



LOUISIANA HOSPITAL ASSOCIATION

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September 6, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1678-P: Proposed Rule: Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (Vol. 82, No. 138, July 20, 2017)

Dear Ms. Verma:

On behalf of our more than 150 member hospitals and health systems, the Louisiana Hospital Association (LHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2018 hospital outpatient prospective payment system (OPPS) proposed rule.

Proposed 340B Drug Payment Reduction

The LHA strongly opposes CMS' proposal to reduce Medicare Part B payment for drugs acquired through the 340B Drug Pricing Program. The current proposal is based on flawed policy arguments, and we urge the agency to withdraw it from consideration. We question not only CMS' statutory authority to impose a payment rate for 340B drugs that so drastically reduces payments to and effectively eviscerates the benefits of the 340B program for hospitals, but also its ability to establish what amounts to a differential payment for 340B hospitals. CMS' statutory authority to establish payments rates for separately payable drugs under OPPS is limited by the plain and ordinary meaning of the precise terms used in the provision CMS purportedly relies on for its 2018 proposal. Indeed, the overall statutory scheme evidences an intent by Congress to tightly constrain the power of CMS in setting payment rates. Moreover, CMS' proposal is inconsistent with the Public Health Service Act, because it would effectively repeal section 340B as it applies to most drugs purchased by nonprofit hospitals. The 340B statute clearly requires that *Medicaid* programs receive the benefit of rebates to which they are entitled under the Medicaid Drug Rebate Program. This is accomplished by requiring safety-net providers either to forego 340B program purchasing for Medicaid utilization or to charge less to Medicaid. Congress could have created a similar rebate program for Medicare, along with a process for Medicare, to capture 340B program benefits, but it has not done so.

Congress created the 340B program to permit safety-net hospitals that care for a high number of low-income and uninsured patients "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." For 25 years, the 340B program has been critical in helping hospitals expand access to lifesaving prescription drugs and comprehensive healthcare services to low-income and uninsured individuals in communities across the country. At no cost to taxpayers, the 340B program has been a success, allowing hospitals that treat large numbers of

uninsured and underinsured patients to generate savings from the discounts that are then used to expand healthcare services and provide access to needed drugs for these vulnerable populations. The financial support hospitals receive is derived from drug manufacturer discounts, rather than federal investments. Given the choice of furnishing a quasi-“rebate” to CMS and other payers or helping hospitals to help their patients, we believe most drug manufacturers would prefer that the hospitals receive the discounts directly.

Congress is the only authority to make changes to the current program, and recent actions by Congressional Committees show that they intend to do so. Recently, the Energy and Commerce Committee sent a letter to the Health Resources and Services Administration (HRSA) requesting that HRSA do an audit of the program. We believe this proposed rule would severely hamper Congress’ ability to investigate and develop legislation to improve the program. The Medicare statute does not allow CMS to create differential payments based on differential costs to a hospital. As a general matter, CMS is required to pay hospitals for their median or mean costs for a service, and not their hospital-specific costs. ASP data expressly excludes 340B drug pricing. Not only does discrimination against safety-net hospitals violate these statutory provisions, it also violates their purpose—a prospective payment pays the same, irrespective of cost, to ensure that hospitals are encouraged to be as efficient about purchasing as possible.

CMS suggests that a payment rate that eliminates the differential between acquisition cost and Medicare OPPS payment may help to reduce the incentive to overprescribe. CMS asserts that the current reimbursement structure incentivizes 340B participating hospitals to over-utilize medications and to prescribe more expensive medications. This makes no clinical sense. Clinicians provide the care that patients need. This is particularly true with cancer patients. Because of new and emerging drug therapies, clinicians often prescribe drug treatments that are more expensive because of the prices set by pharmaceutical companies. Moreover, for these patients, often the first regimen does not work and, multiple drug regimens are needed to find the one that will be successful, which can also drive up total costs.

