

AAOS

AMERICAN ASSOCIATION OF
ORTHOPAEDIC SURGEONS



ADVOCACY REPORT

FALL
2026

Federal Government Affairs

→ Federal Legislative Activity

AAOS Responds to the 2027 Proposed Medicare Physician Fee Schedule

AAOS strongly opposes the proposed 20% cuts to the code valuations for total knee arthroplasty (CPT 27447), total hip arthroplasty (CPT 27130), total shoulder arthroplasty (CPT 23472) and shoulder hemiarthroplasty (23470). We call on CMS to pause implementation of CMS' CY 2027 proposed payment values for these services, maintain the current 2026 values, and work with physicians to develop a more stable and sustainable approach to Medicare physician payment for both these and other services.

President Trump, his leadership team at the Department of Health and Human Services (HHS), and congressional leaders on both sides of the aisle have all made clear their desires to protect independent physician practices, lower health care prices through competition, and prevent further consolidation in the health care system. Orthopaedic surgeons are the last frontier of independent medical practice, with about 50% of orthopaedic surgeons continuing to practice independently. Our physicians take pride in their independence and the ability that gives them to serve the unique needs of their communities by providing high-quality, efficient, cost-effective care through innovative approaches to care delivery and contributing to competition in the market for health care services. As care shifts from independent physician practices to ownership by larger health systems or even non-health care ownership enterprises, patients often face higher costs, fewer choices, and longer wait times.

While each proposal detailed below is concerning individually, together they would reduce Medicare payment to orthopaedic surgeons by approximately 7 percent in 2027 before an additional projected 1.19 to 1.68 percent reduction from the CY 2027 conversion factor.

1. Approximately 20 Percent Reductions for Major Joint Replacement Procedures

The Centers for Medicare and Medicaid Services (CMS) proposes approximately 20 percent payment reductions for major joint replacement procedures, including total hip arthroplasty, total knee arthroplasty, total shoulder arthroplasty, and shoulder hemiarthroplasty.

Total joint replacement is among the most successful procedures in modern medicine, restoring mobility, relieving pain, reducing disability, and allowing millions of Medicare beneficiaries to remain independent. Yet CMS has not demonstrated that payment reductions below current values are supported by sufficient evidence. Instead, CMS primarily attributes the reductions to changes in site of service, even though migration to ambulatory surgery centers reflects advances in surgical techniques, anesthesia, implants, enhanced recovery protocols, and care coordination—not reduced physician work or clinical complexity.

Regarding the code reductions, it is important to note that just because total joint replacement has advanced to the point that the procedure is done in less time and has shifted to the outpatient setting, does not mean that these procedures are simple, routine, elective procedures which hold no risk. These procedures carry significant intra-operative risk of fracture, nerve injury, and blood vessel injury. Post-operative risks include the disastrous complication of infection, deep venous thrombosis and pulmonary embolism, wound healing and bleeding complications, or dislocation. All of these risks are mitigated by the surgeon's ability to assimilate a large number of data points before, during, and after surgery; apply advanced technical skills at the time of surgery; and closely manage the patient post-operatively to understand the signs of complications.

To reiterate, CMS' proposed valuation is NOT accurate: CMS is using proxies—site of service and time—to infer a reduction in physician work without sufficient evidence that the underlying work, skill, intensity, risk, or responsibility has actually declined.

For more than a decade, AAOS and orthopedic surgeons have been leaders in advancing value-based care and have been committed partners with CMS in identifying cost efficiencies that deliver greater value for patients and the Medicare program. This partnership has been especially evident in lower extremity joint replacements, where orthopedic surgeons drove the success of payment models, such as the Comprehensive Care for Joint Replacement (CJR) and the Bundled Payments for Care Improvement (BPCI) Advanced models. Continued payment cuts undermine the opportunity for that collaboration and jeopardize the meaningful impact orthopedic surgeons can deliver through future value-based care initiatives.

In effect, physicians are being penalized for the same transition to lower-cost outpatient care that Congress has long encouraged. Further, CMS's interpretation of Section 220 of the Protecting Access to Medicare Act (PAMA) effectively concentrates nearly the full reduction into a single year, undermining Congress's intent to provide physicians with a meaningful transition period for significant payment reductions.

2. Same-Day E/M and Global Procedure Payment Reduction Proposal

Beginning January 1, 2027, CMS proposes reducing payment when a separately identifiable office/outpatient Evaluation/Management visit is furnished on the same day as a procedure with a 0-, 10-, or 90-day global period by the same physician—or another physician in the same group practice. The highest-paid service would continue to receive full Medicare payment, while all remaining covered surgical procedures and office/outpatient E/M services would be reimbursed at 50 percent of the applicable fee schedule amount. The reduction would apply automatically even when the E/M service is separately identifiable, medically necessary, fully documented, and appropriately reported with Modifier 25.

3. Practice Expense Methodology Changes

CMS also proposes significant revisions to the Medicare practice expense methodology, including eliminating the Indirect Practice Cost Index (IPCI), revising indirect practice expense allocation, and implementing a new practice expense stabilization adjustment. CMS has not adequately demonstrated the need for these sweeping revisions or fully quantified their specialty-specific impacts.

