AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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September 15, 2025

VIA REGULATIONS.GOV FILING

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

RE: 2026 Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule for calendar year 2026 (hereinafter referred to as "2026 OPPS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 5,600 physicians with expertise in total joint arthroplasty 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:

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

Our comments on the 2026 OPPS & ASC Proposed Rule address how OPPS arthroplasty rate increases highlight the disparity in Medicare physician reimbursement:

I. Proposal to Eliminate the IPO List (Sec. IX.C.1)

After extensive deliberation and stakeholder feedback, in 2022 CMS halted plans to eliminate the IPO list over three years because of feedback from providers that the IPO list "serves as an important programmatic safeguard and maintains a common standard of medical

judgment in the Medicare program."[1] Due to the developments in surgical technique and technological advances in the practice of medicine, CMS now proposes to resume its plans from 2021 by eliminating the entire IPO list over three years, including 1,731 services. This is proposed to begin with the removal of 285 mostly musculoskeletal services for CY 2026.

AAHKS Comment:

AAHKS agrees with CMS that as medical practices evolve, the difference the need for inpatient care and the appropriateness of outpatient care may become increasingly less distinct for many services.

However, removal of procedures from the IPO list should be made on a procedure-by-procedure basis only after there is sufficient evidence to justify a shift to the outpatient setting on behalf of the average Medicare beneficiary. *We continue to support maintaining the IPO list in 2026 and removing procedures from the IPO list over time after all regulatory criteria have been satisfied*.[2] This approach helps to "ensures that inpatient only designations are consistent with current standards of practice"[3] and positions CMS to make decisions in light of the most recent data, available medical evidence, and real-word experience from providers.

a. Eliminating the IPO List En Masse Risks Patient Quality

Removing procedures from the IPO list may improve access to care for patients, flexibility for providers, and savings to the Medicare program. We agree that in a setting with excellent patient selection and education, tailored anesthetic techniques, well done surgery, good medical care, and exceptional post-operative care coordination, it may be clinically appropriate for some Medicare beneficiaries to receive procedures currently on the IPO list in an outpatient setting. However, even in the best of circumstances, there are risks to patient safety and quality of care during the transition. This has been observed with individually removed procedures when they rushed of the IPO list before provider consensus.

b. CMS Should Proceed with Caution

We have concerns over unanticipated secondary and tertiary impacts on care quality when regulatory standards on appropriate site of service are removed. We have previously expressed that CMS was moving too fast in removing procedures from the IPO list on a case-by-case basis under pre-existing regulatory standards. By compromising quality of care and imposing additional administrative burden on individual physicians, the swift elimination of the IPO list *could* run in in conflict with the Administration's policy to "reduce the private expenditures required to comply with Federal regulations and to secure […] the highest possible quality of life

[1] A wide collective of stakeholders, including hospital associations and hospital systems, professional associations, and medical specialty societies, vociferously opposed eliminating the IPO list. 86 FR 63675, https://www.federalregister.gov/d/2021-15496/page-42156.
[2] 42 CFR § 419.23.
[3] 86 FR 63672, https://www.federalregister.gov/d/2021-24011/page-63672.

for each citizen."[4] We urge CMS to move carefully and slowly, reviewing feedback from physicians and patients on burden, impact and any unanticipated complexities.

II. Adding New APC Levels for Musculoskeletal Procedures (Sec. III)

CMS proposes to establish a seventh level of the Musculoskeletal Procedures APC series in coordination with its proposal to remove 266 musculoskeletal-related codes from the IPO list in CY 2026.

AAHKS Comment:

We thank CMS for proposing an additional, upper APC level for musculoskeletal-related codes. We have long reiterated the necessity for CMS to create additional levels of musculoskeletal APCs under the OPPS and ASC payment systems. As we shared in response the 2025 proposed rule, by increasing the number of musculoskeletal APCs to more than six, each APC will be more accurately valued to the services and procedures assigned to it. Fewer services will be assigned to each APC and the result will be less frequent need to transfer services between APCs and smaller increases or decreases in rates stemming from those transfers. All providers and stakeholders would be well served to face fewer and less severe year-to-year shifts in payment rates.

Establishing additional musculoskeletal APCs levels can be used to improve payment accuracy. However, our prior requests for one additional APC level were based on the current number of OPPS covered procedures through 2025. Adding several hundred new covered procedures would overwhelm the accuracy of the seven musculoskeletal APC levels. We believe that some number of additional musculoskeletal APC levels will be needed to preserve payment accuracy and stability if CMS finalizes its proposal to remove 266 musculoskeletal-related codes from the IPO list in 2026. Extensive analysis and stakeholder input will be necessary to determine the proper number of APC levels for all covered musculoskeletal procedures.

