# Healthcare Policy

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## Introduction

Health policy is the decisions, strategies, actions, and procedures through which an entity achieves specific healthcare goals. Policy may take many forms, including legislation; regulation; state-, federal-, or association-based standards of care; health insurance policies; payment mechanisms; and public health interventions (see Box 2.1 for definitions). Globally, healthcare systems differ by country based on the historical development of health policy legislation. Although some countries, such as Germany, have had state-based healthcare systems since the early 1800s, health policy became increasingly more popular as a mechanism to reduce healthcare costs and improve healthcare outcomes following World War II. Recognizing a need for a systematic approach to care, the United Kingdom enacted the National Health Service (NHS) in 1948, a federally sponsored program for medical training and care administration. The following year, in 1949, American President Harry Truman proposed the first significant healthcare legislation in the United States, the Fair Deal, beginning what would become a long history of systematic healthcare reform proposals.

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**Box 2.1 Definitions**

**Legislation:** Healthcare requirements and guidance written in law.

**Regulation:** A rule or directive from a local, state, or federal authority. This includes federal interpretation of laws, such as requirements from the Centers for Medicare & Medicaid Services (CMS).

**Standards of care:** Professional guidelines determined by clinical experts and published to inform best practices and clinical standards.

**Health insurance policies:** Rules set by insurers determining who receives coverage, how it is received, what services are covered, cost of coverage for the individual, and amount of payment to providers.

**Payment mechanisms:** Payment may be used to incentivize use or reductions in the use of certain types of services. These policies may be set by federal or state entities, insurers, or employers aiming to achieve specific health outcomes.

**Public health interventions:** State-sponsored public health interventions are a form of policy aimed at targeting specific conditions or health concerns, such as immunization campaigns run through a health department.

## Healthcare Policy Linkages to QHOM

In the QHOM (Mitchell et al. 1998), healthcare policy is in the environmental context that affects all components of the model (Fig. 2.1). As half of the global healthcare professional sector (World Health Organization 2020), nurses are vital stakeholders for health policy and play critical roles in policy development and implementation. At its core, policy is a tool or *intervention* that may influence healthcare quality and safety by either influencing and modifying *system* characteristics or even directly affecting clients. As policy may be developed and implemented at the national or local level, nurses will find health policy influences within each component of the QHOM.

Health policy is frequently considered a vehicle for large systemic change, such as creating the United Kingdom's National Health Service, which trains providers, determines medically necessary criteria, and sets payment standards for providers. In this scenario, the passage of health legislation creating the NHS was a significant intervention that influenced *system* characteristics by providing base funding to hospitals and consistent training for providers. It also influenced *clients* directly by ensuring that clients have access to care regardless of the ability to pay. However, health policy may also take the form of smaller, more specific *interventions.* For instance, some countries and states have established staffing ratio laws to restrict the number of patients a nurse may have at any given time. Such policies are state-based *interventions* that are intended to improve nurse and patient safety through changes in hospital workforce characteristics (Rothberg et al. 2005). Health policy is commonly used as an *intervention* to achieve better health outcomes. Common interventions that aim to improve outcomes through clients include policies that increase access to care, such as health insurance coverage. Other examples include direct

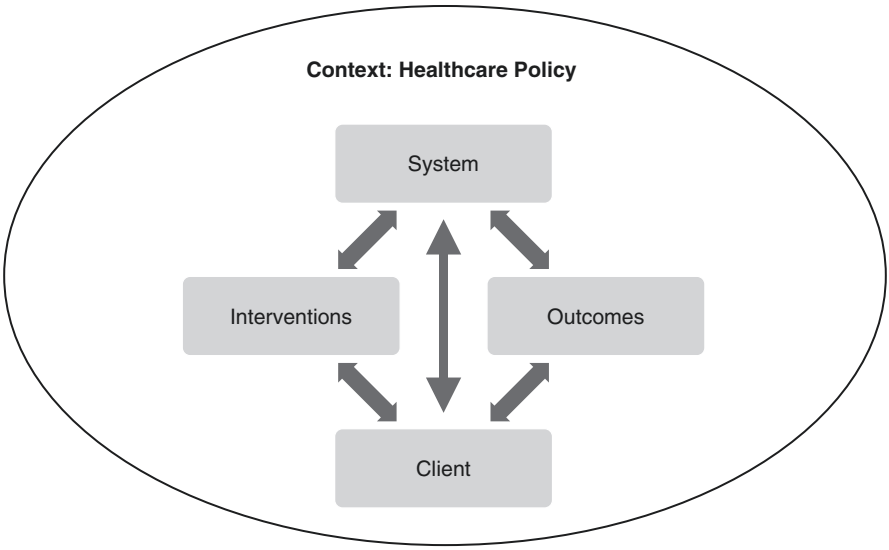


**Fig. 2.1** Framework for healthcare policy context

care programs such as immunization campaigns or testing and treating communicable diseases through local health department clinics. Other policies may be used as interventions aimed at improving outcomes by generating *system* characteristic changes. Like the staffing ratios example, these policies may include workforce regulations or payment mechanisms to incentivize specific behaviors. These types of policies are described in more detail below.