Independent orthopaedic surgery has reached a tipping point. The proposals in this rule would cause irreparable damage, accelerating consolidation of independent practices into large health systems, vertically integrated health insurance conglomerates, and private equity backed ventures, changing the way musculoskeletal care is delivered, and the face of American health care indefinitely. In the process, by undervaluing the work required to diagnose, treat and manage complex musculoskeletal conditions, this rule will result in fewer physician options, longer wait times, and delayed access to care for Medicare beneficiaries.

In response to these significant and harmful proposals, AAOS is urging CMS to withdraw the proposed payment reductions for major joint replacement procedures, withdraw the proposed modifier-25 policy, and provide greater transparency and specialty-specific impact analyses before finalizing the proposed practice expense methodology changes.

[Read the full letter here →](#)



Update on PRORP

AAOS has been closely monitoring and advocating during the appropriations process, particularly for the Peer Reviewed Orthopaedic Research Program (PRORP). AAOS was successful in getting the program reinstated for FY26 at \$20 million and has continued to push for funding of this critical program, successfully securing \$20 million for FY27.

Restoring this funding after it was cut to \$0 in FY25 is a significant win and a testament to the hard work of the many AAOS Fellows who sent letters, shared stories and met with key members of Congress.

The mission of PRORP is to ensure America's warfighters who sustain orthopaedic injuries have every opportunity for recovery and restoration of function. This investment directly supports military readiness, force strength, and our nation's ability to project power across the globe.



Congressional Directed Medical Research Program Letter

A letter that Senator Roger Wicker (R-MS) and Senator Dick Durbin (D-IL) circulated in support of the Department of Defense's (DoD) medical research accounts, including Congressionally Directed Medical Research Programs (CDMRP), secured 21 co-signers. The bipartisan letter requests at least \$3.517 billion in funding for DoD-wide Research, Development, Test, and Evaluation (RDT&E) accounts that fund medical research. Specifically, as related to CDMRP, the letter requests at least \$1.62 billion in investment for Fiscal Year 2027. The letter calls attention to cuts made in Fiscal Year 2025, and the overall increase in inflation as key factors in the need for robust support.

[Read the full letter here →](#)



Key House Committees Advance the Improving Seniors' Access to Timely Care Act

On July 21, the House Energy and Commerce Committee voted unanimously to advance the AAOS-endorsed Improving Seniors' Timely Access to Care Act (H.R. 3514), setting the stage for a full vote in the House later this year. The bill was packaged with other "transparency" bills though an "Amendment in the Nature of a Substitute" (AINS). With this action, the Seniors' Act cleared both House Committees of jurisdiction, following the Ways and Means Committee's unanimous vote (42-0) on July 15. While most changes made by Energy and Commerce (E&C) were technical in nature, there are slight variations from the bill passed by the Ways and Means (W&M) committee.



AAOS Leads Congressional Briefing and Capitol Hill Fly-In with Team Physicians Focused on Athlete Health

AAOS hosted a Congressional briefing featuring Coach Urban Meyer and leading sports medicine physicians. The briefing focused on athlete health, safety in the context of medical liability, and threats to access. Hosting this event reinforced AAOS leadership on sports medicine while engaging with Members of Congress and senior staff.

Advocacy topics included consideration of Utah H.B. 503 that protects physicians' personal assets, and increasing overall awareness of challenges facing team physicians. AAOS connected with 11 Members of Congress in just five hours on Capitol Hill, underscoring the impact and effectiveness of its grassroots advocacy efforts. Looking ahead, AAOS lobbyists will conduct follow-up outreach to legislators and staff to build congressional champions.

Though Congress is presently at a standstill that will likely continue through the November election, we anticipate significant leadership changes when the new Congress begins in January 2027.





Advocacy Win: AAOS Chiropractic Medicare Coverage Modernization Act Letter of Opposition Leads to Removal from Markup Agenda

AAOS opposes the Chiropractic Medicare Coverage Modernization Act of 2025 (H.R. 539) because the bill would expand Medicare coverage for services furnished by chiropractors beyond manual manipulation of the spine and authorize chiropractors to use the title physician under Medicare Part B. AAOS argues the legislation could allow coverage of any medical service a chiropractor could be licensed to perform, including services for which they may have very limited or no formal training, potentially putting patient safety at risk.

AAOS states that chiropractors play an important contribution to physician-led care teams, but emphasizes their training is not equivalent to the education and clinical training required of MDs and DOs. AAOS also warns that the bill could lead to an unnecessary redistribution of scarce Medicare resources away from physician practices to nonphysician practitioners, increase Medicare costs, and jeopardize the health and safety of Medicare patients.

This legislation was scheduled for markup in front of the Ways & Means committee, and AAOS successfully advocated for its removal from the agenda.

[Read our full opposition letter here →](#)



Update on Budget Neutrality Legislation

Rep. Greg Murphy, MD (R-NC) and eight bipartisan original cosponsors introduced the Provider Reimbursement Stability Act (H.R. 8163), a bipartisan bill aimed at modernizing the Medicare physician fee schedule to bring greater predictability to physician reimbursement. Senator John Boozman (R-AR) and five bipartisan original cosponsors introduced a companion bill. Key provisions include raising the budget neutrality threshold from \$20 million to \$54.3 million in 2027 (indexed at five-year intervals thereafter), capping the annual budget neutrality adjustment to the conversion factor at 2.5%, establishing a utilization corrections mechanism, and requiring regular updates to practice expense calculations. The language has passed the Ways and Means Committee. AAOS will continue to monitor this legislation.



