Evaluating and Improving CMS’ Hospital Safety Program

The Hospital-Acquired Condition Reduction Program (HACRP) was introduced by the Centers for Medicare and Medicaid Services (CMS) in 2013 to improve patient safety. The program penalizes the 25% of hospitals with the highest rates of hospital-acquired conditions by reducing Medicare payment rates for inpatient care by 1%. Under the program, hospitals receive penalties of approximately $350 million annually.

Measures of Patient Safety Used in the HACRP

- CMS Recalibrated Patient Safety Indicator (PSI) 90
- Catheter-Associated Urinary Tract Infection
- Clostridium Difficile Infection
- Methicillin-resistant Staphylococcus aureus bacteremia
- Surgical Site Infection - Colon and Hysterectomy
- Central Line-Associated Bloodstream Infection

Takeaways from our Research

- Penalization has not improved safety.
- Risk adjustment is inadequate, leading to disproportionate penalties for teaching hospitals and hospitals caring for more underserved patients.
- The performance measures used to penalize hospitals are not sufficiently reliable or valid.
Concrete Steps to Improve the HACRP

Problems with Implementation

- The current risk adjustment approach is insufficient to account for the large heterogeneity across patients and hospitals, disadvantaging hospitals treating more complex patients.

- Some hospitals lack adequate sample size on measures for which they receive scores, diminishing the reliability of their scores as well as hospital comparisons.

- There is wide variability across hospitals in surveillance, testing, and reporting practices for hospital acquired conditions. CMS definitions of hospital acquired conditions are overly technical and challenging to implement.

- Measures do not always incentivize or reward proven preventive actions to decrease the risk of the given hospital acquired condition.

- Auditing and validation strategies have been insufficient to ensure high quality data.

Potential Solutions

- Include additional risk factors to risk adjustment methodologies (e.g., preoperative diagnosis, whether the case is elective or emergent, patient immunosuppression). Modify penalty thresholds based on hospital peer groups.

- Use more data years to increase sample size and employ Bayesian shrinkage to enhance assessment of hospital safety.

- Establish clear and simple guidelines about proper surveillance, testing, and reporting practices related to hospital acquired conditions. Provide technical assistance.

- Add measures rewarding a reduction in exposures to infection.

- Enhance auditing of performance by implementing more stringent and comprehensive validation or audit approaches, along with more severe consequences for failing validation.

Our published research


AUTHORS
Andrew M. Ryan, PhD, Director of CEHR, Associate Professor of Health Management and Policy, University of Michigan
Emily J. Lawton, MPP, PhD Candidate, Health Management and Policy, University of Michigan
Kyle H. Sheetz, MD, Resident Surgeon, Department of Surgery, Michigan Medicine

CONTACT US
cehr-contact@umich.edu

CONTACT US
cehr-contact@umich.edu

LEARN MORE
www.sph.umich.edu/cehr/index.html