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Nonpayment for Preventable Events and Conditions: Aligning State and Federal Policies To Drive Health System Improvement

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Executive Summary

There is a wide gap between the quality of health care services Americans receive and the care they should receive. Patient safety shortcomings, including preventable adverse events and health care-associated infections, occur too frequently. Health care purchasers can use their leverage to improve patient safety by rewarding high quality, safe performance and encouraging correction of poor performance.

In January 2005, the first U.S. policy related to nonpayment for preventable conditions was implemented by HealthPartners, a not-for-profit health maintenance organization based in Minnesota. The federal government, through the Centers for Medicare and Medicaid Services (CMS) Medicare program, and state agencies in twelve states (Colorado, Kansas, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New York, Oregon, Pennsylvania and Washington), have followed HealthPartners. They no longer pay (or in Maryland's case, adjust the payment for) the increased cost of the hospitalization for the care that results when the patient is harmed.

In October 2009, NASHP convened and facilitated a dialogue among high-level state and national leaders to discuss 1)issues related to nonpayment of adverse events and 2)priority issues for future state/federal dialogue. NASHP synthesized background information about nonpayment for adverse events which has been augmented by meeting discussion to produce this report.

Key lessons from state and federal purchasers' experiences implementing nonpayment policies include:

- Nonpayment for preventable adverse events or conditions represents one initial, relatively easy, visible, and noncontroversial step to purchasing quality care. These policies are an opportunity for purchasers to use their leverage to drive system improvement.

- Alignment of nonpayment policies is occurring among state and federal policymakers, and among purchasers, providers, and the public. They have aligned around a consistent message that the current state of patient safety is unacceptable.

- Purchasers adopt nonpayment policies as a quality improvement tool. Cost savings are not a driver, although as purchasers expand the list of events for which payment will be denied or adjusted in the future, there will be more potential for costs savings.

- Purchasers encounter complicated implementation issues related to nonpayment policies; nevertheless, Medicare's nonpayment policy provides a basis to inform state policies.

- Nonpayment policies are an opportunity to build momentum toward broader system change. Most states that have adopted nonpayment policies have done so as part of broader agendas that build on public/private collaboration to improve quality and reduce costs.

- Alignment of state and federal policies should not stifle innovation; experimentation is needed prior to standardization. Federal policy should provide a floor but not a ceiling, so states can use their unique expertise and experiences to drive systems improvement.

Participants see aligning federal and state nonpayment policies as one of many areas in which future alignment between federal and state policies can advance health system reform.

Building the Case for Nonpayment

Patient care is not as safe as it should be. Research shows that there is a wide gap between the quality of health care services that Americans receive and the care that they should receive.[1] It is widely recognized that many patients in the United States, even those with health insurance, do not receive appropriate, evidence-based health care. One major study found that patients receive only 55 percent of recommended care.[2]

Among the goals for the health care system is the avoidance of sickness or injury to patients from the care that is intended to help them. However, according to the Institute of Medicine (IOM), more people die annually in hospitals as the result of adverse events than the number of deaths due to motor vehicle or workplace accidents, AIDS, or breast cancer.[3] In many cases evidence-based methods are available that can prevent these deaths and injuries. Health care costs represent more than half the estimated total costs of preventable adverse events that occur in hospitals ($17 to $29 billion).[4] Since the release of these numbers, major studies have substantiated errors in other care settings, including ambulatory care settings and nursing homes, as well as errors of omission.[5] A Centers for Disease Control and Prevention study concluded that 99,000 patients a year die as the result of healthcare-associated infections.[6] Almost all of those deaths, experts say, are preventable.[7]

Table 1 provides definitions, examples, and sources of various terms frequently referenced in nonpayment policies described below.

Table 1: Frequently used terms in nonpayment policies

Term	Definition	Examples	Source
Healthcare-associated infection (HAI)	An infection that a patient acquires while receiving treatment for medical or surgical conditions.	Surgical site infection, central line-associated bloodstream infection, ventilator-associated pneumonia, and catheter-associated urinary tract infection	Centers for Disease Control and Prevention (U.S. Department of Health and Human Services (DHHS), HHS Action Plan to Prevent Healthcare-Associated Infections: Executive Summary, (Washington, D.C.: DHHS, June 2009.)
Hospital acquired condition (HAC)	A condition that is a) high cost or high volume or both, b) results in the assignment of a case to an MS-DRG that has a higher payment when present as a secondary diagnosis, and c) could reasonably have been prevented through the application of evidence-based guidelines.	Foreign object retained after surgery, pressure ulcer stages III and IV (For a complete list of HACs, see Appendix A).	Centers for Medicare & Medicaid Services (CMS) (CMS, Hospital-acquired Conditions (HAC) and Present on Admission (POA) Reporting. Washington, D.C: CMS, October 2008.)
Serious reportable event (SRE)	Unambiguous, serious, preventable adverse events that concern both the public and healthcare providers and could form the basis for a national reporting system that would lead to substantial improvements in patient safety. SREs are identifiable and measurable, and their risk of occurrence is significantly influenced by the policies and procedures of healthcare organizations.	Surgery performed on wrong patient, infant discharged to the wrong person (For a complete list of SREs, see Appendix C).	National Quality Forum (NQF) (NQF, Serious Reportable Events in Healthcare 2006 Update: A Consensus Report. (Washington, D.C.: NQF, 2007), vi).

Purchasers can advance the patient safety agenda

Purchasers end up paying for additional care consequent to adverse events when insurance premiums increase in anticipation of future care that would not have been necessary were proper care assured. They can use their leverage to improve patient safety by rewarding high quality, safe performance and encouraging correction of poor performance. According to The Commonwealth Fund's Commission on a High Performance Health System, rewarding performance for quality and efficiency through payment systems is one concrete step that could improve the value of health care in the United States.[8]

In January 2005, the first U.S. policy related to nonpayment for preventable conditions was implemented by HealthPartners, a not-for-profit health maintenance organization based in Minnesota. HealthPartners does not pay for services associated with any of 27 "never events" or allow providers to bill members. The events are the serious reportable events identified by National Quality Forum (NQF) in its 2002 report, *Serious Reportable Events in Healthcare.*[9] (See Appendix C for list of NQF events)

Since 2005, the federal government and states have followed in the steps of HealthPartners by implementing nonpayment policies related to preventable adverse events.

