AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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August 26, 2026

VIA E-MAIL FILING

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare 2027 Physician Fee Schedule Proposed Rule – *Comment Letter 1 of 2*

The American Association of Hip and Knee Surgeons (AAHKS), representing more than 5,600 physicians with expertise in total joint arthroplasty (TJA), **urges CMS to withdraw the proposed drastic RVU reductions to CPT 27130 and 27447** in the CY 2027 Medicare Physician Fee Schedule Proposed Rule. AAHKS shares CMS' goal of modernizing physician payment so that Medicare reimbursement reflects contemporary medical practice, promotes high-quality care, and relies upon accurate, transparent, and reproducible data. **Nevertheless, it is arbitrary and capricious for CMS to base the work RVUs for total hip replacement and total knee replacement, not upon observed, verified surgeon work time on those procedures, but rather on the work time of the unrelated lap band removal and cornea transplant procedures, respectively. It is also inappropriate for CMS to remove payment for any post-operative surgeon/patient visits in the hospital following these procedures, based not upon the actual number of observed visits occurring, but upon surveys of separate, unrelated procedures and blanket assumptions without factual basis.**

In this letter, AAHKS opposes the proposed 20% RVU reductions for total hip replacement (CPT 27130) and total knee replacement (CPT 27447). The available evidence does not support a revaluation of this magnitude. CMS should put the RVU reduction on hold and instead propose reimbursement rates for these codes based on independently validated observed surgeon work times that more accurately reflect modern arthroplasty practice. Any proposed future reduction in RVUs should be accompanied by a projection of the adverse impact of that reduction on (1) worsening Medicare beneficiaries' chronic conditions, (2) increased wait times, (3) adverse arthroplasty outcomes and (4) the impact on independent physician practices and consolidation. AAHKS proposes an immediate collaborative process between CMS, AAHKS, and other stakeholders to comprehensively reevaluate contemporary arthroplasty physician work using transparent, validated, and reproducible data.

Our comments below reflect the following AAHKS principles:

- The costs to patients and the Medicare program of untreated osteoarthritis are far greater than the savings generated from these cuts;

- Reductions in physician reimbursement by public and private payers drives provider consolidation;
- Driving resources out of joint replacement will increase wait times and degrade patient experience for necessary, life improving services by reducing the number of surgeons who are able to provide care for Medicare beneficiaries; and
- CMS overlooks independent data that Medicare currently *undervalues* TJA.

This is the first of two comment letters that AAHKS will submit on the proposed rule. The second comment letter will address other provisions of the 2027 PFS 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 in using evidence based medicine to better define the risks and benefits of treatments for patients suffering from lower extremity joint conditions.

Summary of Comments

- Recent CMS-Cited JAMA Study States that TJA wRVUs are Undervalued, Not Overvalued
- New wRVU Cuts on Top of the 2026 "Efficiency Adjustment" Amount to a "Double Dip"
- CMS Proposed Elimination of Any Post-Operative Hospital Visits is Not Based on Observed TJA Data
- OIG Concludes that Actual Medicare Post-Operative Visits are Underreported to CMS
- "Inpatient" and "Outpatient" Status are Hospital Reimbursement Classifications and Do Not Reflect Actual Surgeon Work Performed on Joint Replacement
- By Ending Payments for Inpatient Post-Operative Patient Visits, CMS Reverses Position and Drives Surgeons to Perform Outpatient Procedures Regardless of Clinical Factors
- Improving TJA Payment Accuracy Requires a Comprehensive Holistic Review of Surgeon Treatment and Management of Underlying Conditions, and a Move to Longitudinal Care, Not Merely Attempts to Cut Post-Operative Visit Values
- A 27.5% Cut to TJA Rates in Two Years Will Not Preserve Seniors' Health Outcomes and Will Have Deleterious Consequences on Patient Experience
- Investment in Medically Necessary Hip and Knee Replacement is Essential to Shift the Healthcare System's Focus from Treating Illness to Preventing It and to Reduce Health Care Costs
- Timely and Appropriate Hip and Knee Replacement Prevents the Costly and Isolating Chronic Conditions that Stem from Osteoarthritis
- Shifting Medicare Funds to Primary Care Cannot *Prevent* Osteoarthritis Due to Genetic and Structural Problems that Eventually Lead to Osteoarthritis
- TJA Prevents Other Costly Conditions Caused by Untreated Osteoarthritis
- A 20% Cut to Hip and Knee Replacements Will Burden Seniors with Surgical Wait Times Comparable to Canada and the United Kingdom's National Health Service as More Orthopaedic Surgeons No Longer Take Medicare Patients
- Untreated Osteoarthritis Dramatically Increases Long Term Care Costs

- A 20% Cut Accelerates Health Care Consolidation
- DOJ Antitrust Standards Already Consider Orthopaedic Surgical Practices to be Highly Concentrated
- Consolidation Undermines Free Market Competition and Increases Health Costs for All
- Sustained Medicare Cuts Have Greatest Negative Impact on Community-Based Small Businesses

Valuation of Specific Codes for CY 2027 (Sec. II.D.3.c.10)

Among the procedures CMS proposes to revalue for 2027 are Total Hip Arthroplasty (THA) (CPT 27130) and Total Knee Arthroplasty (TKA) (CPT 27447). CMS proposes cuts to Relative Value Units (RVUs) that amount to a 20% cut in Medicare reimbursement in 2027. This follows a 7.5% cut to these same procedures in 2026.

A 27.5% cut to hip and knee replacements in two years 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]

CMS should maintain current 2026 level RVUs for CPT 27130 and CPT 27447 in 2027. Future RVUs for these hip and knee replacement procedures should be based on actual independently observed work time of surgeons performing these procedures in a recent timeframe, as opposed to inferences or assumptions based on data for other procedures. Any future proposed reduction in RVUs should be accompanied by a projection of the adverse impact of the reduction on (1) Medicare beneficiaries' chronic conditions, (2) wait times, (3) arthroplasty outcomes and (4) the impact on independent physician practices and consolidation.

