Aetna to Refuse Payment for Preventable Errors

BY MARY ELLEN SCHNEIDER
New York Bureau

In a move that could have significant implications for physicians and hospitals, the insurer Aetna has said it will not pay its network hospitals for care necessitated by certain preventable errors.

The announcement follows a policy shift by the Centers for Medicare and Medicaid Services, which has finalized plans to stop paying for eight preventable events as of October 2008.

Aetna Inc. has incorporated language into its hospital contracts that calls for waiving all costs related to a number of serious reportable events.

The language comes from the Leapfrog Group's "never events" policy, which includes a list of 28 events considered so harmful that they should never occur. The list, compiled by the National Quality Forum (NQF), comprises events ranging from surgery performed on the wrong body part or on the wrong patient, to stage III or IV pressure ulcers acquired after admission to a health care facility.

The policy instructs hospitals to report errors within 10 days to the Joint Commission, state reporting programs, or patient safety organizations. Hospitals also are asked to take action to prevent future events and to apologize to the patient or family affected by the error.

Aetna is the first health plan to endorse the Leapfrog policy. "The major goal here is to get hospitals to focus on having the systems in place to prevent these events from happening," said Dr. Charles Cutler, Aetna's national medical director.

Adopting the Leapfrog Group's never events policy is not about saving money, Dr. Cutler said. In fact, many of the never events carry no additional cost. Instead, Aetna is seeking to send a consistent message to hospitals about quality, he added. "The intent here is not to be punitive."

But the Aetna announcement has encountered some skepticism from the physician community.

The NQF list of never events is much broader than the eight preventable events selected under the Medicare policy, said Cynthia Brown, director of the division of advocacy and health policy at the American College of Surgeons (ACS).

One reason that many of those events were not included on Medicare's list is that they are difficult to measure with the current coding system, she said.

Another problem with the Aetna approach is that it's hard to affix blame to a hospital or a particular physician. "If there's a problem with blood incompatibility, is it the surgeon's fault?" Ms. Brown asked. "It's hard to know how it's going to be operationalized," she added.

When used properly, the NQF never events list protects patients, said Dr. Frank Opelka, chair of the ACS Committee on Patient Safety and Quality Improvement. But, he cautioned, if payers drift from the intentions of the NQF never events, the specifications could be lost and overreporting could create unintended consequences.

For example, because of hospital overcrowding and limited resources in a rural environment, a frail patient may be admitted despite the lack of health care resources. If the patient has a pressure ulcer that progresses from a stage II on admission to a stage III, this should not be considered an NQF never event, he said.

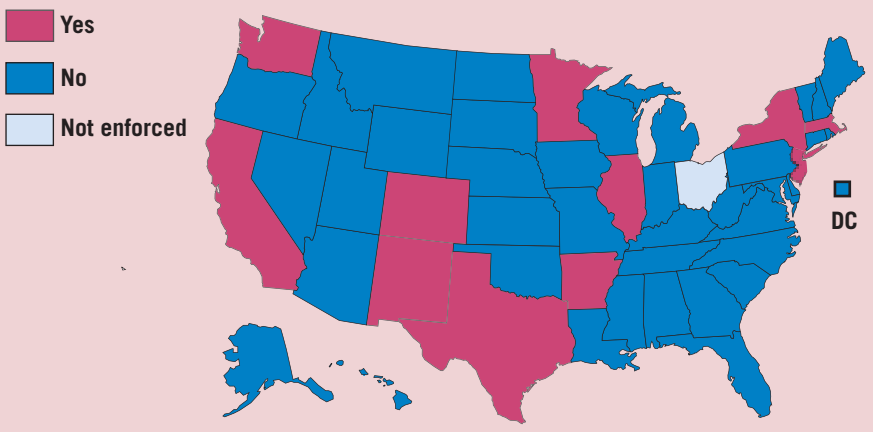
Dr. Opelka also questioned whether hospitals would continue to report these types of serious preventable errors if they aren't being paid for the care. "If the reports are generated from a hospital claims system and the payer no longer recognizes the events as payable, isn't the message to stop reporting rather than to prevent the never events?" asked Dr. Opelka, also vice chancellor for clinical affairs at Louisiana State University Health Sciences Center, New Orleans.

