

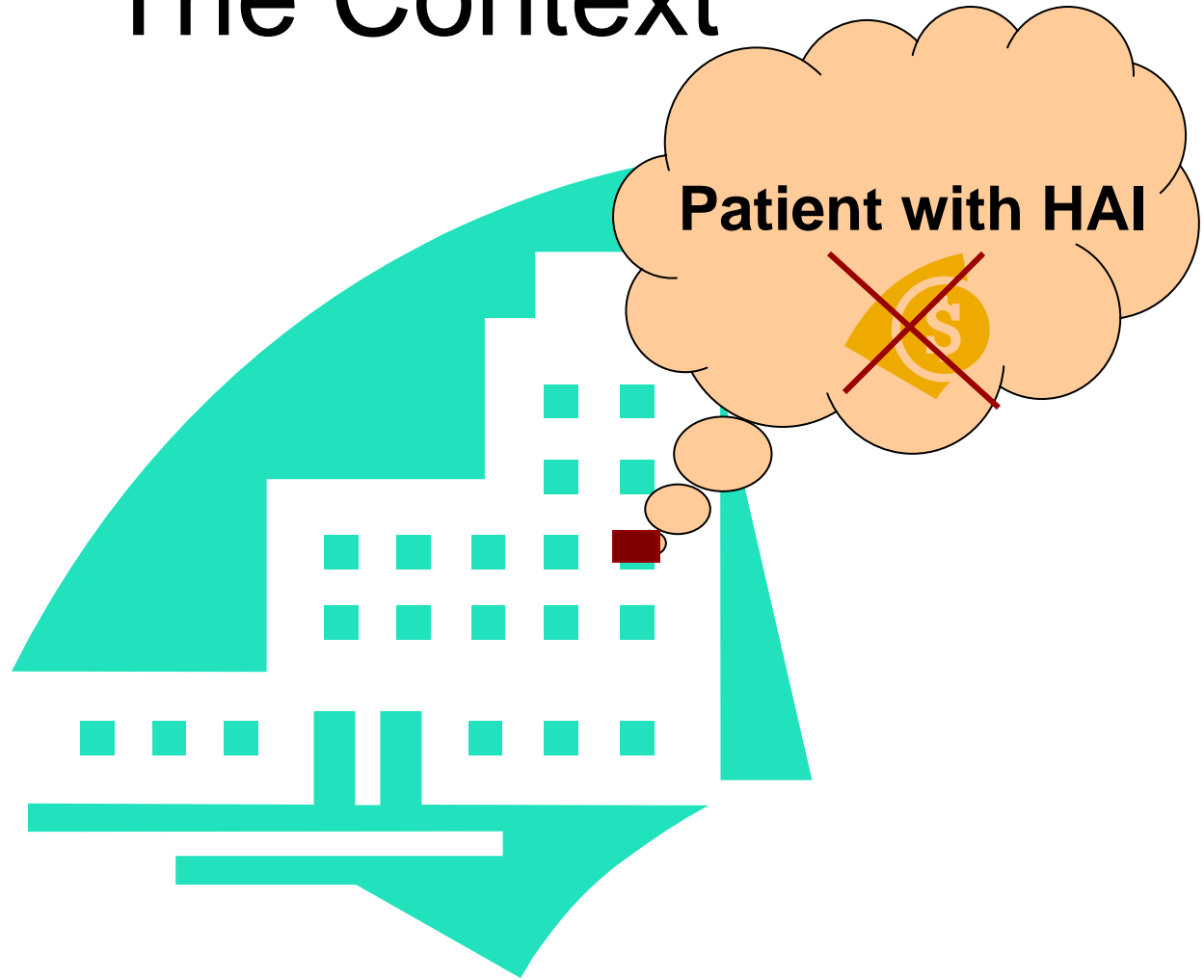
Other Payer and Provider Responses to the CMS HAI Rule