CMS’ proposed new payment rate is procedurally defective under the OPPS statute. The CMS proposal has not offered a reasoned basis for applying savings achieved as a result of its proposed reduction to Part B services generally. Consistent with the Administrative Procedure Act, the agency itself must offer a reasoned basis for taking the unprecedented action it proposes. CMS methodology also assumed that all applicable drugs purchased by hospitals eligible to participate in the 340B drug pricing program were purchased at a discount price under the 340B program. This is inaccurate due to the GPO prohibition-- approximately 30 percent of outpatient drugs are typically purchased at wholesale acquisition cost price by the main purchasers (DSH). These are precisely the kind of factors that should have been considered by the expert Advisory Panel on Hospital Outpatient Payment (HOP) with which CMS is obligated to consult. However, CMS did not consult with the panel as the statute mandates before publishing its proposed payment rate, and at a Aug. 21, 2017 meeting that occurred after publication of the proposal, the Advisory Panel voted overwhelmingly that CMS should not finalize the proposed cut to 340B hospitals for CY 2018. Rather, it urged CMS to: (1) collect data from public comments and other sources; and (2) assess the regulatory burden against changes to the payment rate and the potential impact on 340B hospitals of implementing the modifier.

340B hospitals use the savings they receive on the discounted drugs and reinvest them in programs that help these vulnerable communities. Specifically, their programs enhance patient services and access to care, as well as provide free or reduced priced life-saving drugs to vulnerable patient populations. Many Louisiana 340B hospitals are the lifelines of their community, and the discounts they receive through the 340B program play an important role in allowing these organizations to care for patients. Cuts of this magnitude would greatly undermine hospitals’ ability to continue programs designed to improve access

to services- which is the very goal of the 340B program. A survey by the LHA of Louisiana hospitals participating in the 340B program revealed examples of potential impacts:

- Resources to provide uninsured/indigent care could be reduced;
- Current levels of infusion services may not be sustainable;
- Ability to provide clinical services at current levels could be compromised;
- Current discounts given on drugs and co-pays for low-income and rural patients could be jeopardized; and
- Pharmacy-related services could be reduced, as well as non-pharmacy services that could be funded with savings derived from the 340B program.

340B facilities are financially vulnerable. While many hospitals had negative Medicare margins in 2016, 340B hospital margins are even worse. Specifically, Louisiana 340B hospitals paid under OPSS had total and outpatient Medicare margins of negative 19.35 percent and negative 15.35 percent, respectively. (DataGen Medicare Margin report, August 2017). CMS' proposed cuts would make these hospitals' financial situations even more precarious, thus putting at great risk the programs they have developed to expand access to care for their vulnerable patient populations.

Moreover, if CMS implements the policy as it proposed, in a budget-neutral manner within the OPSS through an offsetting increase in the conversion factor, an American Hospital Association (AHA) analysis shows this will increase overall payments for non-drug APCs across hospitals by about 3.7 percent (compared to the 1.4 percent CMS estimates). This redistribution would result in a net decrease in payments to 340B hospitals of about 2.6 percent, or approximately \$800 million. Plainly stated, even accounting for adjustments to ensure overall budget neutrality, CMS' proposal would remove \$800 million intended to support the congressionally-mandated mission of 340B hospitals from these already vulnerable facilities and redistribute these dollars to other hospitals that do not participate in the 340B program. This would not only undermine the purpose of 340B, but would also further erode the financial viability of 340B hospitals.

The 340B program is not a financial burden to taxpayers and represents only 2.8 percent of the pharmaceutical industry's \$457 billion in U.S. sales in 2015. However, hospitals use those savings to support many programs that are improving and saving lives. In addition, in 2015, 340B hospitals provided \$23.8 billion in uncompensated care. Reducing how Medicare reimburses hospitals that participate in the 340B program for these drugs will not address drug use; rather, it will have the detrimental effect of impeding hospitals' ability to maintain programs that provide services to vulnerable populations, including Medicare beneficiaries. The reduction would also benefit the pharmaceutical industry by forcing hospitals to buy these drugs at full cost. Outpatient drug spending growth is the result of volume, type of service and price. Outpatient volume has increased for multiple reasons, particularly as more services are moving from the inpatient to the outpatient setting. This shift reflects efforts to increase the value of many services and overall represents a savings for the Medicare program.

Growth of the 340B program can be attributed to several factors, not the least of which is congressional action to expand eligibility to critical access hospitals, sole community hospitals and rural referral centers. The number of hospitals in the 340B program more than tripled from 2005 to 2014. Consequently, the amount spent by covered entities on 340B drugs tripled from 2005 to 2014, proportional to the number of eligible hospitals. During that same time, the volume of services delivered in hospital outpatient settings continued to grow across hospitals. Both expanded eligibility and shift in service mix coupled with rising drug prices and enrollment growth in the Medicare program explain increases in the cost of the 340B program. Medicare enrollment has grown as much as 20-25 percent in the past 10 years (MedPAC June 2016 Data Book).