The Federal government takes a leadership role in refusing to pay for select conditions and events

The federal government set the stage for nonpayment for preventable conditions with the Quality Adjustments in Diagnosis-Related Group (DRG) Payments for Certain Hospital Acquired Infections, a part of the Deficit Reduction Act of 2005. This provision requires the Secretary of Health and Human Services to identify conditions that:

- are high-cost, high-volume or both
- result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and
- could reasonably have been prevented through the application of evidence-based guidelines.[10]

If a condition is not present on admission but is acquired during the hospital stay (as evidenced by new reporting requirements), the Centers for Medicare and Medicaid Services (CMS)' Medicare program will no longer pay the increased cost of the hospitalization for the care that results when the patient is harmed. The Medicare program may revise the list of conditions, but it will always contain at least two conditions. Medicare also prohibits the hospital from billing the beneficiary for the difference between the lower and higher payment rates.[11]

In the Inpatient Prospective Payment System (IPPS) fiscal year 2008 final rule, the CMS Medicare program collaborated with public health and infectious disease experts from the Centers for Disease Control and Prevention to select categories of conditions, and added additional conditions in the IPPS fiscal year 2009 final rule.[12]

In January 2009, CMS issued three national coverage determinations (NCDs) to prevent Medicare from paying for certain preventable surgical errors.[13] Medicare does not cover any services related to these non-covered services. Unlike the provisions mentioned above, which affect only payments to hospitals for inpatient stays, these NCDs may affect payment to hospitals, physicians, and any other health care providers and suppliers involved in surgeries.[14]

This federal policy, intended to encourage value-based purchasing, was informed by research on avoidable costs and preventability of certain conditions. Medicare adopted these payment policies to encourage hospitals to 1) reduce the likelihood of hospital acquired conditions such as certain infections, advanced bed sores, or fractures; and 2) reduce preventable medical errors, such as performing surgery on the wrong body part.

This Medicare nonpayment policy, like many federal programs and policies, can support or inhibit state efforts. Policy change at the federal level can spur change at the state level, as well as among private payers and providers. This policy is widely considered to have been the catalyst that sparked other public and private payers to adopt policies to not pay for certain adverse events.[15]

In addition to implementing this policy within the Medicare program, CMS, via its Center for Medicaid and State Operations (CMSO), provided guidance to states on implementing similar policies within Medicaid. In a 2008 letter to state Medicaid directors, CMSO detailed how and why to implement a Medicaid policy that aligns with Medicare's nonpayment policy.[16] The letter encourages states to adopt the same nonpayment policies outlined in the final Medicare rule.[17] Moreover, the letter encourages states to consider implementing policies that go beyond the Medicare policy by, for example, drawing from the full list of NQF serious reportable events. In short, CMS and CMSO have made clear that "payment and performance need to be linked" at both the state and federal levels.[18]

States take action on patient safety

Many states recognize the reduction of preventable adverse events and conditions is a significant opportunity to not only improve individual care experiences but to also contain costs, expand access, improve population health, and improve health system performance. As large purchasers, regulators, conveners, and providers of health care services states have many opportunities to improve patient safety and safeguard the public. Safety is only one area of focus for states within a broader quality agenda.

Since states purchase health care for a sizable share of the market, they have an important role in addressing medical errors and patient safety and can influence the quality and safety of health care. The Medicaid and CHIP programs spend more than $320 billion per year in state and federal funding; Medicaid and CHIP are among the country's major purchasers of health care and account for one-sixth of all health care spending in the U.S.[19]

With momentum at the state and national levels to reform the U.S. health care system, state and federal leaders have an opportunity to identify ways to align efforts and advance reform agendas that focus on improving health system performance. Nonpayment policies for preventable conditions represent such an opportunity.

Project methodology

In October 2009, NASHP convened and facilitated a dialogue among high-level state and national leaders to discuss 1)issues related to non-payment of adverse events and 2)priority issues for future dialogue. NASHP conducted an environmental scan and synthesized background information about nonpayment for adverse events, which has been augmented by meeting discussion to produce this report. A separate issue brief addresses priority issues raised for future state/federal dialogue.

NASHP identified 12 states (at least one payer per state) that deny payment (or in Maryland's case adjust payments) for some type of adverse events or preventable conditions (see Table 2.)

Table 2: State payers with policies that prohibit payment for certain preventable conditions as of December 2009

State	Payer(s) Affected by Policy
Colorado	Medicaid
Kansas	Medicaid
Maine	All payers
Maryland*	All payers
Massachusetts	Medicaid, Health Safety Net (for state residents without access to affordable health insurance), Commonwealth Connector (for uninsured state residents), Group Insurance Commission (for state and other municipalities' employees, retirees, survivors/dependents), Department of Correction
Minnesota	Medicaid, General Assistance Medical Care (for low-income adults without children), and Minnesota Care (for state residents without access to affordable health insurance)
Missouri	Medicaid
New Jersey	All payers
New York	Medicaid
Oregon	Public Employee Benefits Board, Oregon Educators Benefit Board
Pennsylvania	Medicaid
Washington	Medicaid (in effect January 1, 2010)

* Maryland's policy is unique in that it uses an adjusted payment as opposed to nonpayment for identified conditions. See page 12 for further clarification.

Among the 12 states with nonpayment policies, all but Oregon have established them within their Medicaid program. Other public payers include public employee health plans (Massachusetts and Oregon), and other publicly funded programs (Massachusetts and Minnesota). Massachusetts also includes the Department of Correction. Policies in Maine, Maryland, and New Jersey apply to all public payers.

Additional states are considering similar policies:

- Legislation (Assembly Bill 542) pending in the California State Assembly proposes the development of regulations to align state payment policies with those adopted by CMS relating to hospital acquired conditions.

- According to the Center for Medicaid and State Operations at CMS, as of December 2009, nine states have been approved for state plan amendments to modify their Medicaid payment policies to reflect the Medicare nonpayment policy. In addition to Kansas, New Jersey, and New York State, listed above, Florida, Idaho, Indiana, Nebraska, Utah, and Wisconsin have been approved. A request is pending in Connecticut.

In addition to the actions that state governments take independently, they also partner with the private sector. Recently, NASHP identified 10 states with public-private partnerships dedicated to statewide quality improvement.[20] These public-private partnerships help states streamline quality improvement efforts; state partnerships have focused on payment reform as one broad strategy to improve quality and system performance. One of these partnerships, the Colorado Center for Improving Value in Health Care, is building upon the Colorado Medicaid nonpayment policy to create a statewide nonpayment policy expansion beyond hospital settings and beyond Medicaid.

