University of Wisconsin Hospital and Clinics
University of Wisconsin Medical Foundation

600 Highland Avenue
Madison, WI, 53792

Mr. Andrew M. Slavitt
Centers for Medicare & Medicaid
Department of Health and Human Services
Attention: CMS-1656-P
Submitted electronically at http://www.regulations.gov

Dear Mr. Slavitt:

On behalf of the University of Wisconsin Hospitals and Clinics Authority (UW Health), we thank you for the opportunity to offer comments on the Medicare Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule for calendar year 2017, which contains multiple proposals of interest to our organization.

UW Health is comprised of the academic health care entities of the University of Wisconsin-Madison: University of Wisconsin School of Medicine and Public Health, University of Wisconsin Medical Foundation, University of Wisconsin Hospitals and Clinics, SwedishAmerican Health System and UW Health ACO. UW Health offers a network of primary and specialty care clinics throughout south-central Wisconsin and beyond, and provides access to more than 1,400 primary and specialty care physicians. Our physicians comprise the medical staff of UW Hospitals and Clinics and also provide services at other hospitals in the region. UW Health currently participates in the Medicare Shared Savings Program (MSSP). We appreciate your consideration of the following comments.

Section X.A. Implementation of Section 603 of the Bipartisan Budget Act of 2015

At UW Health, we are striving to achieve the triple aim: improve population health, improve care for individuals, and lower costs through these care improvements. As an organization, we have made careful, thoughtful steps to integrate UW Health in the communities across south central Wisconsin with the triple aim in mind. As a result, we are especially understanding of the concerns that led to Section 603 of the Bipartisan Budget Act and support

overall efforts to achieve a community-wide balance between the health care infrastructure afforded through a hospital setting with the access of a physician's office. We understand that federal policymakers have a role in assuring the diversity of health care services available in communities throughout the United States, and appreciate the multiple market forces at play. This includes the Center for Medicare and Medicaid Services' (CMS) critical role in implementing this significant statute change. As CMS states in the rule, the "proposals are made in accordance with our belief that section 603 of Public Law 114-74 is intended to curb the practice of hospital acquisition of physician practices that then result in receiving additional Medicare payment for similar services." In anticipation of CMS's proposed rule, we have amended and accounted for existing plans to expand or relocate currently excepted services to new facilities that will not be paid under the OPPS payment system.

However, we are concerned that specific aspects of CMS's proposal to implement Section 603 are unnecessarily restrictive and do not meet CMS's stated interpretation of statutory intent -- to moderate the incentives for hospital-based services. Moreover, we believe these aspects severely restrict a hospital's ability to make reasonable adjustments to the delivery of patient care within existing limits. Specifically, the proposal to prohibit the relocation of excepted services, even if those services are moving to a currently excepted facility, undercuts our ability to make changes that are critical to patient care, such as limiting unnecessary patient travel from one facility to another for certain tests and lowering costs by allowing two programs to use one shared testing facility. For example, in order to maximize the use of our existing space and staff, we are planning to relocate our cardiac care unit from one provider-based facility to another. However, these services are not within an existing clinical family of services currently being provided at the new location. Under CMS's proposal, the cardiac services would then be paid under the new applicable payment system, rather than the OPPS. It is important to note that UW Health is not proposing to expand its physical footprint in this relocation; we are simply maximizing the utility of existing resources. If we are not able to move these services, we do not believe the community-based physicians have the capacity to pick up the excess patient demand. The end result is that patient care will be sacrificed for negligible savings to Medicare and no promotion of physician practice capacity. CMS's proposal seems to broaden the statutory restrictions in a way that doesn't meet Congressional intent, and we strongly recommend that the agency revise its proposal. Specifically, we recommend permitting hospitals

to relocate currently excepted services to an excepted facility even if it expands the clinical family of services available at the excepted facility.

Similarly, we are concerned that CMS is not anticipating natural evolution of patient care that could require relocation that does not overlap or interact with the provision of services through physician practices. For example, when new technology comes on the market and offers innovations in patient care, hospitals have better access to resources than physician practices to adopt the new technology. In some cases, accommodating these technologies could be a reason to relocate services in order to ensure patients have access to the highest levels of care. We do not expect patient demand for these services to be met in the physician practice setting.