There are also more expensive drugs on the market than ever before, including generic drugs. It is estimated that prices for new drugs entering the market have doubled since 2012. Teaching hospitals report dramatic price increases for oncology medications, particularly new medications. There is no question that drugs have become unaffordable for millions of Americans and imposed uncompensated care costs on the providers that care for them. A bigger issue affecting the growing cost of healthcare is the skyrocketing cost of drugs, both old and new. Rather than addressing the real issue of skyrocketing cost of pharmaceuticals, this proposal punitively targets 340B safety-net hospitals serving vulnerable patients, including those in rural areas of Louisiana where 25 percent of these hospitals are located.

In 2016, almost 1.7 million new cases of cancer were diagnosed. The median age at cancer diagnosis is 65 years – the age most Americans are eligible for Medicare implying that half of these new cases occur in the Medicare population. Much of this care occurs in the outpatient setting. Thus, more patients with cancer will logically mean more outpatient cancer drug costs. It is illogical to believe that reducing Medicare payments to 340B hospitals will in any way address the fundamental drivers of the increase in Part B drug expenditures: volume and price. If CMS wants to address rising drug costs, the Agency should do so directly, not by cutting critical Medicare payments to safety-net hospitals. As to concerns with co-insurance rates, CMS is ignoring that safety-net providers are all required by law to have indigent-care policies, which allow for co-insurance waivers where necessary. CMS' policy would serve as a blunt instrument, removing a revenue source from hospitals eager to help the financially needy. We strongly urge CMS to abandon its misguided 340B proposal and redirect its efforts toward direct action to halt the unchecked, unsustainable increases in the cost of drugs.

Per the AHA, there is evidence that beneficiaries largely do not pay copays so there is no direct benefit for seniors. Moreover, low-income beneficiaries are the direct recipients of the discounted drugs, and CMS now proposes to severely limit hospitals' ability to continue to provide these services. Part of CMS' rationale for proposing a reduction in payment for Part B drugs acquired under the 340B program is that the agency believes the proposal will reduce Medicare beneficiaries' drug copayments when seeking care from 340B hospitals. However, this is not accurate. Most Medicare beneficiaries coming to 340B hospitals do not pay their own copayments. Per a MedPAC analysis, 86 percent of all Medicare beneficiaries have supplemental coverage that covers their copayments, of which 30 percent have their copayments paid for by a public program, such as Medicaid, or by their Medigap plan. Thus, CMS' 340B payment reduction proposal would not directly benefit many Medicare beneficiaries, dually-eligible Medicare beneficiaries included, as it so claims. Further, Medicare beneficiaries may even see increases in out-of-pocket costs for other non-drug OPDS services. This is because the redistributions that result from budget neutrality would increase reimbursement for these other services, thus increasing beneficiaries' copayments in a parallel manner.

Our members have expressed other concerns including the fact that many private payers pay for services based on the Medicare rate, and because commercial insurers will almost certainly follow suit if CMS' policy is finalized, CMS will in effect have dismantled part of the 340B program causing significant disruption to the healthcare marketplace. We also received a comment strongly supporting drugs such as blood clotting factors not be reduced as part of the proposal. Many facilities may find it challenging to participate in the 340B program going forward considering this substantial payment reduction and the significant costs associated with 340B compliance. Indeed, the sizable and ongoing compliance costs associated with the 340B program would outweigh the lack of any meaningful financial benefit for participation in the program.

Lastly, CMS proposes to require entities to attach a claim modifier when non-340B drugs are issued to patients. Member hospitals agree that the addition of a modifier to identify separately payable drugs would be operationally challenging and costly, and it runs counter to the agency's commitment and active efforts to reduce regulatory burden for providers. Reasons listed include:

- The proposal is opposite how several state Medicaid agencies approach 340B, adding complexity to an already complicated program. In fact, CMS commented on an OIG 2016 report that examined state efforts to exclude 340B drugs from Medicaid rebates and opposed the OIG's recommendation that CMS should require that states use claims-level methods for identifying 340B drug claims.
- 340B hospitals have concerns about whether they can possibly implement CMS' proposed modifier accurately. That is, 340B hospitals would have to put the modifier onto the claim at the time service is rendered, or go back and retroactively apply it, thus delaying the submission of the claim. This would be difficult in mixed-use areas, such as emergency departments, catheterization laboratories and pharmacies, where both 340B eligible patients and non-340B patients are served. Further, for some hospitals, the proposal would create a significant increase in workload as the modifier may need to be reported manually.
- Many hospitals report that they are not able to determine whether a patient meets HRSA's 340B eligibility requirement at the time of billing, but do so retrospectively.
- It also will be impossible for hospitals to comply with the proposed implementation date of January 1, 2018. All hospitals, both 340B hospitals and non-340B hospitals, need additional time to adapt billing systems to accommodate the claims modifier, allow for testing to ensure the modifier is working correctly before using, and educate staff who must append the modifier. This process could take up to 12 months to test and implement.

