AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1850-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Medicare 2027 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems 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 the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment system proposed rule for calendar year 2027 (hereinafter referred to as "2027 OPPS proposed rule" or "proposed rule").

AAHKS is the foremost national specialty organization of more than 5,600 physicians with expertise in total hip and knee 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.

We explain below how OPPS arthroplasty and ASC rates highlight the disparity in Medicare surgeon reimbursement for total hip arthroplasty (THA) and total knee arthroplasty (TKA). While CMS proposes to increase OPPS and ASC rates for arthroplasty in 2027, Medicare rates for the surgeons at the center of these procedures are proposed to be cut by 20% in 2027, representing a 27.5% cut in two years.

I. 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. This includes a greater than 10% increase under the OPPS for THA and TKA and a 5.1% increase in payments to ASCs for THA and a 4.2% increase in payments for TKA.

AAHKS Comment:

We support CMS' proposal to increase overall rates under the OPPS and ASC payment systems. However, notwithstanding our overall appreciation of this change, it highlights a grave trend in the Medicare reimbursement system that can no longer be ignored: ***physicians are bearing a disproportionate burden of federal health care cost-reductions with 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 that Medicare's overall reimbursement framework reflects the actual costs and value of physicians' work and better enables physicians to sustain their practice and specializations without increasing consolidation or degrading the patient experience.

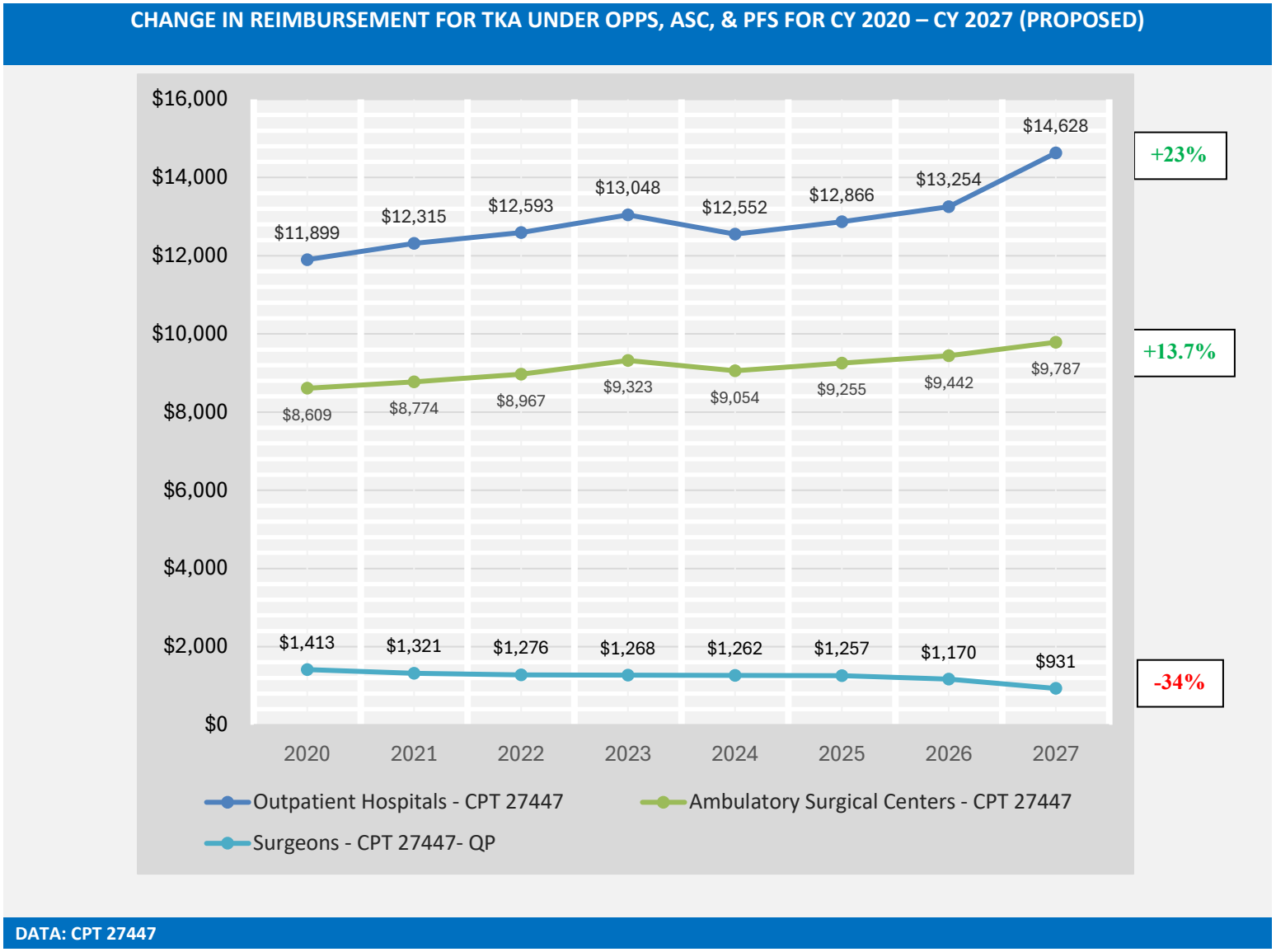
a. Diverging Trends Between Medicare Payments for Physician and Facilities Will Negatively Impact Patients

Although AAHKS acknowledges the need to cut costs and budget neutrality constraints, the federal government cannot derive health care savings solely from physicians. For instance, the surgical fee makes up less than 5% of the hospital episode of care for hip and knee replacement surgery. While payments under the IPPS, OPPS, and PFS may be calculated according to separate statutory formulas, 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.