I. Value: CMS Proposed RVU Cuts Overlook Data that TJA RVUs are Undervalued

AAHKS supports value-based care and modernization in TJA. We further support the use of contemporary, objective data to set RVUs. We question whether CMS' current methodology adequately measures contemporary arthroplasty work, particularly the assumptions and inferences regarding postoperative work and the limitations of claims-based reporting. CMS set the TJA RVUs, not based on observed time in TJA cases but, based on (1) corneal transplant and (2) laparoscopy procedures to remove gastric bands. These procedures have no clinical relation to TJA.

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

RVUs for these procedures should be based on actual independently observed procedure-specific work time of surgeons performing these procedures in a contemporary timeframe, as opposed to inferences or assumptions based on data for other procedures.

a. Recent CMS-Cited JAMA Study States that TJA wRVUs are Undervalued, Not Overvalued

A study published in JAMA compared estimated intraservice times and the PFS wRVU time for a variety of procedures in 2018. CMS cited this study as an important source regarding wRVUs in the preamble to the 2026 PFS Proposed Rule.[2] The study found that total hip arthroplasty took 5% longer than the PFS valued time, while total knee arthroplasty had an equal duration.[3] Notably, when the authors made these conclusions in 2018, these procedures were higher than today, valued at 20.72 wRVUs, far above CMS' proposed 15.3 wRVUs.

b. New wRVU Cuts on Top of the 2026 "Efficiency Adjustment" Amount to a "Double Dip" on RVUs

In 2026, CMS implemented a productivity adjustment (the "Efficiency Adjustment") to cut the intraservice time of the wRVUs for all non-time-based services by 2.5%. CMS did not base the Efficiency Adjustment on an evidence-based determination or any conclusion of over-valuation. Rather, CMS stated that "changes in practitioner experience, operational workflows and new technologies" ***may*** have led to codes ***potentially*** being overvalued.[4]

The 2027 proposed cuts represent a "double dip" cutting TJA wRVUs first in 2026 based on a suspicion of over-valuation and second in 2027 based on code-specific review. The AMA RUC survey and recommended values for 2027 pre-dated the Efficiency Adjustment and presumed 2025 level wRVUs.

c. CMS Proposed Elimination of Any Post-Operative Hospital Visits is Not Based on Observed TJA Data

CMS proposed wRVU reductions will eliminate payment for any hospital post-operative visits. These proposals are based on broad generalizations of all 90-day global surgical codes. CMS proposes instead that surgeons should only be reimbursed for one 15-minute check-in at discharge, regardless of the complexity of the patient or how many days the patient is in the hospital. Further, not all of surgeons' post-operative time is accounted for in current global surgical values. This includes post-operative work outside of office visits: reviewing pictures/videos and calls with patients.

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[2] *See* 90 Fed. Reg. 32401.

[3] Crespin et al., *Variation in Estimated Surgical Procedure Times Across Patient Characteristics and Surgeon Specialty*, 157 JAMA SURG. e220099 (2022), https://doi.org/10.1001/jamasurg.2022.0099.

[4] *See* 90 Fed. Reg. 32401.

d. OIG Concludes that Actual Medicare Post-Operative Visits are Underreported to CMS

Recommendations to eliminate post-operative visits from TJA valuation are based upon broad assumptions about all global surgical procedures generally. Assumptions of reduced post-operative visits based on Rand[5] study estimates are contradicted by the HHS Office of the Inspector General (OIG), which found that Medicare claims data on post-operative visits is inaccurate because of underreporting by physicians.

In one report, OIG found that "[o]f the 105 sampled global surgeries (97 major and 8 minor surgeries), 42 major surgeries had a total of 94 unreported postoperative visits."[6] Furthermore, "these errors occurred because some practitioners and the practices' staff were either unaware that certain practitioners were required to report their postoperative visits to CMS, or they did not understand which visits were considered postoperative visits under Medicare's global surgery policy."[7]

A second recent report by OIG reviewing global surgical codes found "that for 22,713 of the global surgeries in our sampling frame, there were 60,568 postoperative visits that were supported by the patients' medical records, but the practitioners did not report the postoperative visits to CMS." [8] OIG concludes that underreporting occurs because "practitioners did not understand CMS's global surgery policy, their billing systems were not properly designed to always submit CPT code 99024 on claims to CMS, [and] they lacked access to medical records associated with postoperative visits performed outside of the practice location."[9]

e. "Inpatient" and "Outpatient" Status are Hospital Reimbursement Classifications and Do Not Reflect Actual Time or Intensity of Surgeon Work Performed on Joint Replacement

In arguing for ending post-operative visits following TJA, CMS and the RUC point to data that TJA is performed "less than 50 percent of the time in the inpatient setting", yet the proposed code values include *no time for <u>any</u> post-operative E/M visits* in the facility, regardless of the setting. TKA was removed from the Medicare Inpatient Only List (IPO) in 2018 and THA followed in 2020. CMS reassured surgeons at the time that the policy was a change in facility reimbursement only. Specifically, that for TJA procedures that were admitted for a stay less than

[5] Rand reported that Medicare claims data showed the median CPT 27130 procedure was 2.0 post-operative visits. Further that only 18% of hip arthroplasties had no reported post-operative visits. *Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-Day Global Periods: Updated Results Using Calendar Year 2019 Data*, at 50, RAND CORP (2021), https://www.rand.org/pubs/research_reports/RRA203-2.html.
[6] OIG, *CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries*, Rep. No. A-05-20-00021, at 8 (2025), https://oig.hhs.gov/documents/audit/10428/A-05-20-00021.pdf.
[7] *Id*. at 10.
[8] OIG, *CMS Should Confirm It Is Receiving Medicare Postoperative Visit Data on Global Surgeries When Reporting Is Required*, Rep. No. A-05-20-00027, at 10 (Aug. 26, 2025), https://oig.hhs.gov/documents/audit/10899/A-05-20-00027.pdf.
[9] *Id*. at 8.

two midnights, Medicare would reimburse the facility at the outpatient rate and that surgeons would not have to spend less time on the procedures or with patients.

