DELIVERY SYSTEM REDISEIGN

The US health care delivery system is expensive, fragmented, highly decentralized, and poorly organized. The system fails too often to deliver high quality care that is accessible, safe, efficient, and effective for all. While models of integrated care delivery that emphasize coordination and service integration exist, they are not the operating norm. Delivery system reform efforts to date have focused on engineering within the provider setting and have been insufficient to meet the changing health needs of an increasingly complex population. Delivery system re-design requires system-wide reform. The enactment of the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010 provides the impetus to redesign the delivery system, significantly altering the way that care is organized and delivered. Through delivery system redesign, it is possible to move away from a delivery system that is outdated, provider-centric, and uncoordinated towards a system that is patient-centered, clinically integrated, accountable, and maximizes value for consumers. This shift will not be easy. Transformation of the delivery system toward a patient-centered model of care will require simultaneous action on multiple fronts, including increased coordination and service integration along the continuum of care, activated consumers engaged in clinical decision making, and technical systems capable of providing the clinical linkages necessary to guide evidence-based decision making.

PROBLEM STATEMENT - FRAGMENTED DELIVERY SYSTEM

The US health care delivery system is made up of a fragmented network of public and private financing, health care delivery, and quality assurance structures. There is no single national entity or set of policies guiding the health care system. States divide their responsibilities among multiple agencies, and providers who practice in the same community and care for the same patients often work independently from one another. The US health system is the most expensive system in the world and yet health outcomes and quality are no better and often worse than in most developed nations. Evidence of fragmentation in the delivery system includes poor communication amongst providers, a lack of accountability for patients across providers, and deficiencies in clinical information systems that result in misuse of resources and medical errors. A New England Journal of Medicine article by Jencks et al. estimated that one-fifth of the nearly twelve million Medicare beneficiaries discharged from a hospital were rehospitalized within 30 days, with only 10% of those rehospitalizations being planned. An Institute of Medicine report by Aspden et al. estimated that each year there are approximately 1.5 million avoidable injuries resulting from medication errors. Medical errors and avoidable
patient injuries are the product of communication break downs and technical inefficiency. Health information technology (HIT) has been heralded as a potential tool to address delivery system fragmentation along the continuum of care and the subsequent quality and patient-safety problems that ensue. Unprecedented federal dollars are being invested in modernizing the HIT infrastructure of the nation, including incentive payments to providers for adopting Electronic Health Records (EHRs) and the funding of demonstrations and pilot programs on the application of HIT in the care delivery setting. Although financial investments in HIT are an important mechanism for modernizing the nation’s outdated health information system and decreasing clinical fragmentation, it alone does not ensure system integration and improved quality along the continuum of care. The challenge in redesigning the delivery system to successfully utilize HIT to drive improvements in clinical performance lies in implementing and utilizing HIT systems that enable providers to integrate HIT into redesigned practice patterns and improved care patterns.

LACK OF CARE COORDINATION

Underlying the foundation of the delivery system’s poor performance is a lack of care coordination across the continuum of care. The complex structure of the existing delivery system acts as a barrier to accessing care and support services for patients with increasingly complex health needs who would benefit most from greater coordination and communication across the spectrum of providers. Although everyone is susceptible to poor care coordination and communication across the spectrum of providers, the elderly and the chronically ill are especially vulnerable. Advances in health care, technology, and public health have extended the life expectancy of the US population. These advances have enabled individuals to live longer with more complex health needs and increased likelihood of developing a chronic condition. In addition, an increasingly sedentary lifestyle coupled with poor health habits and behaviors have exacerbated the growing problem of the chronic disease burden. Specifically:

- The number of people aged 65 and older in the US is projected to increase from 12.5% of the population in 2006 to nearly 20% of the population in 2030, with the most significant growth occurring in the population aged 85 and over.  
- Approximately 80% of the older population suffers from at least one chronic condition — generally defined as an illness that is persistent and imposes physical limitations — and 50% suffer from two or more chronic conditions.
- The number of obese adults in the US has increased 5% since 1997, with nearly 33% of adults being obese and almost 20% of youth aged 6-19 being obese.
- Chronic disease is the leading cause of death and disability in the US and accounts for an estimated 75% of the nation’s $2 trillion health care price tag.

Shifting age demographics coupled with increased prevalence of chronic disease threaten to break an already fragile and inefficient delivery system. The US delivery system lacks a single entry point to link systems of health care, social services, education, public health services, and home services for patients and their families. Most patients, but particularly those with chronic conditions, have multiple providers located in different offices and settings. The disconnect between providers and locations often results in poor access to patient information, medical histories, and treatment plans; limited or no communication between providers; and a
disjointed and often discouraging patient experience. Care coordination may be part of the solution to the problems caused by system fragmentation. Greater care coordination would allow providers timely access to pertinent patient and treatment information, which has the potential to improve quality of care and reduce medical errors.

Enhancements in care coordination are intended to not only improve care and optimize health, but also to promote independence and reduce unnecessary service utilization in that a more coordinated system can link patients and their families to a range of resources and services that can strengthen a patient’s ability to self-manage their care and conditions. The PPACA lays the foundation for improving care coordination by bolstering community supports and services, creating a voluntary social insurance program for long-term care, and creating incentives for service integration; but it remains unclear how these provisions will be implemented and whether or not they will successfully address the multiple components of care coordination.

SUMMARY OF HEALTH CARE LEGISLATION

The PPACA contains a number of provisions designed to improve the quality and delivery of health care goods and services for all Americans. Underlying the foundation of delivery system redesign concepts is an injection of federal dollars to modernize the nation’s health information technology infrastructure. These investments began with the passage of the American Recovery and Reinvestment Act (ARRA) of 2009 and the Health Information Technology for Economic and Clinical Health (HITECH) provisions. These provisions contained an estimated $30 billion in incentive payments for demonstrating meaningful use (defined as using HIT to track key clinical conditions, communicate that information for care coordination purposes, and initiate the reporting of clinical quality measures and public health information) and other quality-related applications of HIT (including $250 million dollars to 17 communities (Beacon Communities) to serve as pilot communities for wide-scale use of HIT as a quality improvement mechanism, and $267 million dollars to develop HIT regional extension centers in local communities.)

Key provisions of the PPACA provide support to states and communities to experiment with alternative delivery system models that hold promise for improving quality and lowering cost, address the changing health needs of the population, and promote improved health and well-being of the elderly through phased-in changes to Medicare and increased options for long-term care and community living. Key provisions are summarized below.

