



June 10, 2013

Marilyn Tavenner  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard, Baltimore, MD 21244

**Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation [CMS-1599-P]**

Dear Administrator Tavenner:

The Association of Immunization Managers (AIM), representing the 64 federally-funded state, territorial and local public health immunization awardees, strongly supports the use of immunization quality measures in the Hospital Inpatient Quality Reporting (IQR) Program. Specifically, AIM supports the inclusion of the influenza immunization measure (IMM-2) into the Hospital Value Based Purchasing (VBP) Program and the continued inclusion of the pneumococcal immunization measure (IMM-1) in the Hospital IQR Program. Immunization measures provide a platform to maintain and increase immunization rates, and provide a mechanism for hospital providers to routinely assess and vaccinate their patients. Immunization measures in hospitals also provide an important incentive to vaccinate high-risk patients, like those with underlying conditions and chronic diseases.

AIM asks that CMS:

1. Finalize the provision to include the influenza immunization measure for acute care hospitalized inpatients age 6 months or older (IMM-2, National Quality Forum (NQF) #1659) in the Hospital VBP Program; and
2. Reconsider the proposed removal of the pneumonia immunization measure (IMM-1) from the Hospital IQR Program, as this could adversely affect pneumococcal immunization rates, public health, and patient safety.

Each year, influenza causes approximately 200,000 hospitalizations and 36,000 deaths in the United States.<sup>1</sup> Hospital acquired influenza results in longer hospital stays and greater morbidity and mortality among patients.<sup>2</sup> Influenza contracted in hospitals increases healthcare costs due to longer hospitalization and increased use of services like diagnostics and treatments. One study reported mean excess healthcare costs of \$7,545 per case of nosocomial influenza.<sup>3</sup>

Influenza vaccination is the primary method for preventing influenza and is proven to be safe and effective<sup>4</sup> and is recommended for annual use for all people 6 months of age and older by the Advisory Committee on Immunization Practices (ACIP). Quality measures such as IMM-2 help maintain and increase influenza vaccination rates by ensuring the health care providers assess patient vaccine needs and administer the vaccine when needed.

In addition to supporting the IMM-2 measure, AIM strongly encourages CMS to reconsider removing IMM-1 from the Hospital IQR Program in FY2014. IMM-1 provides a platform to fortify pneumonia vaccination rates in patients, especially elderly and high-risk patients, and helps prevent morbidity, mortality and excess medical costs.

Each year, approximately 175,000 people are hospitalized with pneumococcal pneumonia in the U.S., and these patients are at increased risk for myocardial infarction, arrhythmia, or congestive heart failure.<sup>5</sup> In 2012, the total costs for Medicare beneficiaries during and one year following a pneumonia hospitalization were approximately \$15,682 higher than those patients without pneumonia.<sup>6</sup> In 2004, pneumonia caused an estimated 4 million illness episodes, resulting in direct medical costs of \$3.5 billion, and approximately half of these costs were for the care of patients 65 years and older.<sup>7</sup>

Vaccination is the primary method for preventing pneumococcal disease. Vaccination against pneumococcal disease can also help prevent the need for antibiotic treatments and the

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<sup>1</sup> Tilburt J, Mueller P, Ottenberg A, Poland G, Koenig B. Facing the challenges of influenza in healthcare settings: The ethical rationale for mandatory seasonal influenza vaccination and its implications for future pandemics. *Vaccine*. 2008;26(suppl 4):D27-30.

<sup>2</sup> Lindley M, Yonek J, Ahmed F, Perz J, Torres G. Measurement of influenza vaccination coverage among healthcare personnel in US hospitals. *Infect Control Hosp Epidemiol*. 2009;30:1150-1157.

<sup>3</sup> Salgado C, Giannetta E, Hayden F, Farr B. Preventing nosocomial influenza by improving the vaccine acceptance rate of clinicians. *Infect Control Hosp Epidemiol*. 2004;25(11):923-928.

<sup>4</sup> U.S. Department of Health and Human Services. HHS Action Plan to Prevent Healthcare-Associated Infections: Influenza Vaccination of Healthcare Personnel. 2010. [http://www.hhs.gov/ash/initiatives/hai/tier2\\_flu.html](http://www.hhs.gov/ash/initiatives/hai/tier2_flu.html).

<sup>5</sup> National Foundation for Infectious Diseases. Pneumococcal Disease Call to Action. April 2012. [http://aahivm.org/Upload\\_Module/upload/Provider%20Resources/Pneumococcal%20CTA%20HCP%20Roles%20AAHI%20Partner.pdf](http://aahivm.org/Upload_Module/upload/Provider%20Resources/Pneumococcal%20CTA%20HCP%20Roles%20AAHI%20Partner.pdf).

<sup>6</sup> Thomas C, et al. Incidence and Cost of Pneumonia in Medicare Beneficiaries. *Chest*. 2012; 142(4):973-81.

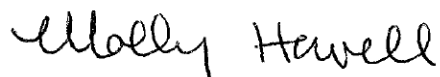
<sup>7</sup> National Foundation for Infectious Diseases. Pneumococcal Disease Call to Action. April 2012. [http://aahivm.org/Upload\\_Module/upload/Provider%20Resources/Pneumococcal%20CTA%20HCP%20Roles%20AAHI%20Partner.pdf](http://aahivm.org/Upload_Module/upload/Provider%20Resources/Pneumococcal%20CTA%20HCP%20Roles%20AAHI%20Partner.pdf).

subsequent spread of antibiotic resistance. Despite the benefits, pneumococcal immunization rates are still low. In 2011, pneumococcal vaccination coverage among adults age 65 and older was only 62 percent, and among high-risk adults age 19-64, it was only 20 percent.<sup>8</sup> The U.S. Department of Health and Human Services' (HHS) *Healthy People 2020* targets for these populations are 90% and 60% vaccination coverage respectively.

Immunization quality measures provide a platform for improving these rates, especially in hospitals where pneumococcal vaccines can be readily administered to vulnerable populations. Since the inclusion of pneumococcal vaccination quality measures (in 2006), large increases in vaccination rates have been observed. For example, between 2006 and 2010, the percentage of pneumonia patients who were assessed and received pneumococcal vaccine increased from 71 to 94 percent.<sup>9</sup>

Given the significant public health and economic impact of pneumonia and hospital acquired influenza and the continued opportunities for improvement in vaccination rates that hospital immunization measures provide, AIM supports the addition of the IMM-2 into the Hospital VBP Program and the continued inclusion IMM-2 measures in the Hospital IQR Program.

Sincerely,



Molly Howell, MPH

Chair, AIM



Claire Hannan, MPH

Executive Director, AIM

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<sup>8</sup> Centers for Disease Control and Prevention. Noninfluenza vaccination Coverage Among Adults – United States, 2011. *MMWR Morb Mortal Wkly Rep.* 2013;63(04):66-72.

<sup>9</sup> Centers for Medicare & Medicaid Services. National Impact Assessment of Medicare Quality Measures. March 2012. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/NationalImpactAssessmentofQualityMeasuresFINAL.PDF>. p. 40-42.

