High quality, efficient care for Medicare beneficiaries – but at what cost?

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Aligning Medicare payment policy with the delivery of high quality, efficient care for Medicare beneficiaries is a laudable goal and one that the Centers for Medicare and Medicaid (CMS) is working hard to attain. However, the increased costs to hospitals in attaining that goal may be higher than previously forecast. On August 22, 2007, CMS published a final rule in the Federal Register with the stated goal to improve the quality of patient care by eliminating preventable complications.[1] The new rule eliminates payment of Medicare claims for specific conditions that patients acquire during an inpatient hospital stay. While CMS's goal to improve quality of care and increase patient safety is commendable, the new regulations change the rules of the game for hospitals, particularly in the area of compliance and reimbursement. The impacts to hospitals' bottom lines to comply fully with the new rule remain unknown.

Hospital-acquired conditions

The CMS final rule implements a provision of the Deficit Reduction Act of 2005 (DRA)[2] that is aimed at eliminating reimbursement for the increased costs associated with treating a Medicare beneficiary who acquires certain preventable conditions during an inpatient stay. Medicare will no longer reimburse for the treatment of eight "hospital-acquired conditions," unless the condition was present when the hospital admitted the Medicare beneficiary. These hospital-acquired conditions are:

1) Serious Preventable Event - Object left in during surgery
2) Serious Preventable Event - Air embolism
3) Serious Preventable Event - Blood incompatibility
4) Catheter-associated urinary tract infections
5) Pressure ulcers
6) Vascular catheter-associated infections
7) Surgical site infection – Mediastinitis after coronary artery bypass graft (CABG) surgery, and
8) Falls[3]

Conditions such as these are often referred to as "never events." According to the National Quality Forum (NQF), "never events" are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a real problem in the safety and credibility of a health care facility.[4] Another example of a "never event" is surgery on the wrong body part.

CMS was guided by the language of the DRA in the selection of the eight hospital-acquired conditions. The DRA requires that each condition CMS selects must meet the following three criteria:

1) high cost or high volume or both;
2) results in the assignment of the case to a diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis; and
3) could reasonably have been prevented by the application of evidenced-based guidelines.

Included among the conditions that CMS considered and did not incorporate in the new rule were ventilator-associated pneumonia, *Staphylococcus aureus septicemia*, deep vein thrombosis, Methicillin-resistant *Staphylococcus aureus, Clostridium difficile*–associated disease, and wrong surgery.[5] Although not included in the current rule, CMS intends to include some, if not all of these additional hospital-acquired conditions in future years. In fact, CMS plans to add ventilator-associated pneumonia, *Staphylococcus aureus septicemia*, and deep vein thrombosis as non-reimbursable hospital-acquired conditions for fiscal year 2009.[6] Hospitals that fail to modify their current operations to address these new regulations may experience significant financial repercussions as discussed below.[7]

Secondary diagnoses present on admission (POA)

The DRA requires that all hospitals participating in the Medicare program report secondary diagnoses that are present on patient admissions, beginning with patient discharges on or after October 1, 2007.[8] Hospitals that fail to do so could experience a significant delay in the otherwise routine payment of Medicare claims. According to a transmittal issued by CMS on May 11, 2007, if hospitals fail to report a valid POA code for each diagnosis on a claim after April 1, 2008, the claim will be returned to the hospital for correct submission of the POA information.

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Consequently, hospitals that fail to make the necessary changes to patient admission and claims submission procedures to identify and report secondary diagnoses POA may experience a slowdown in revenue flow for Medicare claims.

Practical implications

Linking reimbursement with quality of care is clearly good policy, as heralded by patient safety groups, but the potential financial and administrative implications are daunting for hospitals that must comply with these new regulations. As discussed above, hospitals must begin reporting secondary diagnoses that are POA, beginning with patient discharges on or after October 1, 2007. For most hospitals, the new reporting requirement may necessitate a change in the way patients are admitted to the hospital, and hospitals will need to revamp their admission and claims submission procedures to capture secondary diagnoses POA. The regulations also may result in the hospitals performing additional tests to adequately identify conditions that are POA. These additional costs for all patients admitted to the hospital would need to be absorbed without additional revenue.

