NCSL

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MEDICARE NONPAYMENT FOR MEDICAL ERRORS

THE ISSUE

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (Pub. L. 109-171) (DRA) which contained language[1] creating a system for quality adjustment of Medicare payments for inpatient hospital services. The law required the Secretary of Health and Human Services (HHS) to identify at least two hospital-acquired conditions which could have reasonably been avoided through the application of evidence based guidelines and would be subject to the adjustment in payment.

BACKGROUND

The rate of growth in health care costs has made it necessary for payers of health care services to examine every avenue available to conserve health care dollars. According to the Congressional Budget Office (CBO), without any changes to federal law, total spending on health care will rise from 16 percent of the gross domestic product (GDP) in 2007 to 25 percent in 2025 and 49 percent in 2082, and net federal spending on Medicare and Medicaid will rise from four percent of the GDP to almost 20 percent over the same period. CBO sites inefficiency in the health care system as a principle variable contributing to the increased cost. They support this notion through an examination of the variation in health care cost across the country yet noting that the quality in health care is less variable.

The Institute of Medicine has estimated that medical errors cost $17 billion to $29 billion per year with most of the cost being shifted to outside payers such as Medicare. Research conducted by the Harvard School of Public Health[2] in 2006 found after examination of 14,732 discharge records from 24 hospitals in Colorado and Utah, the average cost per injury was $58,766 for all adverse events and $113,280 for negligent injury. They also concluded that 78 percent of the costs associated with all injuries were externalized to outside payers and 70 percent of costs associated with negligent injuries.

FEDERAL ACTION

Taking these factors into consideration, the DRA required CMS to select at least two hospital-acquired conditions that would be subject to a quality payment adjustment. CMS consulted with the Centers for Disease Control and Prevention (CDC) to identify the conditions proposed for reduced payment in FY 2009 and additional conditions that would be considered for reduced payment in subsequent years. The conditions were selected from a list of "never events" or conditions which had been identified by the National Quality Forum[3] in 2002. "Never events" are serious reportable events, which should never have happened and could have been prevented[4]. Specific criteria for selection of the conditions were provided as follows:

1. The condition must be associated with a high cost of treatment or high occurrence rates within hospital settings.
2. The condition results in higher payment to the facility when submitted as a secondary diagnosis.
3. The condition can reasonably be prevented by adoption and implementation of evidence-based guidelines.

Selected Conditions

The first eight conditions, which were selected last year because they greatly complicate the treatment of the illness or injury that caused the hospitalization, resulting in higher payments to the hospital for the patient's care by both Medicare and the patient were:

- *Object inadvertently left in after surgery*
- *Air embolism*
- *Blood incompatibility*
- *Catheter associated urinary tract infection*
- *Pressure ulcer (decubitus ulcer)*
- *Vascular catheter associated infection*
- *Surgical site infection-Mediastinitis (infection in the chest) after coronary artery bypass graft surgery*
- *Certain types of falls and traumas*

2008 Additions

- *Surgical site infections following certain elective procedures, including certain orthopedic surgeries, and bariatric surgery for obesity*
- *Certain manifestations of poor control of blood sugar levels*
- *Deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement procedures.*

The Centers for Medicare and Medicaid Services (CMS) has titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC) and published rules

[1] Deficit Reduction Act Sec. 5001. Hospital Quality Improvement: (c) Quality Adjustment in DRG Payments for Certain Hospital Acquired Infections-(1) Amends Section 1886(d)(4) of the Social Security Act by adding language that states that for discharges occurring after October 1, 2008, the diagnosis related group (DRG) assigned may not result in a higher payment based on a secondary diagnosis associated with conditions identified by the secretary that could have reasonably been avoided through the application of evidence-based guidelines. Hospitals will be required to report the secondary diagnosis present on admission of the patient.

[2] Mello, Michelle M. "Who Pays for Medical Errors? An Analysis of Adverse Event Costs, the Medical Liability System, and Incentives for patient Safety Improvement" Journal of Empirical Legal Studies, 4(4) (Dec. 2007): 835-60.

3 The National Quality Forum (NQF) is a not-for-profit organization created to develop and implement a national strategy for health care quality measurement and reporting. [http://www.qualityforum.org/about/mission.asp].