Inpatient and outpatient status are reflections of the length of the hospital admission. The amount of surgeon work necessary for a safe and effective procedure is similar for inpatient and outpatient billing status, but studies have shown that outpatient procedures require more intense surgeon work because the necessary pre-operative, intraservice and post-operative work that must be performed to ensure multiple touchpoints with the patient when they are out of the hospital. The RUC's recommendation to increase the intensity of CPT 27130 and CPT 27447 is *because of, not in spite of,* the move of so many procedures to outpatient status. Without separate CPT codes describing inpatient TJA and outpatient TJA, CMS' proposal amounts to arbitrary cuts to surgeon time for all TJA procedures based solely upon the hospital's reimbursement classification.

While CMS and the RUC may wish to arbitrarily remove all post-operative visits from the valuation of TJA, even for inpatient cases, that does not mean that there are no Medicare beneficiaries who require and receive post-operative visits. Medicare claims data shows that, of outpatient Medicare TJA procedures, 80% of patients remain in the hospital overnight. Some of those patients are receiving in facility post-operative visits from their surgeon. Surveys should be conducted to determine the proper wRVUs based on the number of visits actually occurring.

f. By Ending Payments for Inpatient Post-Operative Patient Visits, CMS Reverses Position and Drives Surgeons to Perform Outpatient Procedures Regardless of Clinical Factors

When TJA procedures were removed from the IPO, CMS reassured surgeons, "We reiterate that removal of the TKA procedure from the IPO list does not require the procedure to be performed only on an outpatient basis."[10] CMS stated at the time that this was not intended to influence or change physicians' clinical judgement about the best and most appropriate care and services for patients. Now, the IPO change is being used by CMS and the RUC as justification to stop reimbursing surgeons for post-operative visits. By halting payment to surgeons for any post-operative visits for TJA patients, CMS is, in effect, forcing the procedure to be performed only on an outpatient basis. That, or CMS is forcing orthopaedic surgeons to give post-operative patient visits to patients without compensation.

Basing wRVU cuts on incomplete reading of limited studies of a few individual codes emphasize the need for procedure-specific values based on observed time from reliable data sources with robust reporting.

g. Improving TJA Payment Accuracy Requires a Comprehensive Holistic Review of Surgeon Treatment and Management of Underlying Conditions and a Move to Longitudinal Care, Not Merely Attempts to Cut Post-Operative Visit Values

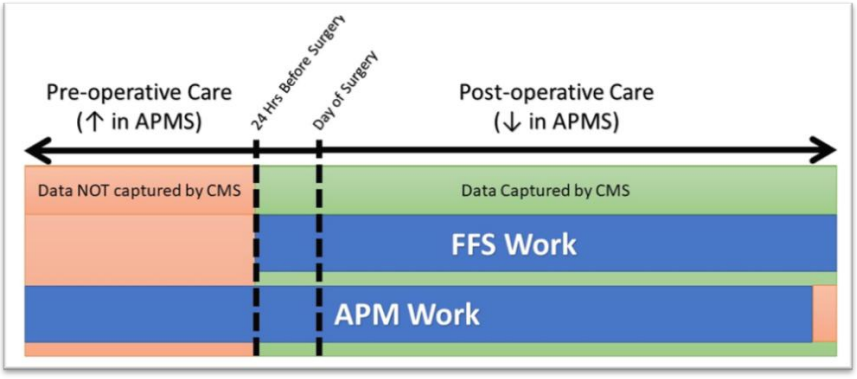
[10] 82 Fed. Reg. 59384 (Dec. 14, 2017).

CMS critiques the AMA RUC for trying to increase the intensity of TJA codes without any change in the CPT code descriptions. Intensity is increasing for TJA as surgeons are at the center of an aggressive transformative move into value-based care for Medicare TJA. The CJR was in effect for eight performance years. Medicare removed TJA from the IPO list. Medicare expanded TJA to the ASC setting. Medicare is about to implement the CJR-X model on a nation-wide mandatory basis. Revising TJA codes may be ultimately necessary but would be inadvisable in the midst of such rapid transformation. The AMA cannot be blamed for not updating TJA CPT codes while waiting to see how CMS next proposes to drastically transform Medicare TJA incentives and payment which impact clinical care.

The shift to value-based care in the last decade has led to evolutions in how many surgical procedures are managed which requires a new comprehensive consideration on assessing value. Orthopaedic surgeons, and THA and TKA procedures specifically, have been at the forefront of the transition to value-based care as high-volume, high-value procedures present significant opportunities for improvements in quality and efficiency. Hip and knee surgeon participation in alternative payment models (APMs) is approaching 50%, the highest rate of any subspecialty. Our members' work at the center of clinical and care management decisions within CJR, TEAM and BPCI-A models have improved outcomes, reduced patient time spent in the hospital and subsequently saved Medicare more than $112 million in just two performance years of the CJR. Now, CMS projects that CJR-X will save Medicare $725 million over five years.

Much of the effectiveness of these programs, however, has come from the shift from reactive, hospital-based postoperative work to proactive, office-based preoperative work. Our members, associated qualified health professionals and clinical staff have experienced significant increases in preservice work to optimize patients through screening, education and coordination of care with other health care providers (patients' primary care physicians, medical specialist consultants, physical therapists, post-acute care and others), and from other activities required to ensure the best outcome for a patient's surgery. However, these activities on behalf of the patient and family fall outside of the global surgical bundle because they are not included in the traditional RUC survey definition of "pre-service activities," nor the time clinical staff spent providing certain pre-service activities for the patient and family.

