AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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VIA REGULATIONS.GOV FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1833-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: 2026 Medicare Inpatient Prospective Payment System 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 hospital inpatient prospective payment systems (IPPS) proposed rule for fiscal year 2026 (hereinafter referred to as "FY 2026 IPPS 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 on the evidence-based medicine issues associated with the risks and benefits of treatments for patients suffering from lower extremity joint conditions. 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, which consequently drives up healthcare costs;
- 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 on the FY 2026 IPPS Proposed Rule are as follows:

I. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS–DRG) Classifications and Relative Weights – IPPS Arthroplasty Rate Increases Highlight Disparity in Medicare Physician Reimbursement – (Sec. II)

CMS proposes to increase the relative weight of the four primary MS-DRGs associated with lower joint hip and knee arthroplasty.[1] Combined with proposed increases in the national standardized amount, on which DRGs are calculated to derive payment amount, this leads to significant increases in Medicare payment rates for all four arthroplasty codes:[2]

MS-DRG	FY 2024		FY 2025		% Change from 2024	FY 2026 (Proposed)		% Change from 2025
	Weight	Payment Rate	Weight	Payment Rate		Weight	Payment Rate	
469	3.3298	$21,636	3.2685	$21,591	**-0.2%**	3.3202	$22,693	**+5.1%**
470	1.8817	$12,226	1.8855	$12,455	**+1.8%**	1.9857	$13,572	**+9.0%**
521	2.9942	$19,455	2.9146	$19,253	**-1.0%**	2.9036	$19,846	**+3.1%**
522	2.1122	$13,724	2.1082	$13,926	**+1.5%**	2.1512	$14,703	**+5.6%**

AAHKS generally supports increased payment rates to facilities for arthroplasty due to the extreme complexity of the procedure, innovations in the standard of care and outcomes, and to recognize increasing costs for labor and supplies. Nevertheless, the ongoing *annual increases in Medicare facility payments* for arthroplasty present a stark contrast with severely *decreasing payments for arthroplasty under the Medicare Physician Fee Schedule* (PFS). Medicare payments for the professional component of arthroplasty have been *cut by 14%* since 2017.

It is a challenging proposition for policy makers to ask that physicians carry the burden of Medicare expenditure reductions while hospital payments continue to increase, especially given the fact that the physician fee accounts for less than 6% of the overall episode of care cost. Reduced reimbursement prevents surgeons from sustaining independent practices, which is directly contributing to an increase in mergers and consolidation in healthcare. Consolidation leads to fewer choices for consumers across the care continuum, higher prices, and decreased access to care, particularly in rural and underserved areas. Reduced reimbursement for THA/TKA also leads 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.

While payments under the IPPS and PFS may be calculated according to separate statutory formulas, CMS and Congress should be alarmed at the divergent trends in facility and surgeon reimbursement for arthroplasty. We have commented previously that CMS should explicitly state whether it believes Medicare beneficiaries and the health care system are best served by rapidly increasing reimbursement rates to facilities for arthroplasty paired with severe cuts to the professional services for those procedures, and if so, why.

[1] Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC (469); Major joint replacement or reattachment of the lower extremity (470); Hip replacement with Principal Diagnosis of Hip Fracture with MCC (521); Hip replacement with Principal Diagnosis of Hip Fracture (522).

[2] These calculations assume national standardized amount for a hospital with a 67.3% labor share, participating as an EHR Meaningful User and a wage index greater than 1.0.

The average length of stay for THA/TKA decreased from 2.9 days to 1.3 days over a recent 10-year span.[3] As patients return home earlier, they are more frequently contacting their physicians' offices via telephone or electronic messaging with immediate post-procedure questions. 10 years ago, these patient questions would have been addressed during the admission. Therefore, the length of stay decrease reduces the amount of work historically performed at the hospital and instead shifts this new burden to physicians outside of the hospital who face continuing Medicare reimbursement decline. Congress and CMS should clearly understand that proposed reductions in Medicare physician rates decreases competition in health care and directly increases industry consolidation.

Because of these concerns, AAHKS supported the *Providers and Payers COMPETE Act of 2023*, which would have required the Secretary of Health and Human Services (HHS) to assess and report to Congress on the impact of any Medicare reimbursement or regulatory changes on consolidation of healthcare providers and payers. Such reporting is an important step to better inform Congress and CMS on how not to exacerbate health industry consolidation through Medicare payment rates.