The policy is likely to affect all of Aetna's network hospitals over the next 3 years as the company renegotiates its contracts, Dr. Cutler said.

Since Medicare announced its policy shift last summer, other insurers have considered changes to their policies. Officials at Cigna, for example, are evaluating how to implement a similar policy within their hospital network. The insurer plans to have a national policy in place by October 2008, said Cigna spokesman Mark Slitt. ■

DATA WATCH

Are Emergency Departments Required to Give Sexual Assault Survivors Information About Emergency Contraception?



Note: Based on state policies as of Aug. 1, 2007.
Source: Kaiser State Health Facts

ELSEVIER GLOBAL MEDICAL NEWS

Evidence Base Lacking for Medicare Coverage Decisions

BY LEANNE SULLIVAN
Associate Editor

Data reviewed by the Centers for Medicaid and Medicare Services to inform Medicare treatment coverage decisions reflect populations that are significantly different from the Medicare beneficiary population, a recent analysis has shown.

In 1998, the CMS established a panel of physicians and other professionals to review the evidence base before the agency makes national Medicare coverage decisions.

The independent panel, now called the Medicare Evidence Development and Coverage Advisory Committee (MedCAC), reviews the literature described in a technology assessment and votes on the evidence to determine the health benefit of the medical procedure or device, wrote Sanket S. Dhruva and Dr. Rita F. Redberg, both of the University of California, San Francisco.

The university, along with the Robert Wood Johnson Foundation, provided support for the study. Dr. Redberg is a member of MedCAC, but had no financial conflicts of interest to disclose.

To examine whether the data used by MedCAC was generalizable to the Medicare population, Mr. Dhruva and Dr. Redberg looked at all six MedCAC decisions involving a cardiovascular product or service and analyzed the sample size, participant demographics, inclusion criteria, study location, and outcome stratification of the relevant technology assessments. The data in the technology assessments used for these six decisions included 141 peer-reviewed reports and 40,009 patients (Arch. Intern. Med. 2008;168:136-40).

Significant differences were found between the study populations and the Medicare population.

Participants in the trials described in the technology assessments were significantly younger (mean age, 60.1 years) than were most Medicare beneficiaries (mean age 70.8 years).

Several trials excluded older patients, but "the mean age in studies with explicit age exclusions (59.0 years) and those without such exclusions (60.9 years) did not differ," the authors wrote.

"Studies for each cardiovascular [technology assessment] also differed significantly from the Medicare population in terms of sex," they continued. Of the study participants, 75.4% were men, compared with 43.7% of Medicare beneficiaries. Several of the studies had excluded women, but none excluded men.

Clinical trial location also was not representative of the Medicare population. Of 135 studies that reported location, 37% took place at least partly in the United States. However, most (51.1%) were done in Europe, 8.9% in Asia, and 6.7% in other locations. Overall, 40% of the technology assessment study participants were U.S. residents, compared with 100% of the Medicare population.

In addition, many of the trials excluded patients with conditions such as renal insufficiency, arrhythmias, and diabetes that are common in the Medicare population.

The researchers concluded that the data used by MedCAC as evidence on which to base national treatment coverage decisions "are derived from populations that differ significantly from the Medicare beneficiary population in terms of age, sex, country of residence, and comorbid conditions."

The trial populations are "younger, healthier, male, non-U.S. populations," reflecting a "persistent underrepresentation of women and elderly people" in clinical trials in general, the authors noted.

To improve the relevance of the data used for coverage decisions, the authors suggested that all future studies include demographic information, as "the accuracy and risk-benefit profiles of many diagnostic tests and therapies differ substantially by age and often by sex."

They also suggested that the CMS adopt a policy requiring data on women and the elderly, which would encourage trial investigators to include such data.

An alternative approach would be for the CMS to issue coverage decisions dependent on the addition of subgroup data within a specified period of time.

"Closer linkage of evidence to coverage would promote better value and improved outcomes" for Medicare patients, the researchers concluded. ■

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