Health policy is a key *intervention* that filters through every level of healthcare. It largely determines what services are reimbursed and how much, who has access to what services, and best practices for providing condition-specific care. For all these reasons, nurses aiming to improve healthcare quality or patient safety, even outside the spectrum of health policy, must consider how health policy influences their environment, creates or reduces barriers, or influences what clients they may reach. This chapter describes the types of policy interventions that nurses will need to consider when evaluating patient safety and quality initiatives and describes examples of how health policy has been used as an *intervention*.

## Access to Care

Health insurance is one of the primary ways that health policy influences healthcare quality and safety. Health insurance can be defined as a contract with an organization (public or private) in which an individual agrees to pay a premium, or regular amount, in exchange for the insurer to pay for some or all healthcare expenses. Although some healthcare systems, such as the NHS in the United Kingdom, consider healthcare services to be public goods and therefore do not require health insurance, in many other countries, including the United States, health insurance is

a key to accessing care. Individuals without health insurance may be unable to receive services or may be very limited in their selection of services due to care costs.

In the United States, health insurance generally is required to access healthcare services. Providers offer healthcare services in exchange for payment, typically based on the number and complexity of services provided. Individuals are expected to cover the cost of the care, whether through their own means or their insurer. Individuals without insurance coverage are more likely to forego needed care, with as many as 30% of the uninsured foregoing medical services due to costs and 20% forgoing needed prescriptions due to cost (Tolbert et al. 2020). In total, 8.5% of Americans, or 27.5 million individuals, report being uninsured (Berchick et al. 2019). Uninsured rates are highest among low-income adults aged 19–64, who may not have access to public insurance programs (Tolbert et al. 2020). The most common reason for not having health insurance is that the cost of purchasing insurance is too high (Tolbert et al. 2020).

In the United States, health insurance may be purchased or gained through three main avenues: (1) it may be provided at no or low cost by the government to eligible populations (public insurance program), (2) an employer may cover all or part of the cost, or (3) an individual may purchase their own coverage plan. Health policy may increase access to care by building new requirements for this public and private system. The Affordable Care Act (ACA; Patient Protection and Affordable Care Act 2010) affected all three mechanisms (see Box 2.2).

**Box 2.2 Patient Protection and Affordable Care Act (2010)**

In March of 2010, President Barack Obama signed the Patient Protection and Affordable Care Act, health reform, into law. The ACA included provisions aimed at reducing cost and improving care quality; however, much of the focus was on increasing access to health insurance. Since its passage, 20 million Americans have gained health insurance (Tolbert et al. 2020).

Major provisions include:

- Increasing eligibility to Medicaid (state-based public insurance) through expanded income limits.
- Creating a state-based Health Insurance Marketplace for individuals to purchase insurance with subsidies provided to low-income individuals.
- Requiring private insurers to offer coverage for dependent children until the child reaches 26 years old.
- Requiring health plans to offer essential health benefits, including preventive services, maternity and newborn care, behavioral health services, hospitalizations, prescriptions, and emergency services.
- Health insurers may not set a cap on the annual or lifetime dollar amount paid for essential benefits, nor may they refuse coverage or increase cost of coverage for an individual based on their medical history.
- Expansion of Medicaid eligibility.
- Medicare pay-for-performance programs including Hospital Readmissions Reduction Program, Hospital Value-Based Purchasing Program, and Hospital-Acquired Condition Reduction Program.

## Public Insurance Programs

### Medicare

In 1965, President Lyndon Johnson signed the Social Security Act into law, establishing the Medicare program (Cubanski et al. 2015). The program provides social insurance to the elderly and persons with disabilities. Medicare is funded through federal taxes and is federally administered, resulting in consistent rules and regulations across all 50 states. Medicare currently covers most Americans over the age of 65, people receiving social security disability insurance (SSDI), people with end-stage renal disease (ESRD), and people with amyotrophic lateral sclerosis (ALS). Medicare is administered by the Centers for Medicare and Medicaid Services (CMS), a federal agency responsible for setting reimbursement methodologies, rates, program requirements, and data collection. CMS is part of the US Government's executive branch and the Department of Health and Human Services.

In total, Medicare covers nearly 60 million Americans (Henry J Kaiser Family Foundation 2020). There are two potential avenues for receiving Medicare services. The first is through the fee-for-service program operated by the federal government with a set premium structure based on beneficiary income. The second avenue is through the Medicare Advantage program, in which a person may opt to receive benefits through a private insurance plan. Medicare coverage is divided into parts A–D (Cubanski et al. 2015).

Upon turning 65, most Americans will automatically receive Part A covering costs associated with inpatient hospitalizations. Part A coverage is funded primarily through income taxes, and there is no additional cost to the participant. Benefits in Part A coverage include costs associated with inpatient hospitalizations, skilled nursing facilities, and some home health and hospice services. In some circumstances, there could be cost sharing required for an inpatient stay; however, no monthly premiums are required.

Part B pays for services such as physician outpatient services and preventive care. Part B is funded in part through premiums paid by the beneficiary and set based on the individual's income and ability to pay. Beneficiaries who want additional coverage for doctor's office visits may opt to enroll in Part B. However, enrollment is not automatic as it is in Part A. Beneficiaries may also be required to pay copayments for provider visits.

Part C, also known as Medicare Advantage, is a substitute option for Parts A and B, and sometimes Part D (see below). As opposed to enrolling in Parts A and B for hospital and physician services, beneficiaries may opt to enroll in a private insurance plan, referred to as Medicare Advantage plans. These plans have the flexibility to offer additional services above those provided through Parts A and B but may also require higher premiums. In addition to offering inpatient, outpatient, and preventive care, many Part C plans will offer prescription medication coverage. The popularity of Part C plans has increased in recent years, with 34% of Medicare enrollees currently enrolled in a Medicare Advantage plan (Henry J Kaiser Family Foundation 2020).