II. Hip or Knee Procedures with Periprosthetic Joint Infection - (Sec. VI.C.5.a)

CMS received a request that all hip or knee procedures with a diagnosis of periprosthetic joint infection (PJI) be reassigned from the lower severity level DRGs (without CC/MCC) to a higher level DRG (with CC). The request applies to several series of codes:

- DRGs 463-465 (wound debridement and skin graft except hand)
- DRGs 466-468 (revision of hip or knee replacement)
- DRGs 480-482 (hip and femur procedures except major joint)
- DRGs 484-486 (knee procedures except major joint)
- DRGs 474-476 (amputation for musculoskeletal system and connective tissue disorders)

The requester argued that in all these code series, cases with PJI cost more and had longer lengths of stay than all the other cases billed under those DRGs. CMS reviewed its own claims data and found the increased length of stay or cost for PJI cases was confirmed for 463, 464, 465, 474, 475, 476, 480, 481, 482.

CMS proposes not to change the assignment of these cases with PJIs but rather to create new DRGs for them: 403 and 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC and without MCC, respectively). The proposed relative weights for the DRGs are 5.8 and 3.12 respectively. We support the creation and valuation of these new DRGs as leading to more accurate reimbursement for PJI procedures. We caution CMS and stakeholders that these DRGs should be closely monitored for several years to observe how

[3] *See* Ryan, Stambough, Huddleston & Levine, *Highlights of the 2023 American Joint Replacement Registry Annual Report*, Arthroplasty Today, Vol. 26 (April 2024).

this new reimbursement may alter referral patterns, utilization, or site of service for any unanticipated secondary or tertiary effects.

Further, we ask CMS to identify the party that requested this reassignment. In the interest of transparency in public programs, when CMS responds to a reclassification request in the annual payment rule, it should be clear to the public which parties are proposing the changes so that stakeholders can take that into account when commenting to CMS. Just as CMS began publicly releasing all external stakeholder nominations of misvalued CPT codes under the PFS, CMS should make available all MS-DRG reclassification requests received through the MEARIS system, including identifying the requesting parties in the IPPS preamble.

III. Inflation Adjustment: Proposed Changes in the Inpatient Hospital Update for FY 2026 Highlight Need for Physician Payment Medicare Economic Index – (Sec. V.B.1)

CMS proposes a net 2.4% payment rate increase for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users—reflecting the projected hospital market basket update of 3.2% reduced by a 0.8% productivity adjustment.

Given measurably high inflation and increased costs for labor, equipment, drugs and supplies, the proposed market basket update is inadequate to meet the actual costs faced by facilities. Since FY 2022, CMS has finalized market basket payment updates based on data that did not anticipate or incorporate the record high inflation and significant increases in the costs of labor, drugs and supplies.

The proposed FY 2026 market basket payment update would severely exacerbate this problem and does not properly recognize the high financial pressures that hospitals currently face. As a matter of principle, AAHKS believes all Medicare payment systems for providers and facilities, and especially physicians, should be annually updated to account for real increases in cost inputs experienced in the real world.

Currently, Medicare payment systems vary significantly in the degree to which annual payment increases correspond with inflation, if they do at all. Focused reform, including for physician payment, is needed on this topic. For the purposes of this proposed rule, AAHKS supports a higher market basket payment update under the IPPS to reflect the actual effects of inflation on hospital operating costs. AAHKS endorses an annual inflation-based payment update based on the full Medicare Economic Index (MEI), as has been recommended by MedPAC.

IV. Hospital Value-Based Purchasing Program (Sec. VI.L.2.a)

CMS proposes changes to the Hospital Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (aka "COMP-HIP-KNEE") beginning in the 2033 performance year. Namely, CMS would expand the measure's inclusion criteria to (1) include Medicare Advantage (MA) patients and (2) shorten the

performance period from 3 years to 2 years. CMS proposes these changes in the interest of a more accurate and up-to-date reflection of the care delivered to all Medicare beneficiaries. The measure would use index admission diagnoses and procedure codes from Medicare FFS claims and CMS-held MA encounter data to determine cohort inclusion criteria, complications outcomes, and present on admission (POA) comorbidities.

We welcome the expanded timeframe for hospitals to prepare for these changes before 2033. Our support of these changes is conditioned on the successful implementation of similar changes to arthroplasty measures under the Hospital IQR Program.

V. Proposed Changes to the Transforming Episode Accountability Model (TEAM) – (Sec. XI.A)

a. AAHKS Principles for Value-Based Care and Alternative Payment Models

Our following comments on TEAM derive from AAHKS' principles for alternative payment models. These principles are formed from our members' direct experience over ten years with the successes and failures of mandatory and voluntary CMMI models, including Comprehensive Care for Joint Replacement (CJR) Model and the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model. These principles include:

- Future APM Participation and Success is Incompatible with Ongoing Reductions in Medicare Reimbursement to Surgeons
- APM Savings are Maximized When Models are Convened and Led by the Physicians Delivering and Responsible for the Care
- Robust Risk Adjustment is Necessary for APM Success
- High Administrative Burden Associated with Quality Measure Capture Undermines Participation and the Integrity of Measures
- Target Pricing Methodologies Cannot Drive a Race to the Bottom in Benchmarks

b. Mandatory Participation (Sec. XI.A.2.a.(2))

The TEAM regulation finalized last year makes participation mandatory for hospitals in the selected mandatory census-based statistical areas (CBSAs). CMS now proposes a cut-off date for mandatory participation, whereby any new hospital identified by a CMS Certification Number—CCN with an initial effective date after December 31, 2024 will not be required to participate in the initial performance year of TEAM (2026). CMS proposes that any new hospital have no less than one year and no more than two years to prepare for TEAM participation.

