

June 9, 2026

VIA REGULATIONS.GOV FILING

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1849-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: 2027 Medicare Inpatient Prospective Payment System Proposed Rule & CJR-X Model

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 2027 (hereinafter referred to as “FY 2027 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.

I. CJR-X: Mandatory, Indefinite, Nation-wide Expansion of the CJR

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

Our following comments on CJR-X 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, the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model and TEAM. 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. Global Reasons Why CMS Should Postpone Implementation of CJR-X

Before addressing technical comments on the CJR-X, we make a general recommendation that CMS postpone implementation of the CJR-X until several key design elements can be verified through the current TEAM model which just began. We have several general concerns. First, too many providers nationwide are untested in value-based care and unprepared to accept 20% risk in an episode payment model.

Second, the lack of ASC participation, where a significant portion of LEJRs occur, will undermine the success of the model. CMS' intentions in leaving ASCs out are unclear. Without ASCs in the CJR-X, physicians will have incentives around shared savings and clinical leadership that differ between ASCs and CJR-X participants that will influence site selection in a way that is not accounted for or measured in the model. Does CMS hope that all high-cost cases alone will be driven to facility participants and all low-cost cases will be driven to ASC? CMS' Benchmarking methodology does not account for this likelihood. CMS says it cannot add ASCs because they were not tested under CJR, but CMS has made other changes from the TEAM model in the CJR-X. It is better to delay CJR-X until the role of ASCs under TEAM can be determined.

Third, as discussed in detail below, the lack of a convening role for physicians and lack of mandatory shared savings with surgeons means CJR-X will further drive consolidation and drive more physicians out of independent practice.

c. Limiting Who May Participate as a Convener

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

CMS proposes to limit CJR-X 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.

Based on our members' extensive experience at the center of successfully generating savings in the CJR and BPCI-A, the long-standing position of AAKS 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.

As a compromise measure, and as discussed later in these comments, we recommend 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 CJR-X could be even greater if physicians share in financial incentives by uniformly being included in the shared savings of a hospital.

ii. Unintentional Impacts of Excluding Physicians: More Health Care Provider Consolidation

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.

If physicians are excluded from a leadership role in CJR-X, 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.

d. Covered Procedures

For covered procedures in CJR-X, CMS proposes to include: DRG 469, DRG 470, DRG 521, DRG 522, CPT 27447, CPT 27130. We support this list as well as the CMS proposal to NOT include Unicompartmental (Partial) Knee Replacement or Total Ankle (CPT 27702) as these were not previously tested under CJR.

e. Risk Tracks

Unlike TEAM, CJR-X has only one financial risk track. Participants would be immediately subject to 20% stop-loss and 20% stop-gain related to the target price, regardless of size, sophistication or prior experience with value-based care. Such an immediate transition to risk is too aggressive for far too many facilities. It is even more confusing given that CMS has just begun testing a transition to 2-sided risk under the TEAM model. The lessons learned from TEAM, within a few years, will be of little use to developing risk tracks in CJR-X now. We and many other commenters were concerned that the TEAM risk transition was too aggressive. CMS should use the same multiple risk transition tracks as the TEAM model at this time to launch CJR-X.

The risk tracks are too aggressive and rigid for a mandatory model. Too many participants are not ready for this level of risk. Medicare-dependent, small rural hospitals and safety-net hospitals would have a stop-loss of 5% but many more hospitals need such a 5% level.

f. Target Price Methodology

CMS proposes using 3 years of baseline data, rebased annually, trended forward to the performance year, to calculate target prices at the level of MS-DRG/HCPCS episode type within

the region. Baseline data for procedure costs will be based wholly on regional data. CMS believes now that basing target prices on hospital-specific data makes a hospital compete against itself in a downward spiral of target prices. Use of regional prices is meant to ensure hospitals compete only against their peers in the region.