III. APC Level Assignment for Procedures Removed from the IPO List (Sec. IX.C.5)

a. Revision Procedures

CMS proposes to assign to APC level 5 the newly OPPS covered CPT 27487, Revision of total knee arthroplasty, with or without allograft; femoral or entire tibial component. This would lead to a payment rate of $13,254 in 2026.

[4] E.O. 14192, 90 Fed. Reg. 9065 (Feb. 6, 2025), available at https://www.federalregister.gov/documents/2025/02/06/2025-02345/unleashing-prosperity-through-deregulation.

AAHKS Comment:

APC level 5 especially is far too law for CPT 27487. Our experience is that such a rate is well below the cost of the procedure. Independent analyses have demonstrated that hip and knee revision procedures proposed for removal from the IPO list for CY 2026 would be materially underpaid in their proposed APC assignments relative to hospital resource use and device costs, even for the types of Medicare short-stay inpatient cases most likely to migrate to the outpatient setting.

Based on a review of Medicare inpatient hip and knee revision cases with lengths of stay of less than 2 days and that excluded outlier cases, cases with ICU care, and room and board costs, there were significantly higher geometric mean costs (GMCs) for revision cases compared with the costs reflected in the proposed APC assignments. In each case, the GMCs indicated that CMS should elevate the APC by at least one level (i.e., APC 5116 vs APC 5115).

A separate review was conducted on CPT code 27487, Revision of total knee arthroplasty, with or without allograft; femoral or entire tibial component. This review of IPPS claims, which excluded cases with more than 1 night stay, in-hospital deaths, outlier payment cases, and cases with ICU charges, indicated that costs associated with CPT 27487 more appropriately align with APC 5117, two APC levels higher than CMS's proposed assignment to APC 5115.

IV. Exemption From Certain Medical Review Activities for Services Removed from the IPO List (Sec. IX.C.4)

CMS proposes to continue to exempt procedures that have been removed from the IPO list from certain medical review activities to assess compliance with the 2-midnight rule until the Secretary determines that the service or procedure is more commonly performed in the Medicare population in the outpatient setting. Specifically, CMS proposes to continue the indefinite exemption from site-of-service claim denials, referrals to Recovery Audit Contractors (RACs), and RAC reviews for "patient status" for procedures that are removed from the IPO list under the OPPS beginning on January 1, 2021.

AAHKS Comment:

The following feedback is based on the experience of AAHKS members following the removal of THA and TKA from the IPO List. We agree that an exemption period is needed to ensure physicians are appropriately educated on the change of policy and to inform facilities and their compliance departments on the totality of the 2-midnight rule *and all of its exceptions*. We have been surprised by repeated evidence and statements on the parts of various hospital compliance departments or CMS contractors who are unaware with the totality of the 2-midnight rule as laid out by CMS. This reiterates the need for CMS to work closely with specialty societies and hospitals to update and release helpful guidance on the 2-midnight rule as applied to procedures removed from the IPO list.

a. Based on AAHKS Experience, Removal of Procedures from the IPO List Inadvertently Adds to Physicians' Administrative Burdens

As AAHKS has shared previously with CMS, many of the adverse impacts from removing procedures from the IPO list arises from hospitals that drive provider admission status decisions based on perceived legal risks under the 2-midnight rule.[5] CMS should consider that for procedures removed from the IPO list and subject to the 2-midnight rule, site of service and admission status are not determined solely by the physician and patient. In reality, many commercial hospitals establish rules making outpatient status the assumed, baseline status for such procedures—regardless of patient characteristics or the physician's clinical assessment.

Many hospital compliance departments make outpatient status the baseline for FFS Medicare beneficiaries for administratively simplicity, to minimize risk of violating the 2-midnight rule, or for some other reason. Regardless of the reason, it falls upon the physician to take the extra step of advocating for an exception when clinically appropriate. Therefore, elimination of the IPO list would force physicians to allocate even more time to contesting with facilities over the most clinically appropriate admission status for a patient.

