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The Hospital-Acquired Condition Penalty: Well Intentioned, Poorly Implemented

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I. INTRODUCTION

The newly instituted hospital-acquired condition penalty would be more effective if changed in two ways: first, if implemented as a function of hospital-acquired conditions per patients treated, and second, if the Centers for Medicare and Medicaid Services excused disproportionate share hospitals and academic hospitals from the penalty altogether. Penalizing hospitals based on data that is published once a year does not effectively incentivize hospitals to improve consistently throughout the year.[1] Not only is the penalty inefficient and ineffective, but it is also unfairly applied to disproportionate share hospitals and academic hospitals because disproportionate share hospitals' patients are more likely to develop a hospital-acquired condition,[2] and hospital-acquired conditions are more likely to be noticed at academic hospitals.[3] Disproportionate share hospitals already face a stark financial picture and penalizing them further undercuts their ability to provide care to those who need it, but may not be able to afford

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1. Maureen McKinney, *Hospitals Question Whether Latest Penalty Program Will Help Them Improve Quality*, MODERN HEALTHCARE (Dec. 7, 2013), http://www.modernhealthcare.com/article/20131207/MAGAZINE/312079990.

2. David Richardson, *Reducing HACs Penalties for Hospital-acquired Conditions Cut into Bottom Line*, MANAGED HEALTHCARE EXECUTIVE 17, 18 (2015).

3. Jordan Rau, *How Medicare Penalizes Hospitals for Being Too Careful*, N.Y. TIMES, (Apr. 20, 2016), http://www.nytimes.com/2016/04/21/health/how-medicare-penalizes-hospitals-for-being-too-careful.html.

it.[4] Academic hospitals should not be penalized for treating some of the sickest patients in the country, and testing their patients more thoroughly.[5] Therefore, disproportionate share hospitals and academic hospitals should be exempt from the penalty.

II. BACKGROUND

When the Affordable Care Act (ACA) was enacted in 2010, Congress included a penalty for hospitals with a comparatively high frequency of hospital-acquired conditions in an attempt to incentivize high-quality care.[6] Beginning in fiscal year 2015, "subsection (d) hospitals" have been required to submit yearly reports on the number of hospital-acquired conditions observed at their respective hospital over the course of the fiscal year.[7] A "subsection (d) hospital" refers to any hospital in the United States that is not a psychiatric hospital, rehabilitation hospital, or children's hospital.[8] If a hospital is in the bottom quartile of all qualifying hospitals for hospital-acquired conditions at the end of the fiscal year, that hospital is penalized one percent of its annual Medicare payments.[9] The ACA gives the Secretary of the Department of Health and Human Services (DHHS) the power to determine what qualifies as a hospital-acquired condition.[10] Such conditions

4. Peter Cunningham & Robin Rudowitz, *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes*, KAISER COMM'N ON MEDICAID AND THE UNINSURED 1, 6 (2016).

5. Rau, *supra* note 3.

6. Patient Protection and Affordable Care Act, 42 U.S.C. §1395ww(p)(1), (p)(2)(B)(i) (2010).

7. *See id.* §1395ww(p)(5) (hospitals are required to submit one report per year and whether the hospital is penalized is based solely off the single report).

8. *Id.* §1395ww(d)(1)(B).

9. *See id.* §1395ww(p)(2)(B)(i) (meaning they are among the worst performing hospitals in terms of hospital-acquired conditions).

10. *See id.* 42 U.S.C. §1395ww(p)(3). The Secretary can add any condition to the definition that has a high cost and/or high volume, results in the assignment of a case to a diagnosis-related group that has a higher payment when the code is present as a secondary diagnosis, or could reasonably have been prevented through the application of evidence-based guidelines.

may include catheter-associated infections, foreign objects retained after surgery, surgical site infections, falls and trauma, and pressure ulcers.[11]

Hospital-acquired conditions present a number of concerns. For example, preventable complications within a hospital, such as hospital-acquired conditions, cost hospitals an estimated $88 billion a year in the United States, and in 2007, they accounted for 12.2 percent of health care facilities' legal liability costs.[12] However, concerns related to hospital-acquired conditions are not limited to financial losses; hospital-acquired conditions also account for an estimated 100,000 deaths each year.[13] The penalty was introduced to both incentivize better care and to save hospitals money.