Regional cost data is an improvement over previous models making facilities compete against themselves, and we appreciate that CMS acknowledges concerns surrounding the “ratchet effect”, where lowering spending could lead to lower future target prices and effectively penalize efficiency. However, regional pricing fails to recognize that regional providers are not directly competing against each other or serving the same populations. Within one region some providers have vastly different resources and costs based upon a location and missions to prioritize different patient populations. Regional prices will result in unjustified benchmarks that may be too easy for some providers and unrealistic for others.

Further, by rebasing the target price annually, weighting the most recent year at 50%, CMS would further penalize hospitals in low-cost regions. If the benchmark is ratcheted down every year, sooner or later “there will be no more juice to squeeze” in terms of trying to cut costs.

g. High-Cost Outlier Cap

For the purposes of a high-cost outlier policy for CJR-X, CMS proposes to cap both baseline episode spending and performance year episode spending at the 99th percentile of spending at the MS–DRG/HCPCS episode type and region level, referred to as the high-cost outlier cap. Although we recognize CMS’s efforts to identify outlier spending in the model, we believe that providers should not be punished for taking the risk of treating the most vulnerable and complex patients. Capping episode costs only above the 99th percentile imposes extraordinary risk on providers. As this model is intended to capture the whole nation including many regions and facilities that are rural, small, and/or with little experience with value-based care, we believe the proposed outlier cap is too aggressive for many of those providers. As an alternative, AAHKS recommends that CMS set the high episode spending cap at the 90th percentile.

h. Discount Factor

To capture savings for the Medicare program, CMS proposes to apply a 2% discount factor is applied to the target price for all procedures. The discount factor is reduced to 1% for a Composite Quality Score above 12.0 and no discount factor is applied for a CQS of 17.0 or above. This is lower than the TEAM model but as this will be applied nationally and on a mandatory basis, this may prove too aggressive for providers who are newer to value-based care or who serve a more chronic, high-acuity disadvantaged population. As this model will capture many regions and facilities that are rural, small, and/or with little experience with value-based care, we believe a 2% discount factor is too aggressive for many of those providers.

i. Financial Arrangements

CMS allows CJR–X participants to enter into financial arrangements with entities that support CJR–X activities to share their reconciliation payment amount or repayment amount. CMS has declined to incorporate AAHKS’ request to require Participant hospitals to share savings with surgeons. Failure to require sharing savings for physicians results in the providers at the center of the episode of care actually being excluded from incentives for performance. While CJR has shown a level of success in reducing Medicare expenditures for LEJR, we believe the savings under CJR-X could be even greater if physicians share in financial incentives by uniformly being included in the shared savings of a hospital.

j. Physician Gainsharing Cap

We thank CMS for proposing to continue the policy in CJR-X of having no physician gainsharing cap. CMS eliminated the CJR gainsharing cap in 2021 at AAHKS’ request.

k. Risk Adjustment

As used in TEAM, CMS proposes for the CJR-X to risk adjust episode-level target prices at reconciliation by the following beneficiary-level variables: age group, Hierarchical Condition Category count (a measure of clinical complexity), and social risk.

AAHKS endorses the application of a robust risk adjustment methodology under the model. AAHKS advocated for the importance of risk adjustment under episode payment models since CJR was first proposed. As we shared at that time, the lack of a risk adjustment methodology would penalize the providers that treat the sickest patients. Hospitals and TJA practices that disproportionately care for medically complex patients would be in direct competition with those that treat a healthier patient base. Subsequent CMMI reports confirmed our concerns by finding that CMMI models without risk adjustment were more likely to see a reduction in patients that were perceived to be sicker and higher cost, as providers were incentivized to shift such patients elsewhere.

We support using this more robust risk-adjustment model as used in TEAM. The lack of risk adjustment in the original CJR was a barrier to access to value-based care for minority and disabled populations. The more robust the risk adjustment is, the less chance for adverse patient selection impacting vulnerable populations or disadvantaging participants serving the most vulnerable.

l. Quality Measures

We support the use of the Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient Reported Outcome -Based Performance Measure (PRO-PM) (CMIT ID #1618) in CMMI models addressing LEJR. However, we are concerned that this measure is not ready for inclusion in *mandatory* models like CJR-X. CMS is currently administering the first mandatory reporting cycle of this measure in the Hospital IQR program – the final data submission deadline is not until September 30, 2026, and CMS does not expect to publicly release results of the cycle until 2027.