Also, hospitals cannot report 340B ceiling prices or the drug's actual acquisition cost in a new location on the Medicare claim form, because hospitals do not have access to 340B drug ceiling prices. The Affordable Care Act required that HRSA make public its 340B Drug Pricing Program ceiling price calculation methodology and develop a system that will grant 340B hospitals access to drug ceiling prices. However, to date, HRSA has not completed its work to create a more transparent and publicly-accessible system for stakeholder to access 340B ceiling prices. As such, 340B hospitals would not be able to report 340B ceiling prices to CMS.

The LHA looks forward to being part of the discussion with CMS and the Administration to address rising drug costs, but reducing Medicare payments to 340B hospitals is not a solution to this problem.

Proposed Changes to the Inpatient-Only List

The LHA opposes the removal of total knee arthroplasty (TKA) from the inpatient-only list, because we do not believe it is clinically appropriate and are deeply concerned that it will put the success of the Comprehensive Care for Joint Replacement (CJR) and the Bundled Payment for Care Improvements (BPCI) programs at risk. CMS has determined that TKA would be an appropriate candidate for removal from the inpatient-only list based on review of clinical characteristics and a 2016 recommendation from the HOP Panel. The agency notes that it would expect providers to carefully develop evidence-based patient selection criteria to identify patients who are appropriate candidates for an outpatient TKA procedure, as well as exclusionary criteria that would disqualify a patient from receiving an outpatient TKA. Therefore, if CMS finalizes its proposal to remove TKA from the inpatient-only list, the agency proposes to prohibit Recovery Audit Contractors' review for patient status for TKA procedures performed in the inpatient setting for a two-year period to allow time and experience for these procedures in these settings.

While the LHA appreciates the audit exemption, we remain opposed to this proposal because it puts existing hospitals in CJR and BPCI programs at greater financial risk. TKAs remain complicated, invasive surgical procedures. While they may be successfully performed on an outpatient basis for non-Medicare individuals, we do not believe it is appropriate for the Medicare population. Nearly half of all Medicare beneficiaries live with four or more chronic conditions, and one-third have one or more limitations in activities of daily living that limit their ability to function independently, which will make even a simple

procedure more complicated. In addition, spinal anesthesia is often used for TKAs, and waiting for full sensation to return can take hours. Finally, pain management, particularly in the immediate postoperative period, remains a challenge. Management of postoperative pain is best controlled in the inpatient setting.

Regarding CJR and BPCI, shifting the less medically-complex Medicare TKA population to the outpatient setting would increase the risk profile of the inpatient Medicare TKA population. This would, in turn, create an apples-to-oranges comparison within bundling programs when evaluating hospitals' actual expenditures versus their historical target prices. Performance under the programs would be inappropriately negatively impacted, potentially to a large degree. Notwithstanding our clinical concerns, we strongly urge the agency to modify the CJR and BPCI programs to account for the removal of TKA from the inpatient-only list if it were to finalize such a policy.

The LHA would also like to be on record as opposing the removal of partial and total hip arthroplasty (PHA/THA) from the inpatient-only list for similar reasons as noted above, and we urge CMS to take extreme caution if it contemplates this change in future years. We do not believe it is clinically appropriate and are further concerned that it could put the success of the CJR and BPCI programs at risk. PHA/THA patients are often medically complex and functionally impaired; they have serious renal, cardiovascular and liver disease, as well as multiple comorbidities. They may require care in an inpatient rehabilitation facility (IRF); in fact, hip fractures are one of the 13 clinical conditions on which Congress and CMS has directed IRFs to concentrate their services.