We agree that such hospitals should not be required to participate in 2026. New hospitals that open shortly before or during the model performance period, as well as hospitals that begin to satisfy the definition of TEAM participant shortly before or during the model performance period, would experience multiple disadvantages relative to others. Hospitals should have at

least one full calendar year of preparation for TEAM after becoming eligible within a mandatory CBSA.

We would prefer that hospitals that are not eligible to participate as of December 31, 2024 would not be required to participate at any point in TEAM. Even with preparation time, the predictive value of a hospital participating for less than the full five years of the model is not enough to justify forcing participation for more hospitals that are poorly equipped to succeed in a risk-bearing value-based care model. Particularly in rural areas where inpatient services and bed spaces are declining, required TEAM participation within under 2 years to prepare discourage communities and stakeholders from opening new facilities.

c. Alignment of Hybrid Hospital-Wide Readmission Measure to Hospital IQR Program (Sec. XI.A.2.b.(2))

CMS has a laudable and welcome goal to align measures among quality reporting programs, in this case TEAM and the Hospital Inpatient Quality Reporting (IQR) Program. Last year, CMS finalized the adoption within TEAM of an IQR measure: Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356). Though CMS already delayed mandatory reporting of this measure under the IQR until the July 1, 2025 – June 30, 2026 reporting period, CMS now proposes to (1) align submission standards for this measure between the IQR and TEAM and (2) utilize the mandatory IQR reporting period of July 1, 2025–June 30, 2026, as TEAM's PY1 baseline period.

We appreciate CMS efforts to simplify and standardize Hybrid HWR across models. AAHKS is supportive of minimizing the reporting burden placed upon hospitals and therefore supports administration of quality measure data through the existing mechanisms of IQR and HAC Reduction Programs. Our concern remains with the appropriateness of HWR being included in any way in a surgical episode payment model.

First, in an episode cost-of-care model, readmission as a quality indicator is redundant and punitive. The significant Medicare spend associated with any readmission during a TEAM episode will result in that episode being a financial loss to the participant hospital. Including readmissions as a CQS measure further penalizes the participant hospital by accentuating the financial repercussions across all other TEAM episodes.

Second, the Hybrid HWR measure is essentially unrelated to the quality performance of the *TEAM program*. All current TEAM episodes are initiated by *surgical procedures*. Analysis of the data published in Table 3.2 of this measure's 2023 Methodology Report shows that 81.3% of hospital readmission are driven by *non-surgical admissions*. Also, analysis of the BORv43 file associated with the Proposed Rule reveals that only 7% of inpatient discharges correspond to DRGs that would initiate a TEAM episode. Consequently, 93% of the denominator for this measure is unrelated to TEAM.

We recognize that CMS has struggled to identify existing quality measures applicable to the five procedures initially included in TEAM, but the clinical credibility of TEAM is severely diminished by financial penalties based on the performance of a measure that is 93% unrelated to TEAM episodes.

d. Information Transfer Patient Reported Outcome-Based Performance Measure (Information Transfer PRO–PM) - (Sec. XI.A.2.b.(3))

CMS proposes adding the *Information Transfer PRO–PM* measure to all outpatient TEAM episodes. We have similar concerns over this measure's applicability to procedures performed under TEAM. It appears that 92.5% of the episodes reported under this measure are for procedures not included in TEAM. As such, we oppose the inclusion of this measure in the CQS.

e. Risk Adjustment Lookback Period

CMS last year proposed a 90-day lookback period for each beneficiary to use the beneficiary's Medicare FFS claims from that lookback period to determine which Hierarchical Condition Category (HCC) variables (or flags) the beneficiary is assigned and determine the HCC episode specific flags as well as the TEAM HCC count flag for risk adjustment purposes. CMS now proposes to increase the lookback period to 180-days, beginning with the day prior to the anchor hospitalization or anchor procedure.