It is possible that the penalty will increase in the future. Before the ACA was passed, a proposed policy was circulated by the U.S. Senate Finance Committee requiring higher penalties than those that were ultimately enacted.[14] Experts predict that because the DHHS has the authority to expand the required reported conditions, and the continuing demand to "bend the cost curve," there will be pressure to increase the penalties and increase the number of conditions at issue.[15]

Financial incentives for hospitals to reduce hospital-acquired conditions have been effective in recent history, suggesting this penalty could be effective as well. Beginning in fiscal year 2009, hospitals no longer received

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11. U.S. DEP'T OF HEALTH & HUMAN SERVS., *FY 2013, FY 2014, and FY 2015 Final HAC List* (2015), https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond/downloads/fy_2013_final_hacscodelist.pdf.

12. Kevin W. Lobdell et al., *Hospital-Acquired Infections*, 92 SURGICAL CLINICS OF N. AM. 65, 65 (2012).

13. Judith Graham, *New List Offers Hospital-Specific Data on Patient Safety*, L.A. TIMES, (Apr. 11, 2011, 2:56 AM), http://www.latimes.com/health/ct-met-hospital-errors-20110410-story.html.

14. Qian Gu, et al., *The Medicare Hospital Readmissions Reduction Program: Potential Unintended Consequences for Hospitals Serving Vulnerable Populations*, 49 HEALTH SERVS. RES. 818, 830–31 (2014).

15. *Id*. at 830.

payment for treatment of conditions not present at the time of admission.[16] During the same time period, public reporting of hospital-level results, technical assistance offered to hospitals, and the use of Electronic Medical Records were all implemented.[17] As a result of the numerous incentives, it is not clear which ones caused the subsequent improvement in hospital-acquired conditions.[18] The Agency for Healthcare Research and Quality reported a seventeen percent decrease in the number of hospital-acquired conditions between 2010 and 2014.[19] As a result, there were an estimated 87,000 deaths averted and a cost-avoidance of $19.8 billion between 2011 and 2014.[20] By broadly incentivizing higher quality care through a variety of efforts, the number of hospital-acquired conditions and their related costs can be effectively reduced. Additional incentives targeted specifically at hospital-acquired conditions, could encourage further improvement.

Clearly, incentivizing hospitals to reduce hospital-acquired conditions can be effective, but penalizing Medicare payments can be dangerous. Many hospitals are losing money on Medicare patients even before the penalty.[21] The Medicare Payment Advisory Commission found that "relatively efficient" hospitals only operate at a one percent margin for Medicare patients and most hospitals only aim to break even on Medicare patients.[22] Additionally, in terms of cost, Medicare only paid eighty-eight percent of

16. Melinda S. Stegman, *The Hospital-Acquired Condition Initiative: Two Years Later*, 13(2) J. HEALTH CARE COMPLIANCE 63, 63 (2011).

17. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, SAVING LIVES AND SAVING MONEY: HOSPITAL-ACQUIRED CONDITIONS UPDATE INTERIM DATA FROM NATIONAL EFFORTS TO MAKE CARE SAFER, 2010–2014, 1, 6 (2015).

18. *Id.*

19. David Carter, *Success Seen in Decline in Hospital-Acquired Conditions*, 116 AM. J. OF NURSING 17, 17 (2016) (seventeen percent decrease in hospital-acquired conditions per 1,000 discharges).

20. *Id.*

21. Chad Mulvany, *Margins Under Pressure*, 70(4) HEALTHCARE FINANCIAL MGM'T. 30, 30 (2016) ("average total Medicare margin for all hospitals in 2014 was minus 5.8 percent").