Delivery System Redesign:

- Encourages the development of new patient care models
  - Establishes a national program for Accountable Care Organizations (ACOs) based on a shared savings model for ACOs that can improve quality and lower costs in Medicare
  - Creates a payment incentive program for hospitals and community-based organizations to improve care transitions for Medicare beneficiaries at high risk of rehospitalization
  - Creates a new state option for chronically ill Medicaid beneficiaries to designate a
provider as their medical home
- Creates new demonstration projects that allow safety-net providers and pediatric medical group providers to experiment with the adoption of capitated, global payments and ACOs
- Creates an independent, non-profit Patient-Centered Outcomes Research Institute
- Establishes a new Innovation Center to develop and test new patient-centered care models in Medicare, Medicaid, and CHIP
- Establishes a new program to implement medication therapy management (MTM) services provided by licensed pharmacists as part of a collaborative approach to the treatment of chronic diseases

- Strengthens the Quality Infrastructure
  - Requires the Secretary of HHS to establish, for the first time, a national strategy to improve health care quality
  - Creates funding opportunities to develop additional quality measures

Increased Access and Decreased System Fragmentation for the Elderly: xiii
- Updates the Medicare Program to Increase Access and Improve Care
  - Provides coverage with no co-pay or deductible, for an annual wellness visit and personalized prevention plan services effective January 1, 2011
  - Gradually closes portions of the Part D doughnut hole, beginning in 2011, while requiring drug manufacturers to provide a 50% discount to Part D beneficiaries during the interim
  - Eliminates Part D cost-sharing for dual eligibles receiving care under a home and community-based waiver
  - Requires information disclosure and accountability for skilled nursing facilities, nursing facilities, and other long-term care facilities

- Bolsters Supportive Services Delivered at Home and in the Community
  - Establishes the Community Living and Assisted Services Support (CLASS) Plan a public, long-term care program that, through voluntary deductions or contributions, contributes to the purchase of community living assistance service and supports for individuals with functional limitations
  - Establishes a Medicaid State Plan Option to provide community-based attendant services and supports benefit to those who meet the state’s nursing facility clinical eligibility standards
  - Protects recipients of Home and Community Based Services (HCBS) by requiring states to apply spousal impoverishment rules to beneficiaries who receive HCBS for a five-year period beginning January 1, 2014

Primary Care and Prevention to Combat Chronic Disease: xiv
- Expands Capacity of the Public Health System to More Effectively Intervene to Treat and Manage Chronic Disease
  - Establishes a public health investment fund to sustain and expand public health prevention programs
- Authorizes the Secretary of HHS to convene a national public-private partnership to launch a national prevention and health promotion campaign
- Establishes a wellness demonstration to assess the impact of a program that provides at-risk populations who utilize community health centers with a risk-factor assessment and individualized wellness plan to reduce risk factors for preventable conditions

- Increases Access to Clinical Preventive Services and Expands Incentives to Encourage Primary Care and Prevention
  - Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services
  - Authorizes a grant program for the operation and development of school-based health clinics
  - Increases the federal medical assistance percentage (FMAP) to states that expand access to preventive services for Medicaid-eligible adults
  - Establishes a grant program in Medicaid that provides incentives for healthy lifestyle initiatives to prevent chronic disease
  - Makes community transformation grants available to promote individual and community health and prevent the incidence of chronic disease

The PPACA loosely stipulates the parameters of delivery system redesign, but the nuts and bolts of implementing reforms will largely be carried out at the community and local levels. It remains unclear what effect the implementation of these reforms will have on populations and health systems at the state and local level.

LOOKING TOWARDS THE FUTURE

With landmark legislation already signed into law, the challenge moving forward is in implementing delivery system reforms at the local level that maximize the system’s potential for delivering safe, effective, patient-centered, timely, efficient, and equitable care. This requires delivery system alignment across all levels of the care continuum. Looking ahead, the following areas are likely to become more salient as implementation unfolds:

- Demonstrating meaningful use. Successfully leveraging the potential of HIT to lay the foundation for delivery system reform will depend on a) defining ‘meaningful use’ criteria in a way that is actionable for providers and b) developing and implementing interoperable HIT systems that can then be meaningfully used at the local level of a provider practice or hospital. It is currently uncertain whether providers will be able to meet Phase I measures of meaningful use criteria by 2011 or the more comprehensive Phase II measures by 2015. Furthermore, it is unclear how EHRs will impact provider practice.

- Resources and capacity at the local level. It is unclear how already financially-strapped states will respond or be able to support delivery system reforms that may require some injection of state funds. Examples include expanding the Patient-Centered Medical Home in the adult Medicaid population, extending the Money
Follows the Person Demonstration project for long-term care supports and services, and collecting and reporting additional data to better measure and track quality.

- Training and professional development for the health care workforce. Transitioning from an episodic, acute model of care delivery towards prevention and population management will require provider buy-in, HIT alignment with provider needs, and training and professional development on how to manage a population. The foundations of prevention, including a strong primary care workforce and the metrics necessary to track, measure, and monitor population and community health, are currently insufficient to meet the increase in demand that delivery system redesign necessitates.

- The composition and distribution of the health care workforce. Seamless transitioning and coordination at all levels of care will likely require an increased but more focused role for care managers. Additionally, increased emphasis on prevention, wellness, and community-based supports will require defining new roles for health care workers. It is unclear if the present supply and training of the existing workforce is sufficient to meet an increase in demand.

- Patient and Community Level Readiness for Reform. Local readiness for healthy communities and the promotion of prevention and wellness to combat chronic disease will vary and will require extensive community outreach, education, and planning in order to successfully combat the problem.

SOME OPPORTUNITIES TO LEVERAGE FEDERAL INVESTMENTS

- Launch local marketing campaigns to increase awareness and visibility of the provisions of PPACA that have an immediate impact on local communities;
- Track and monitor the progress of provider experiences with EHRs and compliance with meaningful use criteria and their subsequent impact on cost and quality over time;
- Consider taking affirmative steps to help small provider organizations form local/regional strategic partnerships;
- Evaluate the readiness of the stakeholder community (providers, state and local public health agencies, consumer groups) to begin implementing PPACA provisions;
- Support implementation and evaluation studies of specific components of delivery system reform and their impact on patient populations (for example the elderly, dual eligibles, public health insurance beneficiaries, the chronically ill) and communities;
- Support the development and testing of data tools and systems that improve patient self-management (among the most important, those that help educate patients on appropriate use of medications); and
- Act as an informal and formal convener of local stakeholders and community groups to develop sustainable multi-stakeholder partnerships.
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The Schneider Institutes for Health Policy at the Heller School was founded in 1978, and conducts domestic and international research in the broad areas of financing, organization, value, high-cost and high-risk populations, and health technologies. The Schneider Institutes are made up of three research and policy groups: The Institute for Behavioral Health; The Institute on Healthcare Systems; The Institute for Global Health and Development.

