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I. NEWS

769 Hospitals Penalized for Patient Safety in 2016

A December 21, 2016 article [FN1] by Kaiser Health News indicates that the federal government has cut payments to 769 hospitals with high rates of patient injuries, for the first time counting the spread of antibiotic-resistant germs in assessing penalties.

The punishments come in the third year of Medicare penalties for hospitals with patients most frequently suffering from potentially avoidable complications, including various types of infections, blood clots, bed sores and falls. This year the government also examined the prevalence of two types of bacteria resistant to drugs.

Nationally, hospital-acquired conditions declined by 21 percent between 2010 and 2015, according to the federal Agency for Healthcare Research and Quality, or AHRQ. The biggest reductions were for bad reactions to medicines, catheter infections and post-surgical blood clots.

Still, hospital harm remains a threat. AHRQ estimates there were 3.8 million hospital injuries last year, which translates to 115 injuries during every 1,000 patient hospital stays during that period.

The penalties come as the Centers for Medicare & Medicaid Services also launches new requirements for hospitals to ensure that the use of antibiotics is limited to cases where they are necessary and be circumspect in determining which of the drugs are most likely to work for a given infection. Hospitals will have to establish these antibiotic stewardship programs as a condition of receiving Medicare funding under a regulation the government drafted last summer.

Patient Deaths after Leaving Emergency Room Raise Questions about Rural Hospitals

A February 1, STAT article [FN2] summarizes a new study [FN3] published in the BMJ on Medicare patients dying soon after emergency department discharges.

More than 10,000 Medicare patients who do not have life-threatening illnesses die each year in the US within seven days of being released from emergency departments, according to the study. Those hospitals with the lowest inpatient admission rates, often hospitals in rural areas, had much higher rates of unexpected deaths.

The study's lead author said that while the data reflect a fraction of Medicare patient deaths, the finding raises questions about the adequacy of hospital resources in rural and underserved areas and whether the US government's quest to cut costs and reduce inpatient admissions from ERs is also cutting out essential care.

America's hidden horror: Sexual abuse in nursing homes and care facilities

An April 23 article [FN4] in the Kansas City Star discusses the largely hidden problem of sexual abuse of residents in long-term care facilities, assisted-living centers and nursing homes nationwide.

The article states the problem hides behind reporting systems that fail to catalog such complaints separately from other forms of abuse that afflict the elderly and disabled. It hides behind business incentives that drive facility owners to conceal abuse.

It hides behind apathy and the reluctance of family, friends and visitors who know or suspect something has happened but don't want to get involved. It hides behind the failure to believe victims.

“People don't even think that an older person would be sexually assaulted, would be raped, would be a victim,” said Edwin Walker, once the head of Missouri's former department on aging and now a deputy assistant secretary at the federal Administration on Aging.

Yet inspection reports, regulatory notices and court documents describe many instances of sexual abuse of long-term care residents. One federal program has cataloged more than 20,000 complaints of sexual abuse at long-term care facilities over 20 years — a rate of nearly three such complaints a day.

Changes to Visa Program Put Foreign-Born Doctors in Limbo

An article in the May 23, 2017, Stateline highlights the problems facing foreign-born doctors and workers due to the suspension of the 15-day expedited process to obtain an H-1B visa. [FN5]

In April the Trump administration announced that it was suspending the 15-day expedited process to obtain an H-1B visa that allows U.S. employers to temporarily employ foreign-born workers in specialty fields such as medicine and information technology.

The article mentions that for parts of the country that have difficulty attracting American-born doctors, the uncertainty swirling around the H-1B program is already creating problems, with doctors tied up in legal uncertainty rather than treating patients.

“For us, this has been a very positive program that has brought health care to areas of Wisconsin that would otherwise go without,” said Lisa Boero, legal counsel for the immigration program at the Marshfield Clinic Health System, which operates more than 50 clinics through largely rural central and northern Wisconsin, areas with a shortage of doctors.

Hospitals in distressed urban neighborhoods also rely on foreign-born medical school graduates to fill medical residencies that might otherwise go vacant.

New Study Looks at Patient Discharge against Medical Advice

Leaving the hospital against medical advice is tied to greater risk of hospital readmission and higher morbidity, mortality, and costs. A new study [FN6] looks at which patients are most likely to do so, by looking at data from more than 29 million hospital stays between 2003 and 2014.

The patients most likely to leave against medical advice: people insured by Medicaid, the uninsured, and patients with mental health conditions. Younger and middle-aged patients are nearly four times more likely than patients age 65 and over to leave against medical advice.

Evidence for Brain Training to Stop Dementia Is Limited

A new report [FN7] from the National Academies of Science indicates there is not enough evidence to support running a public health campaign to encourage cognitive training and exercise as a way to stave off cognitive decline and dementia. There is some evidence to suggest that brain training and bumping up physical activity levels could help prevent dementia. However the experts concluded that evidence is still too inconclusive to carry out a health campaign.

Georgia Doctor to Head US Centers for Disease Control and Prevention

On July 7, the Trump administration announced that Brenda Fitzgerald, a physician in charge of the state of Georgia's public health agency, has been named to head the U.S. Centers for Disease Control and Prevention.

Fitzgerald fills a spot held temporarily by the agency's deputy director since its previous director Tom Frieden left in January.

Fitzgerald is an obstetrician-gynecologist with three decades of experience who has run the Georgia state health agency for six years, the U.S. Department of Health and Human Services said in a press release. [FN8]

CMS Delays Rule to Improve Home Health Agency Care

On July 10, issued a final rule [FN9] called: Medicare and Medicaid Programs; Conditions of Participation for Home Health Agencies; Delay of Effective Date.

The final rule states: “This final rule delays the effective date for the final rule entitled “Medicare and Medicaid Programs: Conditions of Participation for Home Health Agencies” published in the Federal Register on January 13, 2017 (82 FR 4504).

The published effective date for the final rule was July 13, 2017, and this rule delays the effective date for an additional 6 months until January 13, 2018. This final rule also includes two conforming changes to dates that are included in the regulations text.”

Fewer Hospitals Can Care For Children

In Massachusetts, a child who winds up in an emergency room - whether for a routine or a serious problem - is likely to be transferred to a second hospital for care, a “potentially concerning” trend that's being reported by physicians throughout the United States, researchers say. [FN10]

At the root, they maintain, is the disappearance of pediatric community hospital care.

The number of children transferred from one hospital to another increased by more than 36 percent in Massachusetts from 2004 to 2014, and only about 20 percent of the state's 66 hospitals completed care for more than half of their pediatric patients without transferring them, the research team reports [FN11] in JAMA Pediatrics.

“Pediatric hospital care is less available than it used to be, mostly because community hospitals are increasingly transferring children to larger centers,” said senior author Dr. Michael McManus, a pediatrician and professor at Harvard Medical School in Boston.

The research showed consolidation of care into regional centers for both adults and children over the decade studied. But the move to regional care for children far outpaced that for adults.

The likelihood of a hospital completing a child's care without a transfer dropped by 65 percent from 2004 to 2014, while the likelihood of a hospital completing an adult's care without a transfer fell by 11 percent, the study found.

Dr. Nicholas Mohr, a professor at the University of Iowa Carver College of Medicine in Iowa City, said doctors have seen the trend in hospitals throughout the U.S. But the number of children transferred between Massachusetts hospitals surprised him.

McManus is conducting additional research to explore the myriad of possible reasons for consolidation of pediatric hospital care.

Experts Warn Hospitals Particularly Vulnerable To Cyberattacks

Cyberattacks are accelerating worldwide and the U.S. health care system is dangerously unprepared to defend itself, or its patients. [FN12]

From insulin pumps and defibrillators, and on to expensive CT scanners and MRI machines, medical devices are increasingly connected to networks. Patient medical records are online. When networks go down, physicians say it is like operating in the dark.

“It's going to get worse,” said Chris Wysopal, cofounder and chief technology officer at Veracode, a Burlington, Massachusetts, cybersecurity firm. Wysopal pointed to fallout from the WannaCry digital worm that swept the globe in March and the Petya malware that hit in June, leaving collateral damage in the health care sector.

“Every time we see something successful like WannaCry and Petya, you see other actors learning from that rather quickly, and they are able to replicate that style of attack,” Wysopal said.

Cybersecurity in the health care sector — which employs 9 percent of the U.S. workforce and represents a sixth of the nation's economy — “needs immediate and aggressive attention,” a task force mandated by Congress warned in June.

Indeed, security experts expect that the quickening pace of hackers' attacks will soon affect health care. And those who have studied health care's specific vulnerabilities worry that hackers — working for enemy states or cybercrime groups — could train their digital sights directly on U.S. hospitals, health care networks and medical devices.

“We're going to have our digital D-Day, our cyber D-Day, if you will, in medical, and there's going to be patients that die. It's going to be a big deal,” said Dr. Christian Dameff, an emergency room physician and expert on cyber vulnerabilities.

Doctors like Dameff, who recently co-led a summit at the University of Arizona College of Medicine on medical device hacking, are gaming out scenarios of types of attacks that could impact the health care system. Among the scenarios experts predict are possible, include:

• A malicious worm rockets through a particular type of medical device, say, an infusion pump, and hundreds, maybe thousands, of patients collapse.

• Hackers determined to collect ransom or sow destruction attack the networks of hospitals in an entire geographic region, depriving physicians of electronic medical records and forcing evacuation of critically ill patients over hundreds of miles.

• A terror attack on a metropolitan area coincides with a hack against the city's hospitals.

Just when emergency medical care is most needed to deal with victims, the health sector finds itself crippled.

Medicare Launches Hospice Compare Website

On August 16, 2017, the Centers for Medicare & Medicaid Services released Hospice Compare, [FN13] a consumer-focused website that lets families compare up to three hospice agencies at a time, among 3,876 nationwide. Following similar websites for hospitals and nursing homes, the site aims to improve transparency and empower families to “take ownership of their healthcare choices,” according to a press release [FN14] .

Through the website, families can see how hospices performed in seven categories:

• Patients or caregivers who were invited to discuss treatment preferences, like hospitalization and resuscitation, at the beginning of hospice care;

• Patients or caregivers who were invited to discuss beliefs and values at the beginning of hospice care;

• Patients who were checked for pain at the beginning of hospice care;

• Patients who received a timely and thorough pain assessment when pain was identified as a problem;

• Patients who were checked for shortness of breath at the beginning of hospice care;

• Patients who got timely treatment for shortness of breath; and

• Patients taking opioid pain medication who were offered care for constipation.

Health and Human Services Finds Abuse in Nursing Homes Unreported Despite Law

More than 1 in 4 cases of possible sexual and physical abuse against nursing home patients apparently went unreported to police, says a government audit that faults Medicare for failing to enforce a law requiring immediate notification. [FN15]

The Health and Human Services inspector general's office issued an “early alert” on August 28 with preliminary findings from a large sampling of cases in 33 states.

