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AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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VIA ELECTRONIC FILING

Mr. Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5516-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services (CMS-5516-P)

Dear Mr. Slavitt:

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 proposed rule to establish a Medicare Comprehensive Care for Joint Replacement (CCJR) Model ("Proposed Rule").

AAHKS is the essential organization of more than 2500 hip and knee specialists, functioning to serve the needs of patients, care providers and policy makers regarding hip and knee health, including hip and knee replacement surgery. AAHKS's mission is to advance and improve hip and knee patient care through leadership in education, advocacy and research.

Our comments focus on the following provisions of the Proposed Rule:

General Comments

- AAHKS urges CMS to delay testing of the CCJR Model until at least October 1, 2016 or January 1, 2017.
- AAHKS does not agree with CMS that CCJR episode initiators be limited to hospitals. AAHKS recommends that CMS permit surgeons and other physicians with requisite skills and experience to participate in the CCJR Model as third-party conveners.
- AAHKS seeks clarification as to how hospitals participating in the initial 3 year term of the BPCI, which will end this year, will be treated under the CCJR Model.
- AAHKS urges CMS to make the CCJR Model voluntary so that all hospitals and surgeons/groups who would like to participate are able to do so.
- AAHKS recommends that CCJR episodes be solely based on elective total hip and total knee replacement procedures. To ensure that CMS is confining CCJR to these elective

procedures (and to facilitate additional adoption under BPCI) we urge CMS to create two new MS-DRGs that include only these elective total joint procedures. The other lower joint procedures can remain in MS-DRGs 469 and 470, although AAHKS suggests that CMS consider removing prosthetic treatment of hip fractures from MS-DRG 470 as this patient group is substantially different from other patient groups in MS-DRG 470.

- AAHKS recommends that all changes to the CCJR clinical boundaries (inclusion and exclusions of services/items) be made through formal rulemaking.

- AAHKS disagrees with CMS's proposal to wait and transition to regional only data in PY 5. AAHKS recommends that CMS allow participating hospitals to opt in to regional pricing earlier than PY 5 if the hospital desires to do so. While AAHKS urges CMS to allow such an opt in at PY 1, CMS should at least make such option available at PY 3.

- AAHKS agrees with CMS that 95 percent is a reasonable outlier threshold, provided that, as discussed above, total ankle procedures and hip fracture cases are removed from the CCJR Model. Total ankle should not be included in CCJR since the procedure is performed infrequently compared to total hip and knee replacement and it is performed on a different patient population.

- Although AAHKS understands CMS's need to apply a discount factor so that CMS may share in savings – AAHKS disagrees with the universal approach proposed by CMS. Instead, CMS must develop a method whereby hospitals treating high risk patients are rewarded when they achieve the same quality as those hospitals taking on only low risk patients.

- AAHKS reminds CMS that hospitals will ultimately rely on surgeons to ensure the voluntary patient-reported outcome measures data is collected and therefore asks that CMS confirm that surgeons may be compensated for such activities at CMS's estimated value of $75 per episode. Further, AAHKS asks that CMS confirm that any such payment would be treated separately from any gainsharing payments the surgeon may receive.

- AAHKS disagrees that only 30-40% of participating hospitals should be eligible for reconciliation payments. Instead, all participating hospitals should be eligible for at least partial reconciliation payments, subject to AAHKS's recommendations below.

- With respect to a participating hospital's eligibility for reconciliation payments, AAHKS suggests a hybrid model where participating hospitals are eligible for full or partial reconciliation payment and target price discounts, depending on whether they (1) achieve all three required metrics and report voluntary patient reported outcome measures, (2) achieve two of three required metrics and report voluntary patient reported outcome measures, or (3) achieve two of three required metrics but do not report voluntary patient reported outcome measures.

- If HCAHPS survey data is included as one of the measures, CMS must limit successful scores to patients that underwent a LEJR procedure at the hospital – rather than use hospital overall HCAHPS data as a benchmark of achievement. Clinicians performing LEJR should not be held responsible for HCAHPS scores for entire hospital.