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ix Ibid.


xiii L. Shugarman and G. Alkema, A Summary of the Patient Protection and Affordable Care Act (P.L. 111-148) and Modifications by the Health Care and Education Reconciliation Act of 2010 (H.R. 4872), (Long Beach: The SCAN Foundation, 2010).

xiv Ibid.


CONSUMER EDUCATION AND PATIENT ENGAGEMENT TO ENSURE THE BENEFITS OF HEALTH REFORM ARE ACHIEVED

The Patient Protection and Affordable Care Act (PPACA) is a substantial piece of legislation that seeks to improve the American health care landscape in a variety of ways. Among other goals, the PPACA strives to increase access to affordable insurance coverage while working towards structural and other changes that would keep future health care costs under control. The most prevalent goal, however, and the one concept that is nearly universally accepted is the desire to improve the quality of care across the United States (U.S.) for all citizens until it meets the highest of standards.

A significant part of the quality concern is how the U.S. can continue to better use prevention and wellness interventions to delay or avoid both acute and chronic diseases. This challenge will only be met if consumers and patients play an integral role in the development and implementation of the policies and programs that are intended to achieve these expected results.

Foundations will likely play a crucial role in bridging the gap between government and institutional change and individuals and families understanding and navigating new programs and systems. As we have seen with the recent implementation of the Medicare Part D benefit, it is often very difficult to translate good policies into efficient and accessible programs that provide their intended benefits to consumers in a clear and concise way. Likewise, all too often health decisions are made without fully informed shared decision making between clinicians, patients, and their families — a frequent commentary of those involved in end-of-life care. Foundations can help by taking the initiative to fund educational tools, campaigns, and programs that will empower consumers and patients and ultimately lead to a health care system comprised of informed people who recognize and value high quality care.

PROBLEM STATEMENT

The success of the reforms found within the PPACA rests on the assumption that consumers and patients will be able to better navigate their way around this new health care system. A related assumption is that they will be able to analyze information, such as quality reporting, in a way that helps them to navigate the system better. These assumptions may be problematic.
Researchers have identified a considerable gap in health literacy between patients and physicians. For a majority of Americans, understanding and comprehending medical and health information is a challenging task. Additional cultural and language barriers exist and exacerbate this problem for many individuals and families.

The internet has become a source of information for many patients, but individuals searching on-line still must locate and process information, and assess the veracity of what they read. The ‘digital divide,’ literacy gaps, and language barriers also mean that some of the most vulnerable citizens may be left behind. With these challenges in mind, the PPACA has identified different types of data and information that should be made available and easily accessible to the public. These data, including information regarding insurance options, quality measures, and eligibility will be presented on websites and in print formats. Without appropriate planning and guidance, however, there is the potential for significant usability challenges.

The most common concerns for individuals include the following:

- The website/materials are unreadable because of size and/or typeface issues
- Websites are difficult to navigate; there is too much information provided, and it is too difficult to find answers
- Websites and other material are not available in multiple languages
- Information is not culturally sensitive
- Information is misleading or inaccurate
- Concerns about data confidentiality
- Lack of public awareness about websites or difficulty finding the URL

Many, if not all, of these concerns will also be linked to the public health awareness and education components located in the PPACA. Each and every one of these concerns has the potential to reduce the effectiveness of knowledge transfer and adversely affect the outcomes of these campaigns. If policymakers, administrators, and clinicians intend to truly empower people, they must be certain to educate consumers and engage patients in a consistent and effective manner.

SUMMARY OF HEALTH CARE LEGISLATION

Provisions that will affect consumer education and patient protection can be found throughout the PPACA. The following is a brief summary of those parts of the Act that relate to these two areas.

Title II. The Role of Public Programs
- States will construct new websites that will serve as portals for Medicaid, CHIP, and Insurance Exchange application and enrollment. Individuals will be able to use these sites to quickly determine their eligibility for each of these programs.
Title III. Improving the Quality and Efficiency of Health Care
- A program will be created to increase access to coordinated, community-based care. This program will use community health teams and medical homes and encourage medication management services. A health delivery system research center will be established and it will seek to find best practices that improve the quality, safety, and efficiency of health care delivery.
- The new CMS Center for Innovations will focus on novel delivery and payment mechanisms that will ultimately lead to a better experience for patients at a lower overall cost.

Title IV. Prevention of Chronic Disease and Improving Public Health
- The Secretary of Health and Human Services (HHS) will establish, through a public/private partnership, a national prevention and health promotion education campaign. Federal funds will come from the newly created Public Health Investment Fund.
- There will be a new oral healthcare prevention education campaign
- Several new provisions will be adopted in both Medicare and Medicaid that encourage people to seek primary care services by reducing or eliminating all out-of-pocket costs.
- Medicaid will be required to cover tobacco cessation counseling and treatment for pregnant women
- States will receive grants for prompting Medicare beneficiaries to join programs providing incentives for health living.
- States can be awarded grants to promote individual and community health and prevent chronic disease among persons aged 55-64.
- Through the Centers for Disease Control and Prevention, employer wellness programs will be evaluated. The results will be used to disseminate best practices and an educational campaign will promote the benefits of worksite health promotion.
- New restaurant nutrition labeling standards will be implemented.

Title VI. Transparency and Program Integrity
- New systems will be implemented that force physicians, nursing homes, long-term care facilities and others to disclose relevant information that is currently not required. For example, the Nursing Home Compare Medicare website will eventually have standardized staffing data, certification confirmation, complaint forms, a listing of violations, and other information.
- The new Patient-Centered Outcomes Research entity will conduct comparative clinical outcomes research and provide this information to the public.