Part D coverage was added as part of the Medicare Modernization Act of 2003 to include prescription drug coverage for Medicare enrollees. Coverage for prescription drugs is a voluntary component of Medicare, so members are not automatically enrolled. The benefit is administered through private plans that contract with the Medicare program. Members are required to pay a premium, which varies by plan, as do other cost-sharing arrangements.

### Medicaid

Medicaid is the largest single insurer in the United States, covering more than 71 million Americans (Medicaid and CHIP Payment and Access Commission 2020). Medicaid is a safety net program, with coverage guaranteed to people in greatest need based on income and complex disability status. It is also the primary payer for long-term care services (Congresional Research Services 2018) and mental health services (Medicaid.Gov n.d.). Unlike Medicare, which is a federally administered program, Medicaid is a state-federal partnership. Although specific base criteria must be met, each state has the flexibility to determine who is eligible for the program and what services are covered. Additionally, Medicaid is funded through both state and federal dollars. The proportion of state and federal dollars varies by state and is based on the wealth of the respective state's population.

Before the ACA, most states only covered low-income children and pregnant women, with minimal coverage, if any, offered to childless adults. However, as part of the ACA, 37 states have expanded coverage to all adults up to 138% of the federal poverty level (FPL). Pregnant women and children may be covered with higher incomes at the state's discretion through the Children's Health Insurance Program. As a result, Medicaid enrollment has increased by 25% following the ACA's passage (Medicaid and CHIP Payment and Access Commission 2020). See Box 2.2 for other ACA policies.

## Employer-Sponsored Coverage

The most common method of gaining insurance in the United States is through one's employer as part of a benefits package. In total, 153 million, or 49% of Americans, gain insurance through this method (Henry J Kaiser Family Foundation 2019). Employer-sponsored plans are typically provided through a private insurance company with premiums negotiated between the employer and the plan. Employers will generally cover a portion of the monthly premium payments for an employee. On average, employees contribute 18% of the plan's cost for a single individual (Henry J Kaiser Family Foundation 2019). Some employers may offer health insurance to retired employees in addition to current employees. Not all employers offer health insurance as a benefit. Healthcare is generally provided by large employers, with nearly all employers with at least 1000 enrollees offering coverage. However less than half of employers with fewer than nine employees offer coverage. However, firms may not provide healthcare coverage to all employees. For instance, part-time employees may not be eligible for benefits. Still, the

employers of 90% of all workers offer health coverage to at least some workers (Henry J Kaiser Family Foundation 2019).

### Marketplace

The Health Insurance Marketplace, also called the Exchange, was established as part of the ACA to provide uninsured Americans affordable coverage (see Box 2.1). The Marketplace is a website (HealthCare.Gov) that assembles various private plans, organized by level of coverage that individuals can purchase for themselves if they are not offered insurance through their employer or that coverage is unaffordable. Although the federal government runs a Marketplace, some states have set up their own Marketplace with state-specific plans. Whether state or federally run, all Marketplaces provide subsidies to individuals based on their income level to cover part or all of a plan's premium costs. The plans included in the Marketplace are private plans, similar to those that may be offered to employees as an employer-sponsored plan. In 2020, 11.4 million individuals were enrolled in health coverage through a Marketplace plan (CMS 2020a).

Before the passage of the ACA, covered services varied greatly by insurer, and therefore, access to services significantly varied depending on the plans an employer offered to its employees. To ensure access to a minimum set of services, the ACA included a requirement that health plans offered on the Marketplaces, with few exceptions, offer ten essential health benefits. These benefits include (What Marketplace Health Insurance Plans Cover n.d.):

- Outpatient services
- Emergency services
- Hospitalizations
- Pregnancy, newborn, birth control, and breastfeeding services and devices
- Mental health and substance-use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive services
- Pediatric service, including dental and vision services for children (adult dental and vision are not required)

## Healthcare Spending

### Prospective Payment Systems and Managed Care

With the expansion of health insurance coverage, such as Medicare and Medicaid in the 1960s and 1970s, US healthcare expenditures on average grew by 6.5% per year, adjusted for inflation. By the 1980s, healthcare prices quickly escalated, and

utilization of services also increased (Catlin and Cowan 2015). Healthcare services were paid on a fee-for-service basis, meaning that each service had a specific cost. For each service provided, the practitioner would be paid that given amount. The incentive inherent in this payment policy is that the more services provided, the more a practitioner is paid. This incentive resulted in providers offering unnecessary services and escalating care costs (Levit et al. 1996). Escalating cost placed pressure on states and employers who covered the cost of healthcare services and put many services out of reach financially for those who remained uninsured. In recognition of escalating healthcare costs, new policies were introduced to control spending. In 1982, the US Congress capped hospital payments for services provided to Medicare beneficiaries and began developing a payment methodology based on diagnoses instead of services. The change meant that a provider treating any Medicare patient admitted for a given diagnosis, such as uncomplicated diabetes, would be paid the same amount for the admission, regardless of the number of services provided. This payment methodology, called diagnosis-related groups (DRGs), was fully implemented in 1997 with the adoption of the Balanced Budget Act (National Council on Disability n.d.). The use of DRGs for payment is referred to as a prospective payment system (PPS) as opposed to fee-for-service, because it anticipates and sets a payment in advance of when an individual presents with a healthcare need, thus controlling costs by reducing the incentive to provide unnecessary services.