“We hope that we can stop this from happening to anybody else,” said Curtis Roy, an audit manager with the inspector general's office, which investigates fraud, waste and abuse in the health care system. The audit is part of a larger ongoing probe, and additional findings are expected.

Hospital Joint Commission Gives Seal of Approval, Even After Problems Emerge

An investigation by The Wall Street Journal finds that the Joint Commission, which is the accrediting organization for almost 80 percent of U.S. hospitals, typically takes no action to revoke or modify accreditation when state inspectors find serious safety violations.

The September 8, 2017 article [FN16] , found that the Joint Commission revoked the accreditation of less than 1% of the hospitals that were out of Medicare compliance in 2014, In more than 30 instances, hospitals retained their full accreditation although their violations were deemed by CMS so significant they caused, or were likely to cause, a risk of serious injury or death to patients.

Nursing Home Disaster Plan Violations Often Unenforced

A recent Kaiser Health News article [FN17] highlighted that it does not take a hurricane to put nursing home residents at risk when disaster strikes.

Around the country, facilities have been caught unprepared for far more mundane emergencies than the hurricanes that recently struck Florida and Houston, according to an examination of federal inspection records. Those homes rarely face severe reprimands, records show, even when inspectors identify repeated lapses.

In some cases, nursing homes failed to prepare for basic contingencies.

In one visit last May, inspectors found that an El Paso, Texas, nursing home had no plan for how to bring wheelchair-dependent people down the stairs in case of an evacuation. Inspectors in Colorado found a nursing home's courtyard gate was locked and employees did not know the combination, inspection records show. During a fire at a Chicago facility, residents were evacuated in the wrong order, starting with the people farthest from the blaze.

Nursing home inspectors issued 2,300 violations of emergency-planning rules during the past four years. But they labeled only 20 so serious as to place residents in danger, the records show.

In addition, a third of U.S. nursing homes have been cited for another type of violation: failing to inspect their generators each week or to test them monthly. None of those violations was categorized as a major deficiency, even at 1,373 nursing facilities that were cited more than once for neglecting generator upkeep, the records show.

“That's the essential problem with the regulatory system: It misses many issues, and even when it identifies them, it doesn't treat them seriously enough,” said Toby Edelman, a senior policy attorney at the Center for Medicare Advocacy. “It's always the same story: We have some pretty good standards and we don't enforce them.”

Complaints Against Nursing Homes Are Rising

A September 29, 2017 report [FN18] from Health and Human Services Office of Inspector Genera indicates complaints against nursing homes are on the rise. In 2015, there were 62,790 complaints made against nursing homes, compared to 47,279 in 2011, though the number of nursing home residents actually declined slightly. States prioritized more than half of nursing home complaints into the most serious categories — “immediate jeopardy” and “high priority” — which require onsite investigations within 2 or 10 working days, respectively.

Faulty devices cost Medicare $1.5B

Medicare paid at least $1.5 billion over a decade to replace seven types of defective heart devices, a government watchdog says. The devices apparently failed for thousands of senior patients. [FN19]

The Health and Human Services Office of Inspector General, in a report [FN20] released on October 2, said officials need to do a better job tracking these costly product failures to protect patients from harm. More detailed reporting could lead to earlier recognition of serious problems with medical devices and faster recalls of all types of “poorly performing” ones, the IG's office said.

The report marks the first effort by anyone in government to assess the losses to taxpayers and patients 65 and older from medical gear that proves faulty.

Officials said the $1.5 billion lost from the seven devices from 2005 through 2014 was a “conservative estimate.” Patients also paid $140 million in out-of-pocket costs for this care, the report noted.

The report found that nearly 73,000 people on Medicare had one of the seven devices replaced because of recalls, premature failures, medically necessary upgrades or infections. It didn't outline specific injuries patients suffered as a result.

The inspector general did not identify the manufacturers of the seven devices, but officials said they included implanted cardio defibrillators and a pacemaker that either had been recalled because of flaws or had “prematurely failed.” Pacemakers and implantable defibrillators are small devices placed under the skin to help treat irregular heartbeats.

How best to identify these defects and cut Medicare spending associated with fixing them has been under consideration at various times since 2007, according to the report. The inspector general recommended that hospitals and doctors be required to submit detailed information identifying failed devices, such as serial and batch numbers, during the billing process.

“This could help reduce Medicare costs by identifying poorly performing devices more quickly which could also protect beneficiaries from unnecessary costs,” the report states.

David Lamir, an official in the inspector general's Boston office, said the $1.5 billion figure represented a “drop in the bucket” of the true costs to Medicare from faulty medical products.

Cancer Drug Prices Rising Far Faster Than Inflation

The prices of injectable cancer drugs - even older medicines around since the 1990s - are increasing at a rate far higher than inflation, researchers report in the Journal of Clinical Oncology. [FN21]

The study, led by Dr. Daniel Goldstein of Emory University in Atlanta, looked at 24 injectable cancer drugs approved since 1996 and found the average increase was 25 percent over eight years. After inflation, the average increase was 18 percent.

The prices of some drugs were going up by an average of 6 percent or more per year when the inflation rate was just under 1.1 percent.

The results come in the wake of widely publicized cases of drug price gouging, most notably for Turing Pharmaceuticals' anti-parasite drug Daraprim and Mylan's EpiPens, designed to prevent death after a severe allergic reaction. Among cancer drugs, Novartis' Gleevec, which cost $26,000 in 2001 now costs more than $140,000, even though generic versions of the once-a-day pill are available.

“We knew about anecdotal stories of individual price increases, but we didn't know what the overall landscape of price changes were for all these drugs. So we set out to analyze a wide selection,” Goldstein told Reuters Health in a telephone interview.

“What we're seeing in this study is not those massive overnight hikes,” he said. “But we're seeing a gradual price creep in these patented drugs, and over the course of 10 years, that gradual creep becomes significant.”

The team also found that, unlike just about every product, those increases were unaffected by the addition of competition, or the discovery of a new use for the medicine.

“Even when competitors enter the market, the price still continues to go up. You would expect, with more competitors, the price would go down,” Dr. Ravi Gupta of Johns Hopkins Hospital in Baltimore, who reported on dramatic naloxone prices increases last year in a New England Journal of Medicine analysis, told Reuters Health by phone. He was not connected with the latest research.

Such increases are driving up health insurance costs and, in some cases, patients who are facing high out-of-pocket costs may be skimping on life-saving treatments because they can't afford them.

When inflation was taken into account, only two of the 24 drugs tracked by the Goldstein team showed a decline. Nine averaged price hikes of at least 3 percent per year.

CMS Aims To Cut Provider Paperwork; Promises Action on Quality Measures

On October 26, CMS kicked off its “Patients Over Paperwork” initiative to reduce administrative burden and signaled actions are coming on quality metrics and electronic health record use. [FN22]

“What we've done is established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience,” CMS Administrator Seema Verma told provider groups.

Verma added that CMS will modify or eliminate current regulations that set forth “unnecessary regulatory obstacles,” create burdens, increase costs and limit time providers spend with patients.

On October 25, the American Hospital Association released a report that said health systems, hospitals and post-acute care providers spend nearly $39 billion a year on administration activities related to regulatory compliance with requirements from CMS, the Office of Inspector General, Office for Civil Rights and the Office of the National Coordinator for Health IT in nine areas: quality reporting, new models of care, meaningful use, hospital conditions of participation, program integrity, fraud and abuse, privacy and security, post-acute care and billing and coverage verification.

Verma said CMS has made some progress on regulatory relief and pointed to requests for information that were included in Medicare pay rules. She also said the agency has a significant free-standing regulatory reform rule already written and in the clearance process that would update a cross section of Medicare conditions of participation.

Verma said one area that needs attention is quality metrics.

“I think we all agree that quality measures are a critical component of paying for value. But you would probably also agree that until we get to a smaller set of meaningful measures, that the burden associated with reporting quality measures outweighs their utility,” Verma said.

AHA's report said often quality reporting requirements are often duplicative, have inefficient reporting processes and “misaligned reporting requirements.” AHA suggested that quality reporting requirements be evaluated across programs to determine what measures provide meaningful information for patients and providers.

Verma said providers will be hearing more from CMS about initiatives on meaningful quality measurement soon.

Leapfrog Group Releases Its Grades For Hospitals

On October 31, the Leapfrog Group, released its Fall Leapfrog Hospital Safety Grades [FN23] , giving roughly 830 hospitals an “A”—but giving more than 1,100 a “C” or below, USA Today reports [FN24] .

For the rankings, the Leapfrog Group assigned “A” to “F” letter grades to 2,632 hospitals based on their performance on 12 process and structural measures and 15 outcome measures. The group used data from CMS, the Leapfrog Hospital Survey, and secondary data sources such as the American Hospital Association's Annual Survey.

The Leapfrog ratings, which are updated twice a year, focus on acute-care hospitals and exclude facilities such as critical access hospitals, specialty hospitals, and federal hospitals because of missing data. However, for the first time, the rankings included Maryland hospitals. According to the Leapfrog Group, Leapfrog had been unable to rank Maryland hospitals in the past because they were exempt from “key” national safety reporting requirements.

Of the 2,632 hospitals ranked in the latest report: 832 were given an “A”; 662 were given a “B”; 964 were given a “C”; 159 were given a “D”; and15 were given an “F.”

According to the Leapfrog Group, 59 hospitals have been given an “A” in every update since the rankings' inception in spring 2012.

When assessed by state, Rhode Island had the highest share of “A” hospitals, followed by Maine, Hawaii, Idaho and Virginia. By contrast, the states with the lowest shares of “A” hospitals were Delaware, North Dakota, Washington, D.C., Maryland and New York.

FBI Agents Raid Headquarters of Major U.S. Body Broker

Federal agents have seized records from a national company that solicits thousands of Americans to donate their bodies to science each year, then profits by dissecting the parts and distributing them for use by researchers and educators. [FN25]

The search warrant executed by the Federal Bureau of Investigation at MedCure Inc headquarters on November 1 is sealed, and the bureau and the company declined to comment on the nature of the FBI investigation. But people familiar with the matter said the inquiry concerns the manner in which MedCure distributes body parts acquired from its donors.

MedCure is among the largest brokers of cadavers and body parts in the United States. From 2011 through 2015, documents obtained under public-record laws show, the company received more than 11,000 donated bodies and distributed more than 51,000 body parts to medical industry customers nationally. In a current brochure, the company says that 80,000 additional people have pledged to donate their bodies to MedCure when they die.

It is illegal to profit from the sale of organs destined for transplant, such as hearts and kidneys. But as a Reuters series detailed last month, it is legal in most U.S. states to sell donated whole bodies or their dissected parts, such as arms and heads, for medical research, training and education.