- Rather than assume low-volume hospitals meet the quality threshold, AAHKS recommends that CMS create a separate scale to determine when low volume hospitals are entitled to receive reconciliation payments or exclude these hospitals from CCJR.

- As hospitals are already limited by the maximum reimbursement allowed for each procedure they perform, AAHKS urges CMS to remove the stop-gain limit from the CCJR Model.

- AAHKS asks that CMS allow flexibility for hospitals to choose with whom they partner under the CCJR Model and eliminate the restrictions on the definition of "CCJR Collaborator."

- AAHKS recommends that CMS remove all limits on gainsharing between participant hospitals and collaborators and instead allow hospitals and collaborators to freely negotiate the terms of their partnership.

- With respect to the $1,000 limitation on items and services involving technology provided to beneficiaries, AAHKS requests that CMS clarify the definition of "technology."

Our detailed comments are below.

I. Implementation Date – Delay Start Until October 1 – Consistent with IPPS

CMS proposes that it will begin testing the CCJR Model on January 1, 2016.

AAHKS urges CMS to delay testing of the CCJR Model to allow hospitals to adjust to the substantial volume of new requirements and issues implementation will present. In addition, it would allow CMS to provide each hospital with its cost data and allow sufficient time for hospitals to develop more cost-effective care pathways. These issues are described in the detailed comments below. Such delay would also allow CMS to collect and analyze adequate data from the BPCI model, which is likely to influence operation of the CCJR Model. Therefore, AAHKS recommends a delay in the start date until at least October 1, 2016. This would align CCJR with the FY for the Medicare Inpatient Prospective Payment System and may facilitate alignment of establishing target prices.

II. Episode Initiators: Conveners and Collaborators

In the Proposed Rule, CMS is proposing that only hospitals be the episode initiators and bear the financial risk under the CCJR Model. CMS would allow no other group to serve as episode initiators, and further would not allow third-party conveners to participate in the CCJR Model. AAHKS disagrees with CMS's proposal and recommends that CMS

- Permit surgeons and other physicians with requisite skills and experience to participate in the CCJR Model as episode initiators and conveners; and
- As discussed in detail below, allow additional entities/groups to participate as collaborators if they contribute to the redesign of systems, quality measures, data analysis even if these entities/groups do not directly provide services to patients.

AAHKS understands that CMS proposed to limit the episode initiator list to hospitals based on its reasoning that hospitals have the necessary infrastructure to provide care coordination. However, AAHKS disagrees with CMS's proposal to disallow third-party conveners from participating in the CCJR Model. In actuality, if CMS does not allow additional parties to participate as conveners, many of the hospitals may flounder, fail to hit the target price and the orthopedic surgeons and other post-acute providers will be unable to achieve savings. AAHKS reminds CMS that hospitals would be responsible for all aspects of the 90-day stay, even though upwards of 60% of the stay occurs outside the hospital. Most hospitals will not have the capability of managing such a task without substantial additional help from third parties (e.g.,

facilitating conveners under the BCPI). Indeed, many hospitals may not be equipped to redesign care for the 40% of the stay that occurs within the hospital. If orthopedic surgeons will bear the responsibility of a convener, they should be permitted to officially act as such, and share in the benefits received by hospitals.

III. Exclusion of Hospitals in BPCI Model

CMS proposes to exclude hospitals participating in the BPCI Model from participating in the CCJR Model.

CMS does not acknowledge in the Proposed Rule that the first 3 year period of the BPCI Model will be ending this year. AAHKS seeks clarification as to how hospitals participating in this initial term will be treated under the CCJR Model. Specifically, we seek confirmation whether these hospitals will be rolled into the CCJR model.