In addition to legislation targeting hospital payments, the Health Maintenance Organization Act of 1973 provided funds to incentivize health insurers to implement managed care plans, where small groups of providers paid a set fee, or capitated rate, for each patient they managed. By the 1990s, managed care plans had become increasingly popular, with more than half of insured Americans insured through a managed care plan (National Council on Disability n.d.). Although credited with slowing the growth in healthcare spending, these payment policies were not without consequences. The Balanced Budget Act and the implementation of PPS, as well as managed care programs, are associated with cuts to staffing, especially registered nurses (RNs) and licensed practical/vocational nurses (LPNs/LVNs) (Lindrooth et al. 2006). As staffing levels decreased, external entities, including Leapfrog and the American Nurses Association, voiced concerns that the policies may negatively affect health outcomes (American Nurses Association 1995; Huntington 1997).

## Pay-for-Performance Policies

Future iterations of health policies aimed at controlling healthcare spending more directly targeted quality of care and patient safety and shifted incentives to align with quality and safety goals (What is Pay for Performance in Healthcare? 2018). These policies, frequently called pay-for-performance policies, directly tie payments to quality metrics through bonus payments for high performers or penalties for low performers.

### Hospital-Acquired Conditions (HACs)

In 2008, as part of the inpatient PPS update, CMS implemented the first pay-for-performance (P4P) program. This program, called the Hospital-Acquired Condition (HAC) program, identifies events that "could reasonably have been prevented through the application of evidence-based guidelines," and withholds payment from poor-performing hospitals. As of 2020, CMS had identified 14 hospital-acquired adverse events, such as air embolisms and pressure injuries (CMS 2020b). As part of the ACA, three additional reimbursement incentive programs were implemented by CMS between 2012 and 2014 to promote a higher quality of care for Medicare beneficiaries: Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing Program (HVBP), and Hospital-Acquired Condition Reduction Program (HACRP).

### Hospital Readmissions Reduction Program (HRRP)

The Hospital Readmissions Reduction Program (HRRP), implemented in 2012, financially penalizes hospitals with higher-than-expected 30-day readmission rates for myocardial infarctions, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), elective hip or knee replacement, and coronary artery bypass graft (CABG) surgery (CMS 2020c). The policy's intent, or intervention, is to reduce the number of patients who are discharged following a hospital stay for one of the six diagnoses and then readmitted to the hospital for the same diagnosis within 30 days of discharge. This policy was based on a study by the Medicare Payment Advisory Commission (MedPAC) that found that 12% of readmissions within 30 days were potentially preventable (McIlvennan et al. 2015). Hospital performance is based on historical performance, risk-adjusted case mix to account for acuity, case volume, and diagnosis. Penalties are capped at 3% of Medicare PPS payment (CMS 2020c). In the federal fiscal year 2017, CMS estimated that hospitals would pay $528 million in penalties related to readmissions (Boccuti and Casillas 2017). The policy has been shown to reduce the targeted readmissions effectively. In the first 2 years alone, there were 150,000 fewer hospital readmissions than the years prior (McIlvennan et al. 2015).

### Medicare Hospital Value-Based Purchasing Program (HVBP)

The Hospital Value-Based Purchasing Program (HVBP) was also established as part of the ACA and implemented in 2012. Unlike HRRP, which is focused on a single outcome—readmissions—HVBP includes measures for multiple quality measures. Each year, CMS selects a series of quality metrics in these specific domains: patient safety, patient experience or person and community engagement, cost efficiency, and clinical outcomes. Both the domains and specific quality metrics vary by year. Recent quality measures included potentially preventable infections, such as central line-associated bloodstream infections, 30-day mortality rates for pneumonia, heart failure and acute myocardial infarctions, and patient responses on satisfaction surveys (CMS 2017). Performance on each measure is used to calculate an annual Total Performance Score (TPS) for a hospital. The TPS for each hospital determines the hospital's financial reimbursement level for the forthcoming federal fiscal year.

CMS holds hospitals accountable for their performance on these measures by withholding 2% of their total payments until the performance on metrics is determined. The total funds resulting from the 2% withheld are then dispersed among all hospitals based on performance. Hospital performance is measured as the amount a hospital improved compared to its own performance the year prior and compared to a national benchmark attainment level. Therefore, based on their performance and their peers, a hospital may earn more funds than were withheld, the same amount, or less than were withheld. Since the HVBP's implementation, healthcare-acquired infections have declined; however, the degree to which the HVBP is responsible for that decline is unclear. Generally, research has supported the view that outcomes have been improving due to general trends in higher quality care, but likely not as a direct result of the HVBP (AHRQ 2014; Figueroa et al. 2016; Walker 2019).

### Hospital-Acquired Condition Reduction Program (HACRP)

The final Medicare hospital pay-for-performance program, the Hospital-Acquired Condition Reduction Program (HACRP), established as part of the ACA, was implemented in 2015. HACRP was implemented to incentivize quality care further and reduce hospital-acquired conditions (HACs), leading to patient morbidity and costly care. Hospital performance is evaluated using six quality measures from the Agency for Healthcare Research and Quality's (AHRQ) Patient Safety Indicators (PSI) and the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network's healthcare-associated infection (HAI) measures (NEJM Catalyst 2018). The measures are categorized into two weighted domains. The weightings and measures are used to generate the total, risk-adjusted HAC reduction score for a hospital. Hospitals receiving scores in the bottom quartile of performers will have their payments reduced by 1%, generating a savings of approximately $350 million for the Medicare program (NEJM Catalyst 2018).