22. *Id.*

costs incurred by a patient whereas private insurers covered 144 percent of costs.[23] The average penalized hospital loses $480,000 per year in withheld Medicare payments, with some academic hospitals losing significantly more.[24] The penalty is further reducing income to hospitals as reimbursement payments continue to decline.[25] Hospitals' ability to cut costs is narrowing, making this issue even more worrisome when coupled with hospitals' already thin margins.[26] Penalizing hospitals for hospital-acquired conditions intensifies the reality of our healthcare system in which payers and the government ask hospitals to do more with less, when the hospitals are already operating on a tightrope.

III. PROPOSAL

The hospital-acquired condition penalty must be improved. The main problem with the penalty is that it does not distinguish between different types of hospitals.[27] Losing one percent of Medicare income affects hospitals differently—one percent of Medicare funding has a more significant impact on a hospital with a high proportion of Medicare patients than a hospital that primarily serves the privately-insured. Additionally, certain hospitals identify hospital-acquired conditions at a higher rate.[28] To counter this disparity, the penalty's structure should be adjusted. Currently, all subsection (d) hospitals that fall within the bottom quartile of hospitals in terms of hospital-acquired conditions are subject to a penalty of one percent of their

23. Cunningham & Rudowitz, *supra* note 4 at 3.

24. Rau, *supra* note 3 (for example, Northwestern Memorial Hospital was penalized $1.6 million dollars in Medicare payments).

25. Beth Kutscher, *Hospital Margins Slump Due to Squeeze From Volume, Rates, Investments*, 44 MODERN HEALTHCARE 8, 8 (2014) (hospital margins narrowed significantly despite an improving economy do to a decreasing ability to cut costs, low credit ratings, and a patient population delaying care due to high deductible health plans).

26. *Id.*; Mulvany, *supra* note 21.

27. 42 U.S.C. §1395ww(p).

28. Rau, *supra* note 3.

yearly Medicare income.[29] Hospitals file a report once per year and find out at the end of the fiscal year whether they will be penalized. Therefore, to make the penalty more equitable, rather than arbitrarily penalizing the bottom quartile, the penalty should be changed to a set threshold. This should be determined as a function of hospital-acquired conditions per patient treated, with an exemption for academic hospitals and hospitals that receive disproportionate share payments. The yearly reports go to the Secretary of the DHHS, who has the power to include or exclude conditions.[30] Since the Secretary has the authority and requisite information, the Secretary would be best suited to analyze the annual data, identify, and implement a specific threshold.

A. A Static Threshold Would Provide a Better Incentive for Improvement

The current penalty creates an uncertainty as to whether a hospital will be penalized.[31] There is no way for a hospital to predict whether it will fall in the bottom quartile of hospitals for hospital-acquired conditions and incur the penalty.[32] When a hospital is penalized based on performance relative to other hospitals, the inability to judge industry-wide performance creates a lack of incentive to alter behavior to avoid the penalty.[33] Grading hospitals on a curve eliminates a hospital's ability to identify if it will be subject to a penalty and make the requisite adjustments.[34]

Hospitals whose performances are on the verge of incurring the penalty would have a greater incentive to consciously take steps to improve if they knew where they fell on the scale. The CMS data shows that in fiscal year

29. 42 U.S.C. §1395ww(p)(5).
30. *Id.* §1395ww(p)(6)(A) (2010).
31. McKinney, *supra* note 1.
32. *Id.*
33. *Id.*
34. *Id.*

2015, there was a large concentration of hospitals at the threshold for the bottom quartile.[35] A score greater than seven incurs the penalty, and a total of 293 hospitals scored between 6.850 and 7.075.[36] A total of 220 of the 293 hospitals sustained the penalty.[37] There was a large number of hospitals on the verge of incurring the penalty, and if they had been aware of their proximity to a one percent penalty, more hospitals likely would have taken steps to avoid the penalty. Performance rankings are announced only once a year, so not only is there no incentive to improve performance, but there is an inability to effectively set and achieve goals because hospitals do not know how they compare to others. Increasing a hospital's ability to foresee a penalty as drastic as one percent of its yearly Medicare income would allow hospitals to proactively take steps to improve care and reduce hospital-acquired conditions.