Proposed Packaging of Low-Cost Drug Administration Services

For CY 2018, CMS proposes to conditionally package payment for low-cost drug administration services when these services are performed with another service. This policy would package the costs of APCs 5691 (Level 1 Drug Administration) and APC 5692 (Level 2 Drug Administration), both with geometric mean costs less than \$100, into a primary service when these APCs are billed on the same claim as another primary service. However, the LHA recommends that CMS not finalize its proposal to conditionally package payment for Level 1 and 2 drug administration services as we believe that drug administration services are separate and distinct, and deserve to continue to be paid as such. CMS' own HOP Panel, at its recent meeting, also recommended that CMS not finalize this proposal until further analysis can be done. As all drugs are separately payable in the physician office setting, unlike the OPPS, the proposed expansion of packaging to include most Level 1 and 2 drug administration services, as well as the increasing packaging of higher-cost drugs, truly exacerbates differences in reimbursement between the physician office and hospital outpatient department.

In addition, because of the annual increases in the drug-packaging threshold, drugs are increasingly being packaged into other APCs. CMS is proposing to increase the packaging threshold for threshold-packaged drugs from \$110 in CY2017 to \$120 in CY2018. Therefore, drugs costing less than \$120 would have their cost packaged in the procedure for which they are billed, such as an outpatient clinic visit. Despite that more items will qualify for packaging, the costs remain and the reimbursement likely decreases. The LHA supports packaging services where it makes sense but not grouping high-cost drugs into lower-cost services such as clinic visits. CMS' proposal to package low-cost drug administration services represents packaging on top of packaging that could have a disproportionate impact on certain types of services that frequently require drug administration to be furnished during treatment, such as cancer treatment. Therefore, the LHA recommends that CMS not finalize this policy and instead continue to provide separate payment for all drug administration services.

Potential Revisions to the Laboratory Date of Service Policy

The LHA is supportive of CMS' proposal to update its laboratory date of service (DOS) billing policies for separately-payable molecular pathology and Advanced Diagnostic Laboratory Tests (ADLTs) that are

performed on specimens collected from hospital outpatients. Many hospitals do not perform these types of more technologically-advanced laboratory tests in-house and, upon receipt of a physicians' orders, instead send patient specimens to independent laboratories for testing. Specifically, we agree with those stakeholders described in the rule who have expressed concern that the current DOS policy is inconsistent with the agency's OPPTS laboratory test packaging policy, is administratively burdensome for hospitals and laboratories, and can create delays and other barriers to patient access to critical diagnostic testing. We understand that some hospitals are reluctant to bill for Medicare laboratory tests that they do not perform, which can result in orders being delayed for 14 days after discharge. This can lead to interference in timely access to care through delays in testing and treatment. As such, we urge CMS to finalize its proposed policy change, allowing the laboratory that performs certain tests using a specimen obtained from a hospital outpatient to bill the Medicare program directly in certain specified circumstances. We recommend that this policy apply to all molecular pathology tests and ADLTs that are separately paid under the OPPTS packaging policy.

Proposed Enforcement Moratorium on Direct Supervision Policy for Critical Access Hospitals (CAHs) and Certain Small Rural Hospitals

In response to hospital concerns about direct supervision, CMS has, since 2009, adopted several helpful regulatory changes to its supervision policy. In addition, from 2010 through 2013, the agency prohibited its contractors from enforcing the direct supervision policy. Congress has extended this enforcement moratorium every year since 2014, with the most recent enforcement moratorium having expired on Dec. 31, 2016. While these extensions of the enforcement moratorium have provided some relief, this annual reconsideration of a misguided direct supervision policy places CAHs and small rural hospitals in an uncertain and untenable position. In the proposed rule, CMS proposes to reinstate the enforcement moratorium for CAHs and small rural hospitals having 100 or fewer beds for 2018 and 2019, but not for 2017. While we are pleased that CMS proposes to reinstate the enforcement moratorium for CAHs and small rural hospitals having 100 or fewer beds for CYs 2018 and 2019 to give these hospitals more time to comply with supervision requirements and to give providers time to submit specific services to be evaluated by the HOP Panel for a recommended change in supervision level, we urge the agency and Congress to make the enforcement moratorium permanent and continuous.

Blood and Blood Product Coding

The LHA supports the AHA recommendation that CMS convene a stakeholder group including hospitals, blood banks, the American Red Cross and others to discuss a framework to systematically review and revise the HCPCS codes for blood products. In the decade since the codes were created, clinical processes have evolved to ensure the safety of the blood supply. We believe that HCPCS codes should properly reflect current product descriptions while at the same time minimize the reporting burden.

