ADULT VACCINE ACCESS COALITION

June 16, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1632-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-1632-P Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates

To Whom It May Concern:

As participants in the Adult Vaccine Access Coalition (AVAC), we appreciate the opportunity to comment on CMS-1632-P FY 2016 Medicare Program Hospital Inpatient Prospective Payment System proposed rule.

AVAC consists of organizational leaders in health and public health that are committed to tackling the range of barriers to adult immunization, to raise awareness of and to engage in advocacy on the importance of adult immunization. Our mission is informed by a growing body of scientific and empirical evidence of the benefits of immunization through improving health, and protecting lives against a variety of debilitating and potentially deadly conditions, as well as by saving costs to the healthcare system and to society as a whole.

AVAC priorities and objectives are driven by a consensus process with the goal of improving access and utilization of adult immunizations. A top priority for AVAC is to achieve increased adult immunization rates through federal benchmarks and measures that encourage tracking and reporting of recommended vaccines. Required measures through the Medicare hospital inpatient program play a critical role in promoting improved care quality.

That is why we are deeply concerned that the proposed rule seeks to remove the IMM-1 (Pneumococcal Immunization -NQF #1653) from the Hospital IQR Program beginning in FY2016 for the FY 2018 payment determination and in subsequent years. The 2014 National Healthcare Quality and Disparities Report by the Agency for Health Care Research and Quality (AHRQ) found that publicly-reported CMS measures were much more likely than measures reported by other sources to stimulate high levels of performance and specifically note hospital patients age 65+ who received pneumococcal screening or vaccination as an area of success.[1]

[1] AHRQ, "2014 National Healthcare Quality and Disparities Report p. http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/2014nhqdr.pdf

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Furthermore, removing IMM-1 is a step in the wrong direction for health care quality improvement, particularly when CMS is seeking to expand care improvement and readmissions measurement for patients with a pneumonia diagnosis. It is also in contrast to CMS' Quality Improvement Network Quality Improvement Organization (QIN-QIO) 11th Scope of Work (SOW) that includes strategies aimed at improving reporting of all adult immunizations and increasing immunization rates among the Medicare population.

Pneumonia is responsible for over a million hospitalizations and 50,000 deaths each year in the United States. Vaccines are an effective intervention against the high cost of medical care and rates of preventable death associated with this disease, particularly among medically vulnerable populations and the elderly. That is why the Advisory Committee for Immunization Practices (ACIP) 2014 recommendations call for adults aged 65 years or older and individuals with underlying immunocompromising health conditions between 19 and 64 years of age to receive PCV13 and PPSV23. ACIP also recommends PPSV23 for adults 19 through 64 years of age with underlying chronic health conditions like diabetes, heart disease, liver disease or lung disease (including people who smoke or have asthma).

We strongly encourage CMS to modify its approach and preserve pneumococcal immunization measurement in the Hospital IQR program in the final rule. We recognize CMS concern that the current language of IMM-1 is insufficient to capture full immunization of a person over 65 years of age with BOTH ACIP-recommended pneumococcal vaccines. However, rather than rescinding the current IMM-1 measure, we instead urge CMS to work with immunization stakeholders to revise the current language to reflect the recommendations of the ACIP. We would note that the National Quality Forum (NQF) Health and Well-Being Standing Committee is in the process of updating its standards specifications for pneumococcal vaccinations so CMS can assess the IMM-1 measure against the revised standards specifications. The Joint Commission has transferred measure stewardship for IMM-1 to CMS so the changes necessary to bring the measure into compliance with ACIP-recommendations can be implemented.

We also believe that the process of removing the current IMM-1 measure and starting over with the development of a new measure will require more resources and time, with potential detrimental impact to public health. We thus again urge CMS to follow the process of updating the existing measure to better align to ACIP recommendations.

Immunization quality measures are a crucial tool for health care quality improvement and have demonstrated effectiveness in increasing immunization rates. The significant health and economic burden of pneumonia on elderly and medically vulnerable populations and sub-optimal pneumococcal immunization rates remain public health imperatives that require continued leadership from CMS.

Lastly, we would also like to express our support for the proposal to maintain IMM- 2, the Influenza Immunization Measure, as part of the Hospital IQR program for FY 2018 and subsequent years. We agree with CMS' assessment that the benefits outweigh the disadvantages of retaining IMM-2. Moreover, this measure plays a critical role in the CMS Quality Strategy as well as the National Quality Strategy in terms of influenza immunization efforts.

We thank you for this opportunity to offer our perspective on this important public health issue. Please contact the AVAC Coalition Manager at (202) 540-1070 or lfoster@nvgllc.com if you wish to further discuss our comments or learn more about the work of AVAC.

Sincerely,

American Association of Occupational Health Nurses
American College of Preventive Medicine
Biotechnology Industry Organization
Immunization Action Coalition
Infectious Diseases Society of America
National Association of County and City Health Officials
National Foundation for Infectious Diseases
National Minority Quality Forum
Pfizer
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