

Ending Extra Payment for “Never Events” — Stronger Incentives for Patients’ Safety

Arnold Milstein, M.D., M.P.H.

On September 1, 2008, Medicare eliminated a long-standing presumption in its payment rules that, since hospitals were doing everything possible to prevent complications of treatment, taxpayers and patients should primarily bear the average cost consequences when complications occurred. A 2006 law, meant to motivate hospitals to accelerate improvement of patients’ safety, constrains hospitals’ ability to bill Medicare for a higher-paid diagnosis-related group when complications occur.¹ The constraint applies only to hospital-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines. These

include some “never events,” the National Quality Forum’s label for serious complications that should never occur in a safe hospital. Though the resulting reduction in Medicare payments to hospitals is estimated to be less than 0.01% nationally, some hospital leaders have objected to its “mean-spiritedness” and to the inclusion of some complications that are not wholly preventable by hospitals. They also noted that the policy did not reduce payments to physicians, even when a physician plays a primary causal role. One prominent hospital executive reportedly pounded on a table at a Capitol Hill meeting, demanding to know who was responsible for the new law.

listed 18 additional complications it was considering for October 2009. Citing its wish to evaluate the impact of the program to date, the CMS proposed on May 4 that, rather than substantially increase its list, it would add only two additional types of bone fractures to its falls and trauma category. Perhaps partially to address objections from hospitals about physicians’ lack of accountability, the CMS announced in January 2009 that it would cease all payments, including physician payments, in the case of three egregious surgical never events: surgery on the wrong patient, wrong (i.e., unintended) surgical procedure, and surgery on the wrong side of the body or the wrong body part.

Though it has raised hackles among hospital administrators, the new payment approach is actually a relatively small step in a cautious, intermittent, 50-year effort by payers to stimulate U.S. hospitals and clinicians to accelerate improvement in the quality of care and reductions of wasted spending. After initially emphasizing improved affordability, some U.S. payers began, in the 1990s, to create incentives for providing high-quality care, including the awarding of bonuses for primary care physicians and the promotion of centers of excellence for organ transplantation. Stirred by reports from the Institute of Medicine (IOM) that flagged poor clinical quality and payers’ failure to offer incentives for improvement, private payers intensified their efforts. Their incentives now en-

Though it has raised hackles among hospital administrators, the new payment approach is actually a relatively small step in an effort to stimulate hospitals and clinicians to accelerate improvement in the quality of care and reductions of wasted spending.

initially included eight complication categories: foreign objects left in the body after surgery, air emboli, infusion of incompatible blood, falls and traumas, catheter-associated urinary tract infections, mediastinitis after coronary-artery bypass grafting, certain infusion-associated infections, and pressure ulcers. Multiple commercial health plans and state Medicaid plans are following Medicare’s lead.

The complications chosen in-

Far from backing down, however, the Centers for Medicaid and Medicare Services (CMS) encouraged state Medicaid programs to follow suit and expanded its list later in 2008 to include poor glycemic control, deep-vein thrombosis or pulmonary embolism associated with knee or hip replacement, and certain orthopedic and bariatric surgical-site infections. At a December 2008 public “listening session,” the CMS

Additional Burdens on Patients and Their Insurance Pools from Potentially Preventable Hospital Complications.*				
Category of Potentially Preventable Complication	Additional In-Hospital Death Rate	Additional Readmission Rate	Total Additional Payments	
			percentage points	average payment
Infections	3.1	7.7	\$19,480	42.0
Metabolic problems	3.0	6.3	\$11,797	31.8
Postoperative hip fractures and skin ulcers	1.3	1.2	\$12,196	32.9

* This table reflects the consequences of potentially preventable hospital complications over the 90 days after admission, for commercially insured surgical patients. Many of the preventable complications addressed in Medicare's new payment policy fall within these three complication categories. Data are from Encinosa and Hellinger.⁵

compass four approaches: publicly reporting on providers' performance, lowering the cost sharing of patients who select better-performing providers, varying providers' payment amounts on the basis of performance, and instituting new payment methods that shift to providers more cost consequences of preventable complications and other sources of inefficiency. The new law exemplifies the fourth approach, as does, in milder form, Medicare's 25-year-old hospital payment system based on diagnosis-related groups.

Few clinicians or hospital leaders welcome the prospect of greater accountability for the financial consequences of flaws in health care delivery and other clinical sources of inefficiency. Most who accepted capitated payments from health maintenance organizations in the 1990s have since fled from such accountability, insisting on a return to fee-for-service or per-diem payment. But ceasing to pay extra to cover the cost consequences of a preventable treatment complication resonates loudly with U.S. health care “customer groups,” such as large employers, consumer organizations, health insurers, and state Medicaid agencies. The underlying logic also

makes sense to patients: as the *New York Times* put it, “If an auto mechanic breaks your windshield while trying to repair the engine, he would never get away with billing you for fixing his mistake.”²

The scientific community and the lay press have generally embraced the perspective of consumers and purchasers. A recent IOM report on pay for performance concludes that quality and clinical efficiency would improve if more performance-sensitive payment methods were implemented.³ Similarly, newspaper editorialists⁴ have criticized the hospital industry's slow implementation of best practices for patients' safety as championed by the Leapfrog Group and endorsed and expanded by the National Quality Forum's evidence-based consensus process.