Commonly known as body brokers, these businesses often profit by targeting people too poor to afford a burial or cremation. Reuters documented how people who donate their bodies to science may be unwittingly contributing to commerce. Few states regulate the body donation industry, and those that do so have different rules, enforced with varying degrees of thoroughness. Body parts can be bought with ease in the United States. A Reuters reporter bought two heads and a spine from a Tennessee broker with just a few emails.

MedCure is accredited by the American Association of Tissue Banks, a national organization that primarily works with transplant tissue banks. The broker is also licensed by the state health departments in Oregon and New York, among the few states that conduct

inspections. According to Oregon state health records, officials renewed MedCure's license in January, following a routine on-site review.

Ohio Voters Reject Ballot Proposal to Rein in Drug Costs

On November 7, Ohio voters rejected the Ohio Drug Price Relief Act. The ballot initiative sought to curb prescription drug prices paid by the state for prisoners, injured workers, and poor people. [FN26]

The pharmaceutical industry spent approximately $70 million to oppose the measure, saying it would reduce access to medicines and raise prices for veterans and others. Supporters, led by the California-based AIDS Healthcare Foundation, said it would save the state millions of dollars and could force the industry to reduce prices elsewhere.

The measure would have required the state to pay no more for prescription drugs than the Department of Veterans Affairs' lowest price, which is often deeply discounted.

A similar ballot measure went before California voters last year and failed. South Dakota is among states where proponents are looking to try again next year.

Stats Show Initiative To Cut Hospital Readmissions Is A Success. But Critics Say Numbers Hide Darker Truth.

A December 11, 2017 article [FN27] by STAT discusses the impact of financial incentives for hospitals to reduce readmissions.

The policy, known as the Hospital Readmissions Reduction Program, created financial penalties for hospitals whose readmissions exceed the national average for patients suffering from heart failure, heart attacks, and pneumonia. In recent years it has been expanded to include other conditions. Its aim was to encourage hospitals to deliver stepped-up care to severely ill patients even after they leave the hospital, in the hope of preventing return visits that result in more anguish for patients and skyrocketing costs for everyone else.

And one thing scholars generally agree on is that the program has achieved its primary goal: It has reduced readmissions. A wide body of evidence shows that readmissions began to fall in 2012, when financial penalties took full effect. They have since declined several percentage points in each of the three conditions originally included in the program, according to a Kaiser Family Foundation analysis of Medicare data.

But skeptics say those results belie a darker truth — that hospitals are taking shortcuts, and in some cases compromising patient care, to avoid financial pain and public embarrassment.

One recent report by the University of Michigan found that a large percentage of the reduction in readmissions is attributable to changes in the way hospitals are describing their patients in claims data. By describing them as sicker, hospitals can increase their risk adjustments, thus reducing financial penalties.

But the biggest flashpoint emerged last month when researchers at UCLA and Harvard published a study that correlated the reduction in readmissions with an increase in 30-day and one-year mortality rates among heart failure patients.

The study suggested that the program was backfiring for those patients, keeping them out of the hospital but thereby jeopardizing their health. And the result was more deaths. “If further confirmed,” the report concluded, “these findings may require reconsideration of the [readmissions program]” in heart failure.

Like most debates in science and politics, the one over readmissions is far from black and white. The research on its effects is colored by subjectivity and layers of nuance that make it difficult to establish the bottom-line truth of how it is impacting outcomes for patients.

And in this case, experts who have invested years generating and examining these data are in sharp disagreement over what conclusions can be drawn from the numbers.

How Process, Outcome Measures Contribute to Population Health

Navigating the quality measures of hospitals can be difficult to understand and to effectively use. These measures, such as HEDIS, CMS Star Ratings, and Core Quality measures all indicate specific snapshots of data which are indicative of the quality of care that an individual would receive. The article by HealthPayer Intelligence [FN28] suggests that a better source of information regarding the quality of care an individual could expect to receive from a provider would be process measures. Process measures show what providers do to maintain the quality of care, rather than the snapshot reflected in other outcome based quality measures.

Health Insurers Among Leaders in Using Outcome Measures

Blue Cross and Blue Shield of Louisiana and Health Partners are leaders in using outcome measures in order to increase their quality of care. [FN29] By using these measures, health care providers are able to see which insureds are not receiving the preventative care and are able to direct physicians to who they should contact for follow-up care to increase the overall health of the pool.

CMS' Focus on ‘Meaningful Measures' Faces Hurdles

Healthcare providers are in agreement that focusing on CMS' new quality measures is the best way to ensure that patients are receiving the best care, however they remain divided on which quality measures are the most valuable to achieving the stated CMS

goals. [FN30] There are concerns that there are too many measures that have little meaning to patients and healthcare providers. Going forward, the focus on which measures are indicators will hopefully refocus on providing the best quality of care.

Healthcare Costs, Outcomes Vary When VA Outsources Cardiac Care

A cardiology study prepared by JAMA Cardiology has shown that veterans who seek treatment at community hospitals versus at VA hospitals may save on certain travel costs, but will ultimately pay more in procedure costs. [FN31] This study also showed that veteran patients had lower 30-day mortality rates at VA hospitals versus community hospitals. The article makes it clear that this number may not arise from actual quality of care given, but may arise from coordination of care between the VA and community hospitals involved.

Doctors Must Stop Blaming EHRs for Clinical Documentation Shortcut Failures

The article draws attention to the problems of using copy and paste and abbreviations in electronic health records. [FN32] An example presented by the article is the usage of the abbreviation “PE” which now means pulmonary embolism, but previously meant physical examination. This mistake subjected the patient to numerous unnecessary tests and unnecessary costs. Ultimately the article calls for doctors to review the records and ensure that they are not using short hand which could lead to further problems later on.

How Employers Can Get Higher Value Healthcare

Focusing on the transparency of the cost of different health care procedures depending on the facility the procedure is performed at will help increase the quality of care given. [FN33] By employers offering employees tools to review the cost of services, and other metrics, employers will ultimately end up paying less and employees will receive high quality care.

Specialty Practices Anxious Over 2018 Quality Payment Program

The new payment program being used by CMS has specialty healthcare providers worried. [FN34] Previously the payment system had been based on a volume scale. Specialty healthcare providers are worried that the quality based payment system will, and is slowing down the healthcare process. By having to evaluate different measures with each patient, providers are taking more time, seeing fewer patients in a day, and ultimately increasing the wait to get an appointment with a specialist. The importance of quality cannot be overstated, but providers want to find a middle ground where they are able to spend the necessary time with patients, while ensuring that no one who needs care is being delayed.

How Medicaid Expansion Boosts Quality, Timely Surgeries

The Medicaid Expansion has had the effect of earlier detection of common illnesses which require surgical intervention. [FN35] The early detection is key to increasing the success of these operations. Data is continuing to suggest that access to health insurance is encouraging individuals to seek care and they are getting care earlier increasing the chances of successful care.

3 Ways Amazon's Mysterious Healthcare Project Could Impact All of Us

USA Today explores the possibilities that this cooperation between large corporations could have on the healthcare market. [FN36] The author reviews the strengths of these corporations and how these strengths could change the face of the healthcare market. Specifically calling out Amazon's ability to ship and how this could impact individuals receiving their prescriptions regularly and the ability of these large corporations to see inefficiencies and to fix these.

VA to Get “Aggressive” with Hospital Quality Improvement Program

The Department of Veterans Affairs is focusing on the fifteen lowest performing centers and implementing an aggressive plan to increase the quality of care. [FN37] The new program will focus on creating centralized leadership to oversee the improvement at each site. If any site is not making improvements, the centralized leadership will make suggestions on steps to take moving forward, including the possibility of new leadership at the locations. The hope is that by holding leadership responsible for the overall quality of care that concrete steps will be taken at each location in order to make the necessary changes.

Innovative Healthcare Solutions Uniting Patient-to-provider and Patient Medical Records

Teledoc, Inc. announced this month that they will issue a mobile app which will allow users to access a wide pool of healthcare providers to answer their health questions from their own mobile device. [FN38]

The American Health-Care System Increases Income Inequality

Spending in the American Healthcare system still exceeds the paying capabilities of most Americans. [FN39] The article explores the many costs that American's still endure, even with the Affordable Healthcare Act, and how these costs can still cause economic hardship for many families. Also attributed to the inequality of healthcare, is the large deductable attributed to Affordable Healthcare Act plans offered with lower premiums.

The Discrimination of LGBTQ People Still Face from Healthcare Providers

Individuals who are LGBTQ are still facing discrimination from healthcare providers due to lasting stigmas. [FN40] Patients report providers being hesitant to touch the patient for care or asking questions not related to the patients' complaints. Another issue faced by these individuals is based on their HIV status. Individuals who have been diagnosed with the disease may face discrimination from providers or by insurance companies who refuse to cover treatment with Truvada, punishing individuals who are being proactive with their health and limiting their viral load.

Providers Critical of Trump Budget, Which Would Cut Medicare, Kill AHRQ, Slash IT Agency

Trump's budget proposal would call for deep cuts to the agency in charge of monitoring health quality and studying ways to make healthcare more efficient. [FN41] Although Congress is not required to accept the administration's suggestions, it does make it clear the priorities of the White House.

Five States Five Different Patterns for Healthcare Spending – and No Easy Path to Lower Costs

The article discusses the varying costs of healthcare depending on the state and tries to address how, moving forward, quality of care could be increased so that it would not be dependent upon the state in which you live. [FN42] Ultimately the author believes that each state will have to be addressed individually in order to improve the quality and cost of healthcare.

Not Having A Regular Doctor Affects Healthcare Quality For Older Adults

Research is now showing that the 5% of individuals who are on Medicaid and do not have a personal physician report having worse care experiences than those who report having a personal physician. [FN43] Those without a personal physician are also less likely to be enrolled in a prescription drug plan and are less likely to be enrolled in Medicare Advantage plans which also contribute to an individual's overall satisfaction with the quality of care received.

Many Iowans have suffered medical errors, and most weren't told, poll finds

An article by Tony Leys in the Des Moines Register published on January 8, 2018, brings attention to the fact that close to 20 percent of Iowans say they have had an experience with medical errors. Of those who had experience with medical errors, over half were not informed of the error. These results are from a poll by the Heartland Health Research Institute. The article continues discussing the role of disclosure in the quality of care given by hospitals, using the example of the spread of infection in hospitals.

New Website Informs About the Quality of Care at Michigan Hospitals

A new website is offering citizens in Michigan and quick way to review quality measures of hospitals. [FN44] VerifyMICare.org uses information compiled from CMS to provide patients with a better way to make informed decisions regarding their healthcare. Previously this information was difficult to access and understand.

U.S. easing of nursing home penalties could imperil Minnesota's crackdown on elder abuse

Shifting policy focus under the Trump administration has caused ripples in Minnesota. The current administration has been stepping back from federal penalties on nursing homes which violate health and safety rules. Recently, Minnesota had been taking aggressive steps forward to end elder abuse, but officials are concerned that the reduced enforcement will remove teeth from their efforts.