Title X. Strengthening Quality, Affordable Care
- The Act requires the creation of uniform standards for financial and administrative health care transactions.
- The Indian Health Care Improvement Act, whose components include increased access, health promotion and education, and innovative delivery models, is funded.
• Medicare is required to pursue prescription drug review through medication management programs.
• The law funds a new Medicare “Physician Compare” website that will provide information about doctors to Medicare beneficiaries.
• Small businesses are allocated funding for grants to provide and promote worksite wellness programs.
• The HHS Secretary will develop a national education campaign for young women and health care professionals about breast health and risk factors for breast cancer.

ANTICIPATED ISSUES OF HEALTH CARE REFORM IMPLEMENTATION

Consumer education is repeatedly mentioned throughout the PPACA. Many education programs and campaigns, such as those directed towards smoking cessation and cancer awareness, have been very effective in meeting their goals. Even so, there are several possible pitfalls that federal, state, and local authorities must consider as they move forward. The overarching issue that could derail implementation is a lack of consumer knowledge regarding the available benefits. Providing this knowledge involves two important steps. The first is raising awareness that benefits exist. The second is explaining those benefits, keeping in mind the audience(s) and any corresponding limitations (for example, a lack of internet access). Similar issues arise when reporting data on physicians, plans, or hospital quality. People must know that the information exists and how to access the information; and they must be able to understand what they are reading. This can be a much more difficult process than one might anticipate.

According to the PPACA, there are three main areas where patient engagement requires improvement: Patient compliance, disease management and prevention, and shared decision making. Each of these areas requires a patient or a patient’s family to be aware of their options and also what is expected from them. Shared decision making is particularly problematic because of the information asymmetry between medical professionals and patients. Constraints, such as time, can often limit the ability of a clinician to provide extensive options along with the pros and cons of each. Some patients may be too sick to fully comprehend their options, while others may not comprehend because of language or other barriers. In terms of patient adherence and disease management, a host of factors, including comprehension, financial constraints, logistical problems, lack of communication, and cultural barriers can lead to sub-optimal results.

SOME OPPORTUNITIES TO LEVERAGE HEALTH CARE FOUNDATION INVESTMENTS

The PPACA contains a multitude of implementation opportunities for foundations to supplement and enhance consumer education and patient engagement. These opportunities include but are not limited to the following areas:

• Website development has the potential to be the most important part of this legislation in terms of reaching a massive audience, with significant ramifications based on the
quality and usefulness of each site. Consumers have been promised websites focusing on:

- State Insurance Exchanges (including plan comparisons)
- State Medicaid/CHIP/Exchange eligibility and enrollment
- Nursing home quality
- Workplace wellness
- Health promotion and education
- Physician quality ratings
- Hospital quality ratings
- Comparative effectiveness of treatments and procedures

Each of these sites will require extensive content building and testing before they are viable. There are many opportunities for foundations to help shape these sites at local, state, and national levels, including the transfer of best practices from the private to the public sector.

- Once this information “goes live”, there will need to be a large public awareness and education campaign targeting consumers. Almost all consumers must learn how to interpret and analyze the data in order to maximize its potential benefits. This seems like a natural place for foundations to intervene.

- Foundations have a long history working with government and private entities on public health campaigns. This should be no different with the PPACA. Whether it be breast cancer awareness, access to health care services, oral health, or nutrition, foundations can make a significant difference in each of these ventures.

- Foundations are ideally situated to help implement many of the workplace health and wellness reforms contained within the PPACA. A careful review of current programs is needed along with the design of new programs sized to fit different types of businesses. Multiple businesses within a state or community can collaborate to share best practices via one overarching foundation grant.

- As we move towards more chronic disease management and patient-centered medical homes, there will be a need for educational and other resources in order to help individuals understand what these changes are and how they will be affected. Foundations partnering with hospitals, insurers, accountable care organizations, and others can provide this type of assistance.

- Patient engagement, particularly when end-of-life issues are involved, is an ongoing issue that will continue to require leadership and guidance. Foundations can lead this effort, bringing together the interested parties and furthering the dialogue surrounding this critical issue.
• Within the PPACA, there are several directives to evaluate most of its initiatives, from planning to implementation and beyond. These evaluations will be crucial, telling us what works, what does not work, and why. There is certainly a role in the evaluative process for foundations, and it is likely to be a major one.

This background paper was prepared by Jeffrey Sussman, MPH, PhD Candidate.

The Schneider Institutes for Health Policy at the Heller School was founded in 1978, and conducts domestic and international research in the broad areas of financing, organization, value, high-cost and high-risk populations, and health technologies. The Schneider Institutes are made up of three research and policy groups: The Institute for Behavioral Health; The Institute on Healthcare Systems; The Institute for Global Health and Development.

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PAYMENT REFORM

It is frequently stated that the United States (US) has a fragmented health care delivery system which is due in large part to the way in which providers are paid. Each provider is paid on an individual basis (for example, physician, hospital, occupational therapist) even though, depending on the needs of the patient, they need to work together to produce high quality care. US healthcare is also expensive, partly attributable to fee-for-service (FFS) — the predominant payment mechanism in the US. FFS provides higher revenues to physicians who provide more volume of services and with greater intensity, regardless of whether they add value; however, merely cutting FFS payments over time is likely to hurt both quality and access.

A reformed payment system should create incentives for quality over quantity and encourage accountability across the continuum of care. Over the last several years, numerous payment options have been discussed (i.e., recalibrating FFS, pay-for-performance, episode payments, and global payment approaches) to improve quality and slow cost growth. The Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010 includes a number of Medicare and Medicaid initiatives to change how providers are paid and care is delivered.

GOAL OF PAYMENT REFORM

The overall goal of payment reform is to find ways to reward providers financially for efficient use of resources while providing high quality care. To achieve this goal, payment reform strives to:

- Align the use of services with their clinical value. The current fee-for-service payment system creates a strong incentive to increase volume (the more you do the more you can bill.) However, under a value-based system, providers would be encouraged to think beyond individual encounters to an entire episode of care.
- Pay for quality. Currently, Medicare is a passive purchaser of health services. Payment reform is an effort to move Medicare to an active purchaser of high-value health care by linking payment to quality by utilizing performance measures which quantify health care processes, outcomes, organizational structures, and patient perceptions.
• Ensure the separation of performance and insurance risk. One goal of an effective health care payment system is to transfer some or all “performance risk” (the risk of whether a condition can be treated successfully for a specific amount of money) to providers, but keep “insurance risk” (the risk of whether a patient has an illness or other condition requiring care) with the insurance company.