IV. MSA Selection Methodology - Make CCJR Voluntary Across the Country

CMS proposes to select hospitals for mandatory participation in the CCJR Model based on geographic region. In determining which geographic regions would be subject to selection, CMS focused on MSAs, which have an urban population of at least 50,000. Any hospital paid under IPPS located in a county in an MSA selected through stratified random sampling methodology would be required to participate in the CCJR Model.

AAHKS disagrees with the premise of CMS's methodology – that is, that participation must be mandatory for certain hospitals. Instead AAHKS urges CMS to make the CCJR Model voluntary. There are many hospitals selected for mandatory participation that are ill-equipped to participate in the CCRJ Model. Further, there are likely just as many hospitals not within a selected MSA that would like to participate. Therefore, we recommend that participation in CCJR be voluntary – not mandatory and be open to any hospital or physician group as discussed above.

V. CCJR Episode – CMS Should Limit CCJR to Elective Total Knee and Total Hip Replacements

CMS proposes to base the CCJR Model on episodes of care that begin with a hospital stay classified into one of two MS-DRGs, 469 and 470. CMS acknowledges that hip fracture cases and total ankle procedures are included in these DRGs and notes that the resources are much different for these procedures. Nevertheless, CMS declined to alter the MS-DRGs or use ICD codes as the basis for CCJR.

AAHKS urges CMS to reconsider using these two MS-DRGs without modification. Specifically, AAHKS recommends that CMS create two new MS-DRGs specifically for elective total hip and knee replacement procedures and keep the unrelated lower extremity procedures, such as total ankle procedures and hip fracture procedures, which involve different resources and patients with more complex medical problems in MS-DRGs 469 and 470. The only appropriate procedures for the CCJR Model are elective total knee and total hip procedures. Alternately, CMS should base the episodes in CCJR on the ICD codes for these procedures. AAHKS does not believe this will cause any hardship. Contrary to CMS's belief, procedure codes are broadly accepted and widely understood.

VI. Clinical Boundaries – What is In and What is Excluded from Episode

CMS proposes to include specified services in each CCJR episode. Likewise, CMS proposes to exclude certain services in each CCJR episode. Further, CMS proposes that it will update services excluded from CCJR episodes on an annual basis without rulemaking, to reflect annual

changes to ICD-CM coding and annual changes to the MS-DRGs under the IPPS, as well as to address any other issues brought to its attention by public input throughout the course of the model test.

While AAHKS recognizes the need for CMS to update the list of excluded services, its proposal is far too broad. Foregoing rulemaking, in particular to address "any other issues," grants CMS inappropriately broad authority. AAHKS recommends that all changes to the CCJR clinical boundaries be made through formal rulemaking with the opportunity for stakeholder comment.

VII. Target Price Setting – Allow Hospitals to Opt-In to Regional Targets Early

In the Proposed Rule, CMS proposes to establish a two-sided risk model for hospitals participating in the CCJR Model and provide episode reconciliation payments to hospitals that meet or exceed quality performance thresholds and achieve cost efficiencies relative to CCJR target prices established for them, as defined in the Proposed Rule. Similarly, CMS proposes to hold hospitals responsible for repaying Medicare when actual episode payments exceed their CCJR target prices beginning in PY 2 and continuing through PY 5. CMS does not propose to set target prices based solely on historical hospital-specific data but rather intends to use a blend of historical hospital-specific and regional-historical claim data. CMS proposes to transition to using regional only data to set targets by PY 5. CMS asserts this approach will afford early and continuing incentives for both efficient and less efficient hospitals to furnish high quality, efficient care in all years of the CCJR Model.

AAHKS disagrees with CMS's rationale for waiting to transition to regional only data until PY 5. Contrary to CMS's assertions, this approach affords no incentive to efficient hospitals. Indeed, efficient hospitals will be penalized – through lack of payment – for their efficiency until PY 5. In particular, as hospitals perform well and become more efficient, their individual targets will become harder and harder to reach. Therefore, AAHKS recommends that CMS allow participating hospitals to opt in to regional pricing earlier than PY 5. While AAHKS urges CMS to allow such an opt in at PY 1, CMS should at least make such option available at PY 3.