It is unreasonable to expect hospitals to avoid the penalty when they do not know what level of performance will warrant a penalty. Of the 757 hospitals in the worst performing quartile in fiscal year 2016, approximately fifty-three percent were also in the worst performing quartile in 2015.[38] This could indicate that hospitals struggle to improve because they are unable to plan ahead due to the penalty's reliance on relative performance. Awareness of past performance is not helpful for a hospital when the level of performance that warrants the penalty varies year to year. The goal of the penalty is to deter hospital-acquired conditions through improvements in performance, but when hospitals do not know if they are performing well and

35. Charles N. Kahn III, et al, *Assessing Medicare's Hospital Pay-For-Performance Programs and Whether They Are Achieving Their Goals*, 34 HEALTH AFFAIRS 1281, 1285 (2015).

36. *Id.*

37. *Id.*

38. CTRS. FOR MEDICARE & MEDICAID SERVS., HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM FISCAL YEAR 2016 FACT SHEET (Dec. 10, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-12-10-2.html.

are unable to effectively modify their performance, the penalty falls short of this goal.

A better approach would be to implement the penalty as a function of hospital-acquired conditions per patient—creating a static goal, which would allow hospitals foresee an upcoming penalty and incentivize them to improve care to avoid the penalty. This creates an incentive for hospitals that are on the cusp of incurring the penalty to proactively take steps to avoid it. Sometimes a change as simple as altering safety protocols or creating dialogue between staff members and their superiors make a significant impact on the quality of care provided.[39] For example, SynergyHealth in Wisconsin saw an eighty percent decline in hospital-acquired infections after giving nurses the authority, without physician approval, to remove urinary catheters as soon as the patient was appropriately stabilized.[40] This is an example of a simple step that, if aware of a looming penalty, a hospital could take in order to avoid the penalty. When hospitals are unaware of their performance in relation to the penalty, these additional steps may be overlooked or not taken. By implementing a per-patient standard, hospitals will be aware of their performance in relation to the penalty throughout the year and take the necessary steps to avoid it.

Applying the penalty to the bottom quartile is not an efficient or effective manner of minimizing hospital-acquired conditions. Altering the penalty to penalize hospitals that exceed a set threshold of hospital-acquired infections per patients treated would prevent the arbitrary punishment of a static number of hospitals. This eliminates the incentive for a hospital to make improvements throughout the year. The proposed changes provide hospitals the ability to evaluate their performance and improve throughout the year.

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39. Richardson, *supra* note 2 at 19.
40. *Id.* at 20.

B. Academic and Disproportionate Share Hospitals Should Not be Penalized

Academic and disproportionate share hospitals (DSHs) should be exempt from the penalty. Academic hospitals encounter some of the sickest patients and are more vigilant about hospital-acquired conditions and therefore test patients at a higher rate.[41] DSHs are more likely to incur the penalty, but are less likely to receive full reimbursement because their patient population is predominantly low-income.[42] As a result, DSHs and academic hospitals should be exempt from the hospital-acquired condition penalty.

1. Academic Hospitals are Unfairly Affected

The penalty unfairly affects academic hospitals.[43] Some of the most prestigious hospitals in the country have the highest rates of hospital-acquired conditions.[44] Institutions such as Stanford Hospital, the Cleveland Clinic, and Northwestern Memorial Hospital have all been subject to the penalty.[45] These hospitals have plenty of company—almost half of the country's academic hospitals were penalized in 2014.[46] Statistically, hospitals are penalized more often if they are larger, accredited with the Joint Commission, have a Level I trauma center, if they accept a greater number of patients, or have a higher nurse-to-bed ratio.[47] The penalty punishes institutions for

41. Rau, *supra* note 3; Ellen Jean Hirst, et. al, *Infection Rate Penalties Hit Chicago-Area Hospitals*, CHI. TRIB., (Dec. 20, 2014, 9:18 AM), http://www.chicagotribune.com/business/ct-hospital-infection-rates-1220-biz-20141219-story.html.