Arthroplasty Preservice Optimization Time Not Captured



Evidence has made clear that the additional time spent on these preoperative activities has resulted in improved clinical quality for patients and significant savings by reducing patients' post-operative lengths of stay, readmissions and other complications. An April 2019 New England Journal of Medicine article estimated that 42% of TKA and THA procedures over a two-year period were performed under the CJR and resulted in a 3.1% reduction in Medicare spending for TJA.[11] It is important to note that it was the increased work by orthopaedic surgeons, including managing the patient experience and optimization, that led to arthroplasty savings realized in reduced spending by the facility and post-acute care. Further, not all of surgeons' post-operative time is accounted for in current global surgical values. This includes post-operative work outside of office visits, including reviewing pictures/videos and calls with patients.

Penalizing surgeons for this successful collaboration, by eliminating valuation for post-operative visits while not reimbursing preservice optimization time, does not lead to more accurate payments. We encourage CMS to evaluate whether current global surgical bundles are capturing all pre- and post-operative work, and consider whether CPT codes exist for work performed outside the bundles.

h. Proposed Alternative

Section 1848(c)(2)(B)(iii) of the Social Security Act requires the Secretary to "consult . . . with organizations representing physicians" when adjusting RVUs for physician services. We propose a new formal collaboration on RVU measurement with stakeholders that will amount to true and meaningful collaboration with medical societies, and not just a proforma opportunity for notice and comment on the proposed rule. AAHKS can convene the different perspectives of AAHKS, our affected surgeons and other stakeholders to determine the best way to determine TJA RVUs based on actual independently observed contemporary work time of surgeons performing these procedures.

We have prior experience in bringing together such stakeholders with mutual interests in efficient and quality Medicare services. On August 31, 2015, AAHKS convened a Patient Reported Outcomes Summit for Total Joint Arthroplasty in Baltimore, Maryland. Representatives from orthopaedic organizations (AAHKS, AAOS, The Hip Society, The Knee Society and American Joint Replacement Registry), CMS, Yale-New Haven Health Services Corporation Center for Outcomes Research and Evaluation (Yale/CORE), private payors and other stakeholders participated in the Summit. The Summit's goal was to obtain a consensus regarding the patient-reported outcomes (PRO) and risk variables suitable for total hip and knee arthroplasty performance measures, particularly for use in the CJR.

[11] Barnett et al., *Two-Year Evaluation of Mandatory Bundled Payments for Joint Replacement*, 380 NEW ENG. J. MED. 252 (Jan. 17, 2019), https://www.nejm.org/doi/full/10.1056/NEJMsa1809010.

II. Prevention: Investment in Medically Necessary Hip and Knee Replacement is Essential to Shift the Healthcare System's Focus from Treating Illness to Preventing It and to Reduce Health Care Costs

CMS says that it wishes to transform the PFS to help shift the healthcare system's focus from treating illness to preventing it.[12] CMS Administrator Dr. Oz says he wants to "make it easier for clinicians to focus on prevention, improve coordination for patients and ensure Medicare rewards better outcomes rather than more services."[13] Advisors to the Secretary describe "long-running efforts to shift financial incentives toward primary care and prevention instead of costly procedures."[14]

We could not agree more with these goals, and we are confident that joint replacement is best understood as an often-necessary service that prevents a range of chronic conditions that cost taxpayers and limit seniors' mobility, independence and happiness.

a. Timely and Appropriate Hip and Knee Replacement Prevents the Costly and Isolating Chronic Conditions that Stem from Osteoarthritis

i. Causes of Osteoarthritis, Not All of Which Can be Prevented

The most common indication for TJA is osteoarthritis, which is caused by the wearing out of the cartilage covering the bone ends in a joint. The most common risk factors for osteoarthritis are age, being female and family history. There are no changes in Medicare reimbursement policy that will allow any physicians to prevent osteoarthritis risk factors. However, treating osteoarthritis with TJA, when appropriate and without delay, will prevent costly conditions associated with chronic osteoarthritis and decrease subsequent service utilization.

ii. Overall Health and Wellness Benefits of TJA: Preventing Other Costly Conditions

The pain and limitation in motion caused by osteoarthritis leads to depression and social isolation, limitations in activities of daily living, inability to exercise and work limitations.[15] There are extensive documented health benefits of TJA: Pain relief (removing bone rubbing and joint ache); More movement (allowing seniors to walk, climb stairs and do light sports); Weight control (more active days help burn calories and lower joint stress); and Better rest (pain-free nights mean deeper sleep).

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[12] *Id*.
[13] *Id*.
[14] *Trump Officials Seek Public Input on Overhaul of Medicare Payment System*, WASH. POST (July 14, 2026), https://www.washingtonpost.com/politics/2026/07/14/trump-officials-seek-public-input-overhaul-medicare-payment-system/.
[15] Osteoarthritis Action Alliance, *OA Prevalence and Burden*, https://oaaction.unc.edu/oa-module/oa-prevalence-and-burden/.

There are documented mental health benefits as well: Less stress (being mobile lowers worry and sadness linked to chronic pain); Higher confidence (doing things on your own builds self-worth); and Social life (going out with friends and family becomes fun again). All of these physical and mental benefits mean fewer costly chronic conditions for beneficiaries and the costly hospitalizations that they can lead to.

Separately, obesity is a cause of osteoarthritis that can be prevented. However, for those seniors who already suffer from osteoarthritis pain due to obesity, orthopaedic surgeons work with patients to reduce their obesity. Our members "play a key role in directing the optimization of patients before surgery by assessing patient risk factors to inform risk/benefit discussions during shared decision-making and designing optimization programs to address modifiable risks. These efforts can lead to improved health outcomes, reduced costs and preference-congruent treatment decisions."[16]

Significant time spent is optimizing patients prior to surgery to provide the best possible outcomes. Patients are counseled to stop smoking weeks prior to surgery which results in improved skin and tissue healing. Surgeons guide safe weight reduction or personalized metabolic conditioning to lower joint stress and surgical times. Chronic opioid use is evaluated and tapered to prevent severe post-operative pain control issues and withdrawal.

b. The Costs of Untreated Osteoarthritis

Untreated osteoarthritis dramatically increases long-term care costs by causing severe joint damage, chronic pain and permanent disability. This functional decline strips seniors of their independence, forcing early entry into assisted living, nursing homes, or paid home care, with lifetime care expenses easily exceeding $140,000.