Keeping the Focus on NJ's High Maternal-Mortality Rates

New Jersey has a new campaign, including what may be the first maternal Health Awareness Day, in order to bring attention to the high maternal mortality rate in the state. [FN45] A large push for this campaign comes from a father who lost his partner shortly after the birth of their son. He hopes that the push for awareness will encourage health care providers to listen to the concerns of new mothers and investigate rather than overlooking these mother's concerns believing that the pain or discomfort is associated with childbirth. The New Jersey Quality Institute is working with different methods for encouraging health care providers to focus on the quality of the care provided. Some of the suggested methods for improving quality include altering the payment method for providers and creating support groups which will bring pregnant women together to focus on challenges and being an advocate for proper prenatal care.

Health Information Exchange Brings Higher Quality, Lower Costs

Focusing on New York, the article explores the impact that increased access to a patient's full health record would have on the quality of care provided. [FN46] Using a unified system for health records would give health care providers a better picture of the history of the patient in front of them. The problem that the state is running into is that many facilities are not able to use these record system and are showing the holes in the system.

Bipartisan Bill Would Expand Access to Quality Health Care in Pennsylvania

An opinion piece based on PA H.B. 100 regarding nurse practitioners. [FN47] The author believes that passage of this bill would allow nurse practitioners to more freely practice, providing high quality care at lower prices than typical doctors.

Most Americans Miss Out On Preventative Healthcare

Researchers recently conducted a survey of 2800 people over the age of 35 and found that only 8% were receiving all the highly recommended preventative care. [FN48] The survey was conducted by AHRQ. The survey also showed that 20% of respondents were receiving 75% of the recommended services. This result shows that there is clearly room for improvement and that respondents are willing to receive these services. Researchers believe that the system must react to improve these measures. Respondents stated that the most common reasons for not receiving the recommended preventative care include lack of health insurance, lack of a usual doctor or nurse, and problems with health care delivery. There are areas for improvement within these categories.

CMS: Declines in Hospital-Acquired Conditions Saved Almost $3 Billion

Between 2014 and 2016 CMS made a push to reduce hospital caused accidents through monitoring. [FN49] This monitoring has decreased hospital harms by 15%, which saves hospitals money in the long run. CMS is looking to continue the programs to reduce hospital conditions by 20% and reduce costs by $19.1 billion by 2019.

NCQA Project Promotes Patient-Centered, Quality Care

NCQA recently announced a launch of a new project, the Person-Driven Outcome Measures Project, the purpose of which is to focus on patient-centered care for older individuals with complex healthcare needs. [FN50] This project allows older individuals to coordinate care to assure that they are receiving the best care, without overlapping treatments. The ultimate purpose for this project is to capture outcomes that are not properly expressed in existing quality measures.

Declines in Hospital-Acquired Conditions Save 8000 Lives and $2.9 Billion in Costs

A recently published CMS report discussed AHRQ results showing continued progress in improving patient safety. [FN51] This signals that current efforts by CMS are working. This progress has allowed a reduction in hospital-acquired conditions which saves hospitals money. The reduction in hospital-acquired conditions was 8% from 2014-2016. This reduction saved hospitals $2.9 billion dollars. CMS has a goal of reducing hospital-acquired conditions by 20% by 2019, impacting 1.8 million fewer patients. This reduction could save hospitals an estimated $19.1 billion dollars. Continued efforts in improving patient safety is great for patients and hospitals alike.

The Magic Number? AMGA Wants to Reduce Quality Measures from Hundreds to 14

AMGA, the American Medical Group Association, has endorsed a plan to reduce the required number of quality measures down to 14 core measures. [FN52] The organization believes that if the number of required reporting measures is reduced physicians will be able to focus on patients and save the healthcare industry billions of dollars. The suggested measures focus on the quality of care given and were based on the collective views of medical groups that are leading the way in quality improvement.

AHRQ: National Guideline Clearinghouse to Shut Down July 16

An announcement on the National Guideline Clearinghouse's website has stated that it will be closing after July 16, 2018. [FN53] This is due to the AHRQ no longer providing federal funding to the NGC. The purpose of the NGC was “to provide physicians and other health care professionals, health care providers, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation and use.” The NGC will continue posting summaries through July 2. At this point, it is unclear if another entity will take over NGC.

Trump Administration Rule Could Stop Public Reporting of Hospital Infections Despite Death Toll

A proposal by the Center for Medicare and Medicaid Service' would have hospitals stop releasing information on hospital infections. [FN54] This proposal would remove public disclosure for MRSA, post-operative sepsis and surgical site infections, accidents and injuries ranging from bedsores to respiratory failure after surgery. Critics of this rule, including the Leapfrog Hospital Survey, fear that removing the public reporting of these measures would halt progress on hospitals achieving a zero-infection rate. Currently, this is still a proposed rule which could be changed or rejecting, resulting in the continued public reporting of these measures.

Report: CMS Hospital Star Ratings Wrong for Two Years

After a hospital was reviewing their own scoring, it found that the CMS rating system was giving more weight to certain factors depending on the rating period. [FN55] These scores greatly influenced the number of stars that the hospital received during the rating period. The error was found to originate from a modeling program that other hospitals had expressed concern with this modeling program. Due to the errors in the rating system, CMS had to delay the release of scores until July of 2018 for the current period.

Medical Errors May Stem More From Physician Burnout Than Unsafe Health Care Settings

In a study led by Stanford University School of Medicine, physicians with burnout had twice the number of self-reported medical error than others. [FN56] The study also looked at work unit safety and found that low levels of work unit safety were associated with 3 to 4 times the odds of medical error. Ultimately, while both components play a part in reducing the quality of care given, physician burnout needs to be a focus as an area for improvement.

The Unhealthy Business of Healthcare

Physicians are drawn to the career to help patients; however, they are facing direct conflict from administrators who focus on the cost of healthcare. [FN57] While administrators want to reduce costs and ensure that the processes are the most efficient they can be, this leads to physicians being instructed to see as many patients as possible in the time given. Physicians using their time in this manner reduces the quality of care given, increasing the risk that symptoms may be missed, and patients have to return for follow up care. This method also leads to physician burn out, which leads to greater mistakes and a reduction in the quality of care given. Physicians and administrators need to find a method of working together to ensure that all of the goals of reducing cost and increasing the quality of care is given while ensuring that the lives of physicians is not overlooked.

Nursing Homes Get Lower Medicare Ratings Because Of Staffing Concerns

A July 30, 2018, Kaiser Health News article [FN58] explains how staffing problems caused Medicare to lower rating for nursing homes:

Medicare has lowered its star ratings for staffing levels in 1 in 11 of the nation's nursing homes — almost 1,400 of them — because they either had inadequate numbers of registered nurses or failed to provide payroll data that proved they had the required nursing coverage.

Medicare only recently began collecting and publishing payroll data on the staffing of nursing homes as required by the Affordable Care Act of 2010, rather than relying as it had before on the nursing homes' own unverified reports.

The payroll records revealed lower overall staffing levels than homes had disclosed, particularly among registered nurses. Those are the highest-trained caregivers required to be in a nursing home, and they supervise other nurses and aides. Medicare mandates that every facility have a registered nurse working at least eight hours every day.

“It's a real positive that they actually are taking the payroll-based system seriously, that they're using it to punish those nursing homes that either aren't reporting staffing or those that are below the federal limit,” said David Grabowski, a professor of health care policy at Harvard Medical School. “Could they do more? Sure, but I think it's a really good start.”

Nursing home industry officials have acknowledged that some facilities are struggling to meet the new payroll reporting requirements. Katie Smith Sloan, president of LeadingAge, an association of nonprofit providers of aging services including nearly 2,000 nursing homes, said the lowered star ratings were disappointing and attributed them largely to a workforce shortage.

“Our members are battling on multiple fronts to recruit and retain all types of qualified staff, and nurses in particular,” she said in a statement.

Medicare rates nursing homes on a five-star system, and the homes' failures to either keep the facilities consistently staffed with registered nurses or to provide the data to prove they were doing so led the government to give its lowest rating for staffing to 1,387 of the nation's 15,616 skilled nursing facilities, according to a Kaiser Health News analysis of the latest data released by Medicare. They all received one star out of a possible five on July 25, when Medicare updated its Nursing Home Compare website, replacing the first ratings based on payroll data issued in April.

In footnotes on the site, Medicare said those homes either lacked a registered nurse for “a high number of days” over three months, provided data the government couldn't verify or didn't supply their payroll data at all. The downgraded homes reported seven or more days without any registered nurses, the analysis found.

For roughly half of the homes, the downgrades lowered their overall star ratings, which are the measures displayed most prominently on the site. But some of the homes saw their overall ratings stay the same or even rise, buoyed by their scores on other quality measures. Seventy-nine are still rated with a coveted five stars.

While the Kaiser Health News analysis found substantially lower average staffing of nurses and aides at for-profit facilities than at nonprofits and government-owned homes, the number of downgraded nursing homes was roughly proportionally divided among the three categories, indicating an industry-wide issue with staffing by registered nurses in particular.

Medicare concedes that because the payroll system is geared toward reporting hourly work, salaried staff may not always be reflected correctly, especially if they were working overtime. But Medicare had warned the nursing homes in April that the downgrades would be coming if facilities continued to show no registered nurses on duty. The agency noted it has been preparing nursing homes since 2015 for the new payroll system.

“We've just begun to leverage this new information to strengthen transparency and enforcement with the goals of improved patient safety and health outcomes,” the Centers for Medicare & Medicaid Services said in a statement.

The new payroll data, analyzed by Kaiser Health News, showed that for-profit nursing homes averaged 16 percent fewer staff than did nonprofits, even after accounting for differences in the needs of residents. The biggest difference was in the number of registered nurses: At the average nonprofit, there was one RN for every 28 residents, but at the average for-profit, there was only one RN for every 43 residents. Researchers have repeatedly found lower staffing in for-profit facilities, which make up 70 percent of the industry.

The data also revealed that nursing homes have large fluctuations in staffing. The average nursing home had one licensed nurse caring for as few as 17 residents or as many as 33, depending on the day. On the best-staffed days, each certified nursing assistant or other aide cared for nine residents, but on the worst-staffed days, each aide was responsible for 16 residents.

Weekend staffing was particularly sparse. On weekends on average, there were 11 percent fewer nurses providing direct care and 8 percent fewer aides.

Report Says Hospice Lacks Oversight

A July 31, 2018, Kaiser Health News article [FN59] discusses a July 2018 HHS Inspector General's Report [FN60] examining the flaws and fraud in hospice care in the United States:

The report from the Office of Inspector General (OIG) at the Department of Health and Human Services sums up over 10 years of research into inadequate care, inappropriate billing and outright fraud by hospices, which took in $16.7 billion in Medicare payments in 2016.