Other payers, including Medicaid and commercial insurers, are also developing pay-for-performance or value-based payment policies. By 2017, a survey of commercial insurers found that nearly half of all insurance reimbursement was in the form of a value-based care model, meaning that payment was based on quality metrics (NEJM Catalyst 2018). A growing body of literature suggests that pay-for-performance policies have contributed to lower costs and higher quality care (Mathes et al. 2019). However, not all P4P programs are equally effective, and P4P programs are not without consequences. Some providers have criticized programs for inadequate risk adjustment, leading to penalties for providers that care for more vulnerable or acute patients. Additionally, there is some evidence that healthcare provider job satisfaction may be impacted.

Besides the payment policies and programs, there are other initiatives to improve healthcare quality and cost. For example, AHRQ set a national goal to reduce HACs by 20%. The goal is connected to the CMS Hospital Improvement Innovation Networks, a collaborative group of federal and private partners dedicated to improving healthcare quality by reducing HACs (AHRQ 2018a). To improve tracking and reduce HACs and adverse events, AHRQ is developing and testing the Quality and Safety Review System (AHRQ 2018b). The surveillance system automatically pulls

data from electronic health records to generate HAC event rates and measure organizational performance over time. However, payment policies based on incentivizing quality measures and improving accurate reporting on these measures can only be as good as the quality measure itself. While there has been a significant effort undertaken at the federal level to measure quality adequately, refining quality measures with new evidence will continue to be a necessary policy tool.

## Quality Measurement

The concerns related to the unintended consequences of the shifts in payment policies, e.g., reductions in nurse staffing, led to the formation of a coalition of public and private leaders who began to develop healthcare quality and safety measures to be used in quality improvement programs. Early on, measure use was voluntary, and comparison data typically were not available. By 1999, hundreds of measures existed, and the National Quality Forum (NQF) was established to promote the adoption of standardized measures to facilitate comparisons across healthcare organizations (National Quality Forum 2020). NQF remains a key nonpartisan not-for-profit organization tasked with developing and endorsing evidence-based quality metrics to be used across all healthcare measurement programs, whether public or private.

In 2001, the AHRQ implemented three measurement programs: Inpatient Quality Indicators, Patient Safety Indicators, and Prevention Quality Indicators (AHRQ 2018c). AHRQ produced national comparison data for organizations to target and track quality improvement initiatives. These data provided a basis for researchers and policymakers to determine standards and goals for future healthcare initiatives, including those pay-for-performance programs established as part of the ACA. In 2005 CMS implemented public reporting of a set of inpatient measures from their payment programs (e.g., the HVBP) in the Hospital Compare program to promote further improvements in healthcare quality. Hospital Compare is a publicly available website (https://www.medicare.gov/hospitalcompare/search.html) that compares hospitals on their performance on specific quality measures, including patient experience surveys, timeliness of care, and mortality and complication rates. Prospective Medicare patients are encouraged to visit the site and select hospitals based on quality and safety outcomes. See Table 2.1 for major public and private initiatives and policies that influenced the development of measures and measurement programs.

## Other Policy Interventions

### Professional Guidelines and Standards of Care

In addition to legislation and regulations, healthcare policy may take the form of professional guidelines and standards of care. Published standards and guidelines have

**Table 2.1** Chronology of major public and private healthcare quality initiatives and policies

| Year | Responsible organization | Title | Quality incentive |
|---|---|---|---|
| 1997 | American Nurses Association | National database of nursing quality indicators | Performance reports using standardized unit-level nursing quality indicators to support quality improvement initiatives |
| 1999 | National Quality Forum | National consensus standards | Standardized quality measures to support cross-organizational comparisons |
| 2000 | Leapfrog Group | Performance measurement and public reporting Awards programs: Top Hospitals, Hospital Safety Grade, and the Value-Based Purchasing Program | Influences purchasing decisions of employers and insurers Publicly recognizes high-performing hospitals |
| 2001 | Agency for Healthcare Research and Quality | Prevention quality indicators, inpatient quality indicators, and patient safety indicators | Provides national standards and benchmarks for numerous quality measures |
| Established in 2002 Data first published in 2005 | CMS in collaboration with the Hospital Quality Alliance | Hospital Compare | Public reporting of hospital quality and safety measures |
| 2006 | Centers for Disease Control and Prevention | Healthcare-associated infections reporting program | Surveillance reports to be used by hospitals in quality improvement initiatives |
| Legislated in 2005 Implemented in 2008 | CMS | Hospital-acquired condition present on admission indicator program | Nonpayment for treatment of 14 hospital-acquired conditions (HACs) |
| 2009 | Office of the National Coordinator for Health Information Technology (ONC) | Health Information Technology for Economic and Clinical Health Act (HITECH) | Provides funding for adoption of electronic health records |
| Legislated in 2010 as part of ACA Implemented in 2012 | CMS | Hospital Readmissions Reduction Program | Hospital Medicare payment based partially on rate of readmissions for specific conditions |
| Legislated in 2010 as part of ACA Implemented in 2012 | CMS | Hospital Value-Based Purchasing Program | Withholds 2% of Medicare payments and distributes funds based on performance on a variety of metrics in clinical outcomes, patient and community engagement, cost efficiency, and patient safety |