• Adjust properly for patient-level severity. There should be an adjustment where provider reimbursement would be based on the number and severity of the patient’s conditions and characteristics. Proper patient-level severity adjustment ensures that providers receive more money for treating sicker patients.

• Alignment of a critical mass of payers to develop a common payment methodology. Since Medicare is the dominant payer in the market, it can take the lead to create payer alignment while respecting anti-trust regulation. Alignment of a significant number of payers would allow the delivery system to make necessary changes to the structure of delivery processes.

• Better align Medicaid payment policy with industry best practices. Each Medicaid program uses different payment rules, including those in some states that continue to pay hospitals based on cost (an approach generally abandoned for being inefficient.) Moreover, Medicaid payment rates tend to be low relative to both Medicare and private payers. In order to move into more innovative, value-based approaches, Medicaid needs to update both payment methods and levels.iv

SUMMARY OF HEALTH CARE LEGISLATION

The PPACA alters perverse incentives by linking payment to quality in the Medicare program.

• Beginning in FY 2012, it adjusts payments to providers paid under the inpatient prospective system with high rates of hospital readmissions.

• Beginning in FY2013, it establishes value-based purchasing to provide incentive payments to hospitals that meet quality performance standards for common, high-cost conditions.

• It reduces payments to hospitals with high rates of hospital-acquired infections.

• It extends funding for the Physician Quality Reporting Initiative (PQRI) through 2014.

• It establishes a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals, and hospice programs by FY2014.

The PPACA includes numerous initiatives to examine new payment mechanisms primarily through the Medicare and Medicaid programs.
• The Accountable care organization (ACO) Medicare and Medicaid demonstrations will begin in 2012. An ACO is made up of several providers who work together to offer higher quality care at a lower cost for a given panel of patients. Unlike many quality improvement initiatives that focus on the individual provider, the ACO concept shifts attention to shared accountability at the organizational or systems level. Here, providers can realize (and hopefully retain) savings by moving patients through the system efficiently (for example, cardiac rehabilitation after a heart attack rather than increased reliance on medication). The ACO payment system generally involves either shared savings (the ACO keeps a portion of what it saves payers) or partial capitation. Payment models also vary in the amount of risk that is shifted from payer to provider. How to organize ACOs in the real world remains a challenge – leading ideas include virtual networks of physicians centered on a hospital or collaborative networks built around independent practice associations (IPA).

• The Patient-Centered Medical Home Demonstration project will provide Medicare beneficiaries who have multiple chronic conditions with coordinated and comprehensive care through the use of primary care providers (PCPs). The demonstration project enables the Department of Health and Human Services (DHHS) Secretary to award grants to states for the establishment of health teams to support the PCPs and to provide capitated payments to the PCPs in addition to the usual FFS payments. Additional medical home demonstrations will focus on women’s health and high-need beneficiaries.

• Bundled payment is a payment approach frequently discussed by policy makers which would make a single payment for all services related to a particular condition. This is common in maternity care, for example, where insurers pay a lump sum for all prenatal care and an uncomplicated delivery. Like ACOs, the goal of this approach is to encourage providers to work together, as the single payment would likely include multiple providers across multiple settings of care. The PPACA includes two bundled payment demonstration projects. The first is a Medicaid demonstration which will begin in 2012 in up to 8 states. The demonstration will pay for hospital and physician services around a hospitalization. The second demonstration will be held in the Medicare program which will bundle payments for hospital, post-acute, and ambulatory services. The program, which will begin in 2013, will focus on ten specified (yet-to-be-determined) conditions. A global payment system demonstration project is also planned in up to five states. Safety-net hospitals in participating states will be paid via capitation instead of fee-for-service.

• Value-Based Purchasing (VBP) is a payment model where providers are reimbursed on the basis of quality of care, rather than just the number and type of services provided. Quality measurement is central to this approach since physicians or provider organizations receive a portion of their payment by achieving certain performance benchmarks or improving their overall performance over time. Under-performing
organizations are penalized by losing withhold (a portion of the payment retained by insurers to create a pool for rewarding quality.) The PPACA established a physician VBP program, which will begin in 2011, and a hospital VBP program, which will begin in 2013.

- The PPACA has also established a Center for Medicare and Medicaid Innovation (CMI) within the Centers for Medicare and Medicaid Services (CMS). Beginning in January 2010, the Center will begin to test innovative payment and care delivery models for the Medicare and Medicaid programs. The CMI should have several advantages over the traditional CMS research approach. Rather than run demonstrations, that can take up to 5 years to produce results, for example, the CMI may consider running a larger number of pilots to produce information more quickly. The CMI should also have more flexibility to test different models and will have resources to run projects that violate the general CMS rule of budget neutrality.iii

LOOKING TOWARD THE FUTURE - CMS APPROACHES TO LEGISLATIVE MANDATES AND ACHIEVING PAYMENT REFORM GOALS

| Comparative Effectiveness | Supports comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of different medical treatments.
| | The findings from comparative effectiveness research will not be used as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage.
| Physician Quality Reporting Initiative (PQRI) | CMS will provide information to physicians and hospitals on their performance by measuring resource use and providing feedback.
| | The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) specifically requires the DHHS to disseminate confidential feedback reports to physicians using episode groupers.
| Shared savings | The "shared savings" payment model, an extension of the Medicare Physician Group Practice Demonstration, would be given to group practices if the total cost of services to the patients they manage is below expected levels.
| | A limitation of this model is that it does not provide upfront capital to invest in practices. |
### Bundled Payments

The bundled payment model seeks to combine physician and hospital inpatient payment for services that are complementary, so that they can be coordinated effectively in addressing a patient’s condition(s).

Bundled payment would allow the provider system the flexibility to determine which services, and how many services, are appropriate for the patient.

The limitation of inpatient bundling is that it may encourage the shifting of medical procedures to outpatient settings.

### Bundling across providers: Virtual Bundling and Accountable Care Organizations (ACO)

**Virtual Bundling:** In this scenario, the payer continues to pay each of the providers independently for specific services they deliver to a patient or group of patients, but the payer adjusts each provider’s payment according to a pre-defined rule in order to ensure that the total payments to all of the providers for all of the defined services do not exceed a total bundled payment amount.

