Medicare to stop paying for errors

By KEVIN SACK

Seattle Times / The New York Times 10/01/08

ST. PAUL, Minn. — If an auto mechanic accidentally broke your windshield while trying to repair the engine, he would never get away with billing you for fixing his mistake. Today, Medicare will start applying that logic to U.S. 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 listed.

Officials think the regulations could apply to several hundred thousand hospital stays of the 12.5 million covered annually by Medicare. The new policy also will 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 influenced others to establish similar criteria.

In the past year, four state Medicaid programs, including Washington's, said they will not pay for up to 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.

A number of state hospital associations have brokered voluntary agreements that members will not bill for medical errors.

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 think, 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 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 the carrot and the stick. Medicare 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.

America's Health Insurance Plans, the leading industry trade group, has questioned whether some of the conditions on the Medicare list are always preventable, such as pulmonary embolisms and extreme blood-sugar fluctuations.

But Peter Lee, executive director of the San Francisco-based Pacific Business Group on Health, said occasional inequity was a price worth paying to send the message that careless medicine would not be tolerated.

"I don't worry about that 1-in-100 case that can't be avoided, 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," he said.