E&C MACRA Hearing

The House Energy & Commerce (E&C) Subcommittee on Health held a hearing examining the Medicare Physician Fee Schedule on Wednesday, May 20th. This comes on the heels of work the bipartisan GOP and Democratic Doctors' Caucuses are doing to draft comprehensive reform to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). AAOS submitted a [statement for the record](#) in response to this hearing.



Congressional Committees Hold Hearings on Affordability and Access: Healthcare CEOs

On Tuesday, April 28th, the House Ways and Means Committee held a hearing to discuss the current healthcare landscape related to hospital administration and management. Five witnesses, all executive level health care leaders, were called to offer testimony regarding increasing healthcare costs and issues related to access. Topics included the 340B drug pricing program, overall increases in costs, physician-owned hospitals, and hospital transparency. Our [AAOS statement for the record](#) that was submitted in response to the hearing highlights our advocacy for site-neutral payments aimed at increasing patient choice and lowering out-of-pocket costs, as well as support for legislation that improves Medicare Advantage network adequacy.

A similar hearing was held by the Energy & Commerce Subcommittee on Health on Wednesday, March 18th, entitled *Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape*. During this hearing, witnesses representing a broad cross section of physician and hospital groups, explored themes of consolidation, price transparency, and Medicare physician payment. AAOS submitted a [statement for the record](#) that raised concerns regarding Medicare physician payment, administrative burden, narrow networks, downcoding, and value-based care.

Federal Regulatory Policy

2027 Medicare Outpatient Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2027 Hospital Outpatient and Prospective Payment System (OPPS) and Ambulatory Surgery Center (ACS) Payment System proposed rule on July 2, 2026. Several proposals impact musculoskeletal care and access, including updates to the APC codes that have been impacted by the elimination of the Medicare Inpatient Only List (IPO), and complexity adjustments via add-on codes for certain procedures and device codes. AAOS is supportive of policies that ensure codes reflect the resource utilization and clinical complexity necessary to deliver high-quality care. AAOS submitted [comments](#) in response to the proposed rule and recommended these additional changes:

- ➔ **Site Neutral Payment for Non-Contrast Imaging:** AAOS appreciates that CMS recognizes the value of creating parity in non-contrast imaging payment rates across physician office and off-campus provider-based department (PBD) settings. By creating this equilibrium, we believe it will act as an enabling step toward preventing further consolidation and price inflation caused by large healthcare systems absorbing their independent physician competitors' sources of revenue. However, we urge caution against unintended consequences, including limiting access to critically important, low-cost diagnostic tools.
- ➔ **Device Pass Through Payments:** AAOS supports transitional device pass through payments for new technologies supported by adequate evidence demonstrating their safety, efficacy, and effectiveness in Medicare beneficiaries. In general, AAOS supports CMS's efforts to facilitate beneficiary access to innovative technologies and appreciates the agency's collaboration with the U.S. Food and Drug Administration (FDA), including through the Breakthrough Devices Program to encourage the development and adoption of clinically meaningful technologies that improve musculoskeletal care.
- ➔ **ASC Weight Scalar:** AAOS urges CMS to remove the ASC weight scalar. While we appreciate the continued use of the hospital market basket methodology to update ASC payment rates, we remain concerned that the weight scalar constrains ASC payment updates and, in turn, limits opportunities for innovation in patient care and expanded access to surgical services across settings.

CMS Finalizes 2027 Medicare Inpatient Prospective Payment Rule

Following the comment period, when AAOS submitted comments to the Centers for Medicare & Medicaid Services (CMS) on the Fiscal Year 2027 Medicare Inpatient Prospective Payment System (IPPS) proposed rule, CMS has released the final rule with the provisions largely finalized as proposed. The rule included major proposals, including the mandatory expansion of the Comprehensive Care for Joint Replacement model (CJR-X) and updates to the Transforming Episode Accountability Model (TEAM). AAOS is pleased that CMS is moving forward with a demonstration program to allow physician-led hospitals to opt-in to participate in TEAM.

CMS finalized the CJR-X model largely as proposed despite AAOS' serious concerns with the proposed mandatory national expansion. The rule also included a Request for Information on the inclusion of Ambulatory Surgical Centers (ASCs) in TEAM. We recommend that CMS create a separate episode benchmark for procedures performed at the ASC and carefully analyze this data for several years before considering a benchmark combining ASC and HOPD procedures. Since ASCs are a lower-cost, high-quality option for patients who require minimal post-acute care, AAOS is concerned that there are minimal savings to be found by including ASCs in TEAM. AAOS opposes attempts by CMS to artificially create savings by using ASC inclusion to lower the target prices across the model. We also recommended that TEAM and CJR-X participants be required to report data from total hip arthroplasty and total knee arthroplasty procedures to a national clinical data registry such as the American Joint Replacement Registry (AJRR) run by AAOS. Hospitals should then be able to receive credit toward their quality scores for submitting this data.

