

Effective January 23, 2023, the new phone number for the Help Desk is 1-866-498-2945



[Docket \(/docket/CMS-2014-0051\)](/docket/CMS-2014-0051/) / [Document \(CMS-2014-0051-0002\) \(/document/CMS-2014-0051-0002\)](/document/CMS-2014-0051-0002/)  
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## Health Watch USA, Kavanagh, Kevin--KY

Posted by the **Centers for Medicare&Medicaid Services** on Jul 16, 2014

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We would like to voice support for the updated policies regarding the Hospital-Acquired Condition (HAC) Reduction Program as published in the Federal Register. The proposed 1% reduction in payment for the top quartile of hospitals (poorer performers) provides a stronger penalty than the current non-payment policy for HACs and has the potential to stimulate improvements in safety.

The vast majority of HACs are preventable and financial initiatives are needed to motivate quality improvement. The current non-payment of HACs initiative has had a questionable impact on quality improvement, as documented by three recent studies that have reported little impact on lowering rates of mediastinitis following coronary artery bypass graft surgery (CABG), central line associated bloodstream infections (CLABSIs), and catheter associated urinary tract infections (CAUTIs).. In addition, the Commonwealth Fund observed that the non-payment initiative did not produce major changes in care practices of safety net hospitals.

We believe there are several major reasons why the current non-payment of HAC program has garnered such poor results.

- First hospitals are able to avoid the financial penalty by substituting another diagnostic code to serve as a co-morbidity or major-comorbidity factor and still receive maximum reimbursement. Thus, the hospital acquired condition non-payment program only impacts a few of the hospitalizations during which events occur.

McNair, et. al., describe the payment reductions in the non-payment initiative as negligible. Over the first three years of the non-payment initiative, total annual penalties to the more than 3500 hospitals which participate in the prospective payment system ranged from 18.8 to 21.5 million dollars for all HACs



combined. For a number of HACs the number of events penalized each year were in the single digits; for central line associated blood stream infections, this number was less than 30.

- But more important is the flawed policy that makes the hospital in which the HAC event occurred only accountable for a small portion of the inpatient costs incurred by Medicare in caring for the harmed patient. This is similar to the crashing of a transcontinental flight and the passengers still being charged for a prorated portion of the air fare, up to the point of the crash.

- In addition, neither policy covers common consequential costs from readmissions, physician care, medications, wound care, or physical therapy. The complete costs of an error or infection can take years to assess and Medicare ends up paying the bulk of the bill. Thus, strengthening the penalties with the newly proposed HAC initiative is needed.

Of equal importance as the payment incentives, is the public availability of facility specific incident data on HACs. HACs for acute care facilities have been posted on Hospital Compare in the past. This data was incomplete since at that time only the first 9 of 25 submitted diagnoses were uniformly captured for facilities. This problem has been corrected and more complete data is being captured by CMS. However, the facility specific data on HACs is no longer available on Hospital Compare where it is readily accessible by the public. We strongly urge CMS to repost this data on Hospital Compare and to post updated source data on [www.data.gov](http://www.data.gov).

Thank you for this consideration,

Kevin T. Kavanagh, MD, MS  
Health Watch USA  
Somerset, KY 40503

Lenore Alexander  
Executive Director, LeahsLegacy  
Oak Park CA 91377

Joleen Chambers  
FAILED Implant Device Alliance  
Dallas, TX 75201

Alicia Cole  
HAI Survivor/Patient Advocate  
Alliance for Safety Awareness for Patients  
Sherman Oaks, CA

Kerry O'Connell  
Patient Advocate  
Denver, CO 80238

Kathy Day, RN  
McCleary MRSA Prevention  
Bangor, Maine

Julia Hallisy, DDS  
The Empowered Patient Coalition



San Francisco, CA 94132

Helen Haskell, MA  
Mothers Against Medical Error  
Columbia, SC 29205

John T. James, PhD.  
Patient Safety America  
Houston, TX

Patricia Kelmar & Jean Rexford  
CT Center for Patient Safety  
[www.http://ctcps.org](http://ctcps.org)

Al Levine  
Retired Office of Inspector General Senior Program Analyst  
Washington, DC

Mary Ellen Mannix, MRPE  
[www.jamessproject.com](http://www.jamessproject.com)  
Wayne, PA 19087

Patty J Skolnik  
Founder & Director  
Citizens for Patient Safety  
Denver, CO 80230

Jeanine Thomas  
MRSA Survivors Network  
Hinsdale, IL 60522

Yangling Yu & Rex Johnson  
Washington Advocates for Patient Safety  
Seattle, WA 9815

References and Footnotes for the above comment are contained in the enclosed file.

Attachments 1



20140627-HAC-Comments

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