Similar to data released from the voluntary reporting period, we are concerned that this new data will show the threshold for reporting a matched pre- and post-operative PRO-PM survey for 50% of individual patients is too high in a real-world setting. Accordingly, we ask that CMS make this measure “pay-for-reporting” only and not “pay-for-performance” until the FY2030 Hospital IQR payment determination period. This will provide CMS with adequate time to analyze and publicly release the data from the first several mandatory reporting periods and make adjustments to the reporting threshold. It will also provide hospitals, physicians, and their staff with additional time to make the workflow and technology changes necessary to effectively and efficiently collect PRO-PM data from patients. PRO-PMs can meaningfully inform clinical decision making and improve patient care, but the measure's specifications must be realistic and achievable for the measure to have these intended positive impacts.

Further, CJR-X rewards hospitals for quality performance, rather than quality improvement as under Original CJR. Because many CJR-X participants will be new to value-based care, we think it is premature and unfair to participants to have them immediately be judged on the same quality scores. We recommend that CJR-X at least commence with a period of allowing participants to qualify for Reconciliation Payments based on quality improvement.

II. TEAM (Transforming Episode Accountability Model)

a. Request for Information: ASCs as Future TEAM Participants

i. Endorsement of Adding ASCs to the TEAM Model

As more LEJRs are being performed in ASCs, CMS seeks public input on the parameters under which ASCs could be incorporated into TEAM, including, model structure, participant roles and financial accountability, episode and target price construction, and quality measurement. We support including ASCs in TEAM. The effectiveness of TEAM in evaluating efficient risk-based episode payment will be severely limited if the model excludes the fastest growing site of care for LEJRs.

CMS can proceed to add ASCs to TEAM for LEJRs only if it believes that ASCs are not ready for other procedures.

ii. Benchmarking Must be Separate

CMS must create a separate episode benchmark for procedures performed at the ASC based on ASC-specific cost experience, and carefully analyze this data for several years before considering a benchmark combining ASC and HOPD procedures. Further, since ASCs are by definition a lower-cost, high-quality option for patients who require minimal post-acute care, there are less savings to be found by including ASCs in TEAM and ASC participant discount targets

should be set accordingly. We would oppose any policy to blend benchmarks between ASC and hospital participants. Such a merged benchmark model for LEJR may be years away.

iii. Quality Reporting and American Joint Replacement Registry

ASCs that have already adopted EHRs may find the transition into value-based care models, including TEAM and CJR-X, easier with the help of a qualified clinical data registry. The ability to participate in a registry is a positive outgrowth of successful EHR adoption and can further reduce the burdens of data collection and submission, including for quality measurement. Future participant ASCs should report quality data from LEJR procedures to a national clinical data registry such as the American Joint Replacement Registry (AJRR). ASCs should then be able to receive credit toward their quality scores in the form of bonus points for submitting this data. AJRR already has the capability to collect data for the CMS Inpatient Quality Reporting (IQR) THA/TKA Patient-reported Outcomes Performance Measure (PRO-PM) and other quality measures included in TEAM and CJR-X. A growing number of ASCs already participate in AJRR and find it helpful to demonstrate to patients, physicians and regulators that their quality is on par with their regional hospitals.

iv. Leaving ASCs Out of TEAM Undermines the Model

If ASCs remain outside of TEAM, CMS' assessments of the model will be limited as it is difficult to quantify the role of surgeon incentives in site selection. If the surgeon has better leadership, clinical autonomy, and opportunities for shared savings in one site of service than the other, the two sites of service and their patient populations will not be comparable. When Medicare covers surgical procedures at multiple sites of service but proposes an episode payment model covering only some of those sites of service, risks arise for distortions in referral patterns and in the model patient population.