The Medicare hospice benefit aims to help patients live out their final days in peace and comfort: It pays for agencies to send nurses, aides, social workers and chaplains to visit patients who are likely to die within six months and who agree to forgo curative treatment for their terminal illness. Most of the time, this care takes place where the patient already lives — their home, nursing home or assisted living facility.

A Kaiser Health News investigation last year revealed that while many of the nation's 4,000-plus hospices earn high satisfaction rates on family surveys, hundreds fell short of their obligations, abandoning families at the brink of death or skipping other services they had pledged to provide.

The OIG report points to similar gaps in care and raises concerns that some hospices are milking the system by skimping on services while taking in daily Medicare payments.

Regardless of how often their staff members visit, hospices collect the same daily flat rate from Medicare for each patient receiving routine care: $193 for the first 60 days, then $151 thereafter, with geographic adjustments as well as extra payments in a patient's last week of life.

The report calls on the Centers for Medicare & Medicaid Services (CMS) to take 15 actions to improve oversight, including tying payment to quality of care and publishing public inspection reports on its consumer-focused website, Hospice Compare, as it does for nursing homes.

In a letter to OIG in response to an earlier draft of its report, CMS Administrator Seema Verma objected to those two recommendations as well as six others. She concurred with six other recommendations and wrote that CMS is “committed to ensuring that the Medicare hospice program provides quality care safe from fraud, waste, and abuse.”

The OIG findings include:

Basic care only: In 2016, 665 hospices provided only the most basic level of care, called routine home care. This is a red flag, OIG argues, suggesting that patients may not be getting the care they need: Medicare requires hospices to offer three other types of care — general inpatient care for acute conditions such as uncontrolled pain, continuous care in a crisis and respite care to offer a caregiver temporary relief.

Inadequate acute care: Hospices failed to provide adequate nursing, physician or medical social services in 9 percent of general inpatient care stays in 2012. Examples of poor care included a 101-year-old man with dementia who had uncontrolled pain for 16 days, and an 89-year-old man who had uncontrolled respiratory distress and anxiety for 14 days.

Weekend visits rare: Hospices rarely provided services on the weekends to patients in assisted living in 2012. Hospices were also more likely to provide general inpatient care on weekdays than on weekends, according to an OIG analysis of 2011 data.

Missing services: In nearly a third of Medicare claims filed for patients living in nursing homes, hospices provided fewer services than they promised in patients' plans of care, according to a 2009 report. This is notable, the OIG argues, because hospices set their own plan of care for each patient, and fell short of the bars they established.

Few or no visits: On average, hospices provided only 4.8 hours of visits per week, in exchange for $1,100 in weekly Medicare payments, for each patient receiving routine home care in an assisted living facility in 2012, OIG found. Most visits came from aides. In addition, 210 of those patients did not receive any hospice visits that year, despite Medicare paying $2.3 million for their hospice care.

Responding to these findings in her letter, Verma said CMS has taken various actions, including: auditing certain hospices' medical records before claims are paid, monitoring hospices that have many patients in nursing homes and recouping money from hospices that inappropriately billed Medicare for general inpatient care stays.

While many of OIG's findings date back over five years, report lead author Nancy Harrison, deputy regional inspector general of the OIG's New York office, said that the vulnerabilities in the system persist and that CMS has failed to implement many of the recommendations OIG has been making for years. These vulnerabilities have emerged at a time when the industry has changed rapidly, she said.

“Hospice is quite different than it used to be,” Harrison said. “When it started out, there were faith-based and nonprofits,” and most patients had cancer. As of 2016, there were 4,374 hospices receiving Medicare money, about two-thirds of which were for-profit.

Fraud has pervaded the industry, with some hospices ripping off taxpayers by enrolling patients who are not dying, paying kickbacks for patient referrals or carrying out various inappropriate billing schemes. From fiscal years 2013 to 2017, OIG investigators won back $143.9 million from 25 criminal actions and 66 civil actions against hospices.

CMS Rule Would Increase Oversight Of Elder Abuse Reporting In Nursing Homes

The CMS is looking to increase its oversight of post-acute care settings through new civil money penalties on nursing home staff and a new verification process to confirm personal attendants actually showed up to care for seniors when they are at home.

A proposed rule [FN61] in the works to implement a federal law would allow the CMS to impose enforcement actions on nursing home staff in cases of elder abuse or other illegal activities, the agency announced in a notice Friday.

The regulation being developed will outline how the CMS would impose civil money penalties, or CMPs, of up to $200,000 against nursing home staff or volunteers who fail to report reasonable suspicion of crimes. In addition, the proposed regulation would allow a two-year exclusion from federal health programs for retaliating against individuals who report.

Leapfrog Group Jumps To Rate 5,600 Surgery Centers

An October 16, 2018 article by Kaiser Health News indicates that the influential Leapfrog Group, which grades nearly 2,000 U.S. hospitals, is launching a national survey to evaluate the safety and quality of up to 5,600 surgery centers that perform millions of outpatient procedures every year. [FN62]

The group now issues hospitals an overall letter grade and evaluates how hospitals handle myriad problems, from infections to collapsed lungs to dangerous blood clots.

The new surgery center effort will focus on staffing, surgical outcomes and patient experience in facilities that are performing increasingly complex procedures and seeing more aging patients. The grades will also cover surgery centers' closest competitor, hospital outpatient departments.

The new Leapfrog plan will start with a survey of 250 centers in 2019 and include up to 5,600 surgery centers in 2020. At that point, it will publish data on the outcomes of specific procedures, like total knee replacements, across the hospital outpatient departments and surgery centers nationwide.

The Leapfrog Group is funded by employers and health plans that cover the health care of the half of Americans who get health benefits through their job, Binder said. The organization was founded to shed light on health care quality and safety to help consumers pick high-value providers. It plans to disseminate the new surveys through its 40 business group members that steer millions in health spending.

White House Urges States to Repeal Certificate-of-Need Laws

On December 3, 2018, the Trump administration released a report [FN63] , Reforming America's Healthcare System Through Choice and Competition, urging states to scale back their certificate-of-need laws and scope of practice rules, as the executive branch promised to push back against hospital consolidations.

A December 3, 2018 article [FN64] in Modern Healthcare discusses the report indicating that the White House blamed government and commercial insurance for putting up barriers to patients and hurting price transparency.

The White House report asked Congress to repeal the Affordable Care Act's ban on physician-owned hospitals.

The White House called on the Justice Department and the Federal Trade Commission to “monitor the competitive landscape” of providers to “prevent anti-competitive behavior.”

The White House wants states to consider repealing certificates of need, or at least block competitors of providers who want to enter the market from having a say on their certificate-of-need applications.

“The administration wanted to be on the right side of the issue to the extent we can set out a vision and work with state policymakers to loosen restrictions on the provider side of the market,” the official said.

More Than Half Of California Nursing Homes Balk At Stricter Staffing Rules

A December 7, 2018, article [FN65] by Kaiser Health News indicates that more than half of California's nursing homes are asking to be exempted from new state regulations that would require them to spend more time directly caring for their patients.

Under the new rules, which took effect in July but haven't yet been enforced, skilled nursing facilities must provide at least 3.5 hours of direct care per resident per day, up from 3.2 hours of care previously. That care can range from inserting a feeding tube to changing an adult diaper or helping residents with eating and bathing.

Researchers have strongly linked more nursing staff with better care, with some experts recommending from 3.8 to 4.1 hours of care per patient per day as a bare minimum for quality nursing home care. Having enough staff helps prevent falls, pressure sores and other problems that can land fragile seniors in the hospital.

The California Department of Public Health, which oversees nursing homes, is expected to announce in late January which — if any — facilities it will exempt from the new regulations.

Trump Targets Surprise Medical Billing as Administration Pushes for More Transparency in Health Care Pricing

A January 23, 2019, article [FN66] in Kaiser Health News, discusses a recent healthcare roundtable between President Trump and patients. President Trump spoke out against surprise medical bills that patients often cannot afford, highlighting an issue that has received bipartisan concern in Congress.

“The pricing is hurting patients, and we've stopped a lot of it, but we're going to stop all of it,” Trump said during the discussion when reporters were briefly allowed into the otherwise closed-door meeting.

David Silverstein, the founder of a Colorado-based nonprofit called Broken Healthcare who attended, said Trump struck an aggressive tone, calling for a solution with “the biggest teeth you can find.”

“Reading the tea leaves, I think there's big change coming,” Silverstein said.

Surprise billing, or the practice of charging patients for care that is more expensive than anticipated or not covered by their insurance, has received a flood of attention in the past year, particularly as Kaiser Health News and other news organizations have undertaken investigations into patients' most outrageous medical bills.

Trump Administration Proposes Drug Pricing Change

On January 31, 2019, the Trump administration put forth a proposal [FN67] to eliminate certain rebates drug makers pay insurance companies in Medicare, a move it says will ultimately lower prescription drug prices

The proposal would prevent drug companies and pharmacy benefit managers from negotiating rebates in exchange for making it easier for patients to get access to certain drugs. But the proposal would explicitly allow drug companies and PBMs to negotiate rebates as long as the savings are passed directly to consumers at the pharmacy. The proposal technically only affects Medicare, but might also have a more sweeping impact on private plans.

Health secretary Alex Azar said [FN68] the proposal has the potential to “finally ease the burden of the sticker shock that millions of Americans experience every month for the drugs they need.” According to estimates cited by HHS, the proposal would raise premiums for Medicare enrollees, but the amount of money they spend at the pharmacy could go down. The amount of money patients and the government might save — or how much more they have to spend — will depend on what drug companies, PBMs, and insurers do in response.

Will Blockchain Save the Healthcare System?

Originally created to control the flow of bitcoin, blockchain is a universal program that allows administrators to use one program to mark the changes to the account. [FN69] The article examines how the program could increase the quality of care given and reduce that cost of care. A few healthcare providers have created the Synaptic Health Alliance which piloted in 2018 to fix errors in provider directories. By having all the information together in one location the time needed to collect information was reduced, and therefore costs were reduced.

CMS Proposes Rule to Increase Data Sharing Across Health Care Continuum

CMS's new rule proposal would create greater ease of access to a Medicare Advantage patient's records, in network providers, and for dual eligibility patients creates an ease of exchange between Medicare and Medicaid. [FN70]

House Votes to Remove State Approval Needed to Expand or Add Healthcare Facilities

In Florida, the House has again approved a bill which would repeal the requirements that nursing homes, hospitals, and hospices must undergo to build or add beds to existing facilities. [FN71] Similar bills have passed the House before but stalled out in the Senate.

Supporters of the bill believe that the current system disproportionally affects smaller facilities and allows others to freely increase their costs. The goal of passing the bill is to reduce costs and increase the quality of care given.

Opponents believe that supports are inflating the effects of these requirements and that causation and correlation are being confused.

