Preventable Hospital-Acquired Errors: Lowering Costs by Refusing to Pay

By Bruce Patsner, M.D., J.D.

Healthcare costs for citizens, insurance companies, and state and federal government have risen each year for as long as anyone can remember and there is no end in sight.¹ Recent efforts at cost control by private insurers have included raising co-pays on prescription drugs² and restricting coverage for even routine medical and surgical services³ in efforts to shift more of the burden of healthcare costs to consumers. Federal and state governments have tinkered with eligibility requirements for entitlement programs such as Medicaid with little to show thus far in terms of cost savings.

Ever since the publication of the landmark Institute of Medicine study To Err is Human,⁴ it has become increasingly apparent to Congress and the private sector that medical mistakes increase healthcare costs significantly. A subsequent 2002 report by the National Quality Forum (NQF)⁵ listed twenty seven adverse events that were serious, largely preventable, and of concern to both the public and healthcare providers. Awareness of this issue has led private insurance companies, managed care plans, single payers, individual states, and the United States government to collectively begin to focus on the larger issues of whether the quality of medical care being delivered is worth the healthcare dollars being spent⁶ and whether payment should be linked to outcome. In theory, linking financial incentives to improved clinical performance should translate into a safer and less costly healthcare system.

This thinking has led to two recent movements in healthcare finance: (1) rewarding physicians and hospitals for delivering higher quality of care, otherwise known as “pay for performance;”⁷ and (2) refusing to pay for substandard medical care.⁸ There is a significant difference between financially rewarding better clinical outcomes for patients and punishing hospitals for hospital-acquired harms, not the least of which is that individual physicians, physician groups, and hospital may all benefit from the former but only hospitals will likely directly suffer from the latter.

³ Denise Grady, Some Insurers See Past Cesarean as Costly Risk, NEW YORK TIMES, June 1, 2008 at A1.
⁴ INSTITUTE OF MEDICINE, TO ERR IS HUMAN. BUILDING A SAFER HEALTH SYSTEM (2000). The IOM concluded that medical errors, especially hospital-acquired conditions, were responsible for up to 98,000 deaths annually in the U.S.
⁵ NATIONAL QUALITY FORUM, SERIOUS REPORTABLE EVENTS IN HEALTHCARE: A CONSENSUS REPORT (2002).
⁶ Id.
The pay-for-performance (P4P) concept began in the manufacturing/business community in the 1980s as a method of improved product quality while at the same time cutting costs and reducing inefficiencies. The notion of refusing to pay for preventable complications originated with the Center for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services of the federal government following a Congressional mandate directed towards eliminating a system which effectively rewarded hospitals with additional reimbursement for services relating to treating the impact of largely preventable harms. Simply put, Congress was interested in saving money by no longer paying for preventable complications from substandard medical care.

Within the category of substandard medical care there are two distinctly different types of events payment could be denied for, each reflecting distinctly different risk management philosophy: (1) events which should never occur under any set of circumstances (“never events,” defined as something which should never happen to a hospitalized patient, such as leaving an unplanned foreign object such as a sponge or medical instrument in a surgical patient); and (2) complications which are preventable even if they do not rise to the level of seriousness of a “never event.” Although these two categories are similar, they are not identical; it might be relatively easy to agree on which events should never happen in a hospital setting, but there is clearly greater room for disagreement over whether an untoward event is truly preventable and whether hospitals should be punished for complications which might occur even in the best healthcare settings. The financial implications for health care providers and networks are clearly going to be progressively greater if private and government payers both deny payment for preventable events and the list of preventable events continues to grow.

The New Medicare Rule

After the requisite notice and comment period required for agencies under formal rulemaking through the Administrative Procedures Act, CMS published its first list of “never events” in the Federal Register in 2007. The final rule becomes effective October 1, 2008. By definition, these are conditions for which Medicare will not pay more if acquired during an inpatient hospital stay. In rank order these eight conditions are: (1) object left in place during surgery; (2) air embolism; (3) blood incompatibility; (4) catheter-associated urinary tract infection; (5) pressure (decubitus) ulcer; (6) vascular catheter-associated infections; (7) surgical site infection: mediastinitis after coronary-artery bypass graft; and (8) hospital acquired injuries – fractures, dislocations,

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14 Id.
intracranial injury, crushing injury, burn, and other unspecified effects of external causes such as falls from beds.

The incidence of these cases, and the average Medicare payment for admissions in which these conditions occurred, vary enormously among these eight events. For example, there were only 108 cases of Medicare patients developing mediastinitis after coronary artery bypass in fiscal year 2006 though the average additional Medicare payments for admissions in which the condition was present was $304,747; and only 2,591 cases of falls from bed with an average additional Medicare admissions payment of $24,962. By contrast, more common preventable events were the 322,946 cases of decubitis ulcers, with an average added admissions cost of $40,381; and 11,780 cases of catheter-associated urinary tract infections in hospitalized patients in 2006 which added an average of $40,347 to the Medicare hospital payment for each admission.15

The States Get in the Act

There has been little opposition to Medicare’s new policy of withholding the portion of reimbursement to hospitals for the listed preventable complications. Paying providers and hospitals more money for better medical care will likely keep everyone happy, but Medicare’s new policy does pose a potential risk to patients. If private insurers refuse to pay hospital bills when preventable errors occur16 hospitals may or can simply pass the cost of lost revenue due to preventable complications to the patients, and then contract out this debt to collection agencies.17 Fortunately, there is already some movement on the part of individual states such as Maine for legislation that would prohibit health care facilities (defined as hospitals or ambulatory surgical centers) from charging patients or their insurers for preventable adverse events which occur while the patient is in a healthcare facility.18 With this patient protection, hospitals truly have a real incentive for systemic reform to minimize preventable hospital-based adverse events, whether they appear on Medicare’s list or not. As good as the idea of not paying extra for preventable complications is, every state will need legislation similar to Maine’s so that injured patients and their families don’t end up footing the bill for hospital and physician mistakes.

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http://www.law.uh.edu/healthlaw/perspectives/homepage.asp

18 AN ACT TO PROHIBIT HEALTH CARE FACILITIES FROM CHARGING FOR TREATMENT TO CORRECT MISTAKES OR PREVENTABLE ADVERSE EVENTS, PL CHAPTER 605. This new Maine law will take effect July 18, 2008, available at http://www.mainelegislature.org/lesai/bills/ld.asp?id=2044 (last accessed June 18, 2008).