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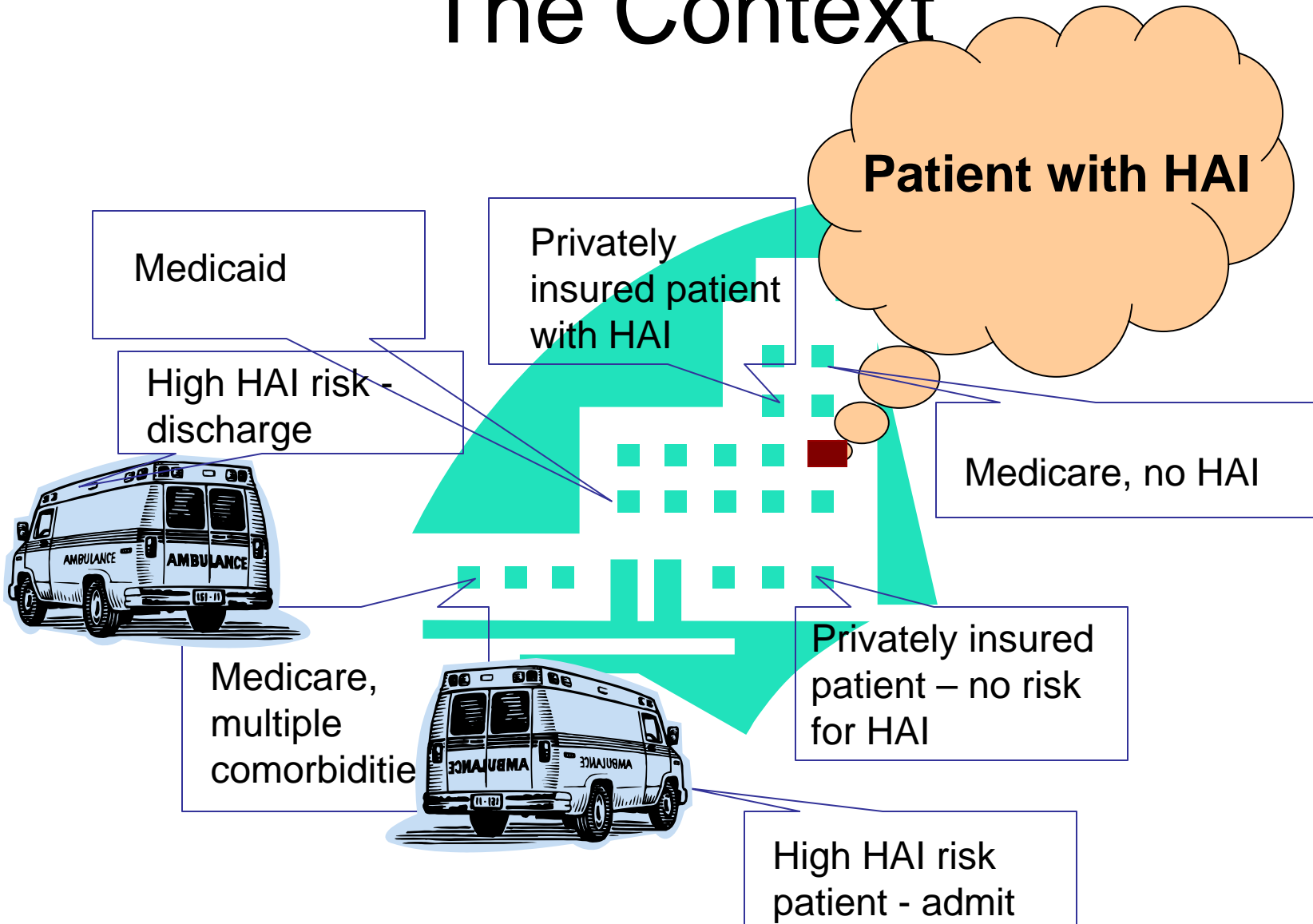
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The Context



The Context



Because action on HAI likely involves fixed costs...

Actions of other payers may:

