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Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1656-P; FY 2017 Medicare Proposed Hospital Outpatient Prospective Payment System Rule

Dear Mr. Slavitt:

As Senior Vice President for Community and Population Health at NewYork-Presbyterian ("NYP"), I appreciate the opportunity to comment on the Medicare Fiscal Year ("FY") 2017 proposed Hospital Outpatient Prospective Payment System ("OPPS") rule, published in the Federal Register on July 14, 2016. NewYork-Presbyterian is one of the nation's largest and most comprehensive hospitals, with over 2,600 beds, 6,500 affiliated physicians, 20,000 staff, and 2 million inpatient and outpatient visits annually.

I. Implementation of Section 603 of the Bipartisan Budget Act

The Centers for Medicare and Medicaid Services ("CMS") has made a number of proposals to implement Section 603 of the Bipartisan Budget Act ("BiBA"). As you know, Section 603 established that items and services furnished in "off-campus" provider-based departments ("PBDs") will no longer be paid Medicare OPPS rates effective January 1, 2017, except for (a) dedicated emergency department services, (b) PBDs located within 250 yards of a remote location of a hospital facility, and (c) off-campus PBDs that were billing under the OPPS prior to November 2, 2015.

Unfortunately, CMS's treatment of the third category of excepted off-campus PBDs, those billing prior to November 2, 2015, would reduce access to care for Medicare and Medicaid beneficiaries in our community. Specifically, CMS's proposals strictly curtailing expansion of services at existing off-campus PBDs and prohibiting these PBDs from relocating are overly broad and not tailored to the policy problem CMS has stated it is attempting to address. We urge CMS to adopt exceptions to Section 603 that would preserve access to needed services for beneficiaries.

A. CMS Should Permit Relocation of Certain Excepted Off-Campus PBDs

NewYork-Presbyterian maintains a broad ambulatory footprint in New York City, with over 200 full-time providers across 51 locations delivering over 670,000 services every year. This work is closely tied to our mission as an academic medical center and safety net provider – in 2015, 84 percent of NYP's ambulatory volume was attributed to Medicare and/or Medicaid patients. Moreover, our PBDs serve as the home to over a dozen NYP community initiatives, such as the Family PEACE Trauma Treatment Center for women and children exposed to domestic violence, New York State designated HIV Centers of Excellence, the Teen Age Pregnancy and Parenting Program ("TAPP") serving pregnant adolescents and their children, the Reach out and Read literacy program, the Outreach Program targeting screening and health literacy activities to uninsured and underinsured members of our community, and the anti-childhood obesity program, Choosing Healthy and Active Lifestyles for Kids (CHALK).

Under CMS's proposed interpretation of BiBA Section 603, NewYork-Presbyterian has nine ambulatory locations that would be defined as off-campus PBDs currently excepted from Section 603 because they were billing prior to November 2, 2015. These sites are all located in leased office space, more than 250 yards away from any remote locations of NYP hospital facilities. They were created in these off-campus sites, in fact, precisely for the purpose of being located outside the hospital, in the communities where our patients live. In 2015, these nine locations provided over 230,000 visits primarily to Medicare and/or Medicaid patients in the following service areas:

- Primary care;
- Pediatrics;
- Psychiatry;
- Obstetrics/gynecology;
- Nutrition;
- Urgent care;
- HIV/AIDS;
- Family planning;
- Geriatrics;
- Infectious disease;
- Dental;
- Domestic violence services;
- Internal medicine; and
- Medicine sub-specialties, including urology, podiatry, neurology, endocrinology, cardiology, and gastroenterology.

CMS's proposed bar against relocation of any existing off-campus PBDs puts these nine PBDs in immediate jeopardy, given that the hospital does not own their office space, a common practice in urban areas. Not only are these PBDs critical to the communities they serve – vulnerable populations such as behavioral health patients, victims of domestic violence, low-income elderly, and HIV/AIDS patients – they are critical to the hospital's population health initiatives, such as reducing hospital readmissions, improving care transitions and care coordination, and participating in the Medicare Shared Savings Program and the New York State Delivery System

Reform Incentive Program. In fact, all nine locations are Level III patient centered medical homes, designated by the National Committee for Quality Assurance ("NCQA").

