Letter to the editor regarding: The effectiveness of Medicare's non-payment of hospital-acquired conditions policy

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Schuller, et al.(1) conclusion on the lack of impact of the Policy regarding non-payment for -(CAUTIs) can be supported by data that has been published in the U.S. Federal Register. The policy of not paying for certain Hospital-Acquired Conditions (HACs) was mandated by the U.S. Congress for Medicare in the 2006 Deficit Reduction Act(2) and for Medicaid by the Affordable Care Act and essentially enacted line item penalties in a largely bundled payment system; a plan some would argue was doomed to fail at its onset.(3) Nationwide data for the initiative has been published in the Federal Register for Fiscal Years 2008-2009 (4), 2009-2010(5) and 2010-2011(6). Later years have not been reported, possibly because of the very low impact of this congressional mandate.

Table 1 shows that very few nationwide penalties have been levied for HACs by Medicare for infections. Out of the estimated 1 to 1.5 million CAUTIs which occur annually nationwide(1), less than 250 events have had penalties levied(See Table 1). Other hospital acquired infections had far fewer events penalized, some in the single digits. The majority of penalties have been for falls, pulmonary embolism & DVT Orthopedic and stage III and IV pressure ulcers. However, considering that over 3500 hospitals participate in the Medicare hospital inpatient prospective payment systems, even these penalties are meager.

New payment incentives are present which may impact at least some HACs. For example: A few healthcare-associated infections are part of the plethora of metrics which make up the algorithm determining Medicare's Value-Based Payment(VBP) reimbursement, which will enact up to a 2% penalty (or bonus) on the entire fee schedule for some facilities.(6,7) CAUTIs will be included in VBP starting in 2016. In addition, unlike other metrics, the onset of infections often may be delayed, thus, infections can also increase the rate of readmissions and impact a facility's penalty (or bonus) regarding their readmission rate. Recently, a proposed rule for fiscal year 2015 would enact a 1% penalty on inpatient Medicare payments to hospital that are in the top quartile for rates of HACs (poorest performers). (8) If this later proposal is approved, incentives to reduce HACs will be substantially increased.

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Table 1: Net Savings Non-Payment of Selected HAC in Medicare Recipients - Chart F Federal Register

	Oct. 2008 to Sept. 2009		Oct. 2009 to Sept. 20010		Oct. 2010 to Sept. 2011	
Metric	**Number of Events Penalized**	**Total Nationwide Penalty**	**Number of Events Penalized**	**Total Nationwide Penalty**	**Number of Events Penalized**	**Total Nationwide Penalty**
Catheter-Associated UTI	223	$642,003	223	$696,662	160	$491,053
Vascular Catheter-Associated Infections	26	$85,254	22	$77, 690	20	$92,100
SSI Mediatstinitis CABG	6	$57,676	4	$32,392	5	$60,438
SSI Orthopedic	5	$43,958	2	$15,044	6	$41,503
SSI Bariatric	1	$2,381	0	$0	2	$3,312
Falls	1577	$8,093,391	1672	$9,200,708	1241	$7,362,538
Pulmonary Embolism & DVT Orthopedic	1024	$6,919,410	1206	$8,826,912	1082	$8,313,098
Pressure Ulcers Stages III & IV	384	$2,156,113	292	$1,795,456	286	$1,846,449
Total Net Savings All HACS	3,416	$18,779,932	3572	$21,450,095	2991	$19,375,777