically relevant quality measures, and technology limitations associated with specialty-specific practice management systems. Participation is further constrained by workforce and operational realities. Unlike large health systems, most OMS practices operate with lean staffing models and lack dedicated personnel for quality reporting, data analytics, or regulatory compliance.

The proposed transition from Traditional MIPS to MVPs does not resolve these longstanding challenges. As CMS phases out Traditional MIPS and makes MVPs the primary reporting framework, OMS practices risk losing practical reporting pathways while facing increased reliance on digital reporting infrastructure that is not widely available within the specialty. Limited Medicare volume, measure misalignment, and restricted access to certified EHR and FHIR-enabled technology continue to impede meaningful participation and limit CMS's ability to accurately assess OMS performance.

Limited Measure Relevance

Current and proposed MVPs do not adequately reflect the procedures, patient populations, or services typically provided by OMS. The CY 2027 proposed rule would remove twenty measures from the MIPS Quality Measure inventory, further reducing an already limited set of reporting options available to OMS practices, including several broadly applicable measures relied upon by small and specialty practices when specialty-specific measures are unavailable.

As a result, OMS may be required to report on measures that are not clinically relevant, producing performance scores that do not accurately reflect the quality of care delivered.

Case Minimums and Scoring Limitations

OMS practices frequently struggle to meet measure case minimum requirements because much of their patient population is below Medicare age and many OMS services are not routinely covered by Medicare. Consequently, Medicare claims often represent only a small fraction of the care OMS provide.

Certain OMS practices may meet Medicare payment thresholds through a limited number of complex trauma, pathology, or reconstructive surgery cases while treating relatively few Medicare beneficiaries. Although reimbursement totals may appear sufficient, beneficiary counts may be too low to support statistically reliable performance assessments. This can lead to excluded measures, distorted performance scores, and payment adjustments that do not accurately reflect provider quality.

Administrative Burden on Small Practices

MVP participation requirements, including subgroup formation and reporting, create significant administrative challenges for small and solo OMS practices that lack the resources and infrastructure necessary to support these activities.

The burden is particularly significant for OMS clinicians practicing within multispecialty groups, who may be assigned to clinically irrelevant MVPs based solely on NPI taxonomy classifications rather than actual practice patterns. These reporting obligations increase administrative complexity and costs without improving the accuracy or usefulness of performance measurement.

Technology Limitations and EHR Certification

These challenges are compounded by the specialty's technology environment. Unlike many physician specialties, OMS practices often rely on specialty-specific practice management systems that do not meet certified EHR requirements and were not designed to support MIPS reporting, digital quality measurement, FHIR-based interoperability, or other CMS reporting specifications.

Quality-reporting data is frequently dispersed across multiple systems and may not exist in standardized or interoperable formats. OMS commonly provide care through referrals from dentists, orthodontists, physicians, hospitals, and emergency departments. As a result, critical clinical information often originates outside the OMS practice and may not be exchanged through interoperable systems. Likewise, follow-up care and outcomes may be documented by referring providers rather than the OMS, making comprehensive data collection difficult, if not impossible.

The CY 2027 proposals would further intensify these challenges by expanding digital quality measurement and FHIR-based interoperability requirements that many OMS technology platforms cannot currently support. CMS's longer-term plans to phase out Qualified Clinical Data Registries (QCDRs) may further reduce viable reporting pathways for OMSs and increase dependence on digital reporting capabilities that remain unavailable to many specialty practices.

For many OMS practices, participation in MIPS or MVPs is not simply a matter of adopting a certified EHR. Many OMS software platforms lack the functionality necessary to support CMS reporting requirements, and improvements cannot occur unless vendors develop and maintain those capabilities. Therefore, OMS clinicians depend not only on their own willingness and ability to invest in new technology, but also on whether specialty software vendors determine that the substantial development costs associated with these enhancements are commercially viable. Until such capabilities are broadly available in OMS-specific systems, many OMS clinicians have no practical pathway for complying with CMS reporting requirements. Even if upgrades become available, practices would face substantial costs associated with implementation, integration, workflow redesign, staff training, and ongoing maintenance. These investments are particularly difficult to justify given limited Medicare patient volume and the shortage of clinically relevant MVP options.

Taken together, these realities demonstrate that OMSs are not unwilling to participate in value-based care initiatives. Rather, they lack a clinically relevant, technologically feasible, and operationally achievable pathway for successful participation under the current MIPS and MVP frameworks. Absent significant modifications, mandatory MVP participation would impose substantial administrative and financial burdens on OMS practices while generating performance assessments that may not accurately reflect the quality of care delivered.

Accordingly, AAOMS strongly recommends that CMS exempt OMSs from automatic inclusion in MVPs beginning with the CY 2029 performance year unless and until CMS develops a specialty-specific pathway that includes:

- Clinically relevant quality measures;
- Appropriate case minimum thresholds;
- Reporting requirements aligned with OMS practice patterns;

- Consideration of OMS Medicare utilization patterns; and
- Technology requirements that reflect the specialty's existing infrastructure and capabilities.

At a minimum, CMS should increase the low-volume threshold applicable to OMS and other dental surgical specialties. Existing thresholds do not adequately account for the specialty's limited Medicare beneficiary volume, particularly where practices exceed payment thresholds through a small number of high-cost cases. Participation requirements should better reflect beneficiary volume and the statistical reliability of available performance data rather than Medicare reimbursement totals alone.

In short, the challenge for OMSs is not merely the transition from Traditional MIPS to MVPs. The design of both programs fails to adequately account for the unique clinical, operational, and technological characteristics of OMS practice. **Until CMS addresses these limitations, AAOMS urges CMS to exempt OMSs from mandatory participation or, at minimum, significantly expand low-volume threshold protections.**

Thank you for considering these comments. We look forward to continued collaboration with CMS to strengthen the outpatient care system, ensure that payment policies support both quality and sustainability, and "Make America Healthy Again." 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,

Robert S. Clark, DMD
AAOMS President