As with any lease of property, the continued viability of each of these PBDs at its current location is limited to the finite term of the lease and, thereafter, is subject to the willingness of a landlord to negotiate an extension of a lease on commercially reasonable terms. In practical reality, CMS's proposed regulation would actually enhance a commercial landlord's leverage in any negotiations on a lease extension, given the hospital's inability to consider alternative locations outside of a 250-yard radius, potentially resulting in above-market rents and other landlord-favorable terms. Moreover, particularly where, as in our case, a PBD is located in an older building with aging building systems and dated space configurations, the suitability of that leased space for the PBD's efficient delivery of its services to meet its current needs must be taken into account. By way of example, the lease for one of NYP's PBDs is scheduled to expire in 2017. Initial estimates of capital upgrades required to maintain the building infrastructure of this PBD in a safe and effective manner exceed $4 million and would require closure of the clinic for a period of six to twelve months. In such instances, the PBD, its delivery of quality patient care and the best interest of the Medicare program, all would be better served by seeking an alternative location (which may not be within the 250 yard radius) and utilizing competition in the local leasing market to secure the best financial deal for the best available space.

We appreciate CMS's stated policy rationale for the bar on relocation of existing off-campus PBDs – that "hospitals would be able to relocate excepted off-campus PBDs to larger facilities, purchase additional physician practices, move these practices into the larger relocated facilities, and receive OPPS payment for services furnished by these physicians." (81 Fed. Reg. 45684) CMS's proposed policy for preventing that outcome, however, is overly broad and involves too many other PBDs, such as NYP's nine leased sites, whose ability to potentially relocate would be in the best interest of the Medicare program.

In addition, although CMS points to the existing definition of PBDs at 42 C.F.R. § 413.65 as a "guide" in crafting its proposals to implement Section 603, the agency's proposed bar against relocation is inconsistent with those rules. As CMS itself notes in the proposed rule, the existing regulatory definition of a PBD "includes both the specific physical facility that serves as the site of services" and "the personnel and equipment needed to deliver the services at that facility." (81 Fed. Reg. 45683) Honing in on and freezing in time one element of a PBD, the physical facility, is shortsighted for the reasons articulated above, as would be any requirement that hospitals never change the personnel or equipment they use at an off-campus PBD, irrespective of whether such changes operate to better serve its patients.

We therefore recommend that CMS adopt exceptions to its bar against relocation for existing off-campus PBDs in cases where the relocation is due to the expiration of a lease, related leasing cost considerations, life safety code issues, the need (and associated cost) to comply with City, State, or Federal laws (e.g., compliance with the Americans with Disabilities Act ("ADA")), or other public health or safety issues. Rather than creating a cumbersome new process for federal exceptions approval that will be difficult and expensive to administer, CMS should rely on a hospital attestation process, similar to the one currently in place for PBDs under 42 C.F.R. § 413.65, under which the CMS Regional Offices could review hospitals' disclosure of relocation

and attestations that substantially the same services and providers would be in place at the relocated site. Moreover, we strongly recommend that CMS provide a path for future exceptions to be made, to provide the agency with flexibility should the competing policy goals of "site neutrality" and population health require balancing.

B. CMS's Strict Anti-Expansion Proposal Ignores Beneficiary Priorities

CMS's proposal to restrict an existing excepted off-campus PBD from expanding services is a heavy-handed and short-sighted policy that ignores the best interests of Medicare beneficiaries and the efforts of off-campus PBDs to meet their clinical and social needs. Again citing the need to prevent hospitals from "converting" services furnished in physicians' offices into OPPS-paid services, CMS proposes to prevent existing off-campus PBDs from ever offering new items and services to their patients (at OPPS rates), unless the services are of the same "clinical family" as the services currently offered at the PBD prior to November 2, 2015.

CMS's proposed remedy, prohibiting expansion of services into new clinical categories, is overly broad and poorly tailored to the stated policy concern (namely, hospitals flipping physician practices to PBDs paid at the OPPS rate). The bar against service expansion is unsupported by statute, as Section 603 very plainly does not limit volume or service type at existing off-campus PBDs. The statute was clearly a forward-looking restriction on OPPS payment at new off-campus PBDs. Reaching backward to existing PBDs that Congress clearly excepted from this rule is unwarranted.