[4] The Leapfrog Group, "Fact Sheet Never Events", Washington D.C., [http://www.leapfroggroup.org/media/file/Leapfrog-Never_Events_Fact_Sheet.pdf], (Internet Document.)

August 22, 2007[5] revising the Medicare hospital inpatient prospective payment system (IPPS) to implement changes in the reimbursement system based on these identified conditions. Medicaid payments were not addressed in the rule. Beginning October 1, 2007, IPPS hospitals were required to submit present on admission (POA) information on inpatient claims. CMS will begin the new payment policy on October 1, 2008.

The rational for the use of POA indicators according to the Healthcare Cost and Utilization Project (H-CUP) is that it will distinguish pre-existing conditions from complications and help to improve the design and fairness of pay-for-performance programs. CMS estimates the federal government will realize savings of $50 million per year for the first three years beginning October 1, 2008. Beginning in FY 2012, they estimate savings of $60 million per year.

Providers may appeal decisions through the standard CMS appeals process.

Affected Hospitals

The Present on Admission Indicator Reporting requirement applies only to IPPS hospitals. The following hospitals are currently ***exempt*** *from the POA indicator requirements:*

- *Critical Access Hospitals (CAHs)*
- *Long-Term Care Hospitals (LTCHs)*
- *Maryland Waiver Hospitals*
- *Cancer Hospitals*
- *Children's Inpatient Facilities*
- *Inpatient Rehabilitation Facilities (IRFs), and*
- *Psychiatric Hospitals.*

PRIVATE SECTOR ACTION

Several major private insurers, Aetna Inc., Cigna HealthCare, Anthem Blue Cross Blue Shield in New Hampshire, Blue Cross Blue Shield of Massachusetts, and WellPoint among them, are adopting similar reimbursement practices in cases of preventable medical errors.

STATE ACTION

State Medicaid programs must consider how the Medicare rule may impact the Medicaid share for payment of affected claims. Claims for dual eligibles impacted by the new reimbursement practice may be submitted to states for either partial or full compensation for those services which resulted from the hospital acquired condition. Several states including Massachusetts, New York, North Carolina, and Pennsylvania (who has delayed implementation upon request of the medical society), have adopted reimbursement practices similar to those found in the federal rule for all Medicaid hospital claims in hopes of increasing quality because of an increased focus on preventable medical errors. Other states including Minnesota, Vermont, and Washington have negotiated agreements with their larger hospital systems and the state hospital association to refrain from billing when these "never events" occur affecting any individual in the state regardless of their health coverage. Delaware, Georgia, and Oregon are currently working with their hospital associations to develop directives for processing claims related to these events.

Before states institute changes in their reimbursement strategies, several variables must be considered. The Joint Commission on Accreditation of Healthcare Organizations[6] contends that a policy of withholding payment for adverse events is reasonable if certain conditions exist:

1. Evidence that the bulk of the adverse events in question can be prevented by widespread adoption of achievable practices.
2. The events can be measured accurately, in a way that is auditable.
3. The events can be measured accurately, in a way that is auditable.
4. It is possible, through chart review, to differentiate the adverse events that began in the hospital from those that were "present on admission" (POA).

CMS issued guidance to State Medicaid Directors in a letter July 31st directing states wishing to implement similar measures to submit a State Plan Amendment describing the criteria they plan to adopt. The State Plan Amendment must also indicate that the policies apply to all Medicaid reimbursement provisions including Medicaid Supplemental or enhance payments and Medicaid disproportionate share hospital payments.

States are not required to implement these changes in their reimbursement practices, but are encouraged to consider how linking payment and performance may impact their programs. CMS will not require states to provide documentation if they deny payment for submitted claims on services previously denied by Medicare for dual eligibles.

RESOURCES

- **CMS Overview and Information**; [http://www.cms.hhs.gov/HospitalAcqCond/01_Overview.asp#TopOfPage].
- **CMS Fact Sheet**; [http://www.cms.hhs.gov/HospitalAcqCond/Downloads/hac_fact_sheet.pdf]

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[5] CMS-1533-FC.

[6] The Joint Commission Journal on Quality and Patient Safety, "Medicare's Decision to Withhold Payment for Hospital Errors: The Devil Is in the Details", Oak Brook, IL, [http://psnet.ahrq.gov/public/Wacher_JQPS_2008.pdf], (Internet Document.)