AAOS Opposes OMB Proposed Rule Impacting Research Grants

In response to a proposed rule from the Office of Management and Budget (OMB) proposing to revise the Guidance for Federal Financial Assistance to improve government-wide policies and requirements related to the management of grants, cooperative agreements, and other forms of assistance, AAOS submitted [comments](#) raising concerns about the impact of this proposal on the ability of physicians to conduct medical research and publish their findings in peer-reviewed academic journals. In addition to our own comments, AAOS also participated in a [sign-on letter](#) with other orthopedic groups. Importantly, a bipartisan group of lawmakers led by Senator Susan Collins (R-Maine) and Chair of the Senate Appropriations Committee, sent a [letter](#) to White House budget director Russell Vought requesting that they withdraw some of the proposed provisions. Specifically, Chair Collins raised concerns about the proposals that would allow federal agencies to terminate discretionary grants should they determine that doing so would align with “national interest”, require senior political appointees to review grant awards after the scientific review process to determine whether they align with President Trump’s policy priorities, require grant recipients to submit written justifications with every payment request thus creating paperwork that would burden small and rural institutions disproportionately, and give greater weight to presidential policy priorities in grant decisions without the necessary transparency to ensure they remain consistent with Congressional intent. OMB has received historic pushbacks on this proposal with nearly 500,000 comments submitted.

AAOS Comments to CMS on Electronic Prior Authorization for Drugs Rule

AAOS has written [comments](#) on the CMS Interoperability Standards and Prior Authorization for Drugs proposed rule (CMS-0062-P). In the letter, we highlight our broad concerns with PA processes, our support for a streamlined electronic PA process for medications, and detailed recommendations on step therapy guardrails. Specifically, as it relates to step therapy, we recommend that plans be required to implement a step therapy exception process, make exceptions standardized across payers, leverage technology to streamline the process and make reporting on it public. We also make notes of the role that artificial intelligence plays in the PA ecosystem.

Department of Education List of Professional Degree Programs

The Department of Education has announced a new list of degrees that qualify as professional degrees under the One Big Beautiful Bill Act's (OBBBA) new caps on borrowing limits for graduate and professional degree programs. The original rule, which was recently blocked by a federal judge for violating the Administrative Procedure Act, included just 11 professional degrees, excluding certain graduate level clinical programs – such as nursing, physician assistant, occupational therapy, and physical therapy. The new definition includes 29 fields. The administration has clarified that the expanded list is intended only to facilitate implementation of the Court's order but may change as litigation proceeds. Under the OBBBA caps, students pursuing professional degrees can borrow up to \$50,000 a year and \$200,000 total, while those in graduate programs can borrow up to \$20,500 annually and \$100,000 total. The new caps went into effect on July 1.



Policy Spotlight: Artificial Intelligence

Artificial Intelligence (AI) has recently moved to the forefront of debate and focus for surgeons. Numerous questions arise when considering the opportunities and challenges that the myriads of technologies falling within the umbrella of "AI" present to orthopaedic surgeons. AAOS has been following this topic closely and is actively engaging where appropriate to ensure that orthopaedic surgeons maintain leadership through AI-augmented procedural pathways.

Defining AI

Machine learning and decision support tools have been used for decades and are more deterministic, while frontier models like ChatGPT, Gemini, and Claude are generative, not task-specific, and generally produce information rather than act. Agentic AI is a different category altogether because it can access new information, set goals, and take autonomous action.

A paradigm shift for surgeons and AI

How AI is used within the field of surgery is as much about change management as it is about the potential of the technology itself. Clinical decision support tools, surgical error prevention, and automating administrative tasks are all ways that AI can improve care. However, the tools themselves must be embraced with deliberate caution and an understanding that surgery will always require a human-first approach. Viewing the evolution of AI in medicine through this lens, there are three key areas of policy development that AAOS is particularly interested in:

- Regulation of AI tools by the FDA and Congressional Oversight: The FDA is looking at how to regulate AI from a software perspective. However, it becomes increasingly challenging to determine the most appropriate model for regulating generative models in which the technology is not static. Traditional FDA-style models of approval may work better for certain software-as-a-medical-device (SAMD) tools, but they are a poor fit for frontier models and the agents they inform because these tools are changing constantly. Frontier models in their pure form may be less like a device and more like a novel form of intelligence or information source, which raises hard questions about whether and how they should be regulated at all.
 - From a legislative perspective, Congress recently introduced the Protecting Patients from Automated Denials Act (H.R. 9734). AAOS endorsed this bipartisan legislation introduced by members of the GOP and Democrat Doc Caucus that is aimed at preventing AI from making insurer coverage denial determinations absent from the review of a physician from the same specialty. It is undeniable that AI will continue to play a role in the administration of insurance plans. However, AAOS supports the stringent oversight of such processes to ensure that clinical expertise and patient needs are placed above profit margins and technological economies of scale.
- Equity and payment: Payment and value-based care are key to whether AI is used in socially beneficial ways. CMS and private payers are increasingly interested in integrating AI into diagnosis and value-based care models, but the number of technologies far exceeds our ability to study them all. There is still enormous work to do to understand how all forms of AI can be used in daily patient care in ways that are useful for patients and health systems. Moreover, new ways of thinking about how surgeons lead care teams must be met with new CP codes that capture the billing and payment for these roles.