Hip and knee replacement should not be evaluated simply as procedural expenditures. They are among the most effective interventions available for reducing the disability burden of chronic disease. For every 1,000 primary joint replacements performed, approximately 1,300–2,100 quality-adjusted years of life are restored. In Medicare alone, a single year's cohort of hip and knee replacements generates approximately one million or more discounted quality-adjusted life-years of health benefit.[17] TJA procedures are highly cost-effective interventions that provide patients with reliable improvements in quality of life and overall satisfaction. In fact, they "drastically improve patient [quality-adjusted life years] QALYs."[18]

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[16] Shapiro et al., *Preoperative Optimization for Orthopaedic Surgery: Steps to Reduce Complications*, 31 J. AM. ACAD. ORTHOP. SURG. e949 (Nov. 2023), *https://doi.org/10.5435/JAAOS-D-22-00192*.

[17] *See* Konopka JF, Lee YY, Su EP, McLawhorn AS. *Quality-Adjusted Life Years After Hip and Knee Arthroplasty: Health-Related Quality of Life After 12,782 Joint Replacements.* JB JS Open Access. 2018 Aug 15;3(3):e0007.

[18] Linton AA, Courtney PM, Krueger CA, Meneghini RM, Rana AJ, Kugelman DN. *Quality-Adjusted Life Year Gains After Total Hip and Knee Arthroplasty: A Review of Cost-Effectiveness Evidence and Policy Implications*. J Arthroplasty. 2026 Feb 23.

III. Patient Experience: A 20% Cut to Hip and Knee Replacements Will Accelerate the Current Trend of Surgeons Opting-out of Medicare and Burden Seniors with Surgical Wait Times Comparable to Canada and the United Kingdom's National Health Service

If the Administration's goal is to "[shift] more payment toward primary care [to] ultimately boost preventive screenings and other options less lucrative for physicians than specialty procedures"[19], then, correspondingly, cutting payment for joint replacement will depress the number of seniors to receive the restoration of mobility and freedom through a joint replacement. Fewer physicians performing joint replacement, amid an obesity epidemic and the longevity of the baby boom generation, means longer wait times for seniors. Reviews of academic studies find that a "shortage of orthopaedic surgeons and increasing workloads may lead to longer wait times, higher complication rates and poorer outcomes."[20]

a. More Orthopaedic Surgeons Will No Longer Take Medicare Patients

With a 27.5% payment reduction in two years, some number of surgeons will determine that they can no longer afford to take new Medicare patients. Also, some surgeons will decide to ration the number of Medicare patients they can take. While the decision to participate in Medicare is an individual one for surgeons and based on a number of factors, there clearly will be some surgeons who are forced into this situation if Medicare rates will no longer sustain an independent practice.

This phenomenon is confirmed to be underway today. In general, "between 2010 and 2024 [,] the share of physicians exiting Medicare in any given year increased significantly."[21] Kaiser Family Foundation reports that 8.1% of psychiatrists, 3.2% of neurologists have already opted out of Medicare.[22] 1.7% of family physicians have left Medicare already but their rate of exit is increasing, accounting for 21.5% of all physicians who left Medicare in 2024.[23] There is no data available that the supply of Medicare participating physicians increases or remains stable in the face of falling Medicare reimbursement.

Up to now, orthopaedic surgeons opting out of Medicare has been modest but steadily increasing for the 10 years preceding 2025 during which Medicare rates fell 10%.[24] Rates of opt-outs should be expected to exponentially increase if Medicare payments fall 27.5% in two years.

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[19] *Trump Officials Seek Public Input on Overhaul of Medicare Payment System*, WASH. POST (July 14, 2026), https://www.washingtonpost.com/politics/2026/07/14/trump-officials-seek-public-input-overhaul-medicare-payment-system/.

[20] Stubnya et al., *Global Trends in Joint Arthroplasty: A Systematic Review and Future Projections*, 14 J. CLIN. MED. 8214 (2025), https://doi.org/10.3390/jcm14228214.

