

A Collaborative Call for Changes in Reimbursement Policies to Achieve Improvements in Hospital Safety Related to Pressure Injuries

To the Editor:

In February 2020, the U.S. Centers for Medicare & Medicaid Services (CMS) reported that among 16 hospital-acquired condition measures, pressure injury was the only outcome undergoing significant rate increases in the past year and likely contributed to longer hospitalized stays, chronic morbidity, and death.

Pressure injuries affect 2.5 million patients per year in the United States, costing U.S. \$26 billion and causing 60,000 deaths.¹ Furthermore, many ventilated patients with COVID-19 are believed to have pressure injuries due to immobility and low oxygen, although nationwide data are not yet available.² The 2020 CMS Quality Conference report illustrated a 14% increase in pressure injury rates, which was compounded by reporting from the Agency for Healthcare Research and Quality that pressure injury rates increased 6% over 4 years since 2014.³ These are disappointing statistics despite U.S. \$200 billion invested per year on quality improvement in the United States.

The reason that pressure injury rates continue to worsen may be related to CMS reimbursement policies launched between 2008 and 2014. In 2008, CMS introduced nonpayment policy for most hospital-acquired conditions, including pressure injuries, which removed incentives for facilities to seek payment for preventable harms.⁴ However, in 2014, CMS further implemented a 1% penalty of total CMS reimbursements on hospitals in the lowest quartile of performance based on composite rates of hospital-acquired conditions.⁵

Not having to improve rates of all conditions to avoid a penalty, hospitals could prioritize preventing outcomes that are least labor-intensive or cost-efficient. Unfortunately, pressure injuries are unlikely the focus because substantial nursing time and approximately U.S. \$100 per patient-day are needed to address prevention needs based on current guidelines.

Given such negative impact of penalties on pressure injuries, how can the United States improve pressure injury prevention incentives without negatively impacting other outcomes?

RECOMMENDATIONS

The National Pressure Injury Advisory Panel (Boston, MA), Wound Ostomy Continence Nursing Society (Mt Laurel, NJ), and Association for Advanced Wound Care (McLean, VA) collectively propose 3 alternative reimbursement models to be considered by the CMS to improve pressure injury prevention and patient outcomes.

TWO-SIDED RISK MODEL

First, we propose a two-sided risk model, whereby hospitals with low-composite rates that fall into the top quartile should be rewarded an additional 1% of CMS reimbursements. Such carrot-and-stick approaches incentivize hospitals to compete for improved performance, including pressure injury prevention. This alternative represents a zero-sum game for CMS, because it would not have to invest more money into the reward system than it would collect from other hospitals' penalties. There could also be conditions installed on this rule, such as rewards that can only go to hospitals that achieve rate reductions for all hospital-acquired conditions, including pressure injury.

DEFERRED PAYMENT MODEL

Second, we recommend a deferred payment model. Deferred payments are popular solutions to rising prices of specialty drugs and gene therapies, whereby manufacturers get paid if their drug heals a patient after the fact. This model could be tailored for preventive technology as well. If CMS shared the cost of prevention with hospitals when patients are safely discharged on-time, then the cost-offset would likely improve hospital compliance with prevention guidelines.

CAPITATED PAYMENT

Third, capitated payments could complement deferred payments, whereby hospitals are reimbursed for expected costs of prevention. The U.S. Center for Disease Control and Prevention reported that hospitals could spend up to 5 times the amount of money on treatment compared with prevention. While some facilities skip on the cost of prevention as a cost-cutting measure, capitated payments for prevention ensure hospitals that up-front investments for patients are not only the right thing to do, but something that hospitals can afford.

With little payment reform since 2014, these are payment models that offer health systems viable solutions to invest in pressure injury prevention during the Biden

administration. Although these alternatives may add some costs to payers, the CMS already pays upward of U.S. \$20 billion on the cost of chronic wound care caused by pressure injuries. Therefore, to meet our shared mission of reducing pressure injury rates in the United States, we would recommend modeling of these proposed strategies with existing CMS data and demonstration projects through the CMS Innovation Center.

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