RE: Support of the Hospital-Acquired Condition (HAC) Reduction Program proposed rule in the Federal Register, 79 FR 27977.

Centers for Medicare &
Medicaid Services, Department of
Health and Human Service
Attention: CMS–1607–P, Mail Stop C4–26–05,
7500 Security Boulevard
Baltimore, MD 21244–1850.

We would like to voice support for the updated policies regarding the Hospital-Acquired Condition (HAC) Reduction Program as published in the Federal Register.(1) 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).(2-4). In addition, the Commonwealth Fund observed that the non-payment initiative did not produce major changes in care practices of safety net hospitals.(5)

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.(6) 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.(7) 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.(8-10) 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.(11) 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.

Thank you for this consideration,

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References:

(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES. Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program; Hospital Inpatient. Federal Register. Executive Summary; Section 2, Summary of Major Provisions; Subsection d. 79 FR 27977. 27977 -28384 (408 pages) 42 CFR Parts 405, 412, 413, 415, 422, 424, 485, and 488. [CMS-1607-P] RIN 0938-AS11. May 12, 2014.

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(3) Lee GM, Kleinman K, Soumerai SB, et al. Effect of nonpayment for preventable infections in U.S. hospitals. N Engl J Med 2012;367:1428-37.

(4) Schuller K, Probst J, Hardin J, Bennett K, Martin A. Initial impact of Medicare's nonpayment policy on catheter-associated urinary tract infections by hospital characteristics. Health Policy. 2014 Apr;115(2-3):165-71. doi: 10.1016/j.healthpol.2013.11.013. Epub 2013 Dec 5.

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(7) McNair PD, Luft HS, Blindman AB. Medicare's policy not to pay for treating hospital-acquired conditions: The Impact. Health Affairs. 2009 28(5):1485

(8) Centers for Medicare and Medicaid Services. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and long term care hospital prospective payment system changes and FY2011 rates; provider agreements and supplier approvals; and hospital conditions of participation for rehabilitation and respiratory care services; Medicaid program: Accreditation for providers of inpatient psychiatric services; final rule. Chart F. Federal Register, 2010:75(157), 50097. Last Accessed on Apr. 6, 2014 from http://www.gpo.gov/fdsys/pkg/FR-2010-08-

16/pdf/2010-19092.pdf

(9) Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting\Requirements for Specific Providers and for Ambulatory Surgical Centers; Final Rule. Chart F. Federal Register, 2011:76(160), 51520. Last accessed on Apr. 6. 2014 from http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf

(10) Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting\Requirements for Specific Providers and for Ambulatory Surgical Centers; Final Rule. Chart F. Federal Register, 2012:77(170), 53300. Last accessed on Apr. 6, 2014 from http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf

(11) Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2011 Rates; Effective Date of Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services Medicaid Program: Accreditation Requirements for Providers of Inpatient Psychiatric Services for Individuals Under Age 21; Proposed Rules. Federal Register. 2010, May 4. 75(85) p23914.