- **The Nexus of AI and Medical Liability:** Who is responsible when AI is used in clinical decision making? The current recommendations for physicians boil down to two key points:
 1. Never assume that AI is correct. Clinical judgment must always be the primary tool, and AI can be used as a supplementary one.
 2. To best protect against litigation, always maintain written documentation that AI is being used as a tool, such as for the purpose of note-taking, but that ultimately all medical information is reviewed at the human level.

Liability remains unsettled and will likely evolve case by case because there is not yet a clear AI standard of care. Currently, the central issue is whether liability attaches when a clinician relies on a defective tool, fails to use a tool, or uses a tool that has not gone through any meaningful certification or regulatory pathway. A surgeon would likely have more protection when using regulated AI, because regulation can provide a clearer framework for due diligence and liability protection.

Coding, Coverage, and Reimbursement Efforts

AAOS Submits Letter to CMS on E/M Modifier 25

AAOS submitted [letters](#) to the CMS Deputy Director at the Center for Medicare, BCBS Michigan, and Cambria Health Solutions expressing concern regarding a Medicare Advantage (MA) policy scheduled for implementation on July 1, 2026. This policy was brought to our attention via the Simply Healthcare Provider Newsletter posted in May 2026. The policy would affect reimbursement for claims billed with “XXX” procedure codes in conjunction with Evaluation and Management (E&M) codes appended with the modifier 25. Several Medicare Advantage plans, specifically: Elevance, Anthem, Simply Healthcare, Aetna Better Health, and Clear Health Alliance, are scheduled to implement the policy. AAOS is deeply troubled by the implementation, which implies that these plans will automatically deny claims reported with E&M codes and modifier 25 reported with “XXX” codes, requiring the submission of supporting documentation for review. We are also concerned that claims billed with these codes may have retrospective refund requests for previously paid claims. We expressed fear that this policy will lead to additional administrative burden and requested that CMS reconsider its implementation.

AAOS Leads Letter to United Healthcare on Problematic Radiology Report Policy

AAOS led a [sign on letter](#) to United Healthcare highlighting our concerns with a new reimbursement policy impacting radiology CPT codes. We raised concern regarding the implementation of this policy which implies that UHC will automatically deny claims reported with radiology codes appended with modifiers 26 and TC and require physicians to manually submit radiology reports with paper claims to obtain reimbursement for services rendered. We asked that UHC consider the value and practicality of this requirement vis-à-vis patient care and quality outcomes.

Advocacy Win: CMS Cracks Down on Upcoding in CY 2027 MA and Part D Advanced Notice

CMS released the final notice for the CY 2027 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and MA and Part D Payment Policies on April 6th, finalizing their proposal to exclude diagnosis information from unlinked Chart Review Records — which is diagnosis information not associated with a specific beneficiary encounter — from risk score calculation starting in CY 2027. While this update aims to reduce administrative burden, create competition equally between MA plans based on value to patients, and ensure payments accurately reflect beneficiary health, the final notice makes an exception to include diagnoses from unlinked records for beneficiaries who switch from one MA organization to another. This update marks an important step in MA reform and aligns with the AAOS-endorsed NO UPCODE Act introduced by Senators Bill Cassidy (R-LA) and Jeff Merkley (D-OR) last year. The final notice also included a higher than proposed estimated increase of 4.98%, to account for continued use of the 2024 risk adjustment model.

[Learn more here →](#)

State Policy and Legislative Activity

→ Introduction

In Q2, activity was focused on tracking bills as the 2026 state legislative sessions are unfolding. We continue to pay attention to what issues are being addressed as well as keeping tabs on AAOS' policy priorities. Per the priorities laid out at the 2025 Combined National Orthopaedic Leadership Conference (NOLC)/Fall Meeting by the Board of Councilors (BOC) and Board of Specialty Societies (BOS), the OGR team remains focused on issues related to prior authorization, artificial intelligence, reform efforts for workers' compensation, medical liability reform, utilization management, scope of practice expansion issues, and emerging issues like artificial intelligence in the healthcare system.

→ Recent State Legislative Wins

Medical Liability



New Mexico Liability Victory

In March 2026, New Mexico enacted HB 99, a bill aiming to address issues around medical liability within the state. Specifically, the bill establishes set caps on recoverable damages for physicians, with amounts above the cap being paid by the Patient Compensation Fund. The legislation also substantially limits the award of punitive damages—only allowing them when convincing evidence shows malicious, wanton, reckless, fraudulent, or bad faith conduct. The same cap for non-punitive damages applies for punitive damages for physicians.



Rhode Island Passes Malpractice Bill

In Rhode Island, legislation SR 3063 was enacted May 21, 2026 and establishes a special legislative commission to conduct a comprehensive study examining the impact of medical malpractice on healthcare providers and healthcare costs across the state. The commission has 13 members including legislators, representatives from physician and insurance groups, risk management specialists, one patient advocate, and members of the public.



Louisiana Establishes Medical Malpractice Taskforce

In Louisiana, a bill SR 160 was officially passed and enacted on June 1, 2026. This legislation establishes a Louisiana Medical Malpractice Taskforce intended to study and recommend improvements to the state's medical review panel process. Legislators hope that this effort will help identify practices from other states to ensure the fair and quick resolution of medical malpractice lawsuits. The task force is slated to bring together stakeholder organizations, including legislators, patient advocates, and physician groups, with the option to add additional members.



