Letters

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Methodology On Adverse Events

In their paper (Sep/Oct 06), Chunliu Zhan and colleagues address a critical issue: Do hospitals make or lose money on adverse events? Their study asserts that “extra payments cover less than a third of the extra costs incurred by hospitals in treating these adverse events,” which leads them to claim that both hospitals and Medicare will gain financially by eliminating the adverse events. The methodology, however, likely underestimates the extra payments associated with preventable adverse events. Not only can the adverse event itself affect the diagnosis-related group (DRG) and payment; other complications caused by the adverse event can affect it, too.

More important, the study overestimates the costs of adverse events by using average costs rather than marginal costs. Analyses being conducted by the Pittsburgh Regional Health Initiative and Pittsburgh’s Jewish Healthcare Foundation have looked at how much more it costs a hospital to treat a patient when that patient gets an infection (a type of preventable adverse event). The traditional way calculates increased costs using cost per day (for example, rooms) as well as out-of-pocket costs (for example, drugs). But it’s the marginal cost that matters—how much more the hospital actually spends because the patient stays longer—and that is much lower. Our analyses suggest that marginal costs to hospitals for treating patients with adverse events represent only about 20–40 percent of the average cost figures typically used for these calculations.

As a result, in many cases, the marginal cost to a hospital of treating the adverse event and its complications is less than the extra payment the hospital receives for the patient. This means that the hospital can lose more money by preventing infections than by treating them—effectively penalizing the hospital for improving patient safety and outcomes.

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Adverse Events: The Authors Respond

“Do hospitals make or lose money on adverse events?”—the question raised by Harold Miller—is somewhat different from what we addressed in our study. To answer his question, one has to calculate marginal costs and extra payments for adverse events. To answer whether a hospital is financially penalized for improving safety, one has to further capture costs in preventing adverse events. These questions are of great interest to people involved in patient safety, but, unfortunately, data to answer them might not exist. Our study took a simpler approach to address an easier question—How much does Medicare pay for selected adverse events under the DRG-based prospective payment system (PPS)—which was possible with the available billing data and PPS payment formula. As Miller noticed, our estimates of the extra costs of adverse events might not be accurate, a limitation we are keenly aware of.

Our study was to provoke thinking and debate on pay-for-performance (P4P) policy. Current P4P programs focus mostly on the provider level, which requires the payers to select measures, compare performance, and determine awarding criteria and amounts; it requires the providers to implement measures and collect and submit data. Such labor-
intensive micromanagement systems are hard to maintain and sustain.

Our study points to an approach focusing on overall payment systems. The Medicare PPS offers an improved alignment between payment and performance when compared with a fee-for-service system. Nonetheless, our analysis exposed elements in the PPS formula that do not align with P4P philosophy: (1) Occurrence of an adverse event could move a discharge into a higher-pay-rate DRG, or (2) adverse events could prolong a hospital stay and make a discharge eligible for cost-outlier adjustments. We show that to deny payment for hospital-acquired infections, as directed by the Deficit Reduction Act of 2005, both the DRG algorithm and PPS outlier adjustments need to be revised.

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Feds Need To Create Standards And Databases

Hoangmai Pham and colleagues say that how quality reporting affects outcomes for patients is an unanswered question (Sep/Oct 06). There’s a reason. For decades, the federal government has shirked its responsibility by refusing to define a uniform national standard for gathering, storing, and exchanging patient-level health care data. It has also refused to mandate public release of robust billing and discharge databases with provider IDs for all patients in every state. Federal momentum has been slow to build on these two interlocking initiatives, in part, for fear of offending provider and health care vendor special interests.

Until recently, the burden of this decades-long delay has fallen on patients and those who pay the bill. Patients suffer because they don't have long-overdue electronic health records and, more important, in most states patients lack the hard-hitting outcomes information about individual providers they need to find high-quality care. Payers, including taxpayers, feel the pain of a system that doesn’t produce adequate results for their investment.

Now the chickens have come home to roost. Increasingly, the burden of such federal government inaction is falling on providers who are realizing that they fundamentally lack the ability to build automated health care quality-monitoring systems. Only the federal government has the clout needed to make uniform database definitions for comprehensive provider systems stick.

There is nothing excessive or needlessly burdensome about the amount of quality analysis done by hospitals today—except that it’s not done efficiently. Data gathering often is done with a pencil when it should be done by a computer. And public access to powerful, deidentified billing and discharge databases is limited. Such databases, if they were publicly available everywhere, could be used easily by purchasers, community leaders, states, and watchdog groups to generate individualized quality and cost metrics.

Much more internal analysis and better public reporting are needed, and we should begin—finally—to prepare for this by defining standards and producing robust, publicly available databases.

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Pre-Deadline Data Reporting By Some Hospitals

In an otherwise thoughtful paper, Hoangmai Pham and colleagues mistakenly characterize hospital participation in the Hospital Quality Initiative (now the Hospital Quality Alliance) as “anemic” until the passage of the Medicare Prescription Drug, Improve-
ment, and Modernization Act (MMA), which assessed a reduction of 0.4 percent in the annual payment update for hospitals that didn’t submit data.

In fact, several hundred hospitals voluntarily reported data in October 2003, a month before MMA was passed, and by February 2004, 1,407 hospitals were reporting data. Given the long lead time that hospitals need to train personnel, bolster information technology (IT) systems, and do other work necessary to report data, the sharp rise in the number of hospitals reporting data a mere four months after the bill’s passage was a result of hospitals’ committing to report data back in early 2003 rather than to any potential financial penalty. Indeed, by November 2003, 1,700 hospitals had signed up to share data.

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Errata

In the paper titled “Employers’ Views on Incremental Measures to Expand Health Coverage” by Heidi Whitmore and colleagues (Nov/Dec 06), Exhibits 1, 3, 4, 5, and 6 contain incorrect data. These resulted in two incorrect statements in the text: (1) On page 1671, first full paragraph, the second sentence should read as follows: “Among firms offering health benefits, just under half said that they would be very or somewhat supportive of this.” The word “under” had previously been “over.” (2) On page 1672, first incomplete paragraph below Exhibit 2, the final sentence should read as follows: “Small employers, however, were significantly more likely than larger firms to be either very or somewhat supportive of such legislation.” The word “small” had previously been “large,” and the word “larger” had previously been “smaller.” A corrected version of the article is available online at http://content.healthaffairs.org/cgi/content/full/25/6/1668. 

Health Affairs and the authors regret any inconvenience these errors may have caused.

Exhibit 2 in the paper titled “Medicare’s Coverage of Colorectal Cancer Drugs: A Case Study in Evidence Development and Policy,” by Tanisha Carino and colleagues (Sep/Oct 06), contained a typographical error. For the second clinical trial listed (CALGB–C80405), the number of patients should be 2,300, not 23,000. The authors and Health Affairs regret any confusion this error may have caused.