measures, 75 percent), and adding together the weighted domain scores to determine the

Total HAC Score (§ 412.172(e)(3)).

For FY 2017, we are proposing to adjust the weighting of Domains 1 and 2 so that

the weight of Domain 1 would be 15 percent and the weight of Domain 2 would be 85

percent. We are proposing to decrease the Domain 1 weight for two reasons. First, with

the implementation of the CDC MRSA Bacteremia and CDI measures in the FY 2017

program, we believe the weighting of both domains needs to be adjusted to reflect the

addition of the fifth and sixth measure in Domain 2. Second, among the public

comments on the FY 2014 and FY 2015 IPPS/LTCH PPS final rules that were

considered, MedPAC and other stakeholders recommended that Domain 2 should be

weighted more than Domain 1 because they believed the CDC NHSN chart-abstracted

measures were more reliable and actionable than claims-based measures. We are inviting

public comments on this proposal to decrease the Domain 1 weight from 25 percent to 15

percent and increase the Domain 2 weight from 75 percent to 85 percent for FY 2017.

6. Proposed Measure Refinements for the FY 2018 HAC Reduction Program

a. Proposal to Include Select Ward (Non-Intensive Care Unit (ICU)) Locations in Certain

CDC NHSN Measures Beginning in the FY 2018 Program Year

We are proposing measure refinements to the CDC NHSN CLABSI and CAUTI

measures that were previously adopted for the HAC Reduction Program to include select

ward (non-ICU) locations beginning in FY 2018. In the FY 2014 IPPS/LTCH PPS final

rule (78 FR 50712 through 50719), we adopted the CLABSI and CAUTI measures

inclusive of pediatric and adult patients in ICUs for the HAC Reduction Program

beginning with FY 2015. We noted at that time that the Hospital IQR Program finalized

data collection for these measures for adult and pediatric patients in medical, surgical and

medical/surgical wards (also referred to as select ward locations), in addition to ICU

locations, effective beginning January 1, 2015, and that we would propose the additional

locations for the HAC Reduction Program in the future.

The refined CAUTI and CLABSI measures that include select ward locations in

addition to ICU locations were endorsed by the NQF in 2012. The MAP 2015 final

recommendations indicated that the CLABSI and CAUTI measures with ICU and select

ward locations be included in the HAC Reduction Program.[74] We note that during the

MAP Hospital Workgroup meeting (December 9-10, 2014) and the MAP Coordinating

Committee meeting (January 26-27, 2015), some members discussed the benefit of

reporting the modified measures publicly before including them in a payment program in

order to allow providers and CMS to gain experience with the modified measures. Other

members expressed concern that this could delay implementation of an improved

measure[75]. The MAP supported the use of the refined measures without stipulating prior

public reporting as a condition of support. However, we acknowledge the importance of

this consideration and took it into account when considering the timing of implementing

the expanded measure in the HAC Reduction Program.

We considered a number of options for when to begin using the refined measures

in the HAC Reduction Program. The CDC NHSN measure data used in the HAC

Reduction Program are obtained from data that hospitals report as part of their

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[74]Available at: http://www.qualityforum.org/map/.
[75]Ibid.

participation in the Hospital IQR program. Therefore, due to the timing of the Hospital IQR Program including select ward locations (beginning January 1, 2015), the FY 2017 HAC Reduction Program, using the applicable period of CYs 2014 and 2015 for the CDC NHSN measures, is the first time data from select ward locations could be included in the program. However, using select ward location data in the FY 2017 program would result in hospitals with ICU locations having the opportunity to contribute 2 years of data, while hospitals without ICU locations would have the opportunity to contribute 1 year of data for measure result calculation. We believe this systematically unequal distribution of data could introduce bias in the program and should be avoided. If the introduction of select ward location data for the CLABSI and CAUTI measures is delayed until the FY 2018 HAC Reduction Program (applicable period would likely be CYs 2015 and 2016), all hospitals, regardless of whether or not they have ICUs, would have the opportunity to contribute 2 years of data for measure result calculations.

In addition, delaying implementation until FY 2018 would allow CMS and providers to gain some experience with the impact that the inclusion of these data would have on a hospital's HAC Reduction Program scores. We also considered the possibility of further delaying implementation of the refined measures until the FY 2019 program (applicable period would likely be CYs 2016 and 2017) in order to not include the first year of reporting (CY 2015) in a payment program measure calculation.

After considering these three options, we are proposing to include data from pediatric and adult medical ward, surgical ward, and medical/surgical ward locations in addition to data from adult and pediatric ICU locations for the CDC NHSN CLABSI and

CAUTI measures beginning with the FY 2018 HAC Reduction Program. This option

balances our belief that the refinement of the CLABSI and CAUTI measures to include

select ward locations results in an improved measure that more accurately captures

hospital-wide performance regarding these HACs with the need to provide hospitals with

the opportunity to submit data for the full period of performance and the desire to gain

experience with the refined measures before incorporating them into the HAC Reduction

Program. We also believe this measure refinement will allow hospitals that do not have

ICU locations to use the tools and resources of the NHSN for quality improvement and

public reporting efforts (78 FR 50787).

        We are inviting public comment on our proposal.

b. Update to CDC NHSN Measures Standard Population Data

        In this section, we provide information regarding upcoming changes to the

standard population data that are used to calculate the SIR for the CDC NHSN measures.

These changes are occurring as part of routine measure maintenance.

        The CDC NHSN measures are used to monitor hospital performance on

prevention of healthcare-associated infections (HAIs). For each NHSN measure, CDC

calculates the SIR, which compares a hospital's observed number of HAIs to the number

of infections predicted for the hospital, adjusting for several risk factors.[76] The predicted

number of infections is determined using patient care location characteristics (for

example, the number of central line days) and infection rates that occurred among a

standard population during a specified time period (sometimes referred to by CDC as

"national baseline" but referred to here as "standard population data"). For example,

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[76]Available at: http://www.cdc.gov/nhsn/PDFs/Newsletters/NHSN_NL_OCT_2010SE_final.pdf.