As we shared with CMS in 2020 regarding the addition of outpatient procedures to the CJR, it is possible that lower resource utilizing, healthier patients who are able to receive TJA procedures in ASCs will not be included in TEAMs denominators for cost and quality performance metrics. Therefore, model evaluations and results will not present a comprehensive assessment of the model's impact on Medicare covered LEJR. Conversely, some hospitals could feel incentivized to direct high-cost, complex LEJR patients (or perceived poorly performing surgeons) to ASCs to improve their own facility's quality scores. Either way, when a covered site of service is not included in a model, it increases the likelihood that additional financial considerations will influence decisions on the site of service for a patient.

Potentially even more problematic with not including ASCs in the TEAMs model is the fact that currently in the US there is a huge shift of LEJR out of the hospitals into ASCs, leaving only the higher risk patients remaining in the hospital. These higher-risk patients are the ones unlikely to perform well compared to historical metrics and costs. Over the time-period outlines for the TEAMs program, this will only accelerate and will distort the ability for CMS to evaluate the

programs efficacy. Finally, LEJR is the only procedure in the TEAMs model that is undergoing this transformative exodus from the hospital setting.

b. Request for Information: Physician Owned Hospitals (POHs) to Opt-in as TEAM Participants

CMS is considering a future voluntary opt-in period to allow POHs in CBSAs not selected for TEAM participation, to participate in the model. CMS seeks input on model design and operationalization for the inclusion of POHs.

We favor an opt-in period for POHs to join TEAM. We do not see significant changes to the TEAM model to operationalize inclusion for POHs, apart from changes to the underlying model that we have recommended previously. Many federal and state restrictions on physician-owned hospitals only serve to reduce competition and accelerate consolidation. These restrictions are not based on concerns over clinical quality but rather reluctance to face competition in delivering quality outcomes for patients at a better price. Such an opt-in would allow CMS to develop comparative data on clinical outcomes and efficiency.

Evidence exists to suggest that POHs may help control costs, maintain or improve patient outcomes, and prevent hospital consolidation. The lack of POHs, combined with collapsing Medicare physician payment rates, accelerates health care consolidation and limited practice options for physicians. Any POHs opting into TEAM would have to be exempted from CJR-X participation.

III. Facility Rates and Payment Methodology

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

CMS proposes that DRGs 469, 470, 521 and 522 will see weight and market basket increases leading to payment rate increases of between 2.7% and 6.4% in 2027. 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 22% 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.

The average length of stay for THA/TKA decreased from 2.9 days to 1.3 days over a recent 10-year span.¹ 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.*

b. Grouping Methodology Used for New Joint Infection DRGs Unintentionally Misdirects Procedure Alignment and Leads to Underpayment for Joint Revision

In order to accommodate new DRGs 403 and 404 (Periprosthetic Joint Infection), CMS changed its methodology for clustering procedure codes (ICD-10) into MS-DRG payment codes. This new alignment is inconsistent with how surgeons actually code these procedures and leads to payment levels unaligned with the actual underlying performed procedures.

The new clustering methodology causes cases previously assigned to Joint Revision (DRGs 466, 467, 468) to be funneled away and instead assigned to Wound Debridement and Skin Graft (DRGs 463, 464, and 465). The only cases that got to stay in Revision are the cases coded with a specific revision ICD-10 code.

Because surgeons code Revision as Removal & Replacement procedures, under CMS' proposal, true joint revisions will be assigned to Wound Debridement and Skin Graft, which is not at all similar clinically or in terms of cost. Specifically, the revision cases have much higher implant costs, lower lengths of stay, and higher costs overall for the cases with CC and without CC or MCC.

¹ See Ryan, Stambough, Huddleston & Levine, *Highlights of the 2023 American Joint Replacement Registry Annual Report*, Arthroplasty Today, Vol. 26 (April 2024).

This mismatch in resource use results in underpayment for most joint revision cases and overpayment for most non-joint revision cases. Keeping the joint revision triplet MS-DRG 466, 467 and 468 as similar in definition as possible to GROUPER v43 is the best way to group procedures in terms of clinical similarity and resource use.

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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