Virginia Adjusts Legislation in Response to Physicians

In Virginia, Orthopaedic Surgeons and other physicians successfully opposed harmful medical malpractice reform legislation when they removed harmful provisions from SB 536 that would have raised the damages cap for medical malpractice cases from \$3 million to \$6 million by 2027. As a result of input from physicians across the state, the legislature rewrote the bill at the last minute—removing the increased cap and instead opting to require hospitals and insurers to disclose more information on malpractice cases. Additionally, advocates successfully defeated SB 99, which would have removed the damage cap in medical malpractice cases involving patients under 10 years of age.



Illinois Passes Legislation to Address Downcoding

On July 10, 2026, Illinois enacted legislation SB 3114 to address downcoding within the state. The bill includes provisions addressing a number of issues related to prior authorization, including:

- Prohibiting downcoding of claims based solely on an AI algorithm;
- Prohibiting downcoding of claims based solely on the reported diagnosis codes;
- Requiring downcoding decisions to be made by a licensed physician in a similar specialty to a physician who routinely manages the medical condition;
- Requiring an insurer to notify the provider when a claim is downcoded along with justification for the decision, the codes and payment amounts involved, and instructions on how to appeal the decision;
- And requiring that appeal processes for downcoded claims are available and that providers have 90 days to submit an appeal.



Virginia Passes Prior Authorization Legislation

This session, Virginia passed a number of bills (HB 484, HB 481) addressing prior authorization practices in the state. The legislation included a number of provisions aimed at improving timeliness of claim review, restrictions on downcoding, and ensuring that claims are manually reviewed by qualified physicians. Highlights from the enacted bills include:

- Mandating that insurers pay claims and notify providers of defects in a timely manner;
- Prohibiting retroactive denials, except in a few specific instances;
- Establishing guardrails for downcoding and ensuring that a dispute process is clearly available;
- Requiring that all adverse prior authorization determinations are made by a licensed physician;
- Shortening determination timelines;
- And mandating that justification for adverse determinations are provided.



Washington State Enacts Two Prior Authorization Bills

Earlier this year, Washington State enacted SB 5395 and SB 5845, bills that make several changes to prior authorization within the state. Notable changes include establishing stricter timelines for determinations, prohibiting AI for being the sole reviewer of any adverse determination or modification of care, prohibiting retroactive denial of preauthorized healthcare services, and improving overall transparency regarding prior authorization requirements.



Alabama Establishes Guardrails Around AI Use in Prior Authorization

Earlier this year, Alabama passed SB 63, which seeks to ensure that AI algorithms use accurate medical data and that adverse determinations or modifications are reviewed by a licensed physician.



South Dakota Passes Legislation to Address Retroactive Denials & Payment Recoupment

In March 2026, South Dakota enacted HB 1292. This legislation seeks to limit the ability of health insurance carriers to recoup payments for preauthorized services and retroactively deny care that was already preauthorized. The bill establishes a set time period in which insurers can recoup payments and requires that justification be made available at the time of notification. The legislation also ensures that recoupment of payment must be limited only to the amount paid without additional fees, penalties, or interest.



Connecticut Passes Legislation Addressing Prior Authorization & Payment Recoupment

In May 2026, Connecticut enacted HB 5377, which aims to shorten the period that insurers can seek payment recoupment, improve transparency around determinations, and establish a clear appeal process for any payment recoupment.



Louisiana Passes Prior Authorization Legislation

On June 1, 2026, Louisiana enacted SB 465, a bill that makes a number of important changes to prior authorization and payment in the state. Notably, the legislation ensures more timely review of health insurance claims, shortens the allowable window for payment recoupment, and improves transparency by requiring timely notification of payment recoupment.



Delaware Uses Rural Health Funds to Fix Prior Authorization

Delaware has announced a \$50 million initiative to modernize the prior authorization (PA) process using funding from the federal Rural Health Transformation Fund. The initiative will create a statewide digital platform that allows providers and payers to exchange PA information using standardized data and common interoperability standards to reduce administrative burden and improve timely access to care. Delaware is the first state to explicitly dedicate a portion of its rural health funding to PA reform, while other states are using the funding to strengthen health data infrastructure, expand the rural workforce, and invest in artificial intelligence. States must implement the policy changes outlined in their approved funding applications by the end of 2027 or risk losing their federal funding.

2026-2027 BOC Committee on State Legislative and Regulatory Issue Award Updates Working to Oppose Scope Creep

In 2026, AAOS has funded two state grants awarded through the BOC State Orthopaedic Societies (SOS) Health Policy Action Fund to help oppose legislation that would expand scope of practice for physical therapists and podiatrists. A grant in Minnesota (H.F. 2689/S.F. 3049) was given to oppose an effort from the Minnesota chapter of the American Physical Therapy Association to allow unlimited direct access to physical therapy services without physician referral. The grant in Massachusetts aimed to prevent a bill (S. 1542 & S.1510) from expanding podiatry scope from passing. So far it appears these efforts have been successful, as neither bill has progressed through their respective legislative bodies.

