



June 20, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1518-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1518-P: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2012 Rates; Proposed Rule

Dear Sir/Madam:

The American Society of Health-System Pharmacists (ASHP) is pleased to submit written comments in response to the Proposed Changes to the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals (Proposed Rule) issued by the Centers for Medicare & Medicaid Services (CMS) and published in the Federal Register on May 5, 2011.¹ For more than 60 years, ASHP has helped pharmacists who practice in hospitals and health systems improve medication use and enhance patient safety. The Society's over 35,000 members include pharmacists and pharmacy technicians who practice in inpatient, outpatient, home-care, and long-term-care settings, as well as pharmacy students.

Specialized Pharmacy Residency Programs

ASHP strongly recommends that CMS reinstate graduate medical education (GME) funding for second-year pharmacy residency programs and address this issue in Section IV. Other Proposed Decisions and Changes to the IPPS for Operating Costs and GME Costs of the Proposed Rule. While the Agency cut funding in 2004, citing that these programs were not required for

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employment as a clinical pharmacist, ASHP surveys indicate otherwise. In fact, the overwhelming majority of institutions surveyed either require or strongly favor pharmacy candidates who have completed residency programs.

In a recent ASHP survey, 80 percent of respondents indicated that if there was an adequate supply of specialized residency trained pharmacists, they would require a candidate with specialized residency training when recruiting for their institution. Additionally, almost 75 percent of respondents cite the loss of Medicare pass-through funding for specialized residencies as making it more difficult to recruit specialized residency trained pharmacists at their institutions.

Second-year, specialized pharmacy programs are vital to our health-care delivery system by providing pharmacists with essential clinical training that enables them to take on direct patient care activities, including participating on patient rounds, monitoring patient responses to their medicines, improving medication therapy outcomes and preventing adverse drug events (ADEs). These programs foster the skills required for pharmacists to care for highly-specialized and complex patients, effectively interact with specialized physicians and nurses, and conduct collaborative research. Similar to residencies in medicine, pharmacy residencies are intense, structured, patient-centered training that involve close work with preceptors and mentors. Their involvement not only provides improved patient outcomes, it can also result in reduced costs for their institutions and the health-care system. In a study published in the *American Journal of Health-System Pharmacy*, an intensive unit clinical pharmacist saved a hospital as much as \$280,000 over a 4.5 month period by preventing potential ADEs and reducing costs.²

Further, ASHP believes that, for future roles involving specialized clinical activities, pharmacists will be required to have completed an ASHP-accredited second-year, specialized residency. With passage of the Patient Protection and Affordable Care Act, changes to the health care delivery system will evolve, particularly in hospitals and health-systems, making completion of these residencies a requirement for practice in these positions.

ASHP has adopted several policy positions that establish the need to complete a residency as a requirement for the clinical pharmacist in a hospital. The intent of the policy positions is to meet the changes in care delivery and the increasing reliance on the interdisciplinary patient care team.

- **Therefore, ASHP strongly recommends that CMS reinstate funding through the Medicare GME program for specialized pharmacy residency programs that was eliminated in 2003.**

Preventable Hospital-Acquired Conditions (HACs), Including Infections

ASHP supports the transformation of Medicare from a passive payer to an active purchaser of higher value health care services through the refinement of the use of value-based purchasing (VBP) tools to prevent certain hospital-acquired conditions. The Society supports the continued use and refinement of International Classification of Diseases-9 (ICD-9) coding used to document the presence of these conditions.

ASHP applauds the inclusion of Contrast-Induced Acute Kidney Injury to the HAC Policy for FY2012. The Society encourages CMS to continue to expand and refine the HACs and categories.

In addition, ASHP supports the proposed adoption of the five new ICD-9-CM diagnosis codes to be added to the existing HACs conditions (Falls and Trauma, SSIs, DVT/PE) as described. We believe the addition of additional HACs and diagnosis codes to existing HACs as described will create a more robust VBP tool.

The Society encourages CMS to continue to analyze POA Indicator Reporting data to provide further insight into how POA data can be used to identify those conditions which are truly preventable and identify the true impact of the HACs payment structure.

Hospital Quality Data Reporting

ASHP appreciates CMS's efforts to promote higher quality and more efficient health care through the use of quality measure reporting programs. The Society also supports the expansion of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program through the addition of new quality measures for FY2012 and beyond.

- **However, as a member of the National Quality Forum (NQF), ASHP strongly recommends that CMS include only those measures that have been endorsed through the rigorous consensus-building process of NQF. Consensus achieved during the measure development process, through broad acceptance and use of a measure, or through public comment does not incorporate the robust and comprehensive process used to establish NQF endorsement.**

The Society supports CMS's efforts to minimize burden on providers by aligning the Inpatient Quality Reporting (IQR) Program measures with existing programs and measures. Specifically, we strongly support the alignment of the clinical quality measure requirements with those authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act so that the burden for reporting will be reduced.

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Proposed Retirement of Quality Measures

ASHP supports the retirement of the seven measures with uniformly high performance nationwide with little variability. We also applaud CMS for proposing not to include the measure on 'timing of receipt of initial antibiotic following hospital arrival' in the FY 2013 measure set because of the potential for unintended consequence of inappropriate antibiotic use. We believe it is critical to continuously assess any potential unintended consequences from the use of quality measures in VBP.

The Society appreciates this opportunity to provide comments. Please contact me if you have any questions or if you would like further detail on the surveys that ASHP has conducted supporting our position that CMS should reinstate second-year pharmacy residency programs. I can be reached by telephone at 301-664-8806, or by e-mail at ctopoleski@ashp.org.

Sincerely,



Christopher J. Topoleski
Director, Federal Regulatory Affairs

¹ Federal Register Volume 76, Number 87, Pages 25788 – 26084.

² Kopp BJ, Mrson M, Erstad BL, and Duby JJ. "Cost implications of and potential adverse events prevented by interventions of a critical care pharmacist." Am J Health-Syst

² Kopp BJ, Mrson M, Erstad BL, and Duby JJ. "Cost implications of and potential adverse events prevented by interventions of a critical care pharmacist." Am J Health-Syst Pharm. 2007; 64:2483-2487.