However, the Medicare program's enormous financial impact on the health care industry and the industry's formidable lobbying clout cause Congress to follow more often than lead the efforts of private payers to provide incentives for improving clinical performance. Perhaps anticipating such Congressional caution, none of my fellow commissioners spoke in support of a reduction of Medicare payments for never

events when, citing the decision of Minnesota's HealthPartners to ask hospitals to waive all charges associated with never events, I proposed such a policy at the January 2004 meeting of Congress's Medicare Payment Advisory Commission. Faced with stakeholder disagreement, why, 2 years later, did Congress subsequently enact such legislation in a form that is all stick and no carrot?

Beyond key Congressional committee chairs who philosophically supported economic performance incentives for hospitals, two subtler forces played important roles. First, employer, consumer, and labor leaders have begun to collaborate more effectively in lobbying for increased accountability for health care providers. At a meeting of progressive, large national employers in Minneapolis in September 2001, participants recognized their common cause with consumers in increasing the health care industry's accountability with regard to clinical performance. They subsequently reached out to consumer and labor leaders to form the Consumer–Purchaser Disclosure Project, which harmonizes advocacy by employer, labor, and consumer organizations for policies that advance the trans-

parency of the health care industry’s performance and providers’ accountability for improved performance. This more cohesive, bipartisan customer voice has boosted the courage of government players to notch up providers’ accountability, despite the wariness of the health care industry.

Second, the terms “never events” and “preventable serious hospital complications” carry a psychological advantage in congressional deliberations. Nobel Prize-winning research by Kahneman, with Tversky, on “negative framing” and the “availability heuristic” suggests that humans are more strongly inclined to take action when the actions in question are labeled so as to convey the loss avoided rather than the benefit gained and when the consequences of failing to act are mentally vivid. Never events and hospital-acquired infections score well on both counts. Indeed, Kenneth Kizer, who coined the term “never events” when he led the National Quality Forum, built on his intuition that it carried “an extra psychological charge.” (Kizer believes that attention to language’s psychological power was key to his success in leading California’s smoking-cessation ini-

tiative and rapidly improving the performance of Veterans Affairs hospitals.)

Congressional and state legislative pressure on health care providers to be more accountable for the financial consequences of quality problems (see table) and other sources of clinical inefficiency is only going to intensify as more middle-income voters become uninsured or underinsured. Such pressure will inevitably require physicians to learn to systematically reengineer clinical work methods in order to reduce errors and waste — a common approach in other complex service and manufacturing sectors. This trend also portends major revision in physician training, greater collaboration of physicians with systems engineers and other clinical team members, and the adoption of electronic information systems. How these fundamental changes will be facilitated remains an unwritten chapter in the advancement of clinical performance in the United States to a trustworthy level.

For now, physicians should anticipate more urgent requests from hospitals for cooperation in addressing large shortfalls in implementing the National Quality

Forum’s best practices for hospital safety. Some of these practices require substantial changes in physicians’ workflow, such as routine use of procedural checklists and computerized order entry. Postponing such practices, which represents a safety risk for patients, now poses a greater financial risk for hospitals.

No potential conflict of interest relevant to this article was reported.

The views expressed in this article do not necessarily represent those of the organizations with which the author is affiliated.

Dr. Milstein is a member of the Medicare Payment Advisory Commission and is also the chief physician at Mercer Health and Benefits and medical director of the Pacific Business Group on Health — both in San Francisco. The Pacific Business Group helps to administer the Consumer–Purchaser Disclosure Project with the National Partnership for Women and Families, where Dr. Milstein is a board member.

1. Rosenthal MB. Nonpayment for performance? Medicare’s new reimbursement rule. *N Engl J Med* 2007;357:1573-5.
2. Sack K. Medicare won’t pay for medical errors. *New York Times*. October 1, 2008:A1.
3. Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs. *Rewarding provider performance: aligning incentives in Medicare*. Washington, DC: National Academies Press, 2007.
4. Medical checks and balances. *Washington Post*. February 26, 2003.
5. Encinosa WE, Hellinger FJ. The impact of medical errors on ninety-day costs and outcomes: an examination of surgical patients. *Health Serv Res* 2008;43:2067-85.

Copyright © 2009 Massachusetts Medical Society.

Medicare Nonpayment, Hospital Falls, and Unintended Consequences

Sharon K. Inouye, M.D., M.P.H., Cynthia J. Brown, M.D., and Mary E. Tinetti, M.D.

In 2005, in response to disturbing and widely cited findings by the Institute of Medicine about the prevalence of life-threatening conditions acquired by patients in U.S. hospitals, Congress authorized the Centers for Medicare and

Medicaid Services (CMS) to implement payment changes designed to encourage the prevention of such conditions. Under an amendment to the Social Security Act that was enacted on January 1, 2007, the secretary of

Health and Human Services was required to identify at least two hospital-acquired conditions by October 1, 2007, that were high-cost, high-volume, or both; that resulted in the assignment of a case to a higher-paying diagnosis-