- Reinforce

or

- Dilute

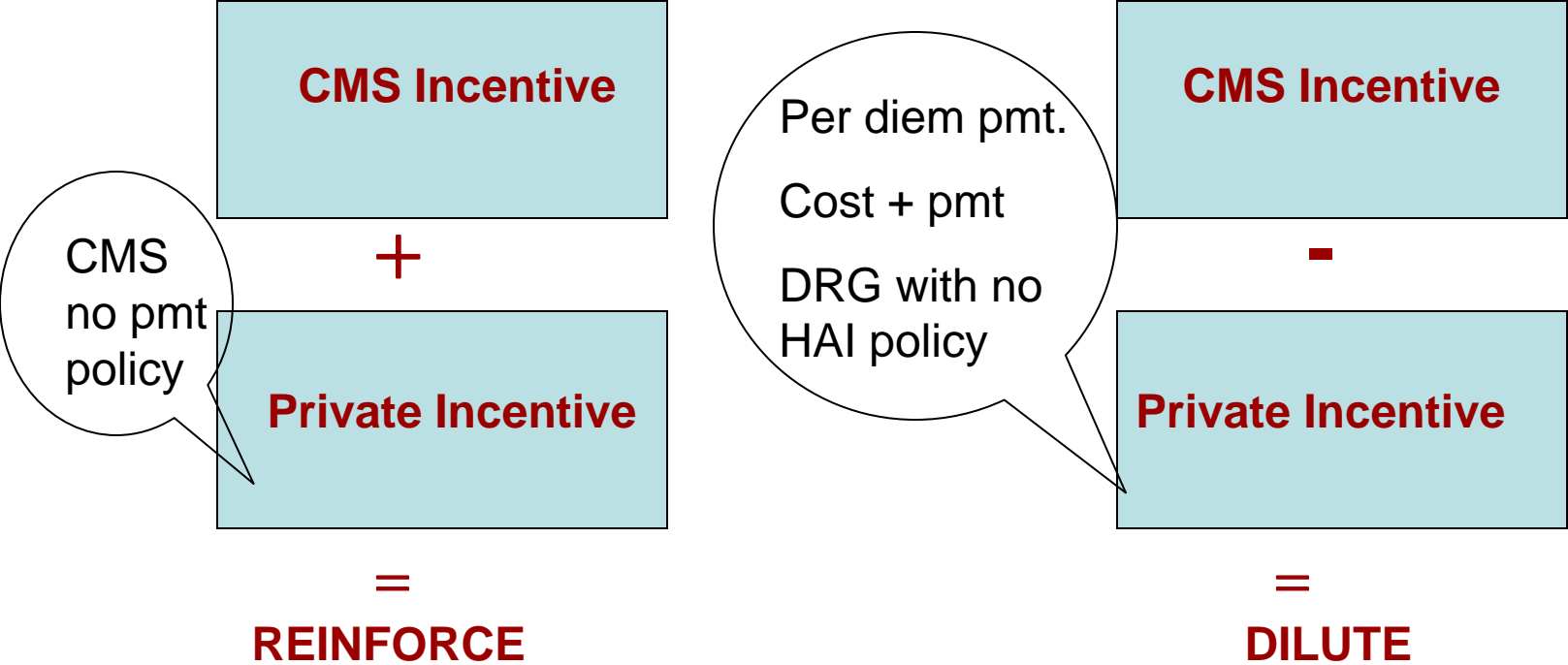
the effects of CMS policies



Evidence

- If doctors are paid capitation for some patients and fee-for-service for other patients...
 - they treat all patients the same – according to the AVERAGE patient mix

Invest in HAI Prevention Protocols?



Will Private Payers and Medicaid Participate?

- Yes if
 - Can be done easily and at low cost
 - Already using Medicare DRGs
 - Involved in QI
 - Able to monitor cases
- No if
 - Complicated or costly or not in interest
 - Not using DRGs
 - Unsophisticated coding or monitoring
 - Hospital ownership

Research Questions (1)

- Will other payers follow CMS?
 - Why or why not?
- Will hospital behavior around HAIs vary with proportion of revenue from Medicare?

Undesired Hospital Responses

- Law of unintended consequences
 - More cultures to affect pre-hospital infections
 - Coding
 - Selection
 - Financial effects
 - Discharges

Logic of HAI Rule

- DRG coding depends on
 - Primary condition
 - Complicating condition(s)
- Examples of major complicating conditions... over 3000...

Acidosis
Acid base imbalance
Acute bronchiectasis
Acute but ill defined cerebrovascular disease
Acute coronary syndrome (unstable angina)
Acute coronary occlusion w/o myocardial infarction
Acute esophagitis
Acute exacerbation of asthma
Acute pericarditis
Acute post-hemorrhagic anemia (acute blood loss anemia)
Alcohol or Drug withdrawal
Alkalosis
Anorexia nervosa
Atelectasis

Hypematremia
Hyperosmolarity
Hyponatremia
Hypoosmolarity
Ileus
Infection post op
Infectious diarrhea
Intermediate coronary syndrome
"itis" gastrointestinal diagnoses
Left heart failure
Malignant hypertensive heart disease w/CHF
Obesity—BMI > 40
Paraplegia
Paroxysmal supraventricular tachycardia
Paroxysmal ventricular tachycardia
Pathological fracture

Pneumonia
Pneumothorax, spontaneous tension
Pulmonary embolism, infarction
Quadriplegia
Ruptured aortic aneurysm
Sepsis
Septic shock
Septicemia
Severe protein calorie malnutrition
SIRS
Ventricular fibrillation
Ventricular flutter

~~Certain HAIs~~

Coding Incentive

- Increased incentive to code secondary conditions that often co-occur with HAI
- Increases payer costs for certain non-HAI patients (who are newly upcoded)
- Dilutes effect of HAI rules

Predictability

- Some HAI risk is predictable:
 - Age, Trauma, Burns, Diabetes, Renal Failure, Malignancies, Endotracheal intubation, Central venous catheters, Urinary catheter, Mechanical ventilation, Invasive procedures, Immunosuppressive agents, Length of stay, ICU Length of stay, ICU, Prior hospitalization, Transplantation, Gastrointestinal surgery, Long term or repeated courses of broad spectrum antimicrobial drugs, Nursing home stay, etc.

Strong incentives for effort = strong incentives for selection

- Choice of medical staff (specialties etc.)
- Facilities offered by hospital
- Timing and frequency of admission from ER
- Relations with nursing homes

Financial Effects

- Population Level Risk Factors
 - SES
 - Frailty – nursing home residency
- Impact of policy likely to be most severe on hospitals with many such patients
 - Financially troubled
 - Difficulty in taking precautions



HAI Rule and Discharge Decisions

- Discharge high risk patients to nursing home sooner?



Research Questions (2)

- 1) Do coding changes occur for conditions that co-occur with HAI?
- 2) Do hospitals with high HAI risk patients alter their service mix?
- 3) Are hospitals with high HAI risk patients affected financially?
- 4) Do discharge patterns of high HAI risk patients change?

Conclusions

- Policy logic makes sense
- Most effects likely to be on patients with HAI
- But context is important