**Table 2.1** (continued)

| Year | Responsible organization | Title | Quality incentive |
|---|---|---|---|
| Legislated in 2010 as part of ACA Implemented in 2014 | CMS | Hospital-Acquired Condition Reduction Program | Reduces hospitals with high rates of HACs by 1% of base Medicare payments |
| Legislated in 2015 Implemented in 2018 | ONC | Merit-Based Incentive Payment System (MIPS) | Began as a Quality Reporting Program, then implemented with financial accountability. Provides bonus payments to providers with high scores on quality measures, electronic interoperability, and cost efficiency |

been used by clinicians for decades to promote effective care as evidence for specific treatments and services. Standards of care and guidelines are interventions intended to inform both clinical practice and policymakers on how to provide optimal care for a condition or population, consequently changing systems of care. Guidelines may be published by governmental agencies such as the CDC (n.d.-a), nongovernmental agencies such as the WHO, or professional organizations such as the American College of Obstetricians and Gynecologists (ACOG) (ACOG 2020; CDC n.d.-b; WHO n.d.).

The US Preventive Services Task Force (USPSTF), for instance, is an independent panel of expert clinicians and researchers who regularly publish recommendations on standards of care regarding preventive services such as screenings, medications, and counseling services. The panel must submit recommendations to Congress annually based on the collection of current evidence. Examples of USPSTF recommendations include criteria for lung cancer screening, timing and criteria for Papanicolaou (Pap) smears, and when to use aspirin as a preventive medication for heart disease and colorectal cancer (U.S. Preventive Services Task Force n.d.). Recommendations are then used to inform clinical practice or may be tied to future reimbursement policies through quality metrics.

## Health Information Technology

As discussed in Chap. 6, there have been three CMS initiatives to improve health information technology that support improvement in patient care quality and safety through electronic health records (EHRs). In 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH) was enacted as part of the American Recovery and Reinvestment Act of 2009 (see Table 2.1). The legislation included more than $30 billion for providers, states, and the Department of Health and Human Services to support the implementation of EHRs, enabling the exchange of patient data (Medicare.Gov 2020). In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) established the Quality Payment Program, a

pay-for-performance program for physicians and other professionals. One method of meeting the requirements set forth through the Quality Payment Program is participating in the Merit-Based Incentive Payment System (MIPS). Providers participating in MIPS may earn bonus payments through quality improvement activities, advancing interoperability of EHRs, or earning high marks on cost efficiency measures.

### Workforce Development

Policies may also be used in a targeted manner to support workforce development. Such policies may include specific state licensure requirements or be broader in scope. For instance, in the United States, Title VIII Nursing Workforce Development Programs are one of the primary sources of federal financial support for nursing education, recruitment, and retention. Title VIII funds include support for student loan repayment programs, diversity grants, and the Nurse Corps, which has been deployed during the COVID-19 public health emergency to areas experiencing care provider shortages (Nursing Community Coalition 2019). Similar policies support other healthcare providers, including graduate medical education (GME) funds to support physician training residency positions. Unlike Title VIII, GME is supported through several policies that support both the direct costs of training a resident and indirect costs to the hospital (CMS n.d.). See Chap. 3 for more information on the nursing workforce.

## Using Multilevel Policies to Manage the Opioid Crisis

A recent illustration of how policies can be used at many levels is the response to the opioid crisis. As clinicians, the public, and the economy grapple with addressing the opioid epidemic, various forms of policy have been implemented to deal with this crisis: legislation has been passed, standards of care have been created, coverage and payment mechanisms have been used, and direct policy interventions have been implemented. Beginning in the 2010s, the United States, especially the Appalachian areas of the country, began to see significant increases in the number of deaths associated with opioid overdoses. The epidemic of overdose deaths appeared to be stemming from abuse and dependence of opioid prescription medications, often obtained legally through overprescribing of opioids by providers. With mixed and sometimes misinformation about the addictive nature of opioids, many providers were prescribing opioids to control chronic and minor pain (National Institute on Drug Abuse 2020).

By 2013, the economic burden associated with prescription opioid abuse and dependence totaled over $78.5 billion, with nearly $30 billion in direct healthcare costs for treatment of addiction management and overdoses (Florence et al. 2016). As the number of people affected grew, health insurance coverage policy was one avenue used to slow down the poor outcomes associated with opioid-use disorder

(OUD) and opioid abuse, such as overdose and high utilization of emergency services. With states selecting to expand Medicaid coverage for low-income adults following the ACA passage, coverage enabled more residents to gain access to OUD services. Through expanded eligibility, Medicaid quickly became the largest payer of OUD treatment (Center on Budget and Policy Priorities 2018). In addition to adding populations eligible to receive services, Medicaid programs changed policy to further influence the system of care to improve OUD treatment quality. Although states are required to cover OUD services, states can establish their own policies around which treatment to cover and how much to pay for a given treatment. Many states used this opportunity to increase medication-assisted treatment rates, which is considered the standard of care for OUD. By focusing on policies aimed at increasing medication-assisted treatment, Medicaid agencies increased the number of people able to access OUD and increased adherence to professional guidelines (Center on Budget and Policy Priorities 2018).