VIII. High Cost Cases – Outlier Threshold

In recognition that hospitals may have limited ability to moderate spending for certain high cost cases, in setting target prices, CMS proposes to set a high outlier limit at two standard deviations above the regional average episode cost. Individual episode costs that exceed the high outlier limit would be truncated to that limit so hospitals' downside risk would be limited.

AAHKS agrees with CMS that 95 percent is a reasonable outlier threshold, provided that, as discussed above, total ankle procedures and hip fracture cases are removed from the CCJR Model.

IX. Medicare Discount Factor – Hospitals and Surgeons Treating High Risk Patients Should be Rewarded

Per the Proposed Rule, CMS intends to apply a 2 percent discount factor when setting an episode target price for a participant hospital. Under this proposal, in PY 2, a hospital that achieves CCJR actual episode payments below a target price based on a 2 percent discount would retain savings below the target price, assuming the quality thresholds for reconciliation payment eligibility are met.

Although AAHKS understands CMS's purpose for applying a discount factor – so that CMS may share in savings – AAHKS disagrees with the universal approach proposed by CMS. Instead, CMS must develop a method whereby hospitals and surgeons treating high risk patients are rewarded when they achieve the same quality as those hospitals taking on only low risk

patients. To fail to do so will undoubtedly disturb patient access for high risk patients. In effect, by failing to reward hospitals and surgeons who treat high risk patients at the same level of quality as those treating low risk patients, CMS will force hospitals to treat only low risk patients. Hospitals will simply be unable to afford to care for high risk patients under the currently proposed methodology.

X. Patient-Reported Outcome Measures

Although CMS proposes to apply a discount factor for repayment and reconciliation, it caveats that hospitals may earn additional discounts for reporting quality measures. In particular, CMS proposes to add a voluntary option to track patient-reported outcome measures. For hospitals that submit the voluntary data, CMS will reduce the discount used to set the target price from 2.0 percent to 1.7 percent.

A. Surgeon's Role in Collecting Measures

AAHKS reminds CMS that hospitals will ultimately rely on surgeons to ensure the voluntary data is collected. Indeed, surgeons will be responsible for collecting the majority of the data prior to the patient even being admitted to the hospital. CMS fails to acknowledge this role surgeons will provide to participating hospitals.

Recognizing the surgeon's part in collecting patient-reported outcome measures data, AAHKS asks that CMS confirm that surgeons may be compensated for such activities. Indeed, CMS has estimated that "value" of gathering this data is about $75 per episode. We recommend that CMS pay this amount directly to the surgeon or group reporting the data, separate from the episode – rather than providing the discount to the episode. If CMS does not agree to pay this amount separately to the surgeon, AAHKS asks that CMS confirm that any such payment for reporting voluntary data would be treated separately from any gainsharing payments the surgeon may receive.

B. Selecting Patient-Reported Outcome Measures

Finally, the patient outcome data requested by CMS is not ideal. Comments for consideration specific to selected measures are as follows:

- PROMIS Global (all items) and VR-12 (all items) – since these surveys are both focused on general patient health, please consider having hospitals report one or the other but not both to mitigate the burden on patients filling out multiple surveys.
- KOOS75 (all items) – this is a 40 question survey and is very time intensive for patients to complete, particularly with all the other questions that are proposed to be asked of patients. Utilizing surveys that require more than a few minutes to complete is particularly challenging in the proposed post-operative timeframe. Please consider the shorter form KOOS JR, a 7 question version of the KOOS, to increase compliance.
- HOOS76 (all items) – this is a 40 question survey and is very time intensive for patients to complete, particularly with all the other questions requested of patients. Utilizing surveys that require more than a few minutes to complete is particularly challenging in the proposed post-operative timeframe. Please consider the shorter form HOOS JR, a 6 question version of the HOOS, to increase compliance.