In addition, we have some technical concerns with the implementation of the new billing system for 2017. Under the Physician Fee Schedule, there are two modifiers for professional (modifier 26) and technical (modifier TC) services. It is unclear to us whether UW Health facilities that move to the new PFS billing system will be permitted to bill or whether the physician services would be billed at the global rate, leaving UW Health to work out internal agreements for the physician vs. technical services. Our facilities will certainly incur costs for the services that are provided under the new system and should be permitted to claim some portion of reimbursement for these services. Furthermore, CMS fails to provide any clarity around the addition of new CPT codes for billing purposes or explain, in detail, how providers will be required to bill these claims next year and in future years.

Section XV. Transplant Outcomes: Restoring the Tolerance Range for Patient and Graft Survival, and Section XVI. Organ Procurement Organizations (OPOs); Changes to Definitions; Outcome Measures; and Document Requirements

We also appreciate the opportunity to comment on CMS' proposals to make modifications to the tolerance range for patient and graft survival, as well as proposals to harmonize CMS definitions and requirements with what are currently the standard at UNOS and the OPTN. At UW Health, we have a long history of developing innovative approaches to donation and transplant, and the UW Organ and Tissue Donation consistently ranks in the top five of organ procurement organizations for donation rate across the country. We have transplanted more than 13,000 organs since our inception in 1966, and continue to be committed

to being a leader in increasing organ donation rates and improving outcomes for patients who receive transplanted organs through our program.

With that in mind, we agree with the changes being proposed by CMS to change the performance threshold from 1.5 to 1.85 for all organ types as well as for both graft and patient survival. Moreover, we agree with CMS' decision to apply that threshold across all organ types. Although there is a statistical difference in ideal thresholds for various organs – as evidenced by the data CMS has included in the proposals – we agree with CMS that it would create too much complexity and create an undue burden for transplant programs if individual thresholds were set.

In addition, we are pleased to see the proposal by CMS to revise the definition of "eligible death" to align with the updated definition approved by the Organ Procurement and Transplantation Network (OPTN) and scheduled to go into effect in January of 2017. The current definition's maximum age for donation and the exclusion of patients with Multi-System Organ Failure (MSOF) has meant that up to 30% of potential donors in our donation service area (DSA) are not eligible to donate. We believe that the new definition will go a long way toward capturing a portion of those otherwise eligible to donate, though it is not clear that these revisions alone will be sufficient to fully capturing the otherwise eligible population.

We note that we agree with the proposal by CMS to align with the OPTN/Scientific Registry of Transplant Recipients (SRTR) aggregate donor yield metric, as the current CMS regulation only captures a small number of characteristics, leading to far less accurate measures for performance. The proposal notes that CMS intends to revise the other OPO measures at a future date. We believe that such revisions have the potential to have a positive impact and look forward to learning more about which measures are being considered for revision and when.

Finally, we strongly agree with the proposal by CMS to revise the requirements for documentation of donor information to be copied and included with the organ being transported for transplant. The current requirements create an undue administrative burden and are duplicative as the information is readily available electronically. We agree with CMS' proposal to continue to require paper documentation of blood typing and infectious disease information when an organ is transported for transplant.

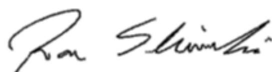
Section XVIII. Proposed Changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs

UW Health continues to support efforts to increase and improve the use of electronic health records, as EHRs have the potential to improve patient care and are a key tool for managing population health. CMS has made several proposals that will simplify the program and make it more consistent with the Quality Payment Program for eligible professionals. The Agency proposes to lower the reporting thresholds for eligible hospitals for the remaining Modified Stage 2 measures for 2017 and Stage 3 measures for 2017 and 2018 for eligible hospitals and critical access hospitals attesting under the Medicare EHR Incentive Program. Many of the threshold requirements presented challenges for hospitals. For example, interoperability depends on vendors and measures that require actions by patients are beyond the control of a provider. CMS is also proposing to change the EHR reporting period in 2016 to any continuous 90-day period for returning eligible physicians and hospitals that have demonstrated meaningful use in a prior year. This provides needed flexibility during a time when the Meaningful Use and Certified Health Technology Certification programs are undergoing significant change.

We appreciate CMS's consideration of stakeholder concerns and encourage CMS to finalize these proposals to reduce burden and align with the Quality Payment Program. Furthermore, we suggest that CMS align EHR incentive programs in both Medicare and Medicaid to mitigate confusion in the different reporting standards.

Thank you for your consideration of our comments, and we would be happy to discuss this with you further.

Sincerely,



Ron Sliwinski
Chief of Hospital Division & President, University Hospital

Bob Flannery, CPA
SVP, Chief Financial Officer, CAO UWMF