May 22, 2023

The Centers for Medicare and Medicaid must include hospital-onset COVID-19 in the Hospital-Acquired Condition (HAC) Reduction Program part of CMS-1785-P.

The following measures should be implemented:

1) CMS should include COVID in its HAC Reduction Program and require hospitals to report and try to minimize hospital-onset COVID, using layered protections, such as universal mask wearing, universal screening testing, and improved air quality to promote patient and staff safety and health equity.

2) Hospital-onset COVID should be defined as infections diagnosed after 5 days of admission or greater.[1,2] Hospitals should report all hospital-onset COVID cases to CMS, and post these numbers publicly.

3) Additional research is needed to better understand COVID transmission and to improve definitions of hospital-acquired COVID, using whole genome sequencing technologies and serial surveillance testing.[1,3] The CDC currently defines hospital-onset COVID as cases diagnosed after 14 days of hospitalization, which is a huge underestimate. Even 5- or 7-day thresholds to define hospital-acquired COVID underestimate its true incidence.[1,2] Hospitals should be required to report all COVID cases to CMS and the CDC and specify how many days patients have been in the hospital when diagnosed with COVID.

The evidence that informs these suggestions includes:

For only three months of 2023, the CDC tallied nearly 138,000 hospital-onset COVID infections, counting only those that arose after 14 days of hospitalization.[4]

COVID has been one of the top five major causes of death in the US since 2020,[5,6] and many of those deaths were likely due to hospital-acquired COVID, which has a 5-10% mortality rate.[7,8] This is significantly higher than several of the other infections CMS includes in its HAC Reduction Program. Catheter-Associated Urinary Tract Infection has a mortality rate of 2.3%,[9] Surgical Site Infections for Abdominal Hysterectomy and Colon Procedures have a mortality rate of 3%,[10] and *Clostridioides-difficile (C. diff)* infection has a mortality rate of 7.9%.[11] Thus, hospital-onset COVID is well worth preventing.

Nearly 40% of all US residents are concerned about COVID outbreaks.[12] Preventing COVID in the hospital is an equity issue. People of color continue to suffer high rates of COVID deaths.[13] Half of health workers go to work with COVID symptoms,[14] amid huge health worker shortages. CMS needs to protect both patients and health workers.

Even when community transmission is low, healthcare settings are the most likely place where people getting care for COVID could encounter vulnerable patients who could be harmed by COVID. Covid outbreaks are already happening in hospitals that ditched masks.[15] If your hospital roommate has COVID, you have a 4 in 10 chance of catching it from them.[16] No one should go to the hospital for a heart attack, an elective surgery or to deliver a baby and catch COVID.

In spite of these facts, hospital administrators lobbied public health departments to end COVID protections in healthcare.[17] Vulnerable patients can still become severely ill or die from COVID. Anyone can get Long COVID, which disables over 4 million people in the United States.[18,19] Hospitals should be protecting us from COVID when we are in their care. But hospitals are in a “crushing” financial crisis.[20] They lose money when they have to cancel procedures when patients test positive for COVID. We are concerned that hospitals are putting profits over patient safety.

Please protect vulnerable patients, prevent health worker shortages, and promote health equity by requiring hospitals to protect patients from hospital-acquired COVID.

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