Action Guides for State and Federal Advocacy

OGR has developed updated action guides for use by stakeholders and advocates on key issues and policy priorities. Whether it's stewarding the interests of surgeons by safeguarding against harmful legislation or advocating for the passage of new legislation, we understand the need for resources that serve state societies in their unique advocacy efforts.

Recently Updated Guides:



Medical Liability Reform (MLR): The action guide addresses the need to end a broken medical liability system currently serving as a barrier between physicians and patients, creating uncertainty in critical care situations. Inside, stakeholders will find information on both federal and state efforts, legislative efforts to address the issues related to MLR, and additional resources including research and even model legislation.

[Access the guide here →](#)



Prior Authorization: The action guide provides context and clarity on the healthcare utilization review process and how payers use administrative rules to control the reimbursement process. Understanding the need for a broad approach, the guide breaks down the different avenues used by legislators and organizations to address the issue of prior authorization; using statistics, policy overviews, and state legislative victories, the resource provides a deep dive into important efforts surrounding healthcare utilization, the review process, and adverse determinations.

[Access the guide here →](#)



Downcoding: The action guide provides an overview of the reemergence of downcoding as a national issue and the various methods that states are using to tackle the problem. Understanding that the issue has been addressed in the past through diverse avenues such as legislation, class-action lawsuits, and regulatory interventions, the issue of downcoding is addressed in the guide through both past policy prescriptions and modern solutions. Additionally, the guide provides links and resources for those looking to delve deeper into the topic.

[Access the guide here →](#)

BOARD OF COUNCILORS (BOC)

The BOC State Orthopaedic Society (SOS) Regional Meetings provide a forum for state society leaders to discuss emerging issues, exchange best practices, and strengthen collaboration across regions. The following advocacy priorities and trends emerged during the four regional meetings held in summer 2026.

The regional meetings culminated in a joint BOC/BOS Advocacy Town Hall led by Joel L. Mayerson, MD, FAAOS, Chair of the AAOS Advocacy Council, focused on the CMS Medicare proposal and AAOS's strategy to support grassroots advocacy efforts.

- **NORTHEAST**
- **MID-AMERICA**
- **SOUTHEAST**
- **WEST**

2026 STATE ORTHOPAEDIC SOCIETY REGIONAL MEETING TOPICS

→ TOPICS IDENTIFIED ACROSS ALL MEETINGS

Topic	Discussion Highlights	Resources / Actions
CMS Medicare Proposal	CMS's proposed CY 2027 MPFS includes payment policies that could threaten patient access to orthopaedic care and place significant pressure on physician practices. AAOS President Wilford K. Gibson, MD, FAAOS, and Joel L. Mayerson, MD, FAAOS, AAOS Advocacy Council Chair, emphasized that AAOS is pursuing an advocacy strategy in collaboration with external stakeholders to oppose the proposed changes.	• AAOS Press Release • The AAOS CY 2027 MPFS Proposed Rule Toolkit is now available and is designed to help communicate the real-world impact of the proposed Medicare physician payment changes to inform grassroots efforts.
Prior Authorization Reform	Participants identified prior authorization as a major and ongoing advocacy concern, citing increased insurer denial practices and delays in patient access to care. The discussion reinforced prior authorization reform as a key advocacy priority for AAOS and state orthopaedic societies.	• Several states described serious challenges with prior authorization requirements, subsequent denials, and insurers filing complaints with health systems "on the patient's behalf" while later refusing to pay for services and raised questions of how state orthopaedic societies can most effectively pursue prior authorization reform at the state level. • AAOS Leadership shared that a win in this arena is the Improving Seniors' Timely Access to Care Act, which has advanced through the House Committee on Ways and Means and has significant bipartisan support • Recent Advancements on Prior Authorization Reform can be found here. ◦ Members were reminded that the BOC Health Policy Action Fund, administered by the BOC State Legislative and Regulatory Issues Committee (SLRI), may help support advocacy initiatives. Previous grant applications are available in BoardEffect/DiligentOne (BOC login required).
Bi-Directional Communication Mechanisms	Councilors have access to key resources to enable their ability to communicate updates to their state or regional orthopaedic societies on AAOS initiatives and updates.	• BOC Resources on AAOS Website: ◦ BOC Update Slides ◦ BOC Now Newsletter (Available 2x per year) • AAOS Office of Government Relations (OGR) Action Guides and Reference Materials (Distributed 3x times per year). • Councilors and Executive Directors of State and Regional Orthopaedic Societies also receive the AAOS Advocacy Now Newsletter via email Distributed Bi-Weekly).

Regional Meeting Highlights



NORTHEAST

Topic	Summary / Overview
Scope of Practice with Podiatry	Leadership discussed concerns about scope-of-practice expansion involving podiatry and emphasized the need for AAOS and state orthopaedic societies to monitor and respond to these efforts. Participants noted related legislative, access-to-care, credentialing, and collaboration considerations. The discussion underscored the importance of coordinated communication to support patient safety, appropriate training standards, and clear guardrails for orthopaedic care delivery, with OGR continuing to track and support this important advocacy issue.
Medical Liability	The discussion underscored medical liability reform as an important advocacy issue, with particular concern noted regarding New York's position as a leading state for medical liability challenges. Overall, the discussion highlighted an opportunity for AAOS and the OGR to provide research, policy insight, and strategic support to state societies seeking medical liability reform. Representatives from the New York State Society of Orthopaedic Surgeons discussed the potential value of pursuing reforms related to Certificate of Merit versus Affidavit of Merit requirements, and what additional research or guidance may be needed to support reform efforts. It was noted that some states already have related legislation or proposed bills addressing name, image, and likeness issues, suggesting there may be existing models that could inform future advocacy strategies.