42. Kahn, *supra* note 35 at 1286; Cunningham & Rudowitz, *supra* note 4 at 2 ("The American Hospital Association (AHA) estimated that Medicaid payments to hospitals amounted to 90 percent of the costs of patient care in 2013, while Medicare paid 88 percent of costs; by contrast, hospitals received considerable overpayment from private insurers, amounting to 144 percent of costs").

43. Rau, *supra* note 3.

44. *Id.*

45. *Id.*

46. Hirst et. al, *supra* note 41.

47. Ravi Rajaram, et al., *Hospital Characteristics Associated with Penalties in the Centers for Medicare & Medicaid Services Hospital-Acquired Condition Reduction Program*, 314 J. OF THE AM. MED. ASS'N 375, 377–78 (2015).

treating more difficult patients.[48] Additionally, evidence shows that academic hospitals are more aggressive in screening patients for problems.[49] Another hypothesis is that academic hospitals perform procedures that are simply more prone to having adverse events than a typical hospital.[50] Regardless, it is likely that academic hospitals are taking aggressive steps to treat patients and are being unfairly penalized for it.

2. Disproportionate Share Hospitals are Unfairly Affected

DSHs are hospitals that serve a large number of Medicaid and low-income uninsured patients.[51] These hospitals generally receive supplemental payments to compensate for treating patients who need care but are unable to pay for the hospital's services.[52] Problematically, the ACA decreased payments to DSHs based on expectations for an increased insured payer mix.[53] Many hospitals are now skeptical that the supposed increase in revenue created by the ACA Medicaid expansion will make up for the loss of Medicaid DSH funds.[54] In addition to being in a financially precarious position, hospitals with a disproportionate share payment patient percentage between 50-65 percent are 1.5 times more likely to be penalized for hospital-acquired conditions.[55] This is due to the prevalence of existing health issues that may show up during a hospital stay in patient populations that have limited access to healthcare.[56] Essentially, low-income patients are more likely to develop a hospital-acquired condition because of their reduced

48. Rau, *supra* note 3.
49. *Id.*
50. Hirst et. al, *supra* note 41.
51. Evan S. Cole et al., *Identifying Hospitals That May Be at Most Financial Risk From Medicaid Disproportionate-Share Hospital Payment Cuts*, 33 HEALTH AFFAIRS 2025, 2025 (2014).
52. *Id*.
53. *Id.* at 2026.
54. Cunningham & Rudowitz, *supra* note 4 at 6.
55. Kahn, *supra* note 35 at 1286.
56. Richardson, *supra* note 2.

access to care.[57] DSHs are tasked with treating patients who are more likely to develop a hospital-acquired condition and less likely to be able to pay for their care. This is an issue because DSHs' supplemental Medicaid funding is being reduced, and, on top of everything else, they may have to forfeit one percent of their yearly Medicare payments.

The penalty unfairly disadvantages DSHs that predominantly treat a low-income patient population. Regardless of whether the penalty impacts the quality of care, hospitals that treat the country's sickest and poorest patients should not be punished with additional payment reduction.

IV. CONCLUSION

The hospital-acquired condition penalty should be altered to be a static percentage of hospital-acquired conditions per patient treated and academic and DSHs should be exempt from the penalty altogether. The penalty is implemented in a manner that does not maximize a hospital's incentive to increase their quality of care and reduce hospital-acquired conditions. Further, it penalizes hospitals that have a higher likelihood of identifying hospital-acquired conditions as well as penalizing hospitals treating patients who have a higher likelihood of developing hospital-acquired condition. With these proposed changes, a hospital's ability to assess its performance in preventing hospital-acquired conditions would improve while removing an arbitrary penalization on hospitals that serve unique populations.

57. Richardson, *supra* note 39 at 18.