Proposed Code Edit for Brachytherapy Services

CMS proposes to introduce a code edit for claims with brachytherapy services that will require the brachytherapy application HCPCS code 77778 to be included on the claim with the brachytherapy insertion procedure (HCPCS code 55875). The LHA opposes the implementation of this edit. It would be burdensome for facilities when the insertion procedure is not performed during the same encounter for the following reasons:

- There are clinical and other reasons when a patient may receive the brachytherapy treatment at a later date other than the brachytherapy insertion procedure. Holding claims to combine the codes would introduce new administrative burdens.

- In some instances, the procedures are done at different facilities within the geographic region making it impossible for the codes to be reported on the same claim.
- To ensure accurate coding, some billing systems already have a soft edit to flag these cases. If the edit is overridden, it is often for one of the reasons above.

Partial Hospitalization Program (PHP) Minimum Service Requirement

Data needed to assess whether, and to what extent, providers are rendering too few services to beneficiaries enrolled in PHPs will not be available until the CY 2019 OPPTS proposed rule. Therefore, we believe it would be premature to implement a claim edit conditioning payment on the provision of 20-hours of therapeutic services per week. Furthermore, we are concerned that a claim edit that is overly strict could result in inappropriate changes and perhaps reduced access to the PHP benefit. In the meantime, the LHA recommends that CMS work with hospital and CMHC PHP providers to evaluate the variety of factors, beyond hours-per-week, that appropriately represent the “intensity” of services for a PHP program. That is, intensity includes other factors, such as the number of units of services provided per day and the types of services provided. The LHA believes that CMS’ focus exclusively on hours-per-week is too limiting.

Hospital Outpatient Quality Reporting (OQR) Program

CMS proposes to remove a total of six measures from the OQR program—two removed starting with the CY 2020 payment year (which is based on 2018 provider performance) and four more removed starting with the CY 2021 payment year (based on 2019 performance).

Measures for Removal: The LHA supports CMS’ proposals to remove six measures. We appreciate CMS’ efforts to remove measures that provide little meaningful information on quality of care and do not support ongoing hospital quality improvement efforts. We applaud CMS for recognizing the potential unintended consequences that the Median Time to Pain Management for Long Bone Fracture (OP-21) measure might have on opioid-prescribing practices, and we appreciate CMS’ strategy of using regulatory relief to address the opioid crisis. However, CMS could do even more to remove measures that do not encourage improvements in hospital quality. First, CMS should remove all six of the measures for the CY 2020 OQR program. If performance on a measure like Aspirin at Arrival (OP-4) is already topped out, for instance, we do not see a reason to continue collecting data on performance for another year. In addition, there are several other measures that meet the same criteria as those addressed here and thus should be considered for removal. For example, a measure that was finalized for removal from the FY 2019 Inpatient Quality Reporting Program should likely be considered for removal in the OQR.

Delay of Outpatient and Ambulatory Surgery (OAS) CAHPS Survey-based Measures: The LHA has long supported the use of rigorously-designed surveys of patient experience of care. However, we agree with CMS that the implementation of the OAS CAHPS is premature and appreciates CMS’ proposal to delay the survey-based measures pending further analysis and modification. The LHA hopes that CMS explore the development of more economical survey administration approaches for this (and all other) CAHPS surveys in the future, such as emailed or web-based surveys. Not only do mailed and telephonic surveys have widely differing response rates, but they are also more expensive and burdensome to administer. Another survey relevant to outpatient surgical patients may result in patients receiving three separate but similar surveys for the same care episode. Thus, we urge CMS to ensure survey administration protocols clearly identify which institution is being surveyed to help guarantee correct attribution of experiences as the agency conducts analyses of the national survey data and plans necessary modifications.

Finally, since the OAS CAHPS survey measures are not endorsed by the NQF, we encourage CMS to pursue NQF endorsement of these measures before the OAS CAHPS is required of hospitals.

Ms. Seema Verma
September 6, 2017
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Thank you for your consideration. If you have any questions or need additional information, please contact LHA Vice President of Healthcare Reimbursement, Kevin Bridwell, at (225) 928-0026 or kbridwell@lhaonline.org.

Sincerely,

A handwritten signature in black ink that reads "Paul A. Salles". The signature is written in a cursive style with a long horizontal flourish extending to the right.

Paul A. Salles
President & CEO