Meeting participants noted that the states with nonpayment policies are leaders in quality improvement and patient safety initiatives, and are building on previous initiatives when adopting nonpayment policies. These states are well represented among those leading the way in developing public/private strategic partnerships and agendas for health systems improvement. They are operating adverse event reporting systems to collect reports from facilities about adverse events, with the intent of improving patient safety;[21] developing policies to advance medical homes;[22] have active patient safety coalitions;[23] rank in the top or second quartile on the 2009 State Scorecard on health system performance;[24] and have hospitals that have agreed voluntarily not to bill for certain preventable conditions.

Review of nonpayment policies for preventable conditions

Table 3 provides comparable information on the twelve identified state and the federal nonpayment policies for preventable conditions. Appendix A contains a detailed list of events specified in state and federal nonpayment policies.

Table 3: Crosswalk of State and Federal policies that deny or adjust payment for certain preventable events

Program	Events Denied Payment[25]	Effective Date (Authorization)	Facilities Targeted	Event Identification	Claim Determination	Prohibition on Patient Billing[26]
Centers for Medicare and Medicaid Services, Medicare	Hospital Acquired Conditions	Oct. 1, 2008 (Aug. 22, 2007, Federal Register, page 47201. Aug. 19, 2008, (Federal Register / Vol. 73, No. 161)	General acute care hospitals	Present on Admission (POA) indicators within hospital discharge data	Prospective	Yes
	Preventable Surgical Errors	January 15, 2009 (National Coverage Determination Decision Memos CAG-00402N, CAG-00403N, and CAG-00401N)	General and acute care hospitals and ambulatory surgical centers	POA indicators	Prospective	Yes
Colorado Medicaid	Serious Reportable Events/24-Hour Readmissions	Oct. 1, 2009 (E.O. D006 09)	Hospitals	POA indicators; claims coding – ICD-9 or E-codes	Prospective	Yes

Table 3: Crosswalk of State and Federal policies that deny or adjust payment for certain preventable events (continued)

Program	Events Denied Payment[25]	Effective Date (Authorization)	Facilities Targeted	Event Identification	Claim Determination	Prohibition on Patient Billing[26]
Kansas Medicaid (Kansas Medical Assistance Program)	Hospital Acquired Conditions	Jan. 23, 2009, or October 2008 for claims processed and paid after January 23 (Medicaid bulletin)	General acute care hospitals	POA indicators	Prospective	Yes
	Preventable Surgical Errors	Pending	General and acute care hospitals	POA indicators	Prospective	Yes
Maine (all payers)	Mistakes or Preventable Adverse Events	July 18, 2008 (P.L. Chapter 605) Amended Sept. 12, 2009 (P.L. Chapter 31)	Hospitals and ambulatory surgical centers	Not specified	Not specified	Yes
Maryland Health Services Cost Review Commission (all payers)	Maryland Hospital Acquired Conditions	July 1, 2009 (Commission vote)	Hospitals	POA indicators and use of 3M Health Information Systems Potentially Preventable Complications Methodology [27]	Prospective	N/A
Massachusetts (5 agencies: Office of Medicaid, Health Safety Net, Commonwealth Connector, Group Insurance Commission, and Department of Correction)	Serious Reportable Events	June 16, 2009 (Interagency policy)	Hospitals, ambulatory surgery centers, physicians	Provider preventability determination and serious reportable event report. Providers should establish written procedures to notify payers of the occurrence of an event	Prospective	Yes

Table 3: Crosswalk of State and Federal policies that deny or adjust payment for certain preventable events (continued)

Program	Events Denied Payment[25]	Effective Date (Authorization)	Facilities Targeted	Event Identification	Claim Determination	Prohibition on Patient Billing[26]
Minnesota (3 programs: Medicaid (Medical Assistance), General Assistance Medical Care, and MinnesotaCare)	Hospital Acquired Conditions	July 2009 (Chapter 256.969 subd. 3b 256B.0625 subd. 3)	Hospitals, physicians	POA indicators, procedure codes	Prospective and Retrospective	Yes
Missouri Medicaid (MO Healthnet)	Preventable Serious Adverse Events or Hospital or Ambulatory Surgical Center Acquired Conditions	June 30, 2009[28] (13 C.S.R. 70-15.200)	Hospitals and ambulatory surgical centers	POA indicators and claims coding – ICD-9 or E-codes	Prospective[29]	Yes
New Jersey (all payers)	Hospital Acquired Conditions (also referred to as Medical Errors)	Feb. 2010 (P.L. 2009, c.122)	General acute care hospitals, physicians	TBD[30]	Prospective	Yes
New York Medicaid	Serious Adverse (Never) Events (SAE)	Oct. 1, 2008 (3 events; Medicaid bulletin)	General acute care hospitals	POA indicators (SAE items #11, #12, and #13 as listed in Appendix A)	Retrospective	Yes
		Nov. 1, 2009 (10 more events; Medicaid bulletin)		Mandatory Hospital Self-Reporting using three identifying rate codes followed by an Independent Review Process		

Table 3: Crosswalk of State and Federal policies that deny or adjust payment for certain preventable events (continued)

Program	Events Denied Payment[25]	Effective Date (Authorization)	Facilities Targeted	Event Identification	Claim Determination	Prohibition on Patient Billing[26]
Oregon Public Employee Benefits Board (PEBB)	Serious Adverse Events	Jan. 1, 2010 [31] (Health plan contract)	Hospitals	PEBB/OEBB will request ad hoc reports for the first year (2010) with additional reporting requirements developed after data collection; PEBB's self-insured carrier most likely uses POA indicators, among other tools.	Retrospective	Yes
Oregon Educators Benefit Board (OEBB)		Oct.1, 2009 (Health plan contract)				
Pennsylvania Medicaid (Medical Assistance)	Preventable Serious Adverse Events	Jan.14, 2008 (Title 55 Pa.Code Chapters 1101, 1150, and 1163 Subchapter A)	General acute care hospitals	Hospital utilization review, POA indicators, and selected ICD-9 codes identified through claims submission.	Retrospective	Yes
		June 2010 (Act 1 of 2009)	Health care providers and facilities			
Washington Medicaid	Hospital Acquired Conditions and Adverse Events	Jan. 1, 2010 (WAC 388-550-1650)	Hospitals	Facility reporting of adverse events to Department of Health or POA indicators	Retrospective	Yes

No state or federal policies existed prior to 2008

All nonpayment policies are relatively recent. Pennsylvania's policy was the first to be enacted in January 2008, prior to CMS' Medicare policy. In most cases, states established nonpayment policies through the legislative or regulatory process, as in Maine, Minnesota, Missouri, New Jersey, Pennsylvania, and Washington. Other mechanisms states have used are Medicaid bulletins (two states), and an executive order or interagency policy (one state each).

