The Hospital-Acquired Conditions (HAC) Reduction Program is a pay-for-performance program mandated by the Affordable Care Act. The program looks to reduce the incidence of common conditions that patients can contract during hospital stays which CMS has deemed avoidable. These include health care-associated infections, foreign objects left after surgery, and a wide array of patient safety issues. Beginning in 2008, Medicare stopped reimbursing hospitals for additional costs of care related to these conditions. The new provisions will look to further curb HACs via substantial revenue penalties. Under the program, CMS will impose a 1% penalty on Medicare inpatient payments to the top quartile of hospitals with the highest HAC scores.

Why is the HAC Reduction Program a key issue for providers?

The HAC Reduction Program will work in tandem with the Value-Based Purchasing (VBP) and Readmissions Reduction programs to continue to raise incentives for higher quality care at a lower cost. CMS has identified preventable conditions to include in the program, and the number is set to expand each year. These conditions include: foreign objects retained after surgery, air embolisms, blood incompatibility, pressure ulcers, falls/trauma, manifestations of poor glycemic control, infections, and thrombosis.

The HAC Reduction Program penalty stands to significantly reduce inpatient Medicare reimbursement, as the worst performing quartile of facilities will receive a 1% flat penalty. Our analysis indicates that organizations receiving a HAC penalty are almost guaranteed to take a net loss overall from the pay-for-performance programs, even after considering potential bonuses under the VBP. Reducing HACs may serve to further improve the inpatient book of business, as they also increase length of stay, mortality rates, and total costs.

How does the HAC Reduction Program work?

The HAC Reduction Program judges hospitals on their performance in two domains:

• Domain 1 is comprised of a single patient safety composite called PSI-90. Eleven individual components are included in the composite indicator, including: severe bed sores, infections, complications from medical treatment, and accidental punctures or lacerations.

• Domain 2 consists of infection rate measures for major infections tracked by the Centers for Disease Control and Prevention’s National Health Safety Network. For fiscal year (FY) 2015 the domain will contain only two measures: central line-associated blood stream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI). This domain will expand to include other infections in future years, such as surgical site infections (SSI), Methicillin-resistant Staphylococcus aureus (MRSA), and C. Difficile.

Each measure is pre-adjusted for risk factors such as age, gender, and patient comorbidities to account for hospitals that serve a disproportionate amount of very sick patients, or that conduct high volumes of surgeries.

Domain scores are calculated by averaging the measures scores in each domain. A “Total HAC Score” is then calculated from the domain scores: for FY 2015 Domain 1 was weighted at 35% while Domain 2 covered the remaining 65%; for FY 2016 the weights will shift to 25% and 75% respectively. For FY 2017 the proposed weights will continue to shift to 15% Domain 1 and 85% Domain 2. It is possible that these weights will continue to change in future years as well.

### Upcoming Changes to HAC Program

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>CAUTI</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>SSI – Colon</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>SSI – Abdominal Hysterectomy</td>
<td>❌</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>MRSA</td>
<td>❌</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>C. Difficile</td>
<td>❌</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

### Questions That Hospital Executives Should Ask Themselves

1. For what conditions does my facility have below-average performance?
2. What programs, processes, or technologies are in place to reduce HACs? Are they targeted at the correct conditions?
3. What are my most effective infection control resources to ensure that all staff are mindful of contamination issues?
How does the HAC Reduction Program affect providers?

Clinical

Clinical staff must ensure that strict hospital protocols are followed to limit infections. For example, nurses should monitor excessive catheterization to decrease risk of infection, and physicians should ensure catheters are removed when medically indicated. In addition, providers must proactively manage older and sicker patients to avoid complications and adverse events as these types of patients are more susceptible to HACs. Furthermore, hospital staff must ensure that patient illnesses that are present on admission are properly catalogued and coded. If not logged, non-coded complications could be considered HACs and potentially contribute to a penalty.

Financial

Five to ten percent of patients acquire an infection in the hospital each year, which results in $45B in additional health care costs. The rapidly growing and aging Medicare population will likely result in more patients with multiple chronic conditions that in turn leads to higher HAC rates. The shift from commercial insurance to Medicare, and a growing older and sicker population, will mean that HACs will remain an ongoing health and financial challenge.

Operational

Timely and detailed documentation is becoming increasingly important to protect inpatient payments, especially when it comes to the HAC program. Incorrect or incomplete documentation may contribute to a greater number of HACs being identified at a facility. From a staffing perspective, providers may wish to expand their Infection Control Personnel (ICP) to help combat HACs. Inadequate staffing is a prime issue for hospitals, as ICPs have to manage many tasks: staff education about antibiotic resistance, epidemiological investigations, infection metric reporting, etc. Janitorial and maintenance staff must also be included in hygiene efforts and educated about their role in patient health. Emphasis on "high risk, high touch" objects (e.g., phones and keyboards) should be paramount for providers.

How might the HAC Reduction Program affect IT?

Innovative Technology and Medicine

- Materials that passively fight infections, medicines that fight drug-resistant infections, anti-microbial facility design elements, and other innovative features will be in high demand.

Enhanced Training and Care Standardization

- Provider training and education on care guidelines are important in reducing HACs. IT can support this with reminders and training tools.

Hygienic Practices

- Increasing hand-washing compliance can vastly reduce HACs. Hospitals may add sinks, antibacterial solution dispensers, or non-irritating soaps in order to ensure staff maintain proper hygiene protocols. A real-time locating system may be used to trigger an alert if the clinician entering the room does not go near the hand sanitizer or sink. Institutions may also use IT services to compile and analyze hygiene practices.

Additional Advisory Board research and support are available

If you would like to learn more about the Advisory Board’s recommendations for fighting HACs, see the Advisory Board Research Brief, The Journey to Zero. To see how the HAC reduction program will be implemented with other CMS measures, see the CMS fact sheet. Sources: CMS.gov; Advisory Board research and analysis.