CMS's proposed ban on services expansion is fundamentally at odds with good public policy. It would stymie innovation and the movement of services from the higher cost inpatient setting into more efficient lower cost settings. The proposed "clinical family" approach is also a provider-focused perspective, classifying categories of medicine largely based on the type of specialty providing them. Patients are not single clinical categories. They are complicated and may have multiple clinical needs – often times complex clinical, social, and psychiatric needs. As a large urban academic medical center, NYP and its off-campus PBDs attract some of the sickest, most complicated patients in our community. Providers like NYP should be able to build and expand services around the needs of our patients, as clinically necessary and appropriate. For example, co-location of mental health services with other clinical areas, such as cancer treatment, should not be prohibited by Medicare payment rules because CMS is concerned about hospital acquisition of physician practices. Placing ancillary services on-site typically makes it easier for patients to get access to the right care at the right time. It would be unfortunate if Medicare payment policy worked against that goal.

Although we appreciate the competing policy priorities facing CMS, we urge the agency not to adopt the ban against service expansion at existing off-campus PBDs.

II. Proposed Changes to the Medicare and Medicaid Electronic Health Record Incentive Programs

A. Revised Meaningful Use Requirements Should be Applauded, but Further Refinements Could be Made

We support CMS's proposed changes in the rule that ease the meaningful use ("MU") requirements under the Medicare and Medicaid electronic health record ("EHR") incentive programs.

Specifically, we applaud CMS's proposal to remove clinical decision support ("CDS") and computerized provider order entry ("CPOE") objectives from the modified Stage 2 and Stage 3 MU requirements. We also support CMS's proposal to reduce the measure thresholds for eligible hospitals and believe the agency has struck the correct balance between encouraging implementation and use of EHRs to further patient engagement and interoperability and ensuring that the thresholds are reasonably attainable.

There are two areas, however, where we believe CMS could make further improvements to the EHR programs. First, although we appreciate CMS's proposal to reduce the reporting period in 2016 from a full year to a 90-day period, from a practical standpoint, the final rule's November effective date renders these changes less than useful for hospitals operationally. We encourage CMS in the future to announce such changes to reporting periods earlier in the year, which would allow hospitals to incorporate these helpful modifications into our operations.

Second, we recommend that CMS reconsider its proposal to require new eligible professionals ("EPs") in 2018 to meet modified Stage 2 MU requirements, as opposed to Stage 3 requirements. Such a policy could be difficult to manage in cases where there is a mixed pool of modified Stage 2 and Stage 3 EPs. Should new EPs elect to meet the Stage 3 MU requirements in 2018, we recommend that CMS permit them to do so.

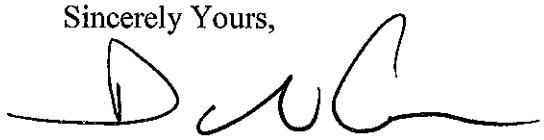
B. CMS Should Modify the Reporting Periods for 2017 and 2018 in the FY 2017 OPPS Final Rule

Although we appreciate CMS's flexibility and willingness to modify reporting periods for providers, as demonstrated by the changes to 2016 reporting included in the proposed rule, we strongly recommend that the agency consider making any planned changes to the 2017 and 2018 reporting periods in the final FY 2017 OPPS rule. We believe a 90-day reporting period for 2017 and 2018 would be sufficient and vastly preferable operationally for providers than a full year period, particularly given the move to Stage 3 MU requirements in 2018. We therefore strongly recommend that CMS consider including such a change in 2017 and 2018 reporting periods when the agency releases the final FY 2017 OPPS rule, so that hospitals can plan accordingly.

III. Conclusion

Thank you for the opportunity to comment on this proposed rule. We would be happy to answer any questions and look forward to working with CMS on this and other issues. Please feel free to contact Kate Spaziani at (212) 305-1190 or kas9171@nyp.org for further information.

Sincerely Yours,



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