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A Revenue Leak Soon Turns to Flood: How Payment Penalties for High Infection Rates Could Drain Hospital Finances

Written by Adam A. Boris, CEO, ICNet Systems | March 15, 2013

As a host of new government payment penalties and reporting requirements take effect, preventing healthcare-associated infections is becoming a matter of financial survival for hospitals. HAIs put millions of dollars in revenue at risk, threaten hospital reputations and tax already limited infection prevention resources.

Accounting for all of the Medicare payment reforms related to HAIs, as well as the costs of extended stays to treat infections, a hospital with $50 million in annual Medicare inpatient revenue would have a potential of $4.82 million in reimbursement at risk this year; that risk will grow to more than $6.6 million by the fall of 2014 (see chart). Those figures do not take into account Medicaid and private payor actions, which are growing in intensity. Nor do they reflect the significant costs of litigation arising from infections.

With 39 percent of hospitals running at a financial loss in 2011, even a small change to reimbursement rates can lead to huge changes in staffing models at hospitals and ultimately the quality of patient care they are able to provide, the American Hospital Association says.

HAIs cause longer lengths of stay and more intensive care, accounting for $40 billion in excess costs in 2009, according to the Centers for Disease Control and Prevention. For example, treating a central-line associated bloodstream infection adds an average of $36,441 to a hospital bill. All of these costs are absorbed by the hospital's operating budget, as most post-infection care will not be reimbursed.

As a result of these pressures, many senior leaders are looking at new ways of preventing infections, including screening new patients and adopting surgical checklists, stronger isolation precautions and electronic surveillance of potential infections.

HAIs and Payment Penalty Calculator
For a 250-bed hospital, with 2013 Medicare inpatient PPS reimbursement of $50 million

Fiscal year 2013		
Program	**% payment at risk**	**$ at risk**
Infection reporting to NHSN	2%	$1 million
Value-based Purchasing	1%	$500,000
Readmissions	1%	$500,000
Nonpayment for HAIs*	NA	$20,000
Total payment at risk:		**$2,020,000**
Cost of extended stay due to HAI**		**$2,800,000**

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Total direct costs and penalties		**$4,820,000**

Fiscal Year 2015		
Program	**% payment at risk**	**$ at risk**
Infection reporting to NHSN:	2%	$1 million
Readmissions:	3%	$1.5 million
Bottom quartile of infections:	1%	$500,000
Value-based purchasing	1.5%	$750,000
Nonpayment for HAIs*	NA	$20,000
Total payment at risk:		**$3,770,000**
Cost of extended stay due to HAI**		**$2,800,000**
Total direct costs and penalties		**$6,577,000**

* Based on total withhold in fiscal year 2012 divided by number of U.S. hospitals subject to payment penalties
** Assumes 10,000 admissions, 4% HAI rate, and 7 days of extended stay per HAI; internal cost of additional patient day assumed to be $1,000

A continuing threat
The contagion in America's hospitals is far from being under control. In fact, emerging threats from multi-drug-resistant organisms and continuing problems in controlling surgical-site and catheter-related infections have, if anything, made the problem more dire.

There is evidence that public reporting and payment reforms have had a positive, but limited, effect. A report issued by the CDC in early 2012 found that in 2010 healthcare facilities complying with mandatory infection data reporting to the CDC's National Healthcare Safety Network had 32 percent fewer central-line-related infections, 6 percent fewer catheter-related infections and 8 percent fewer surgical site infections than expected based on the case mix of patients and locations monitored.

"The mandatory reporting and in some cases public reporting of HAIs has seemed to elevate the importance of infection prevention in hospitals and often resulted in increased attention by the C-suite on the roles, responsibilities and data collected by infection preventionists and hospital epidemiologists," said Patricia W. Stone, a professor of health policy and director of the Center for Health Policy at Columbia University School of Nursing, who has written extensively on HAIs and reimbursement.

Although there has been a reduction in those infections that have been systematically measured and reported, many common infections persist and are increasing in prominence. The reported infections, such as methicillin-resistant Staphylococcus aureus and central-line-related bloodstream infections, are but a small fraction of all infections that occur in a hospital each year. Norovirus, a pathogen that often causes food poisoning and gastroenteritis, is the fastest-growing infection and was responsible for nearly one in five infection outbreaks and 65 percent of unit closures in U.S. hospitals during a two-year period, according to a study published in the February 2012 issue of the *American Journal of Infection Control.*

The high price of inaction
One reason for that failure may have been an unintended consequence of government payment policies, which initially focused attention on a few HAIs. Since 2008, Medicare has refused to pay the added cost of treating catheter-associated urinary tract infections and central-line-related bloodstream infections, a policy since extended to surgical-site infections following coronary artery bypass grafts, bariatric surgeries and orthopedic procedures.