States provide various rationales for the enactment of nonpayment policies, from alignment with Medicare policy and building on broader quality improvement agendas to sending a visible message about intentions to address poor quality care and moving toward value-based purchasing. Pennsylvania initially developed its policy to conform to the Department of Public Welfare's (Medicaid's umbrella agency) responsibility to ensure payment only for medically necessary services. Preventable serious adverse events are by their nature non-medically necessary care. The Kansas Health Policy Authority intended to align with the Medicare policy and built on its vision principle of emphasizing positive outcomes, safety, and efficiency, with care based on best practices and evidence-based medicine.

Events or conditions denied payment often correspond with those identified by Medicare or the National Quality Forum

Nonpayment policies refer to events or conditions denied payment using various terminology, including serious reportable events, hospital (or ambulatory surgical center) acquired conditions, mistakes, preventable adverse events, and medical errors. Despite the variety of terms, most policies reference or use either the Medicare policy's list of hospital acquired conditions (5 states) or the NQF's list of serious reportable events (6 states). Maryland and New Jersey reference neither. Maryland's list of 50 conditions, derived from a list of 64 Potentially Preventable Complications (PPC) developed through a contract with 3M Health Information Systems, includes the most conditions. New Jersey's list of four conditions is shortest. In discussing variability among lists, many of the payers present noted that the list of events included in their policies required negotiation with providers. Participants emphasized the need to base payment decisions on evidence related to events or conditions on the list, and pointed out that hospital acquired conditions as defined in Medicare policy may not be as applicable to Medicaid, which, unlike Medicare, serves mostly children and beneficiaries who more often lose and regain eligibility.

There is overlap among the Medicare policy's list of hospital acquired conditions and the NQF's list of serious reportable events. In the 2008 final rule, CMS selected categories of conditions, some of which were included in the NQF's list. In the 2009 final rule, CMS added an additional condition that is closely related to one of NQF's events. In January 2009, CMS added three more events from the NQF list through the National Coverage Determination process described earlier.

Despite overlap and intermingling of terms, meeting participants pointed out that there are critical distinctions between terms that have implications for payment policies. Meeting participants also noted the need to distinguish events and conditions that are reasonably preventable from those that should be considered always preventable. As evidence of preventability improves, future payment policies may distinguish between events for which payment is denied ("always" preventable, e.g. "never" events) and those for which payment is adjusted ("usually" preventable, e.g. healthcare-associated infections). They

also pointed out differences in frequency of occurrence (serious reportable events are far less common than healthcare-associated infections), which have implications for potential safety improvements and cost savings.

The payer's payment system and methodology influence the implementation of nonpayment policies. Many of the states with nonpayment policies use Diagnosis-Related Groups (DRG), Medicare Severity (MS) DRGs, or All Patient Refined (APR) DRGs which provide a more straightforward mechanism to deny payment. The DRG system provides an extra payment for complicating conditions; the Medicare program used this opportunity to define which complicating conditions did not merit this additional payment. States that pay on a per diem basis encounter more complexities in determining exactly for what they are denying payment.

In Maryland's case, in recognition that the conditions it includes are not entirely preventable all of the time, the Health Services Cost Review Commission has chosen a different strategy in which payments are adjusted based on conditions. It has established a benchmark based on the statewide average for each of its conditions. It then calculates the expected rate for each hospital based on its patient mix and compares the expected rate to the actual rate. If a hospital's actual rate of conditions is lower than expected, the hospital will receive an overall percentage increase in its payment rates in the following year. If a hospital's actual rate of conditions is higher than one would expect, it will receive an overall percentage decrease in its payment rates the following year (within a range of approximately 1 to 2 percentage point changes for the highest and lowest performing hospitals). Hospitals at or near the statewide average levels would have little to no change in their rates. Maryland anticipates that this approach will bring the statewide averages down over time, with the bar raised from year to year.

Meeting participants believe that nonpayment for preventable adverse events is an unassailable first step in eliminating payment for poor quality; all agreed that providers should not be paid for harming patients. They also noted that in order to change the culture of the delivery system, the list of events denied payment would need to expand in the future.

Nonpayment policies most frequently apply to hospitals

All nonpayment policies reviewed affect payment provided to hospitals. Three states (Maine, Massachusetts, and Missouri) also include ambulatory surgery centers, and three (Massachusetts, Minnesota, and New Jersey) include physicians. These three policies prohibit payers from covering physicians' services related to the provision of care related to a treatment for which hospital reimbursement is prohibited, if the physicians' services are billed by a physician who delivered care that contributed to or caused the adverse health care event or hospital acquired condition. Pennsylvania's policy applies to the greatest number of provider types, with plans to expand from hospitals to health care and nursing facilities.

Policies prohibit billing of patients for services denied payment

Nonpayment policies expressly prohibit billing or balance-billing of patients for services related to preventable events and conditions. In some cases, nonpayment policies also expressly prohibit billing next of kin, patient's employers, or other third party payers. Massachusetts requires that patients be informed of events that are part of their care for which payment is denied. Given Maryland's unique approach of adjusting rates based on overall performance, it is not possible for a hospital to bill any particular patient

based on an adverse event or condition. Appendix B contains nonpayment policy language concerning patient billing.

Events are most often identified through present on admission coding

In most cases, state and federal payers use present on admission (POA) coding within hospital discharge billing data to identify events or conditions for which payment will be denied. POA indicators distinguish between conditions that are present at admission and those that arise during hospital stays and can be considered complications, such as pressure ulcers or healthcare-associated infections. CMS required all Inpatient Prospective Payment System (IPPS) hospitals to begin submitting POA information on all primary and secondary diagnoses for inpatient discharges on their Medicare claims on October 1, 2007. Some states require POA coding for other payers as well.

In addition to using POA codes, Minnesota, New York State and Washington State also compare facility self-reporting of events to state adverse event reporting systems. Massachusetts uses this approach as well, and expects providers to establish written procedures to notify payers of the occurrence of an event. Maryland established acceptable ranges for POA coding and examined the quality of coding for a year to ensure accuracy prior to reducing payments. The New York State Department of Health developed three new rate codes to be used when one of ten adverse events occurs. Using one of the three codes indicates that a serious adverse event has occurred for which Medicaid will deny or reduce payment for the admission. The Department of Health identifies claims billed with these codes and instructs its review agent (Island Peer Review Organization) to request the medical record for the admission and conduct a case review.