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 care, among others—the near-annual increases in Medicare facility payments for arthroplasty presents a stark contrast with the drastic cuts to the surgeons performing the procedures.

A 27.5% cut over two years to surgeon reimbursement for hip and knee replacements will not preserve seniors' mobility or well-being. The cut will not improve health outcomes or patient experience, nor will it advance the administration's laudable goal of shifting the focus "from treating illness to preventing it."[1]

[1] *See CMS Proposes Transformational Medicare Reforms to Expand Accountable Care, Modernize Physician Payment, and Shift from Sick Care to Healthcare* (July 14, 2026), https://www.cms.gov/newsroom/press-



b. Adding an Inflationary Adjustment to the Medicare Physician Fee Schedule is a Necessary Start Towards Reform

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

releases/cms-proposes-transformational-medicare-reforms-expand-accountable-care-modernize-physician-payment.

practice today. Long term however, we wish to work with CMS, Congress, and other stakeholders in the multispecialty physician community to redesign how physician contribution and value are measured across contemporary episodes of care.

c. Need for Medicare Payment Reform that Recognizes the Savings Surgeons Generate in Facility Settings for the Medicare Program

More broadly, the growing divergence between facility and physician payment warrants a comprehensive examination of whether Medicare's separate payment systems remain appropriately aligned with the delivery of contemporary episode-based care. The problem isn't simply that the hospital gets more while the surgeon gets less. The problem is that Medicare is increasingly asking physicians to influence the performance and total cost of the entire episode, especially through TEAM and CJR-X, while continuing to value their contribution almost exclusively through an isolated Part B fee-for-service methodology.

AAHKS believes this divergence raises a broader question regarding the alignment of Medicare's payment systems. Arthroplasty surgeons increasingly assume responsibility not simply for performing an operation, but for patient selection, preoperative optimization, appropriate site-of-service determination, care coordination, complication prevention, postoperative management, and outcomes across the episode of care. Many of these activities generate savings elsewhere in the Medicare program through shorter lengths of stay, reduced post-acute utilization, fewer readmissions and complications, and more appropriate utilization of resources. Yet the physician payment system does not adequately recognize this broader contribution to total cost and value. AAHKS encourages CMS to work with Congress and the physician community to develop a contemporary, evidence-based framework that better aligns physician payment with the clinical and economic value physicians create across an episode of care.

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

As CMS continues its phase-out of the Medicare Inpatient Only (IPO) list, 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:

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 of 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.[2] 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 administrative simplicity, to minimize risk of violating the 2-midnight rule, or for other reasons. 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 forces physicians to allocate even more time to contesting with facilities over the most clinically appropriate admission status for a patient. This is work that consumes physician time and exists to comply with Medicare regulatory requirements, but the current valuation methodology largely doesn't recognize it.

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 payers and hospital legal departments.

b. 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

[2] *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/.

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 a 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.[3]

Therefore, we agree that an exemption period remains necessary 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."

III. Expansion of Botulinum Toxin Injection Codes for Prior Authorization Process (Sec. XIX)

CMS uses prior authorization in Original Medicare to address what it considers to be unnecessary increases in the volume of outpatient services. CMS now proposes to require prior authorization for eight additional botulinum toxin injection codes. CMS believes prior authorization is an effective mechanism to ensure Medicare beneficiaries receive medically necessary care while protecting the Medicare Trust Funds from unnecessary increases in volume and improper payments.

AAHKS Comment:

AAHKS believes that, when appropriately implemented, prior authorization is a process to better serve providers and patients, not payors. Prior authorization must be solely a process to ensure medical necessity and not a financial tool to decrease payer expenses, private or public, by overwhelming providers and patients with obtuse paperwork and opaque coverage standards.

There is a place for prior authorization when used in a highly targeted manner in a well-functioning healthcare system. However, the current prior authorization practices employed by private payers, without prioritization or focus on high-risk procedures, impose excessive administrative burdens on medical practices, reduce physicians' time with patients and increase operational costs. Most consequentially, prior authorization regularly delays or completely

[3] 82 FR 59383, https://www.federalregister.gov/d/R1-2017-23932/page-59383 (emphasis added).

prevents patients from receiving necessary care and negatively interferes with the all-important doctor-patient relationship.

We ask CMS to move with extreme caution in expanding any prior authorization within Original Medicare. Correspondingly, CMS should enhance oversight and enforcement of existing regulation of prior authorization practices by MA plans.

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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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