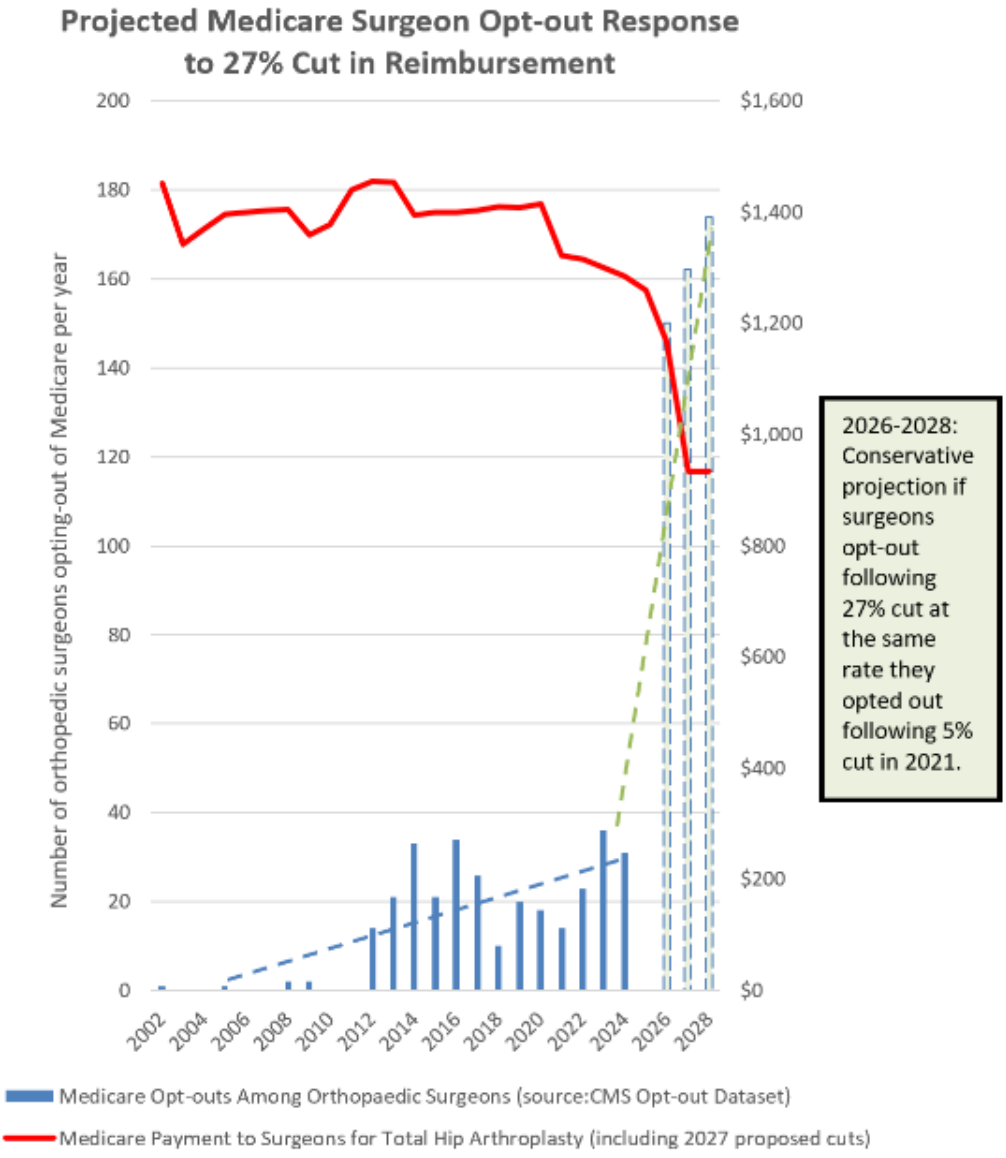
[21] Hannah T. Neprash & Michael E. Chernew, *Trends in Physician Exit From Fee-for-Service Medicare*, JAMA HEALTH F., (2025) at e252267, https://pmc.ncbi.nlm.nih.gov/articles/PMC12274972/.

[22] *How Many Physicians Have Opted Out of the Medicare Program?*, KFF (Jan. 17, 2025), https://www.kff.org/medicare/how-many-physicians-have-opted-out-of-the-medicare-program/.

[23] *Id*.

[24] Rajan et al., *Trends in Orthopedic Surgeons Signing Medicare Opt-Out Affidavits*, 7 J. ORTHOP. EXPERIENCE & INNOVATION (2026), https://doi.org/10.60118/001c.161595.

See the following chart based on data compiled and published in the *Journal of Orthopaedic Experience and Innovation*.[25]



b. Wait Times for Surgery Will Increase, Which Will Lead to Adverse Clinical Outcomes

Reducing the number of orthopaedic surgeons available to treat Medicare beneficiaries would amount to a loss of a key advantage of the US health care system over socialized national health systems that have similarly discouraged access to lifestyle improving surgical interventions like joint replacement. Surveys of wait times for joint replacement surgery frequently find wait times in Canada and the United Kingdom to range from double to quadruple the wait times in

[25] *Id*.

the US.[26] The Canadian Medical Association says that the wait times for elective surgeries are driven by "workforce issues" combined with an increasing demand for services due to an aging population.[27]

Wait Time from Referral to Orthopaedic Surgeon to Surgery	
US[28]	4-10 weeks
Canada[29]	48 weeks
UK National Health Service[30]	57 weeks

Increased wait times lead to adverse clinical outcomes. In the UK, an additional waiting period of six months was associated with significant clinical deterioration in health-related quality of life, where studies found underlying conditions like osteoarthritis and obesity may progress, increasing the risk of postoperative complications and potentially necessitating earlier revision procedures.[31] Other studies found "significant association" between increased presurgical waiting time and "clinically meaningful" deteriorations in post-surgical joint-related function and health related quality of life.[32]

c. Surgeons Remaining in Medicare Have Limited Capacity to Take on Additional Patients

For those surgeons who remain in Medicare, it is unrealistic to expect that they can take on all the former patients of those who opted-out. Taking on too many patients eventually leads to limiting doctor-patient interaction and availability to answer questions, further diminishing the patient experience. Overcommitting to patient volume also accelerates surgeon burnout which in turn further diminishes surgeon supply.

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[26] *See* Skopec et al., *Variation in Processes of Care for Total Hip Arthroplasty Across High-Income Countries*, 2 HEALTH AFF. SCHOLAR (2024), at tbl.3, https://doi.org/10.1093/haschl/qxae043; Mackenzie et al., *Waiting Your Turn: Wait Times for Health Care in Canada, 2025 Report* (FRASER INST.), https://www.fraserinstitute.org/sites/default/files/2025-12/waiting-your-turn-2025-17913.pdf; Patient Claim Line / NHS parliamentary data, https://questions-statements.parliament.uk/written-questions/detail/2025-02-10/HL4888/; Reed et al., *Still Waiting: Is It Just England That Still Has a Backlog Problem?*, NUFFIELD TRUST (2024), https://www.nuffieldtrust.org.uk/news-item/still-waiting-is-it-just-england-that-still-has-a-backlog-problem.

[27] Canadian Medical Association, *Why do Canadians wait so long for non-urgent surgeries*?, https://www.cma.ca/healthcare-for-real/why-do-canadians-wait-so-long-non-urgent-surgeries.