**Accountable Care Organizations:** In a “true” bundled payment, one provider would be accountable for using the bundled payment to achieve the best possible outcome for the patient and for dynamically adjusting the payment allocation based on the way care is changed.\(^{vi}\)

### Episode of Care (EoC)

One technique for comparing resource use of physicians and hospitals may be at the episode of care level. These episodes of care would represent a group of healthcare services for a health condition over a defined period of time for which a physician can be held responsible.\(^{vii}\)

Medicare will be developing an episode grouping software that would organize claims data into a set of clinically coherent episodes, usually linked by diagnosis.

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**SOME OPPORTUNITIES TO LEVERAGE HEALTH CARE FOUNDATION INVESTMENTS**

Foundations have long been involved in the design and implementation of innovative health care financing strategies. PPACA provides new opportunities for foundations to dovetail with or otherwise advance the evolving payment and delivery system. Although specific initiatives will vary depending on the mission of a given foundation and the environment in which it operates, there are several activities that may prove useful. First and foremost, foundations can serve as neutral conveners of conversations across the delivery system. This can take many different forms, such as bringing together private and public payers to share information...
(for example, the creation of an all-payer data base) or bringing together a broader range of stakeholders to work towards a common goal, such as regional ACOs, health insurance reform, or the development of new delivery strategies to address a specific concern. Other strategies include:

- Developing the business case for change. This includes state and regional analyses on the cost and quality of care.

- Public agenda setting. Working with advocacy groups and other stakeholders to make health reform a policy priority. Agenda-setting may be the by-product of local and regional meetings designed to address a specific health priority, such as hospital readmissions or infant morbidity and mortality. Including policy makers in these conversations can have a large payoff in terms of aligning consumer and business interests with policy priorities.

- Public reporting of quality metrics. Value-based purchasing and other techniques put a premium on measuring and reporting quality to providers. However, sharing this information with the public puts additional pressure on providers to improve. Any public reporting effort should pay special attention to patient mix, making sure that providers who treat sicker patients are not penalized.

- Analytic work to design or test measures. Although there has been an explosion in measure development over the past few years, many measures are not ‘actionable’ or generalizable beyond a specific disease subgroup (for example, individuals with diabetes.) Measures also rely heavily on claims or survey data, which lack important clinical detail.

- Bringing the consumer voice to the table. Health reform is unfolding quickly – states need to prepare for Medicaid reform, insurance exchanges need to be created, and new delivery and payment strategies need to be tested before broad roll out. Given the fast pace of reform, it is easy to leave out the voice of consumers. Foundations are well positioned to solicit and share this important perspective through focus groups, interviews, and funded research.

This background paper was prepared by Taroon Amin, PhD Student, Christina Marsh, PhD Candidate and Jennifer Perloff, PhD.

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i RE Mechanic and SH Altman. Payment Reform Options: Episode Payment is a Good Place to Start. Health Affairs (2009).


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viii RE Mechanic and SH Altman. Payment Reform Options: Episode Payment is a Good Place to Start. Health Affairs (2009).
MEDICAID, CHIP, AND THE HEALTH CARE SAFETY NET

Medicaid is considered the “workhorse” of the United States health care system. Medicaid and its sister program, the Children’s Health Insurance Program (CHIP), provide health care coverage to nearly 67 million low-income individuals. In terms of enrollment, Medicaid is the largest public health insurance program in the U.S. Medicaid provides crucial support to the nation’s health care “safety net,” including hospitals and community health centers, and is the largest payer of long-term care services and supports for the elderly and disabled. Under the Patient Protection and Affordable Care Act (PPACA), Medicaid is expected to account for more than half of the reduction in the number of the uninsured and will continue to occupy a major role in the gradual movement towards a universal health care system.1

Under PPACA, Medicaid will change substantially, most significantly by the mandated nationwide coverage of all non-Medicare eligible individuals at or below 133% of the Federal Poverty Level (FPL), effective January 1, 2014. This change alone is expected to result in coverage of at least 16 million uninsured individuals.1,2 Additionally, PPACA adjusts the Medicaid financing states receive from the federal government, payments to providers, provision of long-term care services and supports to the elderly and disabled, and funding and staffing support for community health centers. Collectively, these provisions set the stage for significant transformation of the health care delivery system and will afford providers – both safety net and not – numerous opportunities to participate in the implementation of new models of health care financing and delivery.

PROBLEM STATEMENT

Although many of the most significant Medicaid provisions within the Patient Protection and Affordable Care Act (PPACA) do not go into effect until January 1, 2014, state Medicaid and CHIP agencies and health care safety net providers know they must plan diligently for the anticipated influx of newly insured patients into the safety net. States must make key decisions on how to simplify and fast-track eligibility and enrollment procedures, ensure access to care, and transform how care is delivered while navigating shifting federal financing for Medicaid, all within the midst of a slow economic recovery. Currently, one state (Connecticut) has expanded its Medicaid program, while others have, for the time being, decided not to expand coverage due in large part to ongoing fiscal concerns and uncertainty about a temporary extension of federal funding for Medicaid.3,5
There are a variety of opportunities for health care foundations to support the tremendous changes that will need to take place prior to January 1, 2014 in order to support a high-performing safety net under national health care reform. A recent report by the Commonwealth Fund identified several areas in which the health care safety net’s capacities could be enhanced, including: obtaining off-site specialty care for Medicaid and uninsured patients; building upon community health centers’ capacities to serve as a medical homes to ensure high quality, low cost health care; and improving health information technology infrastructure beyond electronic medical records to support more timely, appropriate, and effective care. These are only a few of a variety of opportunities that foundations have to support the health care safety net during a period of significant transition under national health care reform.

SUMMARY OF HEALTH CARE LEGISLATION - MEDICAID AND CHIP

The Patient Protection and Affordable Care Act (PPACA) establishes a mandatory, nationwide floor of 133% of the FPL ($29,326 for a family of four in 2010) for all non-Medicare eligible individuals, effective January 1, 2014. Medicaid coverage varies widely from state to state, characterized by an income floor ranging from 50-133% depending on the eligibility “category” in which individuals fall. PPACA equalizes the income floor across states, eliminates asset and resource tests, effectively eliminates categorical eligibility, and is expected to result in an expansion of Medicaid coverage to at least an additional 16 million individuals. Consistent with current Medicaid regulations, undocumented immigrants are ineligible for Medicaid. States that have previously been more generous with their Medicaid coverage are likely to see minimal increases associated with expansion (1-2% between from 2014-2019) while states that have been less generous are likely to see more substantial increases (3-5%). States may elect to expand Medicaid coverage prior to January 1, 2014.