We recommend that CMS work with AAHKS and AAOS and identify orthopaedic groups to identify the most feasible and clinically valuable data to collect. In fact, important work on this topic is already underway. On August 31, 2015, AAHKS convened a Patient Reported Outcomes Summit for Total Joint Arthroplasty that was attended by representatives from orthopedic 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 payers, and other stakeholders. The Summit's goal was to obtain a consensus regarding the patient-reported outcomes and risk variables suitable for total hip and knee arthroplasty performance measures, and the consensus recommendation of the represented orthopedic organizations is attached to this comment letter (Attachment 1).

XI. Quality Measures and Reconciliation Payments

CMS proposes to link the reporting of three quality measures to eligibility for a reconciliation payment. The proposed three measures to determine hospital quality of care and eligibility for a reconciliation payment are as follows:

- Hospital-level 30-day, all cause Risk-Standardized Readmission Rate (RSRR) following elective primary THA or TKA, claims-based measure
- Hospital-level Risk-Standardized Complication Rate (RSCR) following elective THA or TKA, claims-based measure
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure

CMS proposes to make reconciliation payments only to those CCJR hospitals that meet the performance threshold for reporting quality measures and other requirements. Among the criteria CMS proposes to use to determine if a participant hospital qualifies for a reconciliation payment is:

- The hospital's measure result is at or above the 30th percentile (in PYs 1-3) or 40th percentile (in PYs 4 and 5) of the national hospital measure results calculated for all Hospital Inpatient Quality Reporting program participant hospitals for each of the three measures.

A. Reconciliation Payment Thresholds

AAHKS believes it is unfair of CMS to adopt a CCJR Model in which 60% of hospitals do not receive reconciliation payments. Such a threshold is both onerous and unfair. No rationale is provided in the Proposed Rule for using a 30th percentile threshold for PYs 1-3 apart from the fact that this level is also used in the Medicare Shared Savings Program (MSSP). We believe the CCJR and MSSP are materially distinct in several respects that do not justify the assumed use of the same quality measure performance threshold. Unlike the CCJR, the MSSP is voluntary and incorporates improved performance on quality metrics in the payment methodology.

Further, we do not agree with the use of a hospital's risk-adjusted point estimate to calculate the national percentiles. We believe that a better approach of assessing a particular hospital's performance is within a confidence interval, which is how the measure was originally designed and endorsed by the National Quality Forum. Even though the Affordable Care Act requires that

point estimates be used to calculate performance under the Hospital Readmissions Reduction Program, there is no such requirement for the CCJR.

We recommend, instead, that CMS establish performance thresholds to qualify for reconciliation payments through the use of broad categories. Specifically, we recommend that there be three categories for performance: "no different than the national rate," "better than the national rate," and "worse than the national rate." Hospitals that are "better than the national rate" or "no different than the national rate" would automatically be deemed eligible for any potential savings.

B. Patient Experience Measure

Importantly, in order for this hybrid model to work, or any model under which CMS would determine eligibility for reconciliation payments, CMS must first revise its proposed application of the third measure. In particular, CMS proposes to use the HCAHPS survey as one of the measurements to determine a hospital's eligibility for reconciliation payments. AAHKS supports the use of patient feedback to evaluate quality of care. However, the HCAHPS survey is given to a random sampling of all hospital patients. Therefore, the results that would be reported under the CCJR Model would relate to all hospital patients, rather than those whose treatment is subject to the Model. In addition HCAHPS only assesses the patient inpatient experience which does not reflect on the whole 90 day episode of care. CMS should require a survey that looks only at patients undergoing elective total hip and elective total knee procedures, or possibly even completely eliminate it as a quality measure.