Nonpayment policies motivate and support broad system delivery change and quality improvement

Meeting participants agreed that nonpayment policies are valuable not only as conversation starters, but also for motivating and supporting broad system delivery change and quality improvement. For participants, nonpayment for preventable events or conditions is a clear-cut, easily justified policy decision. The notion that payment should not be expected for something unnecessary or avoidable is one about which providers, payers, and the public can all agree. Articles and blogs have commented that consumers do not pay for mistakes when purchasing most commodities or services (e.g., food, hair care, car repairs), and the same principle should apply to health care as well.[32] Participants noted that for this reason, the topic of nonpayment for preventable adverse events or conditions was a relatively easy place to find consensus among policy makers and providers. The issue brought new and existing stakeholders to the table, including an array of providers, which created forums for sharing ideas.

At the same time, participants noted that nonpayment policies are crude instruments that are still in their infancy, and the logistics of implementing these policies are complicated. Payers must cope with issues such as which events or conditions to select for nonpayment, how to define those events or conditions, how to handle an event or condition that occurs during a care transition or in an ambulatory or long-term care setting, how and whether to differentiate between events that are "always" or "usually" preventable, how to handle under or non-reporting of events and the possibility that such policies could increase non-reporting, how to pay for treatment or remediation of damage caused by errors and potential cost shifting to pay for this care, and more generally, how to keep the focus on improving the care delivery system rather than assigning provider blame. Ongoing dialogue is essential to begin to understand these broad policy questions and incorporate lessons from other kinds of quality improvement and patient safety policies and initiatives.

A challenge commonly noted was that of characterizing nonpayment as a quality improvement strategy. Since nonpayment by definition affects finances, policy makers may focus on capturing and reallocating dollars; as a result, nonpayment policies are erroneously perceived as cost containment strategies as opposed to quality or health system performance improvement strategies. Currently, costs savings are not a driver of these nonpayment policies, since many of the preventable conditions rarely occur. Nevertheless, savings could be noteworthy.[33] Participants noted that if nonpayment policies expand beyond serious adverse events to include healthcare-associated infections, cost savings could be significant. Pennsylvania has estimated a cost of $3.5 million each year for hospital acquired conditions.[34]

Meeting participants emphasized that despite implementation challenges, nonpayment policies are valuable because they can help drive and support systemic improvements. They noted that nonpayment policies strengthened ongoing efforts by adding momentum, and by spurring discussion among stakeholders of concrete ways to align payment with high-quality and safe care. As previously noted, the twelve states with nonpayment policies are leaders in quality and patient safety and have numerous, coordinated initiatives planned and underway. State officials emphasized that strong relationships with provider communities have enabled them to implement multiple quality improvement and patient safety activities. Participating states also underscored that for them, a nonpayment policy represents a single component of a broad, statewide strategy for and commitment to improved system performance. They continuously ex-

amine policies and initiatives to see how they might better complement each other. For example, meeting participants discussed how events reported into adverse event reporting systems relate to events denied payment, and how events identified through these separate systems might be used to cross-validate each other. Overall, private health plans and state purchasers alike shared the concept that nonpayment is one step toward the larger, inter-related issues of value-based purchasing and system redesign.

Alignment of state and federal policies helps to accomplish shared goals

Meeting participants supported aligning state and federal policies regarding nonpayment for preventable conditions. Alignment supports consistency in efforts, sends a strong unified message to a broader audience, and increases the leverage of each payer.

Meeting participants indicated that despite differences in some operational issues, the various nonpayment policies all send a consistent message that the current state of patient safety is unacceptable. Payers are aligning with consumers and providers who have already voiced this concern, and are taking action to use their leverage to improve care. Several states indicated that the state nonpayment policy also provided an opportunity for private payers to follow suit and align with the state's policy.

Meeting participants also pointed out that although the lists of events denied payment among various state and federal policies differ, the Medicare list and the NQF list contain many similar or identical events and conditions. States that use either of these lists as the basis of their policies are aligning broadly if not in all specific measures.

Participants underscored the role of Medicare in providing leadership on this issue. The Medicare policy can provide states with political cover to help in their adoption of similar policies. For states with few resources, Medicare's policy provides a template that other payers can use to avoid the need to experiment. The group expressed a need for national norms and benchmarks, including clear definitions of events and conditions.

At the same time, participants expressed concern about standardization. Alignment should not stifle innovation. Payers that have developed policies that are more aggressive than the Medicare policy fear alignment could represent a step backwards. Meeting participants agreed that federal policy should provide a floor but not a ceiling. They also expressed concern about implications for future payment reform if standardization is required. Although policies may be aligned at the federal level, implementation continues to occur at the state level.

Participants also stressed that policy alignment must build on the unique expertise and resources that states and federal agencies currently have at their disposal. Medicare has research abilities, while Medicaid can offer expertise in payment models. For their part, states have on-the-ground experience with implementing policies as well as the flexibility to use a trial-and-error approach.

Conclusion

State and federal purchasers are aligning around the understanding that nonpayment for serious reportable events and/or hospital acquired conditions is an unassailable step in eliminating payment for poor quality care and helping to drive health system improvement. Key lessons and recommendations from state and federal purchasers' experiences implementing nonpayment policies include:

- Nonpayment for preventable adverse events or conditions represents a first, relatively easy, visible, and noncontroversial step to purchasing for quality care. These policies are an opportunity for purchasers to use their leverage to drive quality and systems improvement.

- Alignment of nonpayment policies is occurring at various levels—among state and federal policymakers and among purchasers, providers, and the public. They have aligned around a consistent message that the current state of patient safety is unacceptable.

- Purchasers adopt nonpayment policies as a quality improvement tool. Cost savings are not a driver, although as purchasers expand the list of events for which payment will be denied or adjusted in the future (e.g. healthcare-associated infections), there will be more potential for costs savings.

- Purchasers encounter complicated implementation issues related to nonpayment policies; nevertheless, Medicare's nonpayment policy provides a basis to inform state policies. Policies should be informed by evidence.

- Nonpayment policies are an opportunity to build momentum toward broader system change. In fact, most states that have adopted nonpayment policies have done so as part of broader patient safety, quality improvement, or health system performance improvement agendas that build on public/private collaboration to improve quality and reduce costs.

- Alignment of state and federal policies should not stifle innovation; experimentation is needed prior to standardization. Federal policy should provide a floor but not a ceiling, so that states can use their unique expertise and experiences to drive systems improvement.

Participants see value in aligning federal and state nonpayment policies as one of many areas in which future alignment between federal and state policies can advance health system reform.

