



American Society of
Health-System Pharmacists
7272 Wisconsin Avenue
Bethesda, Maryland 20814
(301) 657-3000
Fax: (301) 664-8877
www.ashp.org

June 5, 2008

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1390-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1390-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 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 2009 Rates. ASHP represents pharmacists who practice in hospitals and health systems. The Society's more than 30,000 members include pharmacists and pharmacy technicians who practice in a variety of health-system settings, including inpatient, outpatient, home care, and long-term-care settings.

ASHP will comment on five provisions of the proposed rule: (1) Changes to the Capital Indirect Medical Education (IME) Adjustment (2) Hospital Quality Data Reporting (3) Hospital Acquired Conditions (HACs) (4) National Quality Forum (NQF) Guidelines including "Never Events" and (5) the Reasons for Hospital Readmissions.

Changes to the Capital IME Adjustment

In Fiscal Year 2009, CMS plans a 50% reduction of the capital teaching adjustment, followed by a 0% adjustment in 2010. ASHP strongly recommends that CMS not reduce and then eliminate the Capital Teaching Adjustment.

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. Teaching Hospitals' large capital-related margins are mentioned as the reason the adjustments are no longer

deemed to be necessary. However, if 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 elimination of IME adjustments will impede the ability of teaching hospitals to meet their core responsibility of providing advanced levels of patient care.

Hospital Quality Data Reporting

The Deficit Reduction Act of 2005 (DRA) provides that the payment update for FY 2007 and each subsequent fiscal year will be reduced by 2.0 percentage points for any hospital paid under the Inpatient Prospective Payment System that does not submit certain quality data as specified by the Secretary. In the proposed IPSS rule for Fiscal Year 2009, CMS proposes adding 43 new quality measures to the existing 30, for a total of 74 measures.

ASHP commends CMS for adding new quality measures to the hospital quality data reporting requirement. However, as a member of the National Quality Forum (NQF), ASHP strongly recommends that CMS include only those measures that have been endorsed by NQF. Hospital and health-system pharmacists play a vital role in helping organizations achieve medication-related measures. ASHP believes that health care quality improvement programs should adopt standard quality measures that are developed with the involvement of pharmacists, are evidence-based, and promote the demonstrated role of pharmacists in improving patient outcomes.

Hospital Acquired Conditions (HACs)

Starting in October 2008, Medicare can no longer assign discharges to a higher paying DRG if certain conditions were not present on admission. ASHP recognizes that patients are diagnosed with certain conditions acquired during hospital stays, however, not all HACs are preventable. Some may result from adverse effects of 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 infection is spread from one patient to another due to inadequate infection control practiced by health care professionals.

Delerium is also mentioned. It should be noted that elderly patients commonly experience delirium as a result of confusion prompted by being a hospital inpatient. "Recognizing

delirium is important because it is an indication of an underlying medical condition that should be identified and treated. The identification of the underlying etiology should be aggressively pursued. Delirium can be caused by a medical emergency or a subacute, chronic medical condition. Prescription drugs, illicit drugs, and toxic substances can also cause delirium. The underlying medical condition is not always readily identifiable, and more than one etiology is often responsible for delirium. In fact, in almost one half of elderly patients with delirium, two or more underlying conditions are responsible for the delirium.”¹

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.

National Quality Forum Guidelines and List of Serious Reportable Adverse Events (“Never Events”)

ASHP commends CMS for following NQF’s guidelines by increasing the timeline from 4 to 6 hours for initiation of antibiotics to patients suspected of having pneumonia. This change will help to allay the concern that antibiotics may be given unnecessarily or to treat bacteria that are not sensitive to the antibiotic administered.

“Death/disability associated with use of contaminated drugs, devices or biologics” is listed in NQF’s List of Serious Reportable Events, but has not yet been incorporated into the CMS list of HACs. However, recently reported deaths in the United States and other adverse events associated with heparin manufactured in China bring this issue to the forefront.

Readmissions

CMS is requiring hospitals to report measures related to readmissions of Medicare patients that could be preventable. This requirement is the result of a MedPAC study that showed 18% of Medicare patients are readmitted within 30 days of discharge. ASHP encourages CMS to recognize that a discharged patient’s lack of access to medications, ultimately leading to noncompliance, may contribute to a patient being readmitted to the hospital after a short period of time. Additionally, lack of continuity of care and infrastructure to ensure transitions in care may lead to readmission. The avoidance of some readmissions requires determining whether patients are covered by appropriate Medicare Part D prescription drug plans; also, the role that manufacturers’ Medication Assistance Programs may play in providing medications to patients should be investigated.

¹ *American Family Physician*, Delirium, Ondria C. Gleason, MD, March 1, 2003. Accessed June 4, 2008, <http://www.aafp.org/afp/20030301/1027.html>

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ASHP appreciates this opportunity to present its written comments on the proposed changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates. 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.

Sincerely,

A handwritten signature in cursive script that reads "Justine Coffey".

Justine Coffey, JD, LLM
Director, Federal Regulatory Affairs