Beginning in fiscal year 2009, Medicare will cease paying an increased DRG reimbursement rate to hospitals treating patients who have hospital-acquired conditions, unless the hospital can provide documentation that the condition was POA. This means that hospitals have one year to determine their incidence rates for the eight hospital-acquired conditions. Hospitals will need to examine, and if necessary change, their operating policies and procedures to ensure that they can prevent the occurrence of the eight conditions, to the greatest extent possible.

These payment policy changes likely will be significant for the bottom line at many hospitals. These recent changes do not make the additional cost of a hospital-acquired condition a "non-covered cost." Instead, any additional costs that a hospital incurs as the result of a hospital-acquired condition remain a covered Medicare cost. Under the new rule, hospitals simply will not receive additional payments to cover the cost. This means that the hospital is prohibited from billing the Medicare beneficiary for any charges associated with the hospital-acquired condition.

CMS's outlier policy limits a hospital's financial risk of treating high cost cases. However, the outlier payment methodology requires hospitals to experience large losses on outlier cases. For example, in FY 2007, the fixed-loss amount was $24,485 before a case qualified for outlier payments. Even after qualifying for outlier payments, a hospital only receives 80% of its estimated costs above the fixed-loss cost threshold.[9] Despite hospitals' increased financial risk for costs associated with hospital-acquired conditions, CMS points out that Medicare's high-cost outlier policy is unaffected by the new rule.[10] Consequently, the financial risk of treating high cost cases will still be limited by the outlier policy, even if the costs are the result of a hospital-acquired condition that occurs after admission.

Moving beyond Medicare – The new era of financial incentives for quality

As is often the case, if the hospital-acquired condition rule proves cost effective for Medicare, private insurance companies will quickly implement similar policies.[11] In fact, some companies have already announced that they will stop paying for "never events" and certain medical errors. Included among companies that have announced "never event" policies are members of the National Business Group on Health and the Leap Frog Group.[12] Similarly, Aetna's Chief Medical Director of National Accounts, Charles Cutler, MD, has been quoted as stating that Aetna is considering making non-payment for "never events" a standard part of the company's contracts.[13] Such restrictions will place additional financial burdens on hospitals that do not have effective programs in place to address quality and patient safety and that fail to link quality and safety with their billing and compliance programs.

According to the Institute for Healthcare Improvement, patients in the United States are harmed as the result of medical error at a rate of more than 40,000 a day.[14] The hospital-acquired conditions rule recently adopted by CMS for Medicare beneficiaries provides hospitals with financial incentives to drive patient safety and provide efficient, high quality healthcare. However, in order to succeed in the new climate where quality and patient safety is directly linked to the right to payment, hospitals must reorganize their operations to link billing and compliance with quality and safety initiatives. ■

1 Medicare Program: Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rules, 72 Fed. Reg. 47130, 47200 (Aug. 22, 2007)
2 § 501(c) of Pub. L. 109-171
3 See generally Medicare Program: Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rules, 72 Fed. Reg. 47130, 47200 (Aug. 22, 2007)
4 http://www.cms.hhs.gov/apps/media/press/release.asp?counter=1863. See Appendix 2 for a complete list of "never events"
5 72 Fed. Reg. at 47218 (Aug. 22, 2007)
6 See 72 Fed. Reg. at 47218 for additional information and discussion
7 In a separate initiative, actively supported by The Leapfrog Group, the CMS Office of Inspector General is conducting a study on whether CMS should ever pay for a "never event." Martin Sipkoff, Hospitals Asked to Account for Errors on their Watch, Managed Care, July, 2007
8 72 Fed. Reg. at 47201 (Aug. 22, 2007)
9 Medicare Program: Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rules, 72 Fed. Reg. 47130, 47200 (Aug. 22, 2007)
10 Medicare Program: Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rules, 72 Fed. Reg. 47130, 47201 (Aug. 22, 2007)
11 An article in Managed Care reports that private insurers state that it is too early to "gauge the effect" that the CMS rule will have on their health plans. However, payors are tired of paying for costly mistakes. Martin Sipkoff, Hospitals Asked to Account for Errors on their Watch, Managed Care, July 2007
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