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June 29, 2009

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1406-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

**Re: CMS-1406-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates and to the Long-Term Care Hospital Prospective Payment system and Rate Year 2010 Rates; Proposed Rule**

Dear Sir/Madam:

The American Society of Health-System Pharmacists (ASHP) is pleased to submit written comments pertaining to the proposed changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2010 Rates (proposed rule). 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 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. Pharmacists in hospitals and health systems are experts in medication use who serve on interdisciplinary patient-care teams. Pharmacists work with physicians, nurses, and other health-care professionals to ensure that medicines are used safely and effectively.

**Revision to the FY 2009 indirect medical education (IME) adjustment factor**

In Fiscal Year 2009, the Centers for Medicare and Medicaid Services (CMS) planned a 50% reduction of the capital teaching adjustment, followed by a 0% adjustment in 2010. However, the American Recovery and Reinvestment Act of 2009 (the Act) requires that the 50-percent reduction for FY 2009 should not be applied. The Act further states that this legislation should not be construed to have any effect on the application of paragraph (d) of section 412.322 of title 42, Code of Federal Regulations, which eliminates the teaching adjustment for FY 2010. CMS states in its proposed rule that the elimination of

the teaching adjustment for FY 2010 will remain, consistent with the Act. However, the Act does not require that the 2010 plan remain in place, and CMS has the authority to maintain the teaching adjustment for FY 2010.

ASHP strongly recommends that CMS maintain the capital teaching adjustment, with no reductions, for FY 2010 and beyond. The loss of IME adjustments will reduce available funds for hospitals to acquire needed information systems, electronic medical records, automated dispensing cabinets, bar coding and other technologies necessary to increase patient safety. If teaching hospitals' capital-related margins are examined in the aggregate, it is clear that operational margins are decreasing significantly at the same time capital margins are increasing, resulting in a narrow or even negative hospital margin, particularly relating to Medicare beneficiaries.

Teaching hospitals require more staff and other resources to provide a higher level of care, including Level I trauma services, burn units, transplantation, and adult/neonatal intensive care units. Teaching hospitals by definition train physicians and other healthcare professionals, including pharmacists, to provide specialized patient care. In addition, clinical research at such facilities advances patient care and provides improved outcomes. The reduction and/or elimination of IME adjustments will impede the ability of teaching hospitals to meet their core responsibility of providing advanced levels of patient care.

### **Preventable hospital-acquired conditions (HACs), including infections**

While ASHP commends CMS efforts to develop value-based purchasing policies that address inconsistent or inappropriate patient care, we encourage CMS to recognize that not all HACs are preventable. Some may result from adverse effects related to drugs prescribed for approved indications. For example, *Clostridium difficile* infection is a documented adverse effect of commonly prescribed antibiotics and therefore may not be preventable in some patients. It is only truly preventable if the drug was prescribed inappropriately or the infection is spread from one patient to another due to inadequate infection control practices by health care professionals.

ASHP encourages CMS to re-examine its list of conditions for which it will no longer pay at a higher rate if the condition is acquired during a hospital stay, and include only those HACs that are reasonably preventable through the application of evidence-based guidelines. In addition, the Society encourages CMS to continue to refine the policy, including consideration of benchmarking and population and individual risk adjustment factors that would result in incremental payment if there are patient-specific factors (e.g., immunocompromised, burn or trauma patients) that would increase the likelihood of a patient acquiring the condition. These approaches, which were described during the December 18, 2009 HAC and POA Listening Session (see [www.cms.hhs.gov/HospitalAcqCond/Downloads/HAC\\_Listening\\_Session\\_12-18-2008\\_Transcript.pdf](http://www.cms.hhs.gov/HospitalAcqCond/Downloads/HAC_Listening_Session_12-18-2008_Transcript.pdf), pages 26-29), may more accurately reflect the extent to which some

conditions, including infections, are truly preventable. In addition, ASHP strongly encourages continuation of the research conducted by the Agency for Healthcare Research and Quality on strategies to improve the accuracy and lessen the administrative burden of documenting conditions present on admission.

### **Proposed add-on payments for new services and technologies**

ASHP commends CMS for expanding its assessment of new technologies to include consideration of whether the technology is used for the same or similar type of disease and the same or similar patient population. The current codified criteria for substantially similar—use of the same mechanism of action to achieve a therapeutic outcome and assignment to the same DRG—are important elements, but fail to recognize new uses for existing drug therapies and other technologies. In applying the disease- and patient criteria to clofarabine, CMS acknowledged the important contribution of new evidence to advancing patient care. ASHP encourages CMS to apply these criteria to future decisions about proposed new technologies and to consider codifying these criteria for use in conjunction with the existing criteria.

### **Retirement of Reporting Hospital Quality Data for Annual Payment Update (RHODAPU) program measures**

ASHP applauds the action of CMS in its decision to retire the AMI-6 measure based on evolving clinical evidence, and encourages CMS to establish consistent and transparent processes that address changes in evidence-based guidelines more quickly (i.e., consideration should begin before measure developers seek discontinuation). CMS should establish channels to exchange this type of information between the agency and measure developers.

ASHP agrees that, if hospitals are effectively in compliance with a measure, or the measure is shown not to represent best clinical practice, the measure should be retired or replaced. Additionally, ASHP recommends that measures should be retired when an indicator is developed that more accurately assesses good quality care. Due to rapid changes in technology and research and the development of health care quality measures, it is important to use the most up-to-date measurement tools available. Since these measures are publicly reported, it is also important to limit the number of reported measures for a specific process of care in order to reduce confusion among patients, payers, and providers.

### **National Quality Forum (NQF) harmonization of two existing RHODAPU program measures**

As an inaugural NQF member, ASHP strongly supports the alignment of the RHODAPU program measures with NQF measures by combining the “PSI 04-Death among surgical patients with treatable serious complications” measure with “Nursing Sensitive-Failure to

rescue” measure into one single measure, pursuant to NQF’s recent harmonization of these measures.

**Proposed new chart-abstracted measures**

ASHP recognizes the growing concern regarding hospital acquired infections. While the Society supports the proposed inclusion of the two NQF-endorsed chart-abstracted Surgical Care Improvement Project (SCIP) measures, SCIP-Infection-9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2, and SCIP-Infection-10: Perioperative Temperature Management, ASHP urges the continued expansion of the RHQDAPU program measure set into other patient populations.

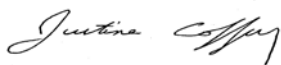
**Possible new quality measures for the FY2012 payment determination and subsequent years**

The Society supports the expansion of the RHQDAPU program through the addition of new quality measures for FY2012 and beyond. However, as a member of 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.

Regarding the fourth venous thromboembolism (VTE) measure listed, ASHP applauds the inclusion of this measure because of the critical component of patient education that is included. It is important to note that simply prescribing a medication at discharge is not sufficient to ensure safe and effective therapy. Inappropriate medication use and non-adherence lead to preventable emergency department visits and costly hospital readmissions. Therefore, it is critical that patient education is addressed in quality measures relating to discharge. ASHP encourages CMS to continue to adopt endorsed measures that assess patient education and ensure that this education is provided at the appropriate reading and health-literacy level.

ASHP appreciates this opportunity to present its written comments on the proposed rule. Feel free to contact me if you have any questions regarding our comments. I can be reached by telephone at 301-664-8702, or by e-mail at [jcoffey@ashp.org](mailto:jcoffey@ashp.org).

Sincerely,



Justine Coffey, JD, LLM  
Director, Federal Regulatory Affairs