States may also use designated “Express Lane Agencies” to streamline eligibility and enrollment. The “Express Lane Eligibility” (ELE) option was introduced through the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to encourage states to identify and enroll eligible individuals more efficiently. Under the provision, state Medicaid/CHIP agencies may use existing information available from approved public agencies to identify and enroll eligible individuals into Medicaid and CHIP. States’ participation under the ELE provision is voluntary. Currently, Alabama, Louisiana, and New Jersey have approved ELE proposals.

Under PPACA, Medicaid beneficiaries must be provided with “benchmark” coverage that mirrors one of the following: 1. Coverage provided through the Federal Employee Health Benefits Program, 2. Coverage provided through states’ employee health benefits programs, or 3. Coverage provided through an HMO with the largest commercial, non-Medicaid enrollment in a state. Medicaid benefits may differ from benchmark benefits if approved by the Secretary of the Department of Health and Human Services (DHHS).

Effective January 1, 2014, the federal government will finance 100% of the costs of coverage for all newly eligible Medicaid beneficiaries (i.e., those individuals not eligible for Medicaid prior to the passage of PPACA). This Federal Medical Assistance Percentage (FMAP) decreases
gradually to 93% by 2019. States that have expanded coverage prior to January 1, 2014 will receive federal financing at current levels, but will receive the enhanced FMAP effective January 1, 2014. Overall, the cost of the Medicaid coverage expansion is estimated by the Congressional Budget Office (CBO) to be $434 billion and $20 billion, for the federal and state governments respectively, from 2014-2019.²,³ The fiscal liability of the states depends heavily on their previous generosity with Medicaid coverage and the percentage of individuals enrolling in Medicaid deemed newly eligible. Most states can expect a 1-2% increase in Medicaid coverage costs.⁷

PPACA increases Medicaid fee-for-service (FFS) and managed care reimbursement for primary care physicians (PCPs) to Medicare levels for 2013 and 2014, funded 100% by the federal government. In anticipation of a reduction in the cost of uncompensated care, Medicaid disproportionate share hospital (DSH) payments will be reduced by $14 billion from 2014-2019, inversely proportional to the percentage of uninsured in each state.

With respect to CHIP, states must maintain current eligibility levels for the program until 2019. Effective January 1, 2014, all CHIP-eligible individuals with family incomes between 100% and 133% of FPL will be transitioned to Medicaid. CHIP-eligible children not enrolled in the program due to federal allotment caps will be screened for eligibility for Medicaid and, if found ineligible, will be provided with tax credits for coverage under a state Health Benefit Exchange plan that is deemed actuarially equivalent to states’ CHIP plans by the DHHS Secretary. Funding for CHIP is extended through 2015 and, beginning that year, states receive a 23 percentage point enhanced FMAP up to 100%.²

COMMUNITY HEALTH CENTERS

The Patient Protection and Affordable Care Act provides $11 billion in funding (from 2011-2015) to federally qualified health centers (FQHCs), $1.5 billion of which may be used for capital improvements. An additional $1.5 billion is allotted to the National Health Service Corps in the form of scholarships and tuition remission to increase the presence of primary care physicians in Health Professional Shortage Areas. Funds are also provided to FQHCs that serve as “Teaching Health Centers” by developing primary care residency programs. Collectively, these provisions support the goal of providing high-quality, low-cost primary care to the uninsured through the health care safety net.

LONG-TERM CARE

Long-term care services and supports account for more than one-third of all Medicaid spending and more than two-thirds of all Medicaid spending for the elderly. Medicaid is the largest payer of long-term care services and supports, more than half of which is institutionally-based.¹

Under the Patient Protection and Affordable Care Act (PPACA), long-term care for the elderly and the disabled is supported by several provisions: expansion of home and community-based services and supports through state plan amendments; the Community Living Assistance
Services and Supports (CLASS) Act; the “Community First Choice” option; and the extension of the “Money Follows the Person” demonstration.

State plan amendments allow states to provide home and community-based services and supports to individuals at or below a threshold of 300% of social security income without having to submit waivers on a case-by-case basis. The CLASS Act establishes a voluntary (opt-out) national insurance program similar to Social Security in which workers pay into the program (a trust fund) throughout their working lives and then draw a cash benefit (no less than $50/day and dependent on functional limitations) that defrays the costs of long-term services and supports. The Community First Choice option is available to individuals <150% of the FPL with disabilities to encourage them to use home and community-based supports and services as an alternative to institutionally-based care. The Money Follows the Person demonstration is a federal initiative included in the Deficit Reduction Act of 2005 and likewise encourages individuals to consider home and community-based alternatives to institutionally-based care. The demonstration provides an enhanced FMAP to states that successfully move individuals out of institutions and into the community. Collectively, these provisions encourage expanded use of home and community-based services and supports and decreased reliance on institutionally-based care.

In addition, a newly established Federal Coordinated Health Care Office will improve coordination of benefits for dually eligible beneficiaries. Dual eligible beneficiaries rely heavily on Medicaid to cover Medicare costs as well as for services not provided under Medicare, long-term care in particular. Nearly 9 million in number, these individuals are the poorest, sickest, and costliest, accounting for nearly 50% of Medicaid expenditures.

ANTICIPATED ISSUES OF HEALTH CARE REFORM IMPLEMENTATION

Despite the enhanced Federal Medical Assistance Percentage (FMAP) for the newly eligible, the federal government’s share of financing will closely track its current FMAP, which means many states are likely to see an increase in Medicaid expenditures of at least 1-2%. Additionally, the Medicaid expansion paired with the individual mandate is likely to create a “welcome mat effect” and draw out individuals who are currently eligible, but not enrolled.\textsuperscript{10} States will be required to cover these individuals at their current FMAP, which may present a further budgetary challenge.

Additionally, the slow economic recovery has depleted states revenues while at the same time increasing demand for Medicaid coverage. Prior work has shown that a 1% increase in the national unemployment rate results in a 3-4% decrease in state revenues and an increase in the uninsured of 1.1 million, 1 million of whom are likely eligible for Medicaid/CHIP.\textsuperscript{11} The national unemployment rate has hovered between 9 and 10% for more than a year and prior work has shown that ongoing unemployment at this level is expected to create a shortfall of at least $125 billion in states’ budgets for Medicaid/CHIP funding.\textsuperscript{11,12} The financial liability for states depends heavily on states’ prior generosity with Medicaid coverage and what categories of people (e.g., newly eligible v. currently eligible) enroll in Medicaid.\textsuperscript{6} However, for
most states, health care reform means that Medicaid deficits will increase before they decrease.