Appendices

Program	Events Denied Payment	List of Events
Centers for Medicare and Medicaid Services (CMS), Medicare	Hospital Acquired Conditions	• Foreign object inadvertently left in patient after surgery • Death/disability associated with intravascular air embolism • Death/disability associated with incompatible blood • Stage three or four pressure ulcers after admission • Hospital-acquired injuries: fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external cause • Catheter-associated urinary tract infection • Vascular catheter-associated infection • Mediastinitis after coronary artery bypass graft surgery • Manifestations of poor glycemic control • Surgical site infection following certain orthopedic procedures • Surgical site infection following bariatric surgery for obesity • Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures
	Preventable Surgical Errors	• Surgery performed on the wrong body part • Surgery performed on the wrong patient • Wrong surgical procedures on a patient
Colorado Medicaid	Serious Reportable Events	As defined as hospital acquired conditions by CMS Medicare
Kansas Medicaid (Kansas Medical Assistance Program)	Hospital Acquired Conditions	The following conditions as defined by CMS Medicare: • Foreign Object Retained After Surgery • Air Embolism • Pressure Ulcers Stages III and IV • Falls and Trauma: fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock • Catheter-Associated Urinary Tract Infection • Vascular Catheter-Associated Infection • Manifestations of Poor Glycemic Control • Surgical Site Infection, Mediastinitis After Coronary Artery Bypass Graft • Surgical Site Infection Following Certain Orthopedic Procedures • Surgical Site Infection Following Bariatric Surgery for Obesity • Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
	Never Events	As defined by CMS Medicare through 3 national coverage determinations (NCDs): • Wrong surgical or other invasive procedure performed on a patient • Surgical or other invasive procedure performed on the wrong body part • Surgical or other invasive procedure performed on the wrong patient Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under the decision.

Program	Events Denied Payment	List of Events
Maine (all payers)	Mistakes or Preventable Adverse Events	Coincides with NQF's 28 Serious Reportable Events.
Maryland Health Services Cost Review Commission (all payers)	Maryland Hospital Acquired Conditions (MHAC)	50 MHACs derived from a list of 64 Potentially Preventable Complications (PPC) developed by 3M Health Information Systems. PPC are complications that are unlikely to be a consequence of the natural progression of an underlying illness. PPC are not present when the patient is first admitted and are associated with the care during the hospitalization: • Stroke & Intracranial Hemorrhage • Extreme CNS Complications • Acute Pulmonary Edema and Respiratory Failure without Ventilation • Acute Pulmonary Edema and Respiratory Failure with Ventilation • Pneumonia & Other Lung Infections • Aspiration Pneumonia • Pulmonary Embolism • Other Pulmonary Complications • Shock • Congestive Heart Failure • Acute Myocardial Infarction • Cardiac Arrhythmias & Conduction Disturbances • Other Cardiac Complications • Ventricular Fibrillation/Cardiac Arrest • Peripheral Vascular Complications Except Venous Thrombosis • Venous Thrombosis • Major Gastrointestinal Complications without Transfusion or Significant Bleeding • Major Gastrointestinal Complications with Transfusion or Significant Bleeding • Major Liver Complications • Other Major Gastrointestinal Complications without Transfusion or Significant Bleeding • Urinary Tract Infection • GU Complications Except UTI • Renal Failure without Dialysis • Renal Failure with Dialysis • Post-Hemorrhagic & Other Acute Anemia with Transfusion • In-Hospital • Trauma and Fractures • Poisonings Except from Anesthesia • Decubitus Ulcer • Transfusion Incompatibility Reaction • Cellulitis • Moderate Infectious • Septicemia & Severe Infections • Acute Mental Health Changes • Post-Operative Infection & Deep Wound Disruption without Procedure • Post-Operative Infection & Deep Wound Disruption with Procedure • Reopening Surgical Site • Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Procedure • Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Procedure • Accidental Puncture/Laceration During Invasive Procedure • Other Surgical Complication – Mod • Post-procedure Foreign Bodies • Encephalopathy • Other Complications of Medical Care • Iatrogenic Pneumothrax • mechanical Complication of Device, Implant & Graft • Gastrointestinal Ostomy Complications • Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection • Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusion • Infections due to Central Venous Catheters • Obstetrical Hemorrhage with Transfusion

Program	Events Denied Payment	List of Events
Massachusetts (5 agencies: Office of Medicaid, Health Safety Net, Commonwealth Connector, Group Insurance Commission, and Department of Correction)	Serious Reportable Events	NQF's 28 Serious Reportable Events. The policy automatically applies to any additional events added to the NQF list.
Minnesota (3 programs: Medicaid (Medical Assistance), General Assistance Medical Care, and MinnesotaCare)	Hospital Acquired Conditions and certain treatments	Partial CMS Medicare Hospital Acquired Condition list: • Foreign object inadvertently left in patient after surgery • Air embolism • Blood incompatibility • Stage three or four pressure ulcers after admission • Falls and trauma: fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external cause • Catheter-associated urinary tract infection • Vascular catheter-associated infection • Mediastinitis after coronary artery bypass graft surgery • Manifestations of poor glycemic control • Surgical site infection following certain orthopedic procedures • Surgical site infection following bariatric surgery for obesity • Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures

Program	Events Denied Payment	List of Events
Missouri Medicaid (MO Healthnet)	Preventable Serious Adverse Events or Hospital or Ambulatory Surgical Center Acquired Condition	NQF's Serious Reportable Events as of December 15, 2008 and the CMS list of Medicare Hospital Acquired Conditions (HACs), non-payable by Medicare as of December 15, 2008. Listed in Regulation: • Surgery performed on the wrong body part • Surgery performed on the wrong patient • Wrong surgical procedure on a patient • Foreign object left in a patient after surgery or other procedure • Intraoperative or immediately post-operative death in a normal health patient • Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility • Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended • Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility • Infant discharged to the wrong person • Patient death or serious disability associated with patient elopement (disappearance) for more than four (4) hours • Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility • Patient death or serious disability associated with a medication error (error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) • Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products • Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility • Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility • Death or serious disability (Kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates • Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility • Patient death or serious disability due to spinal manipulative therapy • Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility • Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances • Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility • Patient death associated with a fall while being cared for in a healthcare facility • Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility • Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider • Abduction of a patient of any age • Sexual assault on a patient within or on the grounds of a healthcare facility