[28] Coyte, et. al, *Waiting Times for Knee-Replacement Surgery in the United States and Ontario*, New England Journal of Medicine, Volume 331, No. 16, pg 1068 (Oct. 20, 1994).

[29] *Waiting Your Turn: Wait Times for Health Care in Canada.*

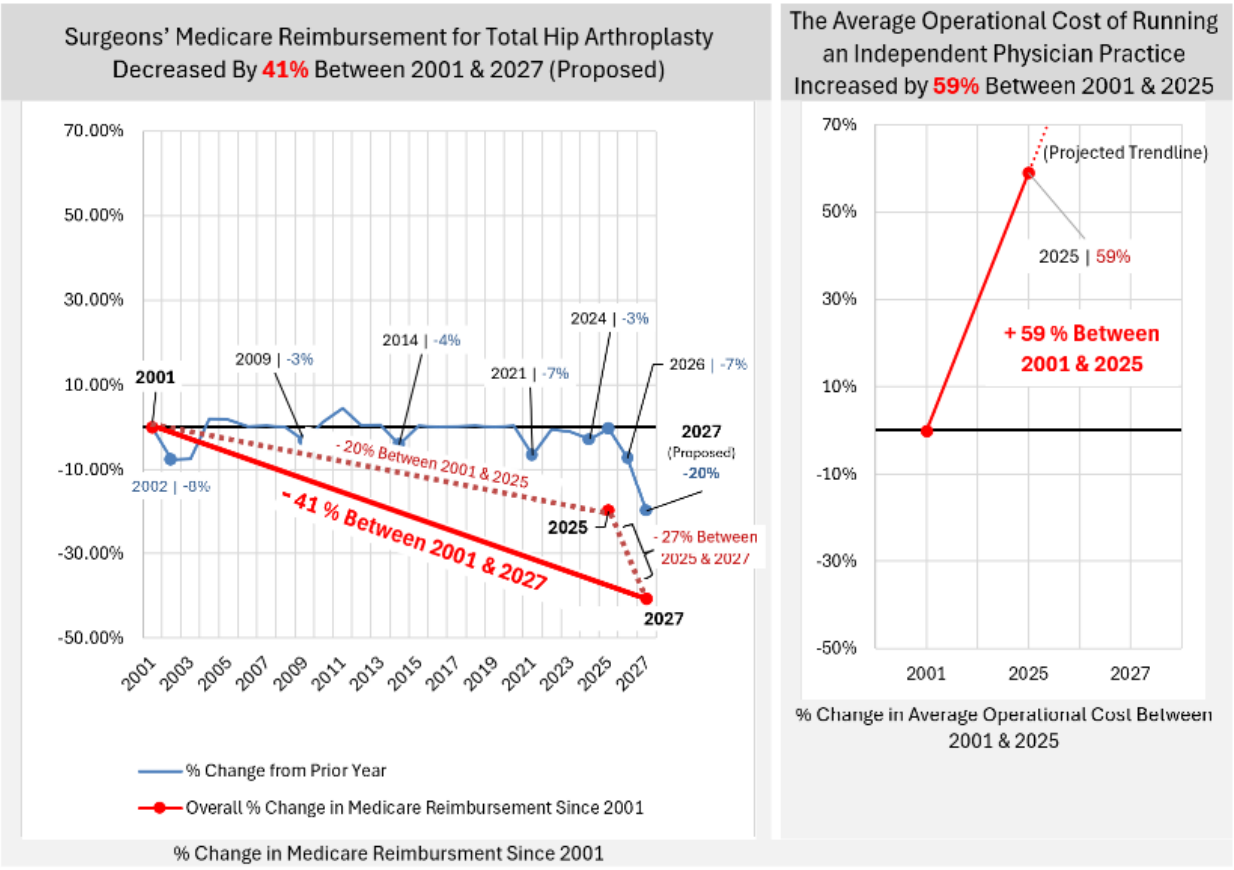
[30] *Still waiting: Is it just England that still has a backlog problem?*.

[31] Stubnya et al., *Global Trends in Joint Arthroplasty: A Systematic Review and Future Projections*, 14 J. CLIN. MED. 8214 (2025), https://doi.org/10.3390/jcm14228214.

[32] *See* Cooper et al., *The Functional and Psychological Impact of Delayed Hip and Knee Arthroplasty: A Systematic Review and Meta-Analysis of 89,996 Patients*, 14 SCIENTIFIC REPORTS 8032 (2024), https://doi.org/10.1038/s41598-024-58050-6.

IV. Consolidation: A 20% Cut Accelerates Health Care Consolidation and Increases Health Care Costs

Current financial, inflationary and administrative pressures have pushed surgeons to adapt either through *hyper-efficiency* with increasing caseloads to maintain profitability (thereby risking burnout), or through consolidated employment models, sacrificing autonomy. The efficiency model can only be pushed so far when the reimbursement on any given surgery continues to decrease, which has put more pressure on surgeons to consolidate.



SOURCE: Numbers have been rounded. Average Operational Costs were calculated using data published by the American Medical Association.

a. The Orthopaedic Surgery Market is Already Too Concentrated

AAHKS has been warning for several years of the dangers of the rapid pace of consolidation of providers and payers. The acquisition of independent physician practices by hospitals and health plans directly correlates with the decline in reimbursement rates under the Medicare PFS. A 20% cut to a key procedure of orthopaedic surgical practices will devastate what currently remains of independent practices and exponentially accelerate consolidation of physician services.

Only 42% of physicians remained in private practice in 2024, down from 60% in 2012.[33] 55% of physicians are now hospital-employed.[34] It is not just hospitals that are buying physician practices, but also large national health insurers and private equity firms. The evidence is consistent and well-documented: consolidation drives up prices for both commercial insurers and Medicare, without delivering commensurate improvements in outcomes.