Last Updated: 8/12/2026

Regional Meeting Highlights

→ MID-AMERICA

Topic	Summary / Overview
Site Neutrality	Representatives from the Tennessee Orthopaedic Society noted that site-of-service payment differentials have contributed to rising healthcare costs by driving annual increases in hospital reimbursement rates. They expressed concern that these differentials incentivize the consolidation of independent physician practices into higher-cost hospital-employed models and requested information regarding AAOS' position on site-neutral payment policies. The AAOS supports appropriately implemented site-neutral payments as part of its advocacy agenda, but with important safeguards to protect patient access and physician practices. The AAOS' position can be summarized as follows: • Support site-neutral payments when the same outpatient service is provided at the same quality, regardless of whether it is performed in a physician office, ambulatory surgery center (ASC), or hospital outpatient department (HOPD). • Reduce incentives for hospital acquisition of physician practices. AAOS believes the current payment differential encourages consolidation because hospitals can bill higher facility fees for the same services. • Increase patient choice and lower out-of-pocket costs. Equalizing payments can reduce Medicare beneficiary copayments while allowing patients to receive care in the most appropriate setting. CMS estimated significant savings to patients from its site-neutral policy."

Last Updated: 8/12/2026

Regional Meeting Highlights

→ SOUTHEAST

Topic	Summary / Overview
UnitedHealthcare's New X-Ray Report Separation Policy	AAOS opposed UnitedHealthcare's new radiology reimbursement policy because it imposes unnecessary administrative burdens on orthopaedic practices by requiring separate radiology reports before payment of the professional component. While AAOS recognizes the need for appropriate documentation, AAOS believes UHC's implementation creates needless delays and administrative costs that detract from patient care. AAOS led a multi-specialty coalition in advocating for changes and continues to work with UnitedHealthcare to reduce these burdens. AAOS led a multi-specialty sign-on letter to United expressing strong concerns about the policy and asking United to reconsider - drawing attention to the administrative burden, and noting the policy conflicts with both CMS and CPT guidelines.
Medicare's 2027 Proposed Rule to only pay 50% Payment for Same-Day procedures.	AAOS is strongly opposed to this rule and is asking CMS to withdraw it. This is part of our broader campaign in opposition to the Physician Fee Schedule. AAOS will be working on this as part of a multi-specialty "Same Day Care Coalition". The coalition will be asking Members of Congress to sign and send to CMS in the coming weeks. The letter notes that: • Orthopaedic surgeons routinely evaluate patients, review imaging, establish diagnoses, discuss treatment options, obtain informed consent, and perform medically necessary procedures during a single visit. • Rather than promoting efficiency or reducing unnecessary spending, the proposal would create financial incentives to split care across multiple visits—even when comprehensive same-day care is clinically appropriate. • The result would be unnecessary return visits, delayed diagnosis and treatment, increased transportation and caregiver burdens, higher administrative costs, and reduced convenience for Medicare beneficiaries. • Notably, CMS considered—but declined to finalize—a similar proposal in the CY 2019 MPFS after concluding the payment reduction lacked sufficient justification and could delay patient care.
Medicare Advantage Network Challenges	It was noted that orthopedic oncologists are experiencing challenges with Medicare Advantage plans that narrow networks to reduce costs, excluding certain cancer centers and limiting patient access to specialized care. This affects treatment timing and outcomes for vulnerable patients and was noted that this is an emerging issues across multiple states.

Last Updated: 8/12/2026

Regional Meeting Highlights

→ WEST

Topic	Summary / Overview
Strategy to Address CMS Medicare Proposal: 2027 Medicare Physician Fee Schedule (MPFS) Proposed Rule	The discussion focused on AAOS' coordinated advocacy response to the proposed 2027 Medicare Physician Fee Schedule work RVU cuts, which the AAOS strongly opposes due to concerns that the reductions undervalue the intensity, technical skill, judgment, and liability involved in orthopaedic care. AAOS leadership noted that the AAOS has taken a more direct approach than in prior years, including issuing press releases, sending letters highlighting the potential impact on seniors' access to care, and aligning with specialty and component societies. AAOS is urging CMS to maintain 2026 RVU values while working with organized medicine to develop an evidence-based methodology that accurately reflects physician work. Continued RVU reductions were described as a threat to physician independence, a driver of consolidation, and a barrier to timely patient access, making this one of AAOS' highest advocacy priorities for the 2027 MPFS comment period and part of its broader commitment to long-term Medicare payment reform with stable annual updates tied to inflation. During the call, meeting attendees stressed the need for resources from AAOS to articulate the importance of this issue to their state legislatures and members within their state orthopaedic societies to activate grassroots advocacy.

Last Updated: 8/12/2026