C. Incremental Incentive Structure

We appreciate that CMS's goal of these metrics is to create an incentive structure that encourages hospitals and providers to improve performance. However, the proposed structure is an all or nothing system that does not reward incremental achievement. CMS acknowledges in its other quality measurement programs that it is problematic to pay providers based on small performance differences that are not meaningful. A more nuanced approach that would reward a wider range of hospitals that make some progress on their metrics should be structured. However, we strongly believe that HCAHPS scores should be limited to total joint arthroplasty patients or completely eliminated as a measure of quality.

A more nuanced approach that would reward a wider range of hospitals that make some progress on their metrics should be structured. However, as stated in B. Patient Experience Measure, we strongly believe that HCAHPS scores should be limited to total joint arthroplasty patients or completely eliminated as a measure of quality.

- If a hospital achieves the targets on all three metrics and voluntary metrics are submitted, then the participating hospital is eligible for reconciliation payments and the 0.3 Target Price discount.
- If two of the three metrics are achieved and voluntary metrics are submitted, then the participating hospital is eligible for partial reconciliation payments and Target Price discount is given.

- If two of the three metrics are achieved and voluntary metrics are not submitted, the participating hospital is eligible for a partial reconciliation payment but not a Target Price discount.

This hybrid model fully rewards the highest functioning hospitals while not discouraging those who are making necessary changes over time.

D. Performance Periods

AAHKS believes that the rolling three year average of measure performance periods should be changed so that the first two performance years are pay-for-reporting, allowing hospitals that submit data to be eligible for savings. Under the current proposal, hospitals penalized in the first year will continue to be penalized in later years without an opportunity to demonstrate improvement. Hospitals should be given enough time to implement quality improvement strategies, and the three months that hospitals would have to improve on quality measures in the first year under the current proposal is simply not enough.

XII. Low Volume Hospitals – No Free Pass/Assumption on Performance

In connection with the requirement to report quality measures as a prerequisite for obtaining reconciliation payments, CMS proposes to treat hospitals with insufficient volume to determine performance as if they are performing at the threshold level.

AAHKS disagrees with CMS's proposal. If CMS bases reconciliation payments upon performance, there is no need to provide any hospital with a pass on providing quality care. Instead, AAHKS urges CMS to create a new scale for low volume hospitals, and those hospitals must be measured by that scale when CMS determines if they are entitled to a reconciliation payment.

XIII. Stop-Gain Limit Payments to Physicians Should Be Eliminated

CMS proposes to place a 20 percent stop-gain limit on all reconciliation payments to hospitals. Specifically, for all five PYs CMS is proposing to limit reconciliation payment to 20 percent of a participating hospital's target prices for each MS-DRG multiplied by the number of the hospital's episodes for that MS-DRG.

AAHKS urges CMS to remove this stop-gain limit from the CCJR Model. There are sufficient safeguards within the system such that the stop-gain limit is unnecessary.

XIV. CCJR Collaborators and Gainsharing Payments: Proposed Limits Unnecessary

In the proposed rule, CMS recognizes that participant hospitals may want to partner with providers and supplier to share in the risks and rewards (gainsharing) under the CCJR Model. However CMS proposes to allow only certain providers to share in the savings and take on risk. Specifically, CMS is proposing to limit gainsharing and risk assumption to providers engaged in caring for CCJR beneficiaries, if those providers have a role in the hospital's episode spending or quality performance. CMS refers to these providers as "CCJR Collaborators." Collaborators would include the following:

- Physicians
- SNFs
- HHAs
- LTCHs
- IRFs
- Physician Group Practices (PGPs)
- Non-physician practitioners (NPPs), and outpatient therapy providers

AAHKS does not agree that hospitals be limited to choosing only certain providers to partner with under the CCJR Model. In order for hospitals to successfully perform under the CCJR Model, hospitals will require the flexibility to make decisions as to how to operate. This includes the flexibility to choose with whom they would partner. The CCJR Model would simply be too difficult for participating hospitals to navigate if collaborators are limited as CMS has proposed. AAHKS therefore asks CMS to allow flexibility for hospitals to choose with whom they partner under the CCJR Model.