Many OB-GYN Residents Miss Out on Trans Care Instruction

Of 100 OB-GYN programs surveyed in the United States, 61 responded and only half of those programs provide specialized training for providing care and health issues relating to LGBTQ patients. [FN72] The issues facing this community are different from the typical community and providing the proper training for compassionate care will improve the quality. The study was in part a response to the rollback in protections from the current administration and the hope that the industry will provide the protections being removed.

Penalties Not Lowering Hospital-Acquired Infection Rates

A program created by the Affordable Healthcare Act that penalizes hospitals for having higher infection rates has come under recent scrutiny. [FN73] A study taking place during the first two years after the establishment of the program has indicated that hospitals that have lower quality of care scores regarding readmittance and patient death do not tend to improve their scores the next year. This penalty for a lower score seems to disproportionally effect hospitals that provide care to individuals with lower incomes. With the penalties on the rise, and the patients served at these hospitals, the program may be increasing inequity of care given. This study was not created to determine the effects of penalties on the quality of care.

HHS Announces Quality Summit to Streamline and Improve Quality Programs Across Government

The administration recently announced the creation of a summit related to the executive action to simplify and streamline current healthcare quality programs. [FN74] [FN75] The goal of this simplification is to allow healthcare professionals to spend less time filling out the existing quality measures and find a core set that most accurately depict the activities of the hospital and their effect on care. The summit hopes to assist HHS in fulfilling the administration's executive order regarding healthcare transparency.

CMS is Bringing Health Plan Quality Ratings to All Exchanges for the First Time

The Trump Administration, in accordance with their goals of increasing the transparency in healthcare, has required that all health plans involved in the exchange display the five-star Quality Rating System score. [FN76] This will allow insureds to directly compare plans before purchase. The Quality Rating System score is based on three categories, medical care, member experience, and plan administration. This method was piloted in 5 states previously before opening it up to the entire exchange.

What Do We Know About Prices and Hospital Quality?

A study reviews the relationship between cost of care, quality of care, and bonus payments. The study suggests that believing that an increase in funding will increase the quality of care given is simplistic and false. The article reviews the relationship between the use of the money and where it provides the greatest return on quality. Ultimately researchers determined that there are too many variables to determine the true relationship between cost and quality.

Telehealth Innovation Bill Heads to Capitol Hill for a Third Try

The Telehealth Innovation and Improvement Act has been introduced for a third time to encourage healthcare providers to utilize telehealth programs to increase effectiveness, reduce costs, and provide an improvement in the quality of care provided using the Center for Medicare and Medicaid Innovation (CMI) program. [FN77] The Act also hopes to promote CMI to find the most effective model for telehealth services and focus on reducing healthcare costs for patients.

CMS Considers the Value of Hospitals Displaying Quality Data

Information regarding hospitals costs and quality scores is already accessible, but CMS is mulling the idea of requiring the hospitals to display this information on the hospital's site. [FN78] The current administration is focusing on healthcare transparency and this step seems like a clear next move. Hospitals are reluctant to this move, fearing the consequences of sharing this information publicly.

CMS Delays Funding Renewal for Quality Improvement Organizations

CMS' quality improvement organizations have had to stop operations and lay off staff due to a failure to renew their contracts until September and November. [FN79] Funding for these projects has been delayed before, but not for this long. CMS is stating that some of the work performed by these agencies does not expire until mid-October and this is just a normal part of the transition process.

Ensuring Quality Health Care for Those with Intellectual Disabilities and Autism

Americans with intellectual and developmental disabilities or autism are more likely than the average to develop health conditions and more likely to have high healthcare needs and costs. [FN80] There is now a bill being presented that would give these individuals access to federal funding for health centers, loan repayment, training programs, and would provide incentives to physicians. Allowing these individuals access to better funding and incentivizing providers to give care with increase the quality of care.

CMS Releases Medicaid Data to Boost Medical Research, Care Quality

CMS has released treatment information to researchers to analyze what services the government is paying for through Medicaid and CHIP programs. [FN81] This data release allows for oversight of these programs and increase the transparency of health programs. The program that has sought this data is also dedicated to allowing a free exchange of information between patients and their providers. By allowing the free flow of information, it is hoped to promote better quality of care.

II. SELECTED LEGISLATION

Arizona

• 2019 AZ S.B. 1089 (NS), adopted April 18, would amend AZ ST § 20-1057.13 to require coverage for telemedicine the same as other healthcare services.

• 2019 AZ H.B. 2512 (NS), introduced May 6, would establish protocols for providing individuals with terminal illness an option to making life ending decisions for a dignified death.

Colorado

• 2019 CO S.B. 15 (NS), adopted May 30, 2019, recreates the former health care task force, renamed as the statewide health care review committee, to study health care issues that affect Colorado residents throughout the state, including the following:

(a) emerging trends in Colorado health care and their effects on consumers, providers, and payers;

(b) the ability of consumers to obtain and keep adequate, affordable health insurance coverage;

(c) the effect of changes in the way health care is delivered and paid for;

(d) trends in health care coverage rates for individuals, employees, and employers and in reimbursement rates for health care services;

(e) access to and availability of federal funds and waivers of federal law;

(f) innovations in health care and health care coverage;

(g) health care issues that arise in or are unique to rural areas of the state;

(h) access to timely and quality health care and emergency and nonemergency medical transportation;

(i) options for addressing the needs of uninsured and underinsured populations;

(j) issues related to the health care workforce, including network adequacy and the adequacy of access to providers; and

(k) any other health care issue affecting Colorado residents that the committee deems necessary to study.

• 2019 CO H.B. 1233 (NS), adopted May 16, creates a primary care payment reform collaborative to encourage the utilization of primary care physicians to reduce the cost of healthcare.

Connecticut

2019 CT S.B. 388 (NS), amended/substituted April 17, would repeal and replace CT ST § 46a-60 with new definitions including the addition of adding intersex individuals to those protected from discrimination on the basis of sex and defines intersex characteristics.

District of Columbia

• 2017 DC L.B. 1011 (NS), introduced October 12, 2018, the “Nursing Facility Quality of Care Fund Amendment Act of 2018” amends the Nursing Facility Quality of Care Fund to allow for an updated reimbursement methodology that considers the acuity of nursing facility residents and increases the promotion of care, safety, and health of nursing facility residents.

Federal

• 2017 CONG US HR 5774, referred to the Senate on June 20, 2018, would require the Secretary of Health and Human Services to develop a plan on pain management and opioid use disorders for hospitals receiving payment under part A of the Medicare program. This includes best practices and the creation of quality measures.

• 2017 CONG US HR 6698, introduced September 4, 2018, to enact the Maternal Care Access and Reducing Emergencies Act, to support States in their work to end preventable morbidity and mortality in maternity care by using evidence-based quality improvement to protect the health of mothers during pregnancy, childbirth, and in the postpartum period and to reduce neonatal and infant mortality, to eliminate racial disparities in maternal health outcomes, and for other purposes.

• 2019 Cong US HR 1551, introduced March 6, 2019, would create maternity quality care measures under the Medicaid and CHIP programs. These core measures include infant and maternal care.

• 2019 CONG US S 1960, introduced in Senate June 25, 2019, would create maternal care quality measures and increase the value of care under the Medicaid and CHIP programs. The bill would establish a core set of measures to help align the quality of care given in the private and public sector.

• 2019 CONG US HR 4013, introduced to the House July 25, 2019, would expand Medicare services to cover telehealth services. The hope is to reduce cost to patients and providers and improve the quality of care.

• 2019 CONG US S 2481, introduced to the Senate on September 17, 2019, would increase resources for facilitate effective research for neglected tropical diseases. This bill would also coordinate domestic and international efforts.

• 2019 CONG US HRES 606, introduced in House on September 27, 2019, would create funding and research opportunities for Sickle Cell trait research.

Florida

• 2019 FL H.B. 231 (NS), introduced March 05, 2019, would create the “Florida Hospital Patient Protection Act”; requires health care facilities to implement staffing plan that provides minimum direct care registered nurse staffing levels; prohibits health care facility from assigning unlicensed personnel to perform functions or tasks that should be performed by licensed or registered nurses; requires AHCA to post on its website information regarding health care facilities on which civil penalties have been imposed.

• 2019 FL H.B. 1113 (NS), adopted June 12, 2019, creates a health insurance savings program which would provide an incentive to insureds to utilize less expensive options for healthcare.

Illinois

• 2017 IL S.B. 2951 (NS), adopted August 21, 2018, requires the establishment of the Early Mental Health and Addictions Treatment Act which requires specified entities to establish a pilot program which would provide a community based mental health treatment program. The program would use a youth-focused community support team.

• 2017 IL H.B. 4844 (NS), filed February 14, 2018, would provide treatment for serious mental illnesses and serious emotional disturbances for all managed care plans amended, delivered, issued, or renewed in the state. States that all the components of the treatment model will be combined for coverage rather than each separate service.

• 2019 IL H.B. 3 (NS), adopted August 23, 2019, amends the Hospital Report Card Act to require that each hospital include in its quarterly report instances of preterm infants, infant mortality, and maternal mortality. Requires the reporting of racial and ethnic information of the infants' mothers, along with the disparity of occurrences across different racial and ethnic groups.

• 2019 IL H.B. 2438 (NS), adopted August 16, amends the Illinois insurance code to include a maternal mental health program which would encourage finding cost effective outcomes. This would include screening for postpartum depression.

Indiana

• 2019 IN S.B. 429 (NS), introduced January 14, 2019, requires a health facility to comply with the following: (1) Have a registered nurse present at the health facility at all times when a resident is in the care of the health facility. (2) Require a registered nurse to delegate certain duties. (3) Provide that there is not less than 4 1/10 hours per resident day of direct nursing care, with not less than 30% of the direct nursing care being provided by licensed nurses. (4) Employ a director of nursing who has obtained certain education or certification.

• 2019 IN S.B. 386 (NS), introduced January 14, 2019, Requires the state department of health to establish a health care price data system to make information concerning certain health care services available to the public. Requires a health care provider to inform a covered individual of certain information when making a referral for a recommended health care service. Requires a health plan to make health care price information available to the public and specifies requirements for a health plan designed to create an incentive for a covered individual to compare health care provider prices.

• 2019 IN S.B. 162 (NS), adopted May 1, adds chronic pain management provisions to varying parts of the healthcare code.

Kentucky

2019 KY REG TEXT 516314 (NS), amended August 1, would establish requirements, licensing procedures and fees for alcohol and other drug treatment facilities.

Maryland

• 2019 MD S.B. 868 (NS), adopted May 6, establishes consumer protections for certain plans issued in the state of Maryland. These protections include but are not limited to, limiting a waiting period, how long children can be kept on their parents' plan, and coverage for gynecological procedures.

• 2019 MD H.B. 697 (NS), adopted May 13, establishes that Maryland wishes to ensure that citizens have access to affordable healthcare and seeks to find methods continue these principles if the Affordable Health Care Act is overturned.