A Harvard study published in the *New England Journal of Medicine* in October 2012 found no evidence that the Medicare non-payment policy had any measurable effect on infection rates in U.S. One issue blunting the impact of the law is that hospitals can continue to bill for not only the diagnosis present on admission, but also co-morbidities for infected patients. In fact, CMS has admitted that nationally only about $50 million to $60 million has been withheld each year from hospital reimbursements.

"If you think about that amount of money spread across 5,000 or 6,000 facilities, hospitals haven't had a lot of skin in this game, but the no-pay rule did get people's attention because it was the first time there were any payment ramifications related to quality," said Ed Septimus, MD, a professor of internal medicine at Texas A&M Health Science Center in Houston, who previously ran infectious disease programs at Memorial Hermann Healthcare System.

Newer payment penalties, however, are rapidly changing the picture, making a focus on a few infections all but impossible for institutions seeking to retain full payment under Medicare. The Patient Protection Affordable Care Act introduced the Hospital Inpatient Value-Based Purchasing program, a readmissions reduction program and a new withholding program for adverse events. The law also broadened the Inpatient Hospital Quality Reporting Program, with more data required to be reported through the National Healthcare Safety Network.

Value-based purchasing began in earnest in October 2012 with a 1 percent withhold of baseline DRG payments (the potential penalty will rise to 2 percent by 2016). To earn back a portion or all of the withhold, hospitals must perform well on a combined score based on clinical quality indicators and patient satisfaction measures. For fiscal year 2013, 70 percent of the score is composed of clinical process measures, including several related to infections.

In all, for fiscal year 2013 Medicare is rewarding 1,557 hospitals with more money and reducing payments to 1,427

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others, according to CMS data.

The VBP program will be even more painful for hospitals when "double jeopardy" kicks in. Beginning in October 2014, another 1 percent penalty on all Medicare payment will be assessed for hospitals in the bottom quartile of all healthcare-associated conditions — the so-called "never events" that include HAIs — doubling down on the nonpayment rule.

"Once you are in it, you might not ever get out of that quartile," Mr. Septimus notes. All hospitals will be racing to improve, using many of the same best practices, such as the Keystone initiative in Michigan, which dramatically reduced central-line-related infections in that state's hospitals.

Readmissions
Under a policy that began to take effect on Oct. 1, 2012, hospitals with high rates of 30-day readmissions will be subject to a payment penalty, with those in the worst quartile losing 1 percent of baseline MS-DRG payment. That maximum penalty will rise over two years to 3 percent.

A recent report found that 2,217 hospitals, or 63.4 percent received penalties for having too many readmissions, and 307 hospitals received the maximum 1 percent penalty.

Post-discharge infections are one of the leading causes of readmissions, especially for surgical patients, studies show.

Hospital patients with a positive clinical culture for MRSA, vancomycin-resistant enterococci or Clostridium difficile are 40 percent likelier to be readmitted within a year than other patients, said a study in the June issue of *Infection Control and Hospital Epidemiology*.

"By 2014 to 2015 we will really see for the first time a real change in reimbursement based on hospital performance on these measures," Mr. Septimus says. "A few percentage points of revenue adds up to some real financial pressure if you do not perform to a certain level for these reportable conditions."

Payment reform is hardly limited to Medicare. Starting July 1, 2012, the PPACA prohibited federal Medicaid matching funds to states for payments attributed to care provided for the same conditions as the Medicare nonpayment rule.

Reporting concerns
Since January 2011, hospitals participating in the Hospital Inpatient Quality Reporting Program have had to report central-line-related infections to the National Healthcare Safety Network or risk loss of 2 percent of baseline Medicare payment. In 2012, the program expanded to cover urinary tract infections and infections from inpatient colon and abdominal hysterectomy surgeries.

Beginning in January 2013 inpatient acute-care facilities must report MRSA and C. difficile infections to NHSN.

Reporting data to NHSN has become a full-time job for many infection preventionists. Hospitals must report not only infections, but also all procedures covered by those codes so the CDC can establish baseline rates of infections. Data about each infection event and each surgical procedure must be entered individually, a process that involves inputting or selecting multiple fields. Manual data entry also increases the opportunity for mistakes — a critical factor as just one data entry error could jeopardize the successful submission of all data entered.

"Many infection control departments are stretched with various mandatory reporting requirements, including the federal, state and perhaps the local Quality Improvement Organization or and/or The Joint Commission," Ms. Stone of Columbia said. "Many clinicians have reported that this takes away time from general prevention activities such as education and patient follow up, as well as from important (infection-related) problems."

To effectively manage the myriad metrics and reporting requirements and their resulting penalties and costs, Ms. Stone says that hospitals need to invest in appropriate resources to ensure they can reliably set objectives for HAI reduction and measure their performance against those objectives.

Adam Boris, MS, MBA, was appointed CEO of ICNet Systems in 2011. He has more than 25 years' experience in leadership positions with various U.S.-based technology companies. ICNet's infection surveillance software helps more than 1,000 hospitals around the world reduce surgical site infections, prevent outbreaks and adverse drug events, and facilitate antimicrobial stewardship.

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