Program	Events Denied Payment	List of Events
New Jersey (all payers)	Hospital Acquired Conditions (also referred to as "Medical Errors")	• Transfusion reaction; • Air embolism; • Foreign body left during the procedure; • Surgery on the wrong side, wrong body part, or wrong person; or wrong surgery performed on a patient
New York Medicaid	Serious Adverse (Never) Events	Partial list of NQF's 28 Serious Reportable Events: • Surgery performed on wrong body part • Surgery performed on wrong patient • Wrong surgical procedure performed on a patient • Patient disability associated with a medication error • Patient disability associated with use of contaminated drugs, devices, biologics provided by healthcare facility • Patient disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended • Patient disability associated with an electric shock while being cared for in a health care facility • Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance • Patient disability associated with a burn incurred from any source while being cared for in a healthcare facility • Patient disability associated with the use of restraints or bedrails while being cared for in a healthcare facility • Retention of a foreign object in a patient after surgery or other procedure • Patient disability associated with a reaction to administration of ABO-incompatible blood or blood products • Patient disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
Oregon Public Employee Benefits Board (PEBB) and Oregon Educators Benefit Board (OEBB)	Serious Adverse Events	NQF's 28 Serious Adverse Events in accordance with the following: • as defined by the Oregon Association of Hospitals and Health Systems in its "Guidelines for Non-Payment for Serious Adverse Events" and adopted by Oregon member hospitals or as defined by the Washington State Hospital Association and adopted by Washington member hospitals; and • to the extent such Serious Adverse Events are readily identifiable through electronic claims data received by Contractor

Program	Events Denied Payment	List of Events
Pennsylvania Medicaid (Medical Assistance)	Preventable Serious Adverse Events	• Wrong surgical procedure on patient • Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by • the healthcare facility • Patient death or serious disability associated with the use or function of a device in patient care in which the device • is used or functions other than as intended • Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility • Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) • Patient death or serious disability associated with a fall while being cared for in a healthcare facility • Unexpected removal of organ • Unexpected amputation of limb • Intraoperative or immediately post-operative death in a normal healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative) • Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products • Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility • Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility, excluding those that progress from Stage 2 to Stage 3 • Severe allergic reaction • Retention of a foreign object in patient after surgery or other procedure • Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products • Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility • Medication Error (patient death or serious disability associated with a medication error)
	Nursing Facility Preventable Serious Adverse Events	To be specified in a Department of Public Welfare bulletin
Washington Medicaid	Hospital Acquired Conditions and Serious Adverse Events	NQF's 28 Serious Adverse Events and CMS Medicare identified Hospital Acquired Conditions

Program	Language Concerning Patient Billing
Centers for Medicare and Medicaid Services, Medicare	"The hospital cannot bill the beneficiary for any charges associated with the hospital-acquired complication."
Colorado Medicaid	"Once such rules are adopted, patients should no longer be billed or balance-billed for services related to SREs."
Kansas Medicaid (Kansas Medical Assistance Program)	Hospitals must follow Medicare billing for hospital-acquired conditions (HACs). HACs must be properly coded using the appropriate present on admission (POA) indicator.
Maine (all payers)	"A health care facility is prohibited from knowingly charging a patient or the patient's insurer or the patient's employer…for health care services it provided as a result of or to correct a mistake or preventable adverse event caused by that health care facility."
Maryland Health Services Cost Review Commission (all payers)	None.
Massachusetts (5 agencies: Office of Medicaid, Health Safety Net, Commonwealth Connector, Group Insurance Commission and Department of Correction)	"Providers of these services are not permitted to bill members for the costs associated with these events." "Charges for services deemed not billable by this policy are not billable to the patient, the patient's next of kin, the patient's representative, or any other payer."
Minnesota (3 programs: Medicaid (Medical Assistance), General Assistance Medical Care, and MinnesotaCare)	"A hospital shall not bill a recipient of services for any payment disallowed under this subdivision." " A physician shall not bill a recipient of services for any payment disallowed under this subdivision."
Missouri Medicaid (MO HealthNet)	"MO HealthNet participant shall not be liable for payment for an item or service related to a serious adverse event or hospital or ambulatory surgical center-acquired condition or the treatment of consequences of a serious adverse event or hospital or ambulatory surgical center-acquired condition that would have been otherwise payable by the MO HealthNet Division."

Program	Language Concerning Patient Billing
New Jersey (all payers)	"A physician licensed by the State Board of Medical Examiners pursuant to Title 45 of the Revised Statutes, who acknowledges responsibility for causing a condition for which a hospital is prohibited from obtaining payment from a patient or any third party payer pursuant to subsection a of this section, shall not charge or otherwise seek to obtain payment from a patient or any third party payer for costs associated with the condition."
New York Medicaid	The provider has to accept the Medicaid payment as payment in full per 42 CFR 447.15. No balance billing (or patient billing) to recover costs that the state adjusts for a never event would be permitted.
Oregon Public Employee Benefits Board (PEBB) and Oregon Educators Benefit Board (OEBB)	Qualified conditions should not be billed to and reimbursed by PEBB's or OEBB's self-insured/fully insured carriers; consequently, PEBB or OEBB members should not be billed corresponding copayments or coinsurance.
Pennsylvania Medical Assistance (Medicaid)	Section 3(a) of Act 1 of 2009 sets forth the general rules around the payment policies for preventable serious adverse events as follows: "A health care provider may not knowingly seek payment from a health payor or patient: (1) for a preventable serious adverse event; or (2) for any services required to correct or treat the problem created by a preventable serious adverse event when that event occurred under their control. Section (b) relating to Refunds sets forth.--A health care provider who discovers that payment has unknowingly been sought for a preventable serious adverse event or services required to correct or treat the problem created by such an event shall immediately notify the health payor, or patient and shall refund any payment received within 30 days of discovery or receipt of payment, whichever is later."
Washington Medicaid	"The client cannot be held liable for payment."

Appendix C: National Quality Forum List of Serious Reportable Events[35]

Surgical Events

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Intraoperative or immediately post-operative death in an ASA Class 1 patient

Product or Device Events

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
- Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

Patient Protection Events

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient elopement (disappearance)
- Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility

Care Management Events

- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
- Death or serious disability associated with failure to identify and treat hyperbilirubinemia in neonates
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
- Patient death or serious disability due to spinal manipulative therapy
- Artificial insemination with the wrong donor sperm or wrong egg

Environmental Events

- Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death or serious disability associated with a fall while being cared for in a healthcare facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

Criminal Events

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Abduction of a patient of any age
- Sexual assault on a patient within or on the grounds of the healthcare facility
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the healthcare facility

Endnotes

1 Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academy Press, 2001).

2 E. A. McGlynn et.al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348, no.26 (June 2003): 2635-2645.

3 Institute of Medicine. *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, 1999), 26.

4 Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, 1999), 2.

5 Institute of Medicine, *Patient Safety: Achieving a New Standard of Care* (Washington, D.C.: National Academy Press, 2004), 31.