Massachusetts

2019 MA H.B. 4134 (NS), introduced October 18, adds an entire section to the MA code that establishes a task force to make recommendations to ensure consistency in the use of quality measures in contracts between payers, including the commonwealth and carriers, and health care providers in the commonwealth. The goal of the task force is to ensure consistency in methods for evaluating providers, improve transparency for consumers, improve health system monitoring and oversight by the relevant state agencies and improve quality of care.

Minnesota

2019 MN S.F. 1170 (NS), introduced February 14, would amend MN ST § 62D.115 to require a record of the resolution of a complaint procedure and require that there is a receipt of the resolution made within 45 days of the resolution. It requires that the receipt keep information confidential.

Montana

• 2019 MT H.B. 771 (NS), introduced March 25, would create new sections relating to the treatment of opioid addiction including the prior authorization for step therapy, authorization of prescriber authorized medication-assisted treatment drugs, requirements for opioid use disorder treatment facilities, and extending existing requirements for health insurance to opioid use disorder treatments.

• 2019 MT H.B. 555 (NS), adopted May 10, would amend MT ST § 33-32-101 to state that the purpose of healthcare is to promote cost effective and high-quality care.

New Jersey

• 2018 NJ S.B. 3143 (NS), introduced October 22, 2018, to establish the Working Group on End-of-Life Care and Palliative Care in the Department of Health. The purpose of the working group is to develop a plan to implement the legislative, administrative, and policy recommendations for State agencies, policy makers, and third party payers; report on the performance goals and benchmarks developed by the New Jersey Advisory Council on End-of-Life Care to measure the ability of the DOH or other relevant State entities to provide patient access to, and choice of, high quality, cost-effective palliative care and end-of-life care, and assist patients and their families in making informed health care decisions with regard to such care; and study and make recommendations on strategies to further improve the end-of-life care provided to the citizens of the State.

• 2018 NJ A.B. 4684 (NS), introduced October 29, 2018, to establish the Working Group on End-of-Life Care and Palliative Care in the Department of Health.

• 2018 NJ S.B. 1109 (NS), adopted August 9, 2019, renames the “Physician Order for Life-Sustaining Treatment Act” to the “Practitioner Orders for Life-Sustaining Treatment Act”.

New Mexico

• 2019 NM H.B. 178 (NS), introduced January 17, 2019, enacts Patient Safe Staffing Act, requiring hospitals to establish staffing levels for hospital nursing units; giving a nurse the right to refuse an assignment under certain circumstances; requiring hospitals to post and report their daily hospital nursing unit patient census and staffing levels; making the department of health responsible for posting hospital reports on the department of health's website for consumers; authorizing the department of health to enforce compliance with the patient safe staffing act through penalties and corrective action; authorizing the department of health to promulgate rules to implement the patient safe staffing act; providing whistleblower protection to employees who file a grievance or complaint under the patient safe staffing act.

• 2019 NM S.B. 153 (NS), introduced January 17, 2019, enacting the Elizabeth Whitefield End of Life Options Act; to establish rights, procedures and protections relating to medical aid in dying; establishing reporting requirements; and removing criminal liability for providing assistance pursuant to the Elizabeth Whitefield End of Life Options Act.

New York

2017 NY A.B. 5281 (NS), amended/substituted February 06, 2018, would establish a state health care quality and cost containment commission, focused on improving health care in the state. The goals of the commission would be to review the latest evidence based medical literature to find the best methods to improve the quality of care.

Ohio

• 2017 OH H.B. 286 (NS), effective March 19, 2019, to create the Palliative Care and Quality of Life Interdisciplinary Council and a related education program, to require identification of patients and residents who could benefit from palliative care, to authorize hospice care programs to provide palliative care in their inpatient facilities or units to non-hospice patients, to specify that Medicaid coverage for palliative care is not being expanded, to modify the pain management clinic licensing law relative to certain palliative care patients, and to authorize the Director of Health to approve the transfer of certain nursing home beds to a facility in a contiguous county.

• 2019 OH S.B. 254 (NS), introduced December 11, 2019, would enact measures to establish the parity requirements for mental health and substance use disorder treatment coverage.

Oklahoma

• 2019 OK H.B. 2334 (NS), adopted May 28, 2019, creating the Maternal Mortality Review Act which shall have as its purpose the coordination, development and enhancement of a system of maternal health services in the state in order to decrease maternal mortality.

• 2019 OK H.B. 1035 (NS), introduced February 4, would require that any plans issued on or after November1, 2019, provide coverage for evidence-based pain management treatment.

• 2019 OK H.B. 1279 (NS), adopted May 14, 2019, amends OK ST T. 280 § 5-502 requiring that juveniles who are being involuntarily admitted to mental health treatment receive a hearing with or without a jury as they wish.

Oregon

2019 OR S.B. 889 (NS), adopted July 15, establishes an emergency related to the cost of healthcare.

Rhode Island

• 2017 RI H.B. 7368 (NS), introduced January 31, 2018, would require health insurance plans to provide coverage for effective communication access services between patients who are deaf and their health care professionals to ensure that health care needs and treatments are effectively and clearly communicated.

• 2019 RI H.B. 5579 (NS), introduced February 27, would amend RI ST § 40-8-19 to adjust the per diem rate for nursing facilities to reflect changes in costs. The bill would also require a change in direct and indirect care components of Medicaid rates when the state increases the minimum wage.

Tennessee

• 2019 TN S.J.R. 181 (NS), adopted April 30, 2019, requires insurance companies to cover treatment for substance use disorder patients in the same manner as those with other disabilities such as diabetes and heart disease. This is based on the increasing need of citizens.

• 2019 TN REG TEXT 502103 (NS), effective June 27, repeals certain sections related to licensing and create new regulations regarding opiate treatment facilities.

Texas

2019 TX H.B. 1111 (NS), engrossed April 30, 2019, would develop a pilot program to establish pregnancy medical homes that provide coordinated evidence-based maternity care management to women who reside in a pilot program area and are recipients of Medicaid through a Medicaid managed care model to study the benefits and costs for prenatal and postpartum care delivered through telemedicine medical services and telehealth services.

Virginia

• 2018 VA S.B. 1161 (NS), enrolled April 03, would not require that patients who have cancer and received an adverse coverage determination to exhaust the insurer's internal appeal process and would provide for an expedited review process.

• 2018 VA S.B. 1161 (NS), enrolled April 3, would amend VA ST § 38.2-3559 to include cancer diagnosis to conditions which would trigger an expedited review process.

• 2018 VA H.B. 2766 (NS), enrolled April 3, would amend VA ST § 32.1-102.2 to exclude nursing homes from the list of medical care facilities which require a certificate of public need.

Vermont

2019 VT H.B. 528 (NS), adopted May 16, would create a Rural Health Services Task Force to better the quality of care given in rural Vermont.

Washington

• 2019 WA H.B. 1877 (NS), introduced February 4, creates a possible framework for universal healthcare in the state of Washington. The bill provides methods of funding and renewal.

• 2019 WA H.B. 1876 (NS), amended/substituted February 15, would create a pilot program between the University of Washington department of psychiatry, Seattle Children's hospital, and public schools to give children more access to mental health care.

Wisconsin

2019 WI A.B. 443 (NS), introduced September 13, would allow increase the bed allowance for psychiatric hospitals by 22 beds.

III. SELECTED REGULATION

California

2019 CA REG TEXT 521064, effective September 24, 2019, renumbering 15 CA ADC 335.1 (Dental Care) and making permanent emergency amendments 15 CA ADC 3999.99, 15 CA ADC 3999.206, 15 CA ADC 3999.234, 15 CA ADC 3999.237, 15 CA ADC 3999.367, 15 CA ADC 3999.375, and 15 CA ADC 3999.395.

Colorado

2018 CO REG TEXT 507579 (NS), effective February 14, 2019, promulgates rules to assist communities with underserved health care or behavioral health care needs by establishing the state-specific methodologies for designating areas experiencing a shortage of health care professionals or behavioral health care providers.

Federal

• 83 FR 6587-01, February 14, 2018, would establish a new system of records called the Quality Payment Program (QPP). This restructures the way that providers are paid through Medicare. This new system would focus on high-value patient centered care.

• 84 FR 38330-01, proposed August 6, 2019, would create a new payment system for the treatment of end-stage renal disease. It would alter the payment pool and fee schedule.

• 84 FR 65524-01, effective 01/01/2021, requires hospitals operating in the US to establish, update, and make public a list of their standard charges for the items and services they provide. This is necessary to provide for transparency of healthcare pricing.

Utah

2019 UT REG TEXT 528504 (NS), EFFECTIVE September 17, amends UT ADC R414-2A-1, UT ADC R414-2A-2, UT ADC R414-2A-3, UT ADC R414-2A-4, UT ADC R414-2A-6, UT ADC R414-2A-7, UT ADC R414-2A-9, UT ADC R414-2A-10, UT ADC R414-2A-11, UT ADC R414-2A-12 adding inpatient intensive physical rehabilitation services to coverage and requiring that routine services must be included in the daily service charges for hospitals.

Washington

2019 WA REG TEXT 528952 (NS), proposed November 20,2019, would mirror ACA protections, and establish the Commissioner's expectations with compliance with non-discriminatory requirements of ACA.

[FN1]

. Jordan Rau, *"Latest Hospital Injury Penalties Include Crackdown On Antibiotic Resistant Germs",* Kaiser Health News, December 21, 2016, available at http://khn.org/news/latest-hospital-injury-penalties-include-crackdown-on-antibiotic-resistant-germs/

[FN2]

. Casey Ross, STAT, February 1, 2017, "Medicare patient deaths shortly after leaving the ER raise questions about rural hospitals ", available at https://www.statnews.com/2017/02/01/medicare-emergency-room-deaths-hospitals/

[FN3]

. BMJ 2017;356:j239, available at: http://www.bmj.com/content/356/bmj.j239

[FN4]

. 2017 WLNR 12519876

[FN5]

. Michael Ollove, Changes to Visa Program Put Foreign-Born Doctors in Limbo, Stateline, May 23, 2017, available at: http://pew.org/2rJwd1K

[FN6]

. Lelieveld, C., Leipzig, R., Gaber-Baylis, L. K., Mazumdar, M., Memtsoudis, S. G., Zubizarreta, N. and Poeran, J. (2017), Discharge Against Medical Advice of Elderly Inpatients in the United States. J Am Geriatr Soc. doi:10.1111/jgs.14985, available at: http://onlinelibrary.wiley.com/doi/10.1111/jgs.14985/full

[FN7]

. National Academies of Sciences, Engineering, and Medicine. 2017. Preventing Cognitive Decline and Dementia: A Way Forward. Washington, DC: The National Academies Press, available at https://doi.org/10.17226/24782.