Adding to this difficulty, our experience is that not all hospitals (and payers) review the essential physician-centric regulatory preamble language in the OPPS. A number of our members have dealt with hospital legal departments that had not updated their 2-midnight rule compliance policies to incorporate the case-by-case exception policy added by CMS in 2016. The 2-midnight rule is very complex and CMS should not put individual surgeons in the position of trying to educate payer and hospital legal departments.

b. Surgeon Anecdotes of Administrative Burden

Our members have shared with us the following personal examples of dealing with hospitals when TKA was removed from the IPO list.

> *An ASA llll risk level TKA patient with Parkinson's was denied inpatient status and while stable for 23 hour discharge, and voiding without retention signs, was sent home. I indicated ASA lll risk and readmission risk, but under the effect of CMS pay practice the utilization review staff insisted he did not qualify for inpatient stay. In less than 1 week he was readmitted with severe urinary retention, bladder distention compressed iliac veins which likely directly contributed to bilateral femoral vein DVT and PEs. He survived anticoagulation and is now doing well. Readmissions cost staggering.*

[5] *See* Yates, Adolph J. et al., *The Unintended Impact of the Removal of Total Knee Arthroplasty From the Center for Medicare and Medicaid Services Inpatient-Only List*, 33 J. ARTHROPLASTY 3602 (Dec. 2018), https://pubmed.ncbi.nlm.nih.gov/30318252/.

Another AAHKS physician shared the following:

> *At one of the largest multispecialty physician groups, multiple traditional Medicare patients received bills that they would not have otherwise received because their total knee was completed as an outpatient procedure instead of documented as an inpatient. One patient recently received a bill for $20,000. This new ruling is creating confusion for the patients who have no idea what the bill will be until after the surgery is completed. The surgeon and the staff are not able to tell patients what the cost will be which is really unfair to our patients. The healthy patients are being penalized for being healthy.*

Another AAHKS physician shared the following:

> *We have absolutely no useful guidance for when to admit the patient or not. Our hospital has us start with the assumption that the patient will be an outpatient. I then use known risk factors to determine when I should admit. Usually when I reach 3 (obesity, OA, DM most commonly), I will admit. It does often prompt a call from hospital administration.*

c. Implications Regarding Private Payers

The IPO list also has ripple effects in the Medicare Advantage (MA) program. Absent appropriate oversight, some MA plans will continue to use any pretext based on a cursory reading of CMS policy to drive as many TKA procedures as possible to the outpatient setting. Among our membership in 2019, 43% of 721 respondents reported that local MA plans had changed coverage policies to declare all/majority of TKAs to be scheduled as outpatient procedures.

These actions by hospitals and plans undermine surgeon's ability to treat Medicare beneficiaries according to the principle articulated by CMS:

> We continue to believe that the decision regarding the most appropriate care setting for a given surgical procedure is a complex medical judgment ***made by the physician based on the beneficiary's individual clinical needs and preferences*** and on the general coverage rules requiring that any procedure be reasonable and necessary.[6]

[6] 82 FR 59383, https://www.federalregister.gov/d/R1-2017-23932/page-59383 (emphasis added).

Therefore, we agree that an exemption period is needed to ensure physicians are appropriately educated on the change of policy and to inform facilities and their compliance departments on the totality of the 2-midnight rule and all of its exceptions. Further, CMS oversight and enforcement of MA plans should ensure that "the most appropriate care setting for a given surgical procedure is a complex medical judgment [that should be] made by the physician based on the beneficiary's individual clinical needs and preferences."

V. Updates Affecting OPPS & ASC Payments (Sec. II)

CMS proposes a 2.4% increase to payment rates under the OPPS and ASC payment systems. This update is based on the projected hospital market basket percentage increase of 3.2%, reduced by a productivity adjustment of 0.8 percentage points.