Only 54% of orthopaedic surgeons remain in private practice, but this proportion has steadily declined, with physician groups of less than 10 comprising almost half of all practices.[35] The percentage of AAHKS members who have given up independent practice for hospital employment has more than quadrupled since 2009.

Consolidation and the overall decline in independent physician practices is primarily a result of declining Medicare rates over time. Without an inflation adjustment in the Medicare PFS, physician rates have dropped 60% in real dollars over 30 years and over 40% in nominal dollars. With such reductions in Medicare reimbursement, which are matched by commercial payers, fewer surgeons can afford an independent practice and are forced to seek employed-status. The economic model of a practice (ownership/employment/independence, etc.) should be a realistic choice for physicians and a choice in providers that is available to patients. Physicians should not feel driven to become hospital employed out of necessity.

b. DOJ Antitrust Standards Measure Orthopaedic Surgical Practices to be Highly Concentrated

Orthopaedic surgical practices are already considered highly concentrated, even if the field has been a *relative* holdout against consolidation. The Herfindahl-Hirschman Index (HHI) for orthopaedic surgery practices increased from 2,032 in 2008 to 2,594 in 2019.[36] The Antitrust Division of the US Department of Justice considers HHI scores greater than 1,800 to be highly concentrated.[37] Further cuts will lead to an even greater level of consolidation.

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[33] AMA Physician Practice Benchmark Survey (2024), https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf.

[34] Advisory Board, *Over 77% of Physicians Are Employed. Here's How That's Shaping Healthcare*, ADVISORY BOARD (Apr. 16, 2024), https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023.

[35] Carol K. Kane, *Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties*, AM. MED. ASS'N (2024), https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf.

[36] Henretty et al., *Trends in Orthopedic Surgeon Practice Consolidation From 2008 to 2019*, 37 J. ARTHROPLASTY 409 (2022), https://doi.org/10.1016/j.arth.2021.11.015.

[37] DOJ Antitrust Division, *Herfindahl-Hirschman Index*, https://www.justice.gov/atr/herfindahl-hirschman-index (last visited Aug. 5, 2026).

c. Consolidation Undermines Free Market Competition and Increases Health Care Costs for All

In a California-based report, the increase in physician practice consolidation to hospital ownership from 25% in 2010 to 40% in 2016 was linked to a 12% increase in insurance premiums.[38] Other analyses have shown that expenditures by practices owned by health systems with more than one hospital were 19.8% higher than physician-owned practices.[39] A study of cardiology Medicare claims data reported that moving from low to high market concentration was associated with a 7 to 11% increase in expenditures.[40]

The concern specifically related to TJA is that consolidation into hospital systems will create incentives for the surgeries to be performed in the higher-cost setting of a hospital or hospital outpatient department, despite CMS policy changes designed to support outpatient total joint arthroplasty in ASCs, where the cost of care is much less.

If CMS wishes to "shift financial incentives toward primary care and prevention *instead of* costly procedures",[41] or "move away from values that reward providers for surgeries or other costly procedures",[42] this cannot be done solely through cutting physician reimbursement. While CMS proposes to cut surgeon reimbursement for TJA by 27.5% in two years, CMS proposes to increase payments to hospitals by 13.6% in two years for these same procedures.

For patients, consolidation results in reductions in access to care. As health systems acquire more control within a geographic region, market competition decreases. This trend provides the health system with increased leverage to further restrict access and gain higher facility reimbursements. Higher costs can also raise the barrier to entry for patients.[43] We remind CMS that consolidation leads to fewer choices for consumers across the care continuum, higher prices and decreased access to care, particularly in rural and underserved areas.

Consolidation and decreased market pressures lead to higher costs of services, medical devices and pharmaceutical products. This results in increased insurance premiums and out-of-pocket costs passed on to patients and employers.

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[38] Scheffler et al., *Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices*, 37 HEALTH AFF. 1409 (2018), https://doi.org/10.1377/hlthaff.2018.0472.

[39] Robinson et al., *Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California*, 312 JAMA 1663 (2014), https://doi.org/10.1001/jama.2014.14072

[40] Koch et al., *Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries*, 53 HEALTH SERVS. RES. 3549 (2018), https://doi.org/10.1111/1475-6773.12825.

[41] *Trump Officials Seek Public Input on Overhaul of Medicare Payment System*, WASH. POST (July 14, 2026), https://www.washingtonpost.com/politics/2026/07/14/trump-officials-seek-public-input-overhaul-medicare-payment-system/.

[42] Dr. Mehmet Oz, CMS Administrator, speaking to America's Physician Groups Fall Conference, National Harbor (Nov. 5, 2025).

[43] Bradley et al., *Fractured Autonomy: The Cost of Orthopaedic Practice Consolidation*, 41 J. ARTHROPLASTY 631 (2026), https://doi.org/10.1016/j.arth.2025.11.008.

d. Sustained Medicare Cuts Have Greatest Negative Impact on Community-Based Small Businesses

A physician practice operates fundamentally as a small business. Operating a private clinic requires balancing clinical care with core business responsibilities, including startup capital, cash flow management, regulatory compliance and staffing. The average orthopaedic surgical practice employs five surgeons and an additional 30 support personnel, where members of the community are best positioned to serve community-specific orthopaedic needs.[44] As sustained RVU cuts make independent practices less sustainable and surgeons are driven to health system or health plan employment, communities will be negatively disrupted. Patients will have fewer choices in practices and health system-owned practices will not incorporate all displaced practice staff.

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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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Ryan Howe, Deputy Director, A-B, Center for Medicare

[44] Jeannette Y. Wick, *Taking a Closer Look at the Roles and Responsibilities of Orthopedic Surgical Group Managers*, MED. ECON. (2015), https://www.medicaleconomics.com/view/taking-a-closer-look-at-the-roles-and-responsibilities-of-orthopedic-surgical-group-managers.