[FN8]

. 7/7/17 Reuters News 13:41:05

[FN9]

. 82 FR 31729-01

[FN10]

. 7/14/17 Reuters Health eLine 13:44:11

[FN11]

. JAMA Pediatr. Published online July 10, 2017. doi:10.1001/jamapediatrics.2017.1096

[FN12]

. 8/7/17 Washington D.C. Bureau 04:01:00

[FN13]

. https://www.medicare.gov/hospicecompare/

[FN14]

. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-08-16.html

[FN15]

. 2017 WLNR 26539947

[FN16]

. Hospital Watchdog Gives Seal of Approval, Even After Problems Emerge, WSJ, September 8, 2017, available at: https://www.wsj.com/articles/watchdog-awards-hospitals-seal-of-approval-even-after-problems-emerge-1504889146

[FN17]

. Jordan Rau, Nursing Home Disaster Plans Often Faulted As ‘Paper Tigers', KLN, September 19, 2017, available at: https://khn.org/NzY4MjU3

[FN18]

. https://oig.hhs.gov/oei/reports/oei-01-16-00330.asp

[FN19]

. 2017 WLNR 30416526

[FN20]

. https://oig.hhs.gov/oas/reports/region1/11500504.asp

[FN21]

. 10/18/17 Reuters Health eLine 15:02:23

[FN22]

. 2017 WLNR 33415149

[FN23]

. http://www.hospitalsafetygrade.org/

[FN24]

. Transparency pays: Hospitals score poorly in last state required to disclose safety, Jayne O'Donnell ,USA Today, Oct 31, 2017, available at: https://www.usatoday.com/story/news/politics/2017/10/31/transparency-pays-hospitals-score-poorly-last-state-required-disclose-safety/812880001/

[FN25]

. 11/7/17 Reuters News 19:43:25

[FN26]

. 11/8/17 AP Alerts 05:28:21

[FN27]

. Casey Ross, The data are in, but debate rages: Are hospital readmission penalties a good idea?, STAT December 11, 2017, available at: https://www.statnews.com/2017/12/11/hospital-readmissions-debate/

[FN28]

. Thomas Beaton, “How Process, Outcome Measures Contribute to Population Health” HealthPayer Intelligence (Dec 28, 2017), available at https://healthpayerintelligence.com/news/how-process-outcome-measures-contribute-to-population-health

[FN29]

. http://www.modernhealthcare.com/article/20180120/NEWS/180129996/health-insurers-among-leaders-in-using-outcome-measures

[FN30]

. http://www.modernhealthcare.com/article/20180120/NEWS/180129995

[FN31]

. https://revcycleintelligence.com/news/healthcare-costs-outcomes-vary-when-va-outsources-cardiac-care

[FN32]

. http://www.healthcareitnews.com/news/doctors-must-stop-blaming-ehrs-clinical-documentation-shortcut-failures

[FN33]

. https://www.benefitnews.com/opinion/how-employers-can-get-higher-value-healthcare

[FN34]

. https://ehrintelligence.com/news/specialty-practices-anxious-over-2018-quality-payment-program

[FN35]

. https://www.forbes.com/sites/brucejapsen/2018/01/24/how-medicaid-expansion-boosts-quality-timely-surgeries/#5990b39c1ea1

[FN36]

. http://www.wtsp.com/article/news/local/3-ways-amazons-mysterious-healthcare-project-could-impact-all-of-us/513391294

[FN37]

. https://healthitanalytics.com/news/va-to-get-aggressive-with-hospital-quality-improvement-program

[FN38]

. https://www.prnewswire.com/news-releases/innovative-healthcare-solutions-uniting-patient-to-provider-and-patient-medical-records-671931333.html

[FN39]

. https://www.theatlantic.com/politics/archive/2018/01/health-care-income-inequality-premiums-deductibles-costs/550997/

[FN40]

. https://www.healthline.com/health-news/the-discrimination-lgbtq-people-still-face-from-healthcare-providers#4

[FN41]

. https://www.mcknights.com/news/providers-critical-of-trump-budget-which-would-cut-medicare-kill-ahrq-slash-it-agency/article/743924/?utm_source=newsletter&utm_medium=email&utm_campaign=MLT_DailyUpdate_20180213&DCMP=EMC-MLT_DailyUpdate_20180213&hmSubId=&hmEmail=5X8kad4kl-g1&email_hash=F2F56CD35455743AF0A44E424A3A6430&spMailingID=19007218&spUserID=NDIwMzE0OTI0NDk3S0&spJobID=1200810334&spReportId=MTIwMDgxMDMzNAS2

[FN42]

. http://www.modernhealthcare.com/article/20180213/NEWS/180219969

[FN43]

. https://newswise.com/articles/not-having-a-regular-doctor-affects-healthcare-quality-for-older-adults

[FN44]

. http://www.uppermichiganssource.com/content/news/New-website-informs-about-the-quality-of-care-at-Michigan-hospitals-469538963.html

[FN45]

. http://www.njspotlight.com/stories/18/01/21/keeping-the-focus-on-nj-s-high-maternal-mortality-rates/

[FN46]

. https://healthitanalytics.com/news/health-information-exchange-brings-higher-quality-lower-costs

[FN47]

. http://www.post-gazette.com/opinion/Op-Ed/2018/01/17/Bipartisan-bill-would-expand-access-to-nurse-practitioners-and-quality-health-care-in-Pa/stories/201801140043

[FN48]

. http://kfgo.com/news/articles/2018/jun/11/most-americans-miss-out-on-preventive-healthcare/

[FN49]

. https://www.healio.com/internal-medicine/practice-management/news/online/#0dc9d276-a47b-4964-bdc6-2197d7c81e86'/cms-declines-in-hospital-acquired-conditions-saves-lives-costs

[FN50]

. https://healthitanalytics.com/news/ncqa-project-promotes-patient-centered-quality-care

[FN51]

. https://www.ahrq.gov/professionals/quality-patient-safety/pfp/index.html

[FN52]

. https://www.fiercehealthcare.com/amga-wants-to-reduce-quality-measures-jerry-penso

[FN53]

. https://www.aafp.org/news/government-medicine/20180627guidelineclearinghouse.html

[FN54]

. https://www.usatoday.com/story/news/politics/2018/06/19/feds-oppose-public-reporting-hospital-infections/710682002/?utm_campaign=KHN#D#aily#ealthP#olicyR#eport&utm_source=hs_email&utm_medium=email&utm_content=63901737&_hsenc=p2ANqtz-8yBX
hsmi=63901737

[FN55]

. https://www.mcknights.com/news/report-cms-hospital-star-ratings-wrong-for-two-years/article/774029/?utm_source=newsletter&utm_medium=email&utm_campaign=MLT_DailyUpdate_20180629&hmSubId=&email_hash=f2f56cd35455743af0a44e4

[FN56]

. http://med.stanford.edu/news/all-news/2018/07/medical-errors-may-stem-more-from-physician-burnout.html

[FN57]

. https://www.medpagetoday.com/publichealthpolicy/generalprofessionalissues/74233

[FN58]

. Jordan Rau and Elizabeth Lucas, Kaiser Health News, 1,400 Nursing Homes Get Lower Medicare Ratings Because Of Staffing Concerns, July 30, 2018, available at: https://khn.org/news/1400-nursing-homes-get-lower-medicare-ratings-because-of-staffing-concerns/view/republish/

[FN59]

. Melissa Bailey, Kaiser Health News, Missed Visits, Uncontrolled Pain And Fraud: Report Says Hospice Lacks Oversight, July 31, 2018, available at: https://khn.org/news/missed-visits-uncontrolled-pain-and-fraud-report-says-hospice-lacks-oversight/

[FN60]

. https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf

[FN61]

. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/MPD-New-FY19-MPD.pdf

[FN62]

. Christina Jewett, Influential Leapfrog Group Jumps In To Rate 5,600 Surgery Centers, Kaiser Health News, October 16, 2018, available at: https://khn.org/news/influential-leapfrog-group-jumps-in-to-rate-5600-surgery-centers/view/republish/

[FN63]

. 2018 WL 6303916

[FN64]

. Susannah Luthi, White House urges states to repeal certificate-of-need laws, Modern Healthcare, December 3, 2018, available at: https://www.modernhealthcare.com/article/20181203/NEWS/181209987

[FN65]

. Barbara Feder Ostrov, More Than Half Of California Nursing Homes Balk At Stricter Staffing Rules, Kaiser Health News, December 7, 2018, available at: https://khn.org/news/more-than-half-of-california-nursing-homes-balk-at-stricter-staffing-rules/view/republish/

[FN66]

. Emmarie Huetteman, Kaiser Health News, January 23, 2019, Trump Zeroes In On Surprise Medical Bills In White House Chat With Patients, Experts, available at: https://khn.org/news/trump-zeroes-in-on-surprise-medical-bills-in-white-house-chat-with-patients-experts/view/republish/

[FN67]

. Available at: https://www.federalregister.gov/documents/2019/02/06/2019-01026/fraud-and-abuse-removal-of-safe-harbor-protection-for-rebates-involving-prescription-pharmaceuticals

[FN68]

. Available at:

https://www.hhs.gov/about/news/2019/01/31/trump-administration-proposes-to-lower-drug-costs-by-targeting-backdoor-rebates-and-encouraging-direct-discounts-to-patients.html

[FN69]

. https://www.modernhealthcare.com/article/20190209/TRANSFORMATION02/190209953/will-blockchain-save-the-healthcare-system

[FN70]

. https://www.homecaremag.com/news/cms-proposes-rule-increase-data-sharing-across-health-care-continuum

[FN71]

. https://www.staugustine.com/news/20190323/house-votes-to-remove-state-approval-needed-to-expand-or-add-healthcare-facilities

[FN72]

. https://newsroom.uw.edu/postscript/many-ob-gyn-residents-miss-out-trans-care-instruction

[FN73]

. https://www.reuters.com/article/us-health-hospitals-infections/penalties-not-lowering-hospital-acquired-infection-rates-idUSKCN1U528P

[FN74]

. https://www.hhs.gov/about/news/2019/07/09/hhs-announces-quality-summit-streamline-improve-quality-programs-government.html

[FN75]

. https://www.hhs.gov/about/news/2019/07/09/hhs-quality-summit-fact-sheet.html

[FN76]

. https://www.cms.gov/newsroom/press-releases/cms-bringing-health-plan-quality-ratings-all-exchanges-first-time

[FN77]

. https://mhealthintelligence.com/news/telehealth-innovation-bill-heads-to-capital-hill-for-a-third-try

[FN78]

. https://www.modernhealthcare.com/safety-quality/cms-considers-value-hospitals-displaying-quality-data

[FN79]

. https://www.modernhealthcare.com/government/cms-delays-funding-renewal-quality-improvement-organizations

[FN80]

. https://thehill.com/blogs/congress-blog/healthcare/457349-ensuring-quality-health-care-for-those-with-intellectual

[FN81]

. https://ehrintelligence.com/news/cms-releases-medicaid-data-to-boost-medical-research-care-quality

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