We thank CMS for proposing this increase. Last year, we commented that a 90-day lookback period was far too short. Nevertheless, we reiterate that the preferred approach is for CMS to instead continue the CJR policy of using HCCs from prior years' annual file. For smaller, rural providers and those treating an underserved population, it is not necessarily the case that all chronic conditions that can add costs and complexity will be captured in patient medical records from the 180 days prior to the procedure. Many fee-for-service providers have not been incentivized up-to-now to record all diagnosis codes in all encounters. A 180-day look-back period acts as a limit and participants will be disadvantaged relative to CJR participants and others due to the coding practices of other providers over whom they have no control.

f. Remaining Concerns with TEAM Participant Eligibility

i. <u>Inclusion of Acute Care Hospitals and Exclusion of the Physicians Who Actually Manage an Episode</u>

CMS finalized regulations last year to limit TEAM participants to acute care hospitals as the only entity able to initiate a model episode. We understand CMS' multiple reasons for limiting participation in this way: having an adequate volume of episodes, access to resources, readiness for mandatory participation, hospital experience in discharge planning, administrative efficiency, and others.

Yet, based on our members' extensive experience in the CJR and BPCI-A, the long-standing position of AAHKS is that physicians with requisite qualifications should be permitted to participate in any CMMI model as episode initiators and conveners. This includes allowing non-physician organizations to serve as "conveners". Notwithstanding the reasons cited by CMS for limiting participants to acute care hospitals, it is the physicians who actually are responsible for managing a procedure within a facility and who are in the best position to broadly manage included items and services in the episode in the context of the underlying condition and procedure.

For example, orthopaedic surgeons are deeply involved in the discharge planning process following LEJR, beginning planning well before the procedure itself to anticipate where the patient can find care, support, and a safe stair-free environment during the immediate recovery period. Also, orthopaedic surgeons are not solely procedure specialists but also serve as a patient's primary care provider for the purposes of managing long-term chronic orthopaedic conditions like osteoarthritis.

We understand that many physician surgical practices may be unprepared for mandatory participation as participant/bundle-holder in an episode payment model, but more must be done to recognize and favor the physician's role in the model as the individual responsible for clinical care. When the patient has a question about the procedure, they call the physician, not the hospital.

We remind CMS of our proposed compromise measure: that participating acute care hospitals be required to enter into shared savings agreements with the applicable surgeon. Under the CJR, CMS anticipated that hospitals "might" choose to share savings with physicians, but the experience of our members is that such agreements are few and far between. While CJR has shown a level of success in reducing Medicare expenditures for LEJR, we believe the savings under TEAM could be even greater if physicians share in financial incentives by uniformly being included in the shared savings of a hospital.

Further, we recommend CMS allow physician groups to voluntarily participate in the TEAM model in geographic regions NOT selected for mandatory participation. This would allow CMS to accomplish its objective of evaluating the model results of all hospitals in the mandatory regions head-to-head, but also maintain a model that is physician centered. CMS could evaluate performance differences between mandatory participant hospitals and voluntary physician participant/conveners.

ii. <u>Unintentional Impacts of Excluding Physicians: More Health Care Provider Consolidation</u>

Another concern with limiting model participation to acute care hospitals and excluding the physicians who actually manage care and hold the doctor-patient relationship is that it amounts to yet another federal action that gives more power to facilities and health plans relative

to physicians. Such federal policies are the primary driver behind the consolidation in health care providers that this administration has stated is a concern.

There is a misconception that consolidation happens because retiring physicians want to sell their practices to "cash out." Instead, for many physicians, selling to private equity (PE), a large health system or to a private payer is the only means to continue to practice medicine in the face of reimbursement cuts and cost increases. Our members are clear: private practice surgeons by definition would like to remain independent, and the ONLY reason consolidation occurs is because running a practice with the current level of Medicare reimbursement coupled with inflation is financially unfeasible. Unfortunately, according to the American Medical Association (AMA), the numbers of doctors owning their practices has declined drastically in recent years.

Continued Medicare cuts to physician reimbursement for LEJR, which has drastically outpaced overall cuts to the physician fee schedule over the past 30 years, is the primary factor driving health care consolidation in orthopedic surgery and the growing inability of physicians to maintain an independent practice. These declining reimbursement rates, particularly a 65% cut in real dollar Medicare rates over 30 years, make maintaining an independent practice financially unfeasible.

For example, current Medicare reimbursement to physicians for total hip arthroplasty is only 35% of the amount it would have been if adjusted for inflation each year since 1992. Illustrated another way, current Medicare reimbursement to physicians for total hip arthroplasty has fallen 22% since 1995. When adjusted for inflation, current Medicare reimbursement to physicians for total hip arthroplasty has fallen 65% since 1995. Such sustained cuts inarguably make it financially unfeasible for our members to afford to practice independently.

If physicians are excluded from a leadership role in new CMMI episode payment models, the number of independent physician practices will decline even faster. Payers and facilities will be encouraged in their attitude that physicians and the doctor-patient relationship are simply cost-inputs to be reduced and managed.

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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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