Medicare Won’t Pay for Medical Errors

By KEVIN SACK
October 1, 2008
New York Times

ST. PAUL — If an auto mechanic accidentally breaks your windshield while trying to repair the engine, he would never get away with billing you for fixing his mistake. On Wednesday, Medicare will start applying that logic to American medicine on a broad scale when it stops paying hospitals for the added cost of treating patients who are injured in their care.

Medicare, which provides coverage for the elderly and disabled, has put 10 “reasonably preventable” conditions on its initial list, saying it will not pay when patients receive incompatible blood transfusions, develop infections after certain surgeries or must undergo a second operation to retrieve a sponge left behind from the first. Serious bed sores, injuries from falls and urinary tract infections caused by catheters are also on the list.

Officials believe that the regulations could apply to several hundred thousand hospital stays of the 12.5 million covered annually by Medicare. The policy will also prevent hospitals from billing patients directly for costs generated by medical errors.

Because Medicare is the largest insurer in the country, its decision to refuse payment for preventable conditions has already influenced others — public and private — to set similar criteria.

Over the last year, four state Medicaid programs, including New York’s, have announced that they will not pay for as many as 28 “never events” (so called because they are never supposed to happen). So have some of the country’s largest commercial insurers, including WellPoint, Aetna, Cigna and Blue Cross Blue Shield plans in seven states.
A number of state hospital associations, including here in Minnesota, have brokered voluntary agreements that members will not bill for medical errors. In April, Maine became the first state to ban the practice statutorily.

The Congressionally mandated Medicare measure is not projected to yield large savings — $21 million a year, compared with $110 billion spent on inpatient care in 2007. But it carries great symbolism in the Bush administration’s efforts to revamp the country’s medical payment system, which has long been criticized as driving up costs through perverse incentives that reward the quantity of care more than the promotion of health.

The real money, many health economists believe, may come from reorienting the payment system to encourage prevention and chronic disease management and to discourage unnecessary procedures. The two major-party presidential candidates support such a realignment, a rare point of consensus in a polarized health care debate.

“This is a specific case of the larger pay-for-performance trend, the idea that you should pay more for quality than lack of quality, or in this case pay less for defects,” said Dr. Donald M. Berwick, president of the Institute for Healthcare Improvement. “This whole trend is like a juggernaut, and it is not going to stop.”

Pay-for-performance makes use of both the carrot and the stick. Medicare now grants bonuses to doctors and hospitals that report quality measures. It is experimenting with rewarding physicians who follow protocols for treating diabetes, coronary artery disease and congestive heart failure. The Medicare Payment Advisory Commission, an arm of Congress, recently recommended reducing payments to hospitals with high readmission rates.

Three years ago, HealthPartners, a Minnesota-based health maintenance organization, was first in the country to refuse payment to hospitals for never events. Company officials said the policy has yet to save much money. But at Regions Hospital in St. Paul, which is owned
by HealthPartners, the change has reinforced a new focus on reducing medical errors.

“Historically, there’s been some acceptance that these things happen,” said Brock D. Nelson, the hospital’s president. “We’ve come to now accept that they’re avoidable. And that’s a sea change.”

Some improvements have been technological, like an electronic prescribing system that has helped cut medication errors in half. Others are breathtaking in their obviousness, like diligent hand-washing.

Nurses have been trained to provide more information during shift changes about whether patients are prone to falls. High-risk medications like heparin are now marked with pink labels to ward against mix-ups.

Shortly before Cynthia A. Kehborn’s recent ankle fusion surgery, her orthopedic surgeon, Dr. Peter A. Cole, checked records and asked her repeatedly whether he would be operating on her left leg. He then took a sterile marker and signed his initials on her left ankle.

As they prepared for surgery, technicians tallied sponges and blades so they could later be sure that none were left behind. Before taking up his scalpel, Dr. Cole was reminded by the “Time-Out!” towel covering his surgical tray to call for a brief break.

“We have Cynthia here for a left ankle fuse,” he announced. “Does everybody agree?” After all in the room chimed their agreement, he made his incision.

In pre-op, Ms. Kehborn, 48, said it had never occurred to her that patients might be charged for a medical error.

“It should be the hospital’s and doctor’s responsibility to step up to the plate and own up to their mistakes,” she said. “I’d be livid if we had to pay for it.”
The patient safety movement picked up steam in this country in 1999, when the Institute of Medicine, a prestigious advisory group, estimated that 44,000 to 98,000 Americans died each year from preventable medical errors.

In response, at least 20 states have passed laws requiring hospitals to report mistakes or preventable infections publicly, according to the National Conference of State Legislatures. The federal Centers for Medicare and Medicaid Services now requires hospitals to report on 42 quality measures. Hospitals that do not fully report may be docked up to 2 percent of their reimbursement.

In 2002, the National Quality Forum, a standard-setting consortium for the health care industry, compiled a list of 27 largely preventable adverse events, a list that grew to 28 in 2006 with the addition of “artificial insemination with the wrong donor sperm or egg.” In 2003, Minnesota became the first state to require reporting of all errors on the list, and last year the state’s hospital association became the first to announce that its members would not bill for them.

The number of never events in Minnesota reported to the state has been low — 106 in 2004-5, 154 in 2005-6 and 125 in 2006-7. The most frequent errors have been bed sores, retained objects and wrong-site surgeries. Regions Hospital had six or seven reportable errors in each of those years, including one death, a suicide.

Because individual hospitals may report only a few serious errors a year, they have started collaborating to look for common threads and propose solutions. Some of the innovations were initially greeted with rolled eyes, but hospital officials say that has lessened. Nonetheless, studies by the University of Minnesota found that some of the safety procedures, like the pre-surgery time-outs, have largely become rote.

Clear trend lines are not expected for several years. Some states have found through audits that not all errors are being reported, but Minnesota officials believe that compliance is high.
“There’s been an understanding by hospitals that we’re not trying to get them, that we’re really focused on what we can learn from these events,” said Diane C. Rydrych, the state health department official in charge of reporting.

Nancy E. Foster, vice president for quality and patient safety at the American Hospital Association, said hospitals had generally accepted that many of the 28 adverse events should never happen, like giving a patient the wrong type of blood. But she said other areas could be gray, like an injury caused by a malfunctioning device.

“Anyone — I don’t care who they are — always finds it a little provocative to be held accountable for something that is not within their control, especially when you have dedicated yourself to doing the right thing for your patients,” Ms. Foster said. Such unforgiving standards, she said, can “set an expectation among patients that staff will be closer to perfect than they actually can achieve.”

Even America’s Health Insurance Plans, the leading industry trade group, has questioned whether some of the conditions on the Medicare list are always preventable.

But Peter V. Lee, executive director of the Pacific Business Group on Health, based in San Francisco, said occasional inequity was a price worth paying to send the message that careless medicine will not be tolerated. “I don’t worry about that 1-in-100 case that can’t be avoided,” he said, “because the benefit of not paying for the 99 that shouldn’t happen means a far greater focus on avoiding harm. What we want is to encourage doctors and hospitals to get to zero.”