However, the opioid crisis changing nature was evident in 2018, wherein synthetic opioids, such as fentanyl, had entered the market and increased the number of opioid-related overdoses to 67,000 from 29,000 in 2014 (CDC 2020; Rudd et al. 2016). Synthetic opioids tend to be more potent than traditional opioids. As death tolls increased, a number of policy responses developed. One such policy was the establishment of the Guidelines for Prescribing Opioids for Chronic Pain by the CDC. These clinical guidelines provided a policy framework for clinicians and insurers to improve their care quality for individuals with chronic pain. By describing an appropriate indication and dose for opioids, the CDC guidelines synthesized evidence to counter the misinformation that had resulted in the overprescription of opioids. With the establishment of these guidelines, other policy interventions became possible too, for example, the requirement of prior authorizations for new opioid prescriptions, especially those for higher dosages or uses outside of CDC's recommendation, before it may be filled or paid.

As the access to recommended treatment increased and opioid prescribing decreased, policies aimed at improving OUD care quality began to develop. These types of policies are still in their infancy and may follow various models. For instance, Vermont Medicaid had developed a "hub-and-spoke" model, which identifies the primary provider to initiate treatment (hub) in a region, and then connects the patient with other resources, e.g., other providers (spokes). Pennsylvania Medicaid has developed a "Centers of Excellence" program where patients can see one provider and receive comprehensive OUD treatment and medical care for other conditions. This program is similar to the Virginia Medicaid model, which uses credentialing policy to identify "preferred" OUD providers, referred to as Office-Based Opioid Treatment programs, who have met specific criteria to meet patients' comprehensive needs, including medical and behavioral (OUD) health needs.

In this scenario, policies were used as an intervention to influence the system characteristics, such as services covered, administrative burden, structure of the delivery system, and guidelines to establish standards of care. Policy was also used to impact clients through expanding eligibility for Medicaid to include more individuals.

## Summary and Future Directions

In summary, health policy is a powerful tool to influence healthcare quality and safety. Health policy may be used to set the standard for high-quality care and provide more granular interventions to modify and structurally change systems. Major interventions include the use of health insurance to improve access to high-value care or reduce access to low-value care if services are not covered. Health policy may also be used to control spending and promote specific outcomes through payment mechanisms, such as reducing payment for iatrogenic conditions. Finally, through targeted funding, health policy may promote specific initiatives of interest, such as funding provided to increase the use of EHRs among hospitals and outpatient providers.

The future of health policy is reliant on evidence-based quality metrics that meaningfully improve patient outcomes. As quality measures continue to improve and increase in number, pay-for-performance policies will need to be developed and honed to incentivize high-quality care properly while maintaining staffing morale. The measures may require additional risk-adjustment criteria to ensure that providers continue to reach vulnerable patients. Additionally, to date, most pay-for-performance policies are single-payer programs. Although both public and private insurers use these policies, they often do not align, leading to providers that must react to numerous policies in a less focused manner.

To date, most quality measures are at the individual patient level. However, health policy tends to deal with populations, regulating thousands of providers and millions of individuals at a time. Health policy will need to move towards population-based measures in order to promote health equity. With nearly 9% of the US population still uninsured, continued focus on increasing access to healthcare services remains a critical component of the future of health policy (Berchick et al. 2019).

## References

Agency for Healthcare Research and Quality (2014) Interim update on 2013 annual hospital-acquired condition rate and estimates of cost savings and deaths averted. https://www.ahrq.gov/sites/default/files/publications/files/interimhacrate2013_0.pdf

Agency for Healthcare Research and Quality (2018a) AHRQ national scorecard on hospital-acquired conditions: updated baseline rates and preliminary results 2014–2016. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/natlhacratereport-rebaselining2014-2016_0.pdf

Agency for Healthcare Research and Quality (2018b) AHRQ quality and safety review system. https://www.ahrq.gov/professionals/quality-patient-safety/qsrs/index.html.

Agency for Healthcare Research and Quality (2018c) AHR quality indicators™. https://www.ahrq.gov/cpi/about/otherwebsites/qualityindicators.ahrq.gov/qualityindicators.html.

American College of Obstetricians and Gynecologists (2020) Home Page. https://www.acog.org/

American Nurses Association (1995) Nursing report card for acute care. American Nurses Publishing, Washington, DC

American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115 (2009)

Balanced Budget Act of 1997, Pub L. No. 105-33, 111 Stat 251 (1997)

Berchick E, Barnett J, Upton R (2019, November) Health Insurance Coverage in the United States: 2018. Current Population Reports. US Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf

Boccuti C, Casillas G (2017) Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program. Henry J Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/

Catlin A, Cowan C (2015) History of health spending in the United States, 1960–2013. Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf

Center for Medicare and Medicaid Services (2017) Hospital value-based purchasing. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf

Center on Budget and Policy Priorities (2018) Medicaid works for people with substance use disorder. https://www.cbpp.org/research/health/medicaid-works-for-people-with-substance-use-disorders

Centers for Disease Control and Prevention (2020) Drug overdose deaths. https://www.cdc.gov/drugoverdose/data/statedeaths.html

Centers for Disease Control and Prevention (n.d.-a) Guidelines for prescribing opioids for chronic pain. https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf

Centers for Disease Control and Prevention (n.d.-b) Home page. https://www.cdc.gov/