CMS proposes a host of requirements for financial arrangements between participant hospitals and collaborator providers. Many are similar to or based on requirements under existing demonstration projects, such as BPCI Model 2. In outlining the requirements, CMS proposes to define key terms applicable to the CCJR model as follows:

- CCJR sharing arrangement means a financial arrangement between a participant hospital and a CCJR collaborator for the sole purpose of sharing: (1) CCJR reconciliation payments; (2) the participant hospital's internal cost savings; (3) the participant hospital's responsibility for repayment to CMS.
- Gainsharing payment means a payment from a participant hospital to a CCJR collaborator under a CCJR sharing arrangement, composed of only reconciliation payments, internal cost savings, or both.
- Internal cost savings means the measurable, actual, and verifiable cost savings realized by the participant hospital resulting from care redesign undertaken by the hospital in connection with providing items and services to beneficiaries within specific CCJR episodes of care. Internal cost savings does not include savings realized by any individual or entity that is not the participant hospital.
- Alignment payment means a payment from a CCJR collaborator to a participant hospital under a CCJR sharing arrangement.

With respect to gainsharing payments to physician group practice collaborators that have signed a sharing arrangement, CMS proposes that payments may only be shared with physicians or NPPs that actually furnished services to the CCJR beneficiary during the year involved and a physician group practice must stipulate that the physician group practice may not retain any portion of a gainsharing payment or distribute any portion to a physicians that did not furnish a service to a CCJR beneficiary. CMS also states that hospitals may not distribute amounts under CCJR sharing arrangements that are not internal cost savings/reconciliation payments and internal cost savings may not reflect "paper" savings from accounting conventions or past investment in fixed costs. CMS is also proposing that total gainsharing payments for a year to an individual physician or group practice may not exceed 50 percent of the total approved physician fee schedule payments for services furnished to CCJR beneficiaries.

AAHKS also opposes the gainsharing limit CMS proposes to place on physician group and individual physician collaborators. CMS proposes that the total gainsharing payment to physician collaborators may not exceed 50 percent of the total approved amounts under the Physician Fee Schedule during a CCJR episode by that physician or non-physician practitioner. Further CMS proposes that participant hospitals must retain at least 50 percent of its

responsibility for repayment to CMS and that Alignment Payments from any one collaborator may not exceed greater than 25 percent of the repayment amount reflected on the participant hospital's annual reconciliation report.

AAHKS recommends that CMS remove all the above limits and allow hospitals and collaborators to freely negotiate the terms of their partnership. AAHKS specifically disagrees with the limits on gainsharing imposed on the primary physician surgeons. These physicians will have expanded responsibility and data collection duties and will play a critical role in redesigning care. These physicians should be adequately compensated for the additional time and work involved in CCJR and AAHKS believes that the surgeon/physician should not be subject to the same gainsharing limits as other collaborators.

XV. Beneficiary Incentives

CMS proposes to allow participating hospitals (not CCJR collaborators) to provide certain patient incentives to beneficiaries in the CCJR model provided the incentive, item or service is reasonably connected to the beneficiaries' medical care. CMS specifies that any items and services involving technology provided to beneficiaries may not exceed $1,000 per beneficiary per CCJR episode. AAHKS requests that CMS clarify the definition of "technology." For example, does technology include only medical equipment or may technology include smart phones, smart watches or ride services such as Uber, which are utilized via smartphone applications? AAHKS also questions why CMS allows hospitals but not collaborators to provide incentives to CCJR beneficiaries. Such a limitation may thwart the ability of physicians and post-acute providers to ensure beneficiary adherence to follow-up care.

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AAHKS appreciates your consideration of our comments. You can reach me at mzarski@aahks.org, or you may contact Joshua Kerr at jkerr@aahks.org.

Sincerely,

Michael J. Zarski, JD
Executive Director
AAHKS