6 Klevens et al. *Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002* (Public Health Reports. March–April 2007), Volume 122. http://www.cdc.gov/ncidod/dhqp/pdf/hicpac/infections_deaths.pdf.

7 Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, 1999), 26.

8 The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, (New York, NY: The Commonwealth Fund, February 2009). Retrieved 22 October 2009.

9 National Quality Forum (NQF), *Serious Reportable Events in Healthcare: 2006 Update: A Consensus Report, (*Washington, DC: NQF; 2007).

10 Deficit Reduction Act of 2005 (Pub. L. 109-171).

11 Aug. 22, 2007, Federal Register, page 47201.

12 Aug. 22, 2007, Federal Register, page 47201. Aug. 19, 2008, (Federal Register / Vol. 73, No. 161)

13 Medicare coverage of items and services is determined through National Coverage Determinations, an evidence-based process with opportunities for public participation. For more information about the process, see http://www.cms.hhs.gov/DeterminationProcess/

14 CMS Office of Public Affairs, "CMS Issues Three National Coverage Determinations to Protect Patients from Preventable Surgical Errors," Press Release. January 15, 2009, Retrieved December 8, 2009. http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3408

15 As of December 2009, the majority of Blue Cross and Blue Shield health plans had developed nonpayment policies for serious adverse events.. CIGNA implemented a nonpayment policy for never events and hospital acquired conditions in October 2008, and Aetna implemented nonpayment for serious adverse events in August 2009. See CIGNA, "Reimbursement Policy Number: R05 Never Events and Avoidable Hospital Conditions." Retrieved December 8, 2009. http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/R05_Never_Events.pdf and Aetna, "Aetna Reinforces Patient Safety Measures." Press Release. August 25, 2009. Retrieved December 8, 2009. http://www.aetna.com/news/newsReleases/2009/0825_Patient_Safety.html.

16 Center for Medicaid and State Operations, State Medicaid Director Letter #08-004, July 18, 2008.

17 CMS Office of Public Affairs (July 31, 2008), "Medicare and Medicaid Move Aggressively to Encourage Greater Patient Safety in Hospitals and Reduce Never Events," Press Release. Retrieved December 9, 2009. http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3219&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

18 Center for Medicaid and State Operations, State Medicaid Director Letter #08-004, July 18, 2008, 3.

19 Lisa Duchon and Vernon Smith, *Quality Performance Measurement in Medicaid and SCHIP: Results of a 2006 National Survey of State Officials* (Alexandria, VA: National Association of Children's Hospitals, August 2006), 7.

20 Of states included in this report, Colorado, Kansas, Maine, Massachusetts, Minnesota, Oregon, Pennsylvania, and Washington were identified by NASHP as having a public/private partnership. See Jill Rosenthal and Carrie Hanlon, *State Partnerships to Improve Quality: Models and Practices from Leading States*, (Portland, ME: National Academy for State Health Policy, June 2009).

21 Among states with nonpayment policies, only Missouri does not have a state authorized reporting system. See Jill Rosenthal and Mary Takach. *2007 Guide to State Reporting Systems* (Portland, ME: National Academy for State Health Policy, December 2007).

22 Among states with nonpayment policies, only New Jersey does not have a Medicaid-led medical home project. See National Academy for State Health Policy, "Medical Home State Map." Retrieved December 9, 2009. http://www.nashp.org/med-home-map.

23 Sharon Conrow Comden and Jill Rosenthal. *Statewide Patient Safety Coalitions: A Status Report.* (Portland, ME: National Academy for State Health Policy, May 2002).

24 Joel Cantor et al., *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York, NY: The Commonwealth Fund, June 2007). Retrieved December 9, 2009. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551.

25 Please see Appendix A for detailed listings of events denied payment.

26 Please see Appendix B for policy language prohibiting patient billing.

27 Maryland uses an adjusted payment as opposed to "non-payment." A technical payment workgroup meeting with industry representatives will negotiate the methodology for linking individual hospital performance on MHAC to financial incentives through the rate setting system. Methodology will reallocate an anticipated $100 million in revenue from worst performing hospitals to best performing hospitals based on performance of risk adjusted rates of complications across 50 categories of potentially preventable complications.

28 POA is required for facilities paid under the Medicare Inpatient Prospective Payment System (IPPS) by August 2009. For those not paid under the IPPS, coding is required by July 1, 2010.

29 Workgroup meeting with industry representatives to link coding of performance to payment.

30 Commissioners of Health and Senior Services and Banking and Insurance and the Director of the Division of Consumer Affairs in the Department of Law and Public Safety will develop standards for general hospitals and third party payers to implement this law.

31 PEBB's self-insured carrier has implemented these measures in some form already.

32 See, for example: Kevin Sack. "Medicare Won't Pay for Medical Errors", October 1, 2008, *New York Times*. http://www.nytimes.com/2008/10/01/us/01mistakes.html and Vanessa Fuhrmans. "WellPoint Won't Pay for Never Events". April 2, 2008, *Wall Street Journal* Health Blog. http://blogs.wsj.com/health/2008/04/02/wellpoint-wont-pay-for-never-events/. Also Arnold Milstein, "Ending Extra Payment for "Never Events" — Stronger Incentives for Patients' Safety", June 4, 09 NEJM, 360(23):2388-90, http://healthcarereform.nejm.org/?p=455.

33 The anticipated reduction in spending for CMS based on its nonpayment policy is $21 million of a total of $105 million (0.02%). According to one study, potentially preventable complications are estimated to add 9.4%-9.7% to hospital inpatient costs, or $88 billion dollars of the national estimate of the $940 billion spent on inpatient hospital costs in 2006. See Richard L. Fuller et al, *Estimating the Costs of Potentially Preventable Hospital Acquired Complications, Health Care Financing Review*, Vol. 30 No. 4, Summer 2009, 17-32. Also, for Maryland's approach, it is estimated that during fiscal year 2008, hospital-based preventable complications were present in approximately 53,000 of the State's total 800,000 inpatient cases and represented approximately $500 million in potentially preventable hospital payments. See the Maryland Health Services Cost Review Commission, http://76.12.205.105/init_qi_MHAC.cfm

34 Pennsylvania Health Care Cost Containment Council. *Hospital-acquired Infections in Pennsylvania: Data Reporting Period: January 1, 2005 - December 31, 2005* (November 2006). http://www.phc4.org/reports/hai/05/docs/hai2005report.pdf

35 Source: National Quality Forum (NQF). *Serious Reportable Events in Healthcare 2006 Update: A Consensus Report*. (Washington, D.C.: NQF, 2007), vi.