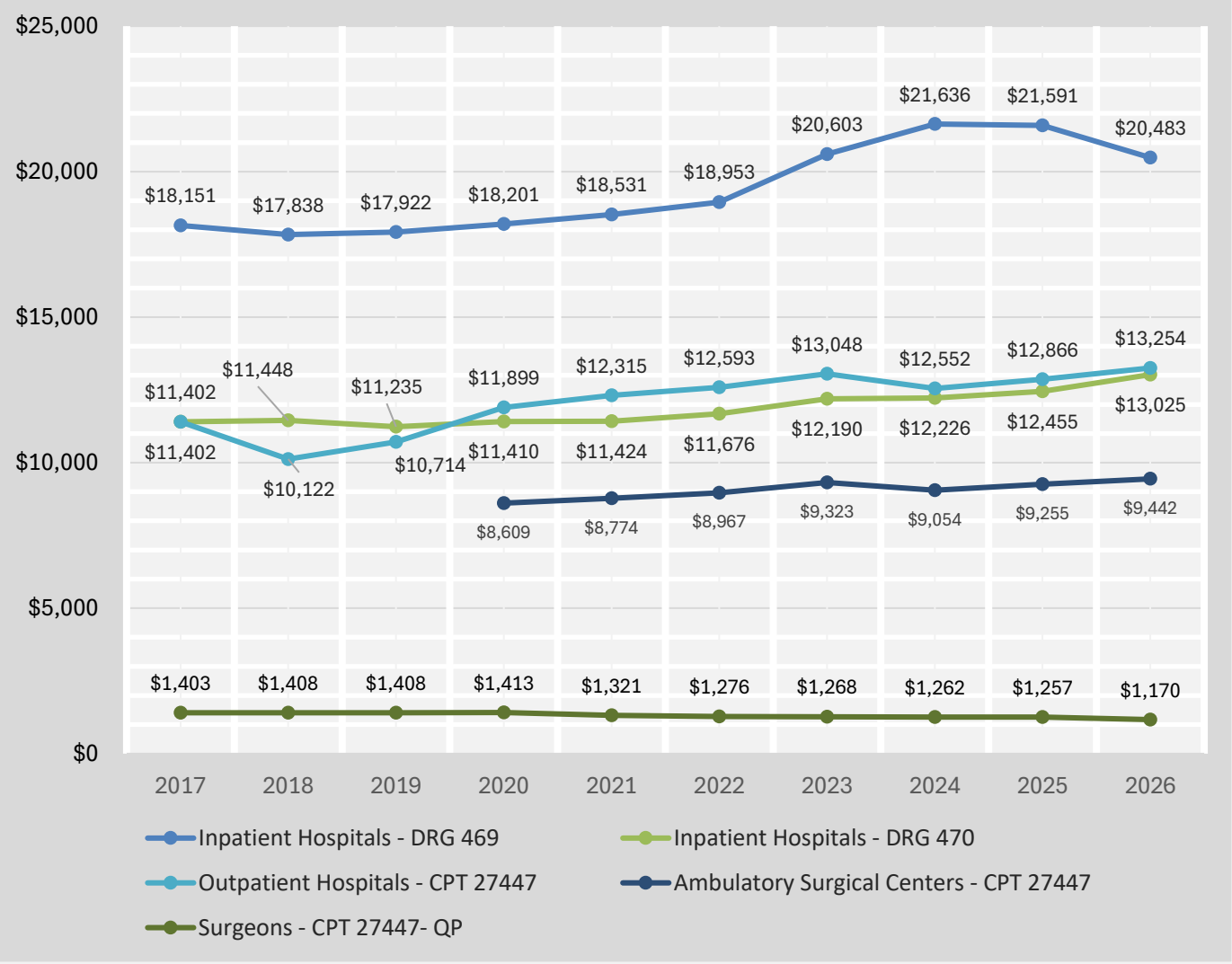
AAHKS Comment:

We support CMS' proposal to increase rates under the OPPS and ASC payment systems by 2.4% for 2026. However, notwithstanding our overall appreciation of this change, it highlights a concerning trend in the Medicare reimbursement system: *physicians bearing a disproportionate burden of federal health care cost-reductions through falling reimbursement that does not account for inflation*. This burden impedes physicians' ability to sustain independent practice and furnish specialized services. We urge CMS to work closely with Congress to advance comprehensive and long-term physician payment reforms to ensure Medicare's overall reimbursement framework reflects the actual costs of physician encounters and better enables physicians to sustain their practice and specializations without increasing consolidation.

Although AAHKS acknowledges the need to cut costs and budget neutrality constraints, the federal government cannot derive health care savings solely from physicians. While payments under the IPPS, OPPS, and PFS may be calculated according to separate statutory formulas, AAHKS believes CMS and Congress should be alarmed at recent trends in facility and surgeon reimbursement for arthroplasty, which make the lack of coordination and consistency between Medicare payment systems evident.

The diverging payment amounts between providers and facilities for procedures must be rebalanced. Over time—but particularly since 2020—Medicare payments for the professional component of arthroplasty have been cut significantly, while Medicare payments to facilities for the same procedures over a similar timeframe have substantially skyrocketed. Although AAHKS generally supports increased payment rates to facilities for arthroplasty due to a variety of reasons—such as procedural complexity and innovations in of care, among others—the near-annual increases in Medicare facility payments for arthroplasty presents a stark contrast with severely decreasing Medicare payments to the physicians performing the procedures.

