September 23, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 2020

Re: Request Withdrawal of the Proposed 2027 Drastic 20% Reduction in Reimbursement to Surgeons Performing Hip, Knee and Shoulder Replacement Surgery on Medicare Beneficiaries

Dear Secretary Kennedy and Administrator Oz:

We write to request that the Centers for Medicare & Medicaid Services (CMS) reconsider the proposed more than 20% reduction in work relative value units (RVUs) for major hip, knee, and shoulder replacement procedures in the proposed 2027 Medicare Physician Fee Schedule. Specifically, we urge CMS to maintain the CY 2026 work RVUs for total knee arthroplasty (CPT 27447), total hip arthroplasty (CPT 27130), total shoulder arthroplasty (CPT 23472), and shoulder hemiarthroplasty (CPT 23470). We further urge that any future reimbursement adjustments be based on independent, procedure-specific observed data that accurately reflect physician work. We appreciate the Administration's commitment to reduce health care costs and help Americans live longer healthier lives, but we are deeply concerned that this proposed cut, which is more than double the size of the next largest specialty reimbursement cut in the proposed rule, will negatively impact innovation, system-wide cost savings, wait times, access and outcomes for the 1.5 million Medicare beneficiaries that rely on these surgeries every year to free them from the pain of osteoarthritis and return them to a healthier and mobile lifestyle.

Hip, shoulder and knee surgeons have been the highest participating specialists in CMS's alternative payment models; advancing patient care while saving the health system tens of billions of dollars. For more than a decade, these surgeons have helped drive the success of initiatives such as the Comprehensive Care for Joint Replacement (CJR) Model and BPCI Advanced, demonstrating that greater efficiency and lower total spending can be achieved without assuming that the physician work required to perform these complex procedures has diminished.

It was not long ago that patients would need over a week in the hospital to recover from lower joint replacement surgery. Orthopaedic surgeons have shifted substantial time and resources to working with the patient prior to surgery to optimize their health for the best possible surgical

outcome. Pre-surgical optimization focuses on the same interventions that the Administration has prioritized: managing diabetes, lowering body mass index and treating other chronic conditions that could complicate surgical outcomes. The importance of this additional work is reflected in dramatically shortened patient recovery times, and has paved the way for these procedures to be performed in the outpatient and ambulatory settings for the first time ever.

These improvements should not be interpreted as evidence that the physician work required to perform major joint replacement has diminished. A modest reduction in measured operative time does not necessarily mean a proportional reduction in physician work; greater efficiency can require the same or greater intensity, skill, and judgment. Similarly, migration from inpatient hospitals to outpatient settings does not mean that the underlying surgery or Medicare patient has become less complex. Advances in surgical technique, anesthesia, implants, pain management, preoperative planning, and recovery protocols have allowed appropriate patients to leave the hospital sooner without reducing the complexity of the procedure itself.

Importantly, an independent analysis conducted by ADVI Health using Medicare claims data found that patient severity and complexity remained consistent before and after these major joint replacement procedures migrated from the inpatient setting. The analysis found no evidence that the shift to outpatient care resulted in a less-complex Medicare patient population.

Further, United Health Group[1] estimated that shifting total hip and knee replacement surgeries alone to outpatient settings will save the healthcare system $70 billion over 10 years, including $30 billion in Medicare savings. These significant savings demonstrate the broader value created by advances in joint replacement care and the movement of appropriate procedures to lower-cost settings. This is a victory for value-based care, reducing costs and improving outcomes that should be supported.

At the same time, these surgeons have experienced significant cuts in recent years and now account for less than 5% of the overall cost of a hip or knee replacement, but they are the key to controlling costs in the other 95%. There are no further savings that can be extracted by cutting the physician, but much could be lost. The medical complications from even a modest increase in wait times, during which the Medicare beneficiaries' mobility is impaired, are far more costly to both the system and their quality of life. Despite generating enormous cost savings and clinical improvements through additional patient-centric work, orthopaedic surgeons have been subject to a series of cuts specifically targeting total lower joint replacement surgery, including a substantial 7.5% just last year. The fundamental flaw that has caused hip and knee surgeons reimbursement to be cut for these successes is that legacy fee-for-service systems do not capture value-based work. None of the critical patient pre-operative optimization, which can occur over weeks and months, is counted because it occurs more than 24 hours prior to the surgery. This year's proposed rule would also eliminate payment for the surgeon to visit their patient in the hospital post-surgery, even though roughly 50% of patients still need those visits. The burden of work is also shifted onto the physician for the 50% of patients that go home early, as the questions and post-operative guidance that would have been addressed by hospital staff in the past, is now being directed to the surgeon's office. The proposed rule further deepens the cuts by