Centers for Medicare and Medicaid Services (2020a) Health insurance exchanges 2020 open enrollment report. https://www.cms.gov/files/document/4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf

Centers for Medicare and Medicaid Services (2020b) Hospital-acquired conditions. CMS.gov: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions

Centers for Medicare and Medicaid Services (2020c) Hospital readmissions reduction program. CMS.gov: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program

Centers for Medicare and Medicaid Services (n.d.) Direct graduate Medicare education. CMS.Gov: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME

Congressional Research Services (2018) Who pays for long-term services and supports? https://fas.org/sgp/crs/misc/IF10343.pdf

Cubanski J, Swoope C, Boccuti C, Jacobson G, Casillas G, Griffin S, Neuman T (2015) A primer on Medicare: key facts about the Medicare program and the people it covers. Henry J Kaiser Family Foundation. http://files.kff.org/attachment/report-a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers

Figueroa J, Tsugawa Y, Zheng J, Orav E, Jha A (2016) Association between the Value Based Purchasing pay for performance program and patient mortality in US hospitals: observational study. BMJ 353:i2214. https://doi.org/10.1136/bmj.i2214

Florence C, Luo F, Xu L, Zhou C (2016) The economic burden of prescription opioid overdose, abuse and dependence in the United States, 2013. Med Care 50(10):901–906

Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (1973)

Henry J Kaiser Family Foundation (2019) 2019 Employer health benefits survey. https://www.kff.org/report-section/ehbs-2019-summary-of-findings/

Henry J Kaiser Family Foundation (2020) Total number of Medicare beneficiaries: 2018. https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Huntington J (1997) Health care in chaos: will we ever see real managed care? Online J Issues Nurs 2(1):1. Manuscript 1. www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol21997/No1Jan97/HealthCareinChaos.aspx

Levit K, Lazenby H, Braden B, Cowan C, McDonnell P, Sivarajan L et al (1996) DataView: National Health Expenditures, 1995. Health Care Finan Rev 18(1):175–214
Lindrooth R, Bazzoli G, Needleman J, Hasnain-Wynia R (2006) The effect of changes in hospital reimbursement on nurse staffing decisions at safety net and nonsafety net hospitals. Health Serv Res 41(3):701–720. https://doi.org/10.1111/j.1475-6773.2006.00514.x
Mathes T, Pieper D, Morche J, Polus S, Jaschinski T, Eikermann M (2019) Pay for performance for hospitals. Cochrane Datab Syst Rev 7(7):CD011156. https://doi.org/10.1002/14651858.CD011156.pub2
McIlvennan C, Eapen Z, Allen L (2015) Hospital Readmissions Reduction Program. *Circulation* 131(20):1796–1803. https://doi.org/10.1161/CIRCULATIONAHA.114.010270
Medicaid and CHIP Payment and Access Commission (2020) Medicaid enrollment changes following the ACA. https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/
Medicaid.Gov (2020) Federal financial participation for HIT and HIE. Medicaid.gov: https://www.medicaid.gov/medicaid/data-systems/health-information-exchange/federal-financial-participation-for-hit-and-hie/index.html
Medicaid.Gov (n.d.) Behavioral Health Services. Medicaid.Gov. https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html
Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (2015)
Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-174, 117 Stat. 2066 (2003)
Mitchell PH, Ferketich S, Jennings BM (1998) Quality health outcomes model. Image J Nurs Sch 30(1):43–46
National Council on Disability (n.d.) A brief history of managed care. https://ncd.gov/policy/appendix-b-brief-history-managed-care
National Institute on Drug Abuse (2020) Opioid overdose crisis. https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis#two
National Quality Forum (2020) Home page. http://www.qualityforum.org/Home.aspx
NEJM Catalyst. What is Pay for Performance in Healthcare? (2018) New England Journal of Medicine, Catalyst. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245
Nursing Community Coalition (2019) Promoting America's Health through nursing care: priorities for the 116th congress. http://dnanurse.org/docs/advocacy/TitleVIII2019Brochure.pdf
Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111–148, 124 Stat. 119 (2010)
Rothberg M, Abraham I, Lindenauer P, Rose D (2005) Improving nurse-to-patient staffing ratios as a cost-effective safety intervention. Med Care 43(8):785–791
Rudd R, Aleshire N, Zibbell J, Gladden M (2016) Increases in drug and opioid overdose deaths—United States, 2000–2014. Morb Mortal Wkly Rep 64(50):1378–1382. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm
Tolbert J, Orgera K, Damico A (2020) Key facts about the uninsured population. Henry J Kaiser Family Foundation. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=In%202019%2C%2028.9%20million%20nonelderly,Hispanic%20people%20and%20for%20children
US Preventive Services Task Force (n.d.) Recommendations. https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P
Walker L (2019) Patient-centered medical homes and hospital value-based. VCU Scholars Compass. https://scholarscompass.vcu.edu/cgi/viewcontent.cgi?article=6892&context=etd
What is Pay for Performance in Healthcare? (2018) New England Journal of Medicine, Catalyst. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245
What Marketplace Health Insurance Plans Cover (n.d.) HealthCare.Gov: https://www.healthcare.gov/coverage/what-marketplace-plans-cover/
World Health Organization (2020) Nursing and midwifery. Health workforce: https://www.who.int/hrh/nursing_midwifery/en/
World Health Organization (n.d.) Home page. https://www.who.int/