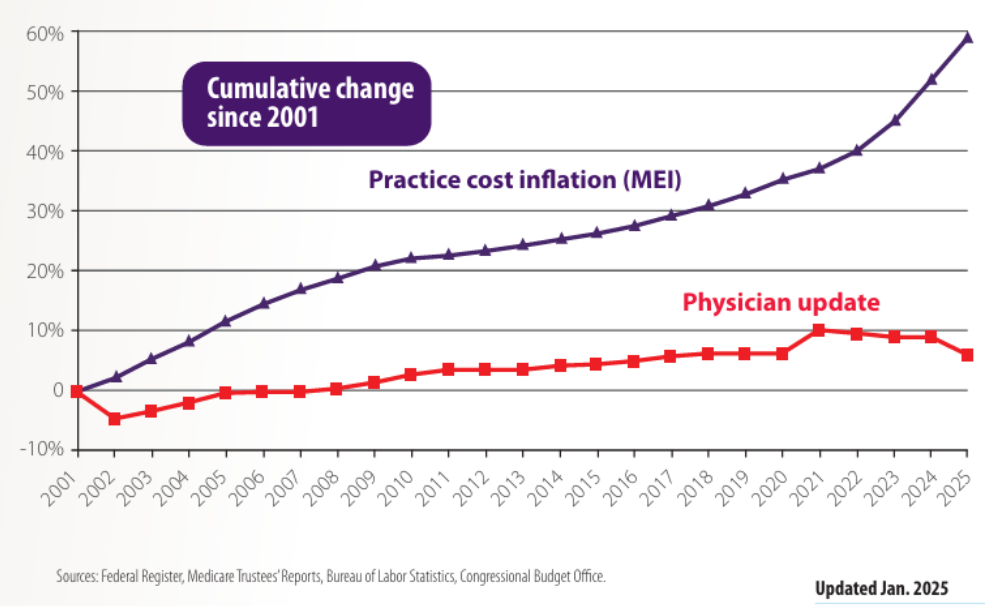
REIMBURSEMENT FOR TOTAL KNEE ARTHROPLASTY UNDER IPPS, OPPS, ASC, & PFS FOR CY 2020 – CY 2026 (PROPOSED)



DATA: CPT 27447

Physicians' payments under the PFS should adequately account for inflation—similar to IPPS and OPPS. Unlike the OPPS and the IPPS payment systems, which adjust for inflation annually, the PFS payment system does not currently adjust physicians' payment for inflation. The disparity in provider and facility payments highlights the need for Congress to add an inflationary adjustment factor for Medicare physician payments. Our members firmly believe an inflationary adjustment factor for Medicare physician payments is one such way to ensure that Medicare payment rates keep up with the actual costs physicians encounter in real medical practice today.

Medicare Physician Fee Schedule Updates Compared to Inflation in Practice Costs (2001-2005)



We urge CMS to work closely with Congress to advance comprehensive and long-term physician payment reforms that tackle current systemic issues, including the addition of an inflationary adjustment factor.

VI. Proposed Additions to the ASC Covered Surgical Procedures and Covered Ancillary Service List (Sec. XIII.D)

For CY 2026, CMS proposes significant changes to the standards and exclusion criteria CMS uses to define "covered surgical procedures" to add to the ASC covered procedures list ("ASC CPL"), and to revise existing regulatory requirements addressing the process to add new procedures to the ASC CPL. CMS also propose to (i) add approximately 276 potential surgery or surgery-like codes to the ASC CPL that are not on the CY 2025 IPO list using its proposed CY 2026 ASC CPL Criteria and (ii) to add 271 surgery or surgery-like codes to the ASC CPL that are currently on the IPO list if CMS finalizes its proposal to remove these services from the IPO list for CY 2026.

AAHKS Comment:

AAKHS has historically favored the addition of procedures to the ASC CPL only on a case-by-case basis, following notice and public comment from specialty societies and other stakeholders. We urge CMS to move carefully and slowly, reviewing feedback from physicians and patients on burden, impact and any unanticipated complexities.

Physicians play the most important role in health care and should be able to exercise their clinical judgment in making site-of-service determinations. This is a fundamental concept that cannot be over-emphasized by CMS in related guidance to plans and facilities. It is imperative

that any ASCs preparing to perform newly covered procedures on Medicare beneficiaries are adequately prepared to handle the potential unique needs of the Medicare population. This includes having necessary defined plans of care for each patient following surgery, as well as having formal arrangements for admission to a nearby hospital if the patient is unable to return directly home following the procedure.