[1] https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2025/2025-06-uhg-shifting-joint-replacement-surgeries.pdf

comparing joint replacement surgery to retina repair surgery and other incomparable procedures for a crosswalk. It's important to the future of our health care system that reimbursement adjustments be based on independent, procedure-specific observed data that reflect the modern practice of medicine that may not be counted under legacy fee-for-service valuations.

Approximately half of orthopaedic physicians continue to practice independently. They directly bear the costs of clinical staff, supplies, equipment, technology, and other practice expenses. They do not have hospital or facility revenue available to offset reductions in physician payment. If continued payment pressure accelerates consolidation or shifts more care into hospital-owned settings, Medicare may save money on the physician fee schedule while paying more elsewhere in the program. Further consolidation can also reduce patient choice and local competition. Once an independent practice closes or is acquired, that community-based capacity is extremely difficult to recreate.

We appreciate the Administration's focus on care coordination, managing chronic diseases, and supporting independent physician practices. Our request to maintain the CY 2026 work RVUs for CPT codes 23470, 23472, 27130, and 27447 for CY 2027 advances the Administration's goals to improve patient care, extend quality life years of our Medicare beneficiaries while saving the health care system billions of dollars. We further urge CMS to work with surgeons to develop a stable, evidence-based approach to valuation that reflects the actual time, intensity, complexity, and physician work involved in these procedures. CMS has the opportunity to break the headwinds that have stifled health care innovation for decades and invest in CMS's physician partners to the benefit of millions of Medicare beneficiaries.

We appreciate your consideration of this urgent request.

Sincerely,

Gregory F. Murphy, M.D.
Member of Congress

Greg Landsman
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Mike Kennedy, M.D.
Member of Congress

J. Luis Correa
Member of Congress

Earl L. "Buddy" Carter
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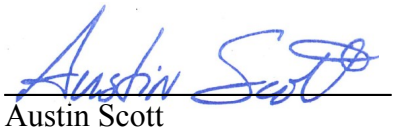

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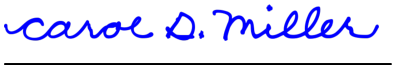

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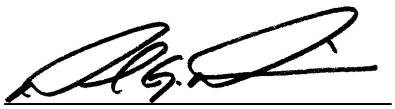

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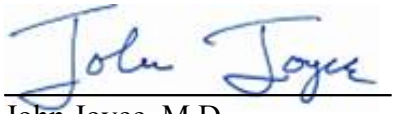

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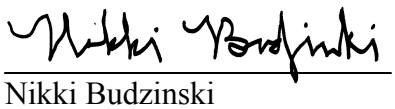

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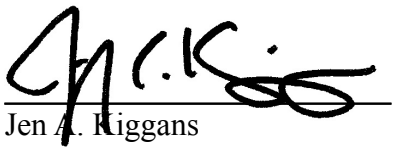

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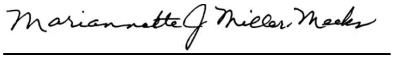

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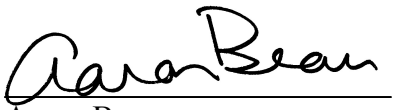

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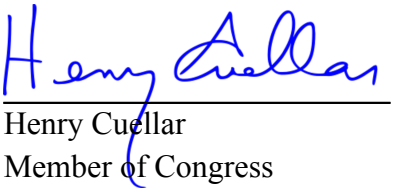

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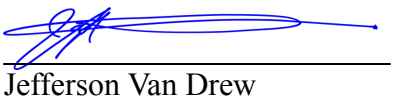

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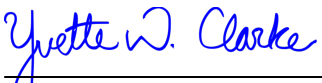

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