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Trump Budget Would Cut $636 Billion From HHS Agencies

As part of his $4 trillion budget for next year, President Donald Trump is proposing a $636 billion cut in federal funding for CMS programs over the next decade.

The cuts are intended to make room for more spending on defense and border security. The budget also proposes deep cuts to Medicaid—-about $800 billion over the next decade.

The savings would come from transforming Medicaid into a per capita cap program starting in 2020. Medicare is not directly cut in the budget, allowing the President to maintain part of his campaign promise not to touch either entitlement program despite federally subsidized healthcare being one of the biggest contributors to the national debt.

Trump's budget extends funding for the Children's Health Insurance Program as well, which is up for renewal at the end of this year. States, however, would lose the enhanced match provided by the Affordable Care Act. The law gave states a 23-percentage-point bump in federal matching rates. The draft budget also ends a provision that has prevented states from narrowing the pool of eligible CHIP beneficiaries below what it was in 2010, the first year the ACA went into effect.

The proposed budget still needs to be passed by Congress, which is unlikely to happen in its current form. Other changes include repealing the Independent Payment Advisory board, a panel that was created in the ACA whose purpose was to rein in Medicare costs if the program reached insolvency. That move would garner $7.6 billion in administrative costs over 10 years, according to the budget proposal.

The President's plan promises that overhauling the tax code and easing regulations will lift economic growth from the lackluster 2.1% average rate of recent years to sustained annual gains of 3% or higher.

Trump's plan folds in more than $2 trillion in unspecified deficit savings over the coming decade from "economic feedback" to promise balance.

Diana Zuckerman, president of the National Center for Health Research, does not expect Congress, which was generous to the institutes earlier this month, to support Trump's cuts. "I have never known Congress that enthusiastically cut NIH funding," she said. The administration is prioritizing opioid abuse prevention efforts, combating childhood obesity, vaccine stockpiling and investing in CDC infrastructure.

The budget also proposes a 17% cut to the CDC's sexually transmitted disease and tuberculosis prevention efforts. Chronic disease prevention and health promotion would be cut by 19%.

Frailty Level Accurate Predictor Of Post-Op Complications

Assessing a patient's level of frailty before an operation can provide important insight into which individuals might develop postoperative complications.

"For a long time, frailty was overlooked," said Felix Balzer, MD, MSC, PhD, in the Department of Anesthesiology and Intensive Care Medicine at Charite Universitatsmedizin Berlin, in Germany. "Today, we know that frail patients are especially vulnerable to stresses in the preoperative context."

Dr. Balzer and his colleagues conducted a review of patients 65 years of age or older who were seen in the outpatient anesthesiology department for elective surgery between January 14, 2016-April 30, 2016. A frailty assessment was administered to 196 patients, consisting of a grip strength measurement, timed up-and-go test, hemoglobin test and a body mass index or serum albumin level as a test for malnutrition. After reviewing the data, Dr. Balzer and his team found the incidence of complications following the procedure—-specifically delirium, cardiac or cerebral ischemia or pneumonia—-was significantly higher in pre-frail and frail patients than the reference group.

"We believe frailty assessment should be implemented in every preoperative assessment in anesthesiology," said Dr. Balzer. He believes these findings should reinforce the benefits of preoperative assessments in order to plan for, and help prevent, postoperative complications.

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Changes To Locum Tenens Arrangements
By Kimberly Flayhart, CMPE, CPC

Centers for Medicare and Medicaid Services (CMS) is amending the terminology it uses to describe locum tenens agreements. Effective June 13th, CMS will describe these agreements as fee-for-time compensation arrangements. Review this CMS MLN Matters article for more information. If a physician is unavailable to provide the services, and the services are furnished pursuant to an arrangement that is either informal and reciprocal or involves per diem or other fee-for-time compensation for such services, the services must not be provided by the second physician over a continuous period of more than 60 days. The exception would be if the regular physician is called or ordered to active duty as a member of the Armed Forces reserves component.

About The Author

Kimberly Flayhart has over 25 years of coding, compliance, practice management and business intelligence experience. Before joining Periop, her past positions included 22 years as a Associate Administrator for University of Maryland Anesthesiology Associates, P.A.

Study Shows One Of The Deadliest Hospital-Acquired Infections Is Preventable

Researchers at the Johns Hopkins Armstrong Institute of Patient Safety and Quality led a study that demonstrated that health care providers can take steps to curb ventilator-associated events.

“When patients are sick, complications can happen, and, in some cases, health care-associated infections are thought to be inevitable,” said Sean Berenholtz, M.D., professor of anesthesiology and critical care medicine at the Johns Hopkins University School of Medicine and a faculty member in the Armstrong Institute. “This is the largest study to date to show that these complications of mechanical ventilation, or ventilator associated events, are also preventable.”

The study was conducted at 56 ICUs at 38 hospitals in Maryland and Pennsylvania from October 2012 to March 2015. The goal was to improve adherence with evidence-based practices, unit teamwork and safety culture. “Unfortunately, patients don't always receive the evidence-based therapies they should,” says Berenholtz. During the study period, the research team trained and coached quality improvement teams that included providers and staff at the designated sites, focusing on currently recommended interventions by the Society for Healthcare Epidemiolo-gy of America and the Society of Critical Care Medicine for patients on ventilators, including elevating the head of a patient’s bed, suctioning a patient’s mouth tube, performing oral care, such as tooth brush-ing and using chlorhexidine, a mouthwash that reduces dental plaque and treats gin-givitis, and performing spontaneous awakening and breathing trials by reduc-ing narcotics and sedatives and screening the patient for improvement.

Teams were also trained to implement the Agency for Healthcare Research and Quality’s (AHRQ) Comprehensive Unit-based Safety Program, or CUSP, on their units, a five-step culture change intervention that engages frontline health care staff members in preventing harm.

During the study period, the total number of ventilator-associated events in the ICUs decreased from 7.34 cases per 1,000 patient ventilator days to 4.58 cases after 24 months — a nearly 38 percent reduction. The number of infection-related ventilator-associated complications dropped from 3.15 to 1.56 cases, or more than 50 percent, and possible and probable ventilator-associated pneumonia cases dropped from 1.41 to .31 cases per 1,000 patient ventilator days, a 78 percent reduction.

“These complications prolong the duration of mechanical ventilation, and they keep patients in the hospital longer,” Berenholtz says. “This, in turn, leads to higher complications, higher mortality, higher lengths of stay and higher costs. So decreasing these complications is a national priority and helps our patients recover sooner.”

The Johns Hopkins researchers and their team have expanded this study to hospitals in all 50 states.