CMS proposes a payment rate of $10,312 for CPT 27487, revision knee joint. Our experience is that such a rate is well below the cost of the procedure. If CMS's goal is to make knee revision available at ASCs, the proposed reimbursement rate may be so low that many ASCs will decline to perform the procedure for FFS patients. Instead, we believe that CPT 27487 warrants a higher payment level.

VII. Proposed Market-Based MS–DRG Relative Weight Data Collection and Change in Methodology for Calculating MS–DRG Relative Weights Under the Inpatient Prospective Payment System (Sec. XX)

CMS proposes modifications to require that hospitals report on the Medicare cost report the median of the payer-specific negotiated charges that the hospital has negotiated with all of its Medicare Advantage Organizations, by MS-DRG, for use in a market-based MS-DRG relative weight methodology effective for the relative weights for market-based pricing effective for FY2029. CMS's goal is to replace the current use of gross charges that are reflected on a hospital's chargemaster and cost information from Medicare cost reports with median payer-specific negotiated charges for the development of the IPPS MS-DRG relative weights.

CMS' proposal is based on research that indicates "chargemasters are usually highly inflated and that these inflated charges have been used to secure higher payments from Medicare and private payers" and that "[h]ospital bills that are generated off these chargemaster rates can be inherently unreasonable when judged against prevailing market rates." When this policy was first introduced, the purpose was to reduce reimbursements to health care providers, as was cited in the Secretary's report, "'Reforming America's Healthcare System Through Choice and Competition,' which recognized the importance of price transparency in *bringing down the cost of healthcare*."[7]

AAHKS Comment:

In this case, "bringing down the cost of health care" is unfortunately based on reimbursing health care providers less for treating Medicare beneficiaries. We believe that the nation's health care providers should not be expected to carry the weight of system-wide cost reduction solely through cuts in reimbursements for services delivered to Medicare FFS beneficiaries. Nor does evidence suggest this is a driving force behind health care inflation.

[7] 85 Fed. Reg. 32790 (May 29, 2020) (emphasis added).

Further, we disagree with CMS' presumption that relative prices paid by either MA plans or other commercial insurers would be a better reflection of hospitals' true relative costs across DRGs than the current system of using cost report data to estimate relative costs. This is an unfounded assumption. Contracting and MA reimbursement model trends are an evolving phenomenon and illustrate that MA and commercially negotiated rates take into account any number of unique circumstances and factors that are unrelated to the cost of care. Privately negotiated rates between providers and MA plans have never been intended to be solely a proxy for the cost of care.

Areas in the country that have dominant MA programs relative to provider hospitals have greater leverage than those parts of the country with multiple MA providers and fewer hospital systems. It also does not account for those MA programs that are part of vertically integrated and local market dominant systems that negotiate charges on a system favorable basis rather than through pure market forces. In short, MA rates negotiated with hospitals are influenced by free market forces by design; this is far different than Medicare FFS rates and should not be used to influence those rates.

Concerns also arise in the many cases where MA-provider contracts reimburse for procedures based on a percentage of Medicare's FFS reimbursement rate. In some cases, MA-provider contracts reimburse at a lower percentage than Medicare FFS rates. In these cases, if CMS lowers a FFS DRG reimbursement based on MA commercial contracts, it would lead to a cascading reduction in reimbursements to providers under those MA provider contracts. Eventually a downward spiral would be created under such contracts wherein the Medicare FFS program and MA plans refer to each other's reimbursement rates to further and further reduce payments to providers.

In the reverse cases where MA rates are higher than FFS, if MA plans see Medicare FFS rates increasing, the plans may renegotiate contracts rather than implement a corresponding increase in their reimbursements. Driving industry-wide contract negotiation would be time consuming for plans and providers. This process would need to be frequently repeated as Medicare FFS rates were constantly evolving based on commercial contracting trends. Or, as MedPAC has suggested, to the degree plan contracts reimburse the FFS rate, this effort would not reflect commercially negotiated rates, but rather would be a circular confirmation of the Medicare FFS rate.

For these reasons, we urge CMS not to collect average MA and commercial rates through hospital cost reports and not to use such data as a factor in establishing DRG weights. Any such efforts require vastly more analysis of the secondary impacts of its proposal on MA contracting and the corresponding impacts on providers and access to care.

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

Sincerely,

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