States that participate in Medicaid must establish websites that allow individuals to apply for and renew Medicaid and CHIP benefits. Whether or not states elect to designate Express Lane Agencies, resources will need to be committed to planning and coordination among public agencies to ensure a simplified application process, accurate enrollment, and secure sharing of data. States’ existing enrollment procedures will not do. Additionally, states that have expanded Medicaid coverage beyond 133% of the FPL will need to establish a system that will successfully transition individuals above 133% of FPL to a Health Benefit Exchange plan. States are prohibited from modifying eligibility for children (adults) between the enactment of the legislation on March 23, 2010 and 2019 (2014). However, states retain discretion over benefits (above the minimum) and exercise some flexibility in provider reimbursement rates (except in the case of primary care, which will be 100% federally financed in 2013 and 2014). Additionally, states are prohibited from capping enrollment into community and home-based services and supports.

The Patient Protection and Affordable Care Act (PPACA) presents both opportunities and challenges to the health care safety net. While Federally Qualified Health Centers (FQHCs) benefit from $11 billion in funding and an influx of Medicaid dollars, safety net hospitals face definite revenue losses from eliminated disproportionate share hospital payments and possible revenue gains from the influx of new Medicaid patients. Whether or not safety net hospitals will realize revenue gains by attracting newly insured non-Medicaid patients depends on the position – in terms of provider mix, payer mix, and capital investment among others – of safety net hospitals relative to their non-profit and private competitors. The overall financial outlook for safety net hospitals at this point remains unclear.

Safety net hospitals are likely to see a spike in demand for specialty care services because of the influx of newly insured patients and the role of safety net hospitals in meeting the “excess demand” for specialty services not normally provided by CHCs. Additionally, an aging Medicaid population requiring increasingly complex care will contribute to the demand for specialty services and points to a need for safety net providers at all levels to work collectively to provide high-quality, coordinated care.

In thinking about staffing the health care safety net, states will need to make decisions to maintain funding for primary care physicians (PCPs) at current levels after 2014, when federal funding expires. Additionally, despite $1.5 billion in funding to increase the presence of PCPs in Health Professional Shortage Areas, there will be a lag of several years between the expected influx of new patients and the supply of PCPs in these areas.

OPPORTUNITIES TO LEVERAGE HEALTH CARE FOUNDATION INVESTMENTS

Some illustrative examples of how health care foundations can support the provision of high-quality, low-cost health care to low-income individuals through the health care safety net include:
• Encouraging the development of formal linkages among providers – both inside and outside the health care safety net – for the provision of ambulatory and inpatient care, in particular specialty care for Medicaid and uninsured patients. These linkages might be based on the concept of accountable care organizations (ACOs), which are provider-managed organizations responsible for the entire spectrum of care, including quality and costs, for a defined population. ACOs may take a variety of organizational forms, but the essential element of a successful ACO is a strong foundation in primary care.14

• Enhancing safety net providers’ capacity to operate as medical homes to ensure high-quality, low-cost health care. In support of the preceding recommendation, safety net providers functioning as medical homes may take the helm in providing a strong primary care foundation for their patients. Foundations could provide crucial support in enhancing safety net providers’ existing infrastructure to satisfy National Committee for Quality Assurance standards for provision of care as a medical home.6

• Examining and evaluating models of long-term care services and supports that promote a medical home model of care. Likewise, as PPACA contains a variety of provisions that encourage the provision of long-term care services and supports in the community and the home, foundations could work with long-term care providers to identify measures of success for coordination and quality of care that ensure individuals successfully age in a place of their choosing.

• Supporting the efforts of the National Academy for State Health Policy, the National Governors Association, the National Association of Insurance Commissioners, and the National Association of State Medicaid Directors to share states’ experiences, issues, and solutions.

• Providing straightforward information to the public on what coverage and care options are currently available as well as what changes will take place under PPACA. Particular attention should be given to the breadth and quality of services at safety net hospitals and community health centers as well as to long-term care options, especially home and community-based services.

These funding opportunities are not exhaustive and, by working with safety net providers foundations can identify additional areas where support for the provision of high-quality, low-cost health care to low-income individuals through the health care safety net would be critical.

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IMPROVING WORKFORCE EFFICIENCY

Developing and training a health care workforce to meet the increased demand on services due to an increase in access from health reform, an aging population, and an increase in the prevalence of chronic illness is a challenge for the United States healthcare system. The passage of the Patient Protection and Care Affordability Act (PPACA) and its phased rollout over the next few years will offer a new lens through which to examine a set of philanthropic strategies, some new and some already familiar to foundations. Although the PPACA does not explicitly suggest partnerships with foundations, reexamination of foundation strategies is certainly an activity worth employing given the sweeping changes anticipated in the delivery and payment systems.

Mark Miller, Executive Director of the Medicare Payment Commission recently challenged health policy experts to conduct more research on how many professionals will be needed to implement the policy challenges of PPACA, as well as to identify competencies in a system that will be more coordinated and quality focused than in the past. In other words, analyses of how physician and nurse shortages — and training/education — figure into the new PPACA. Thus, a knowledge building agenda is needed by foundations to explore the education, training and supply of healthcare workers against the requirements of the PPACA.

PROBLEM STATEMENT

Unlike most industrialized countries, the United States has barely any semblance of a health workforce strategic plan. One probably is not surprised to learn that the preparation of each generation of health workers is just as fragmented and confusing as the health care system they will one day join. The nation’s healthcare delivery system is a reactionary model in which acute illnesses and specialty care dominate. This model has led to unsustainable spending and utilization growth. Researchers have identified three key areas that will drive the conversion from the current system to a new one focused on primary care, disease prevention, and care coordination for chronic illness. First, there are serious doubts that the current healthcare workforce is sufficient in size to provide the care needed today, let alone in the future as the population continues to age. Second, the current composition of the health care workforce is not optimal. For example, the U.S. is
well known for having a significantly higher ratio of specialists to generalists, compared with its European counterparts. In addition, there is a deficit of nurses, direct care, and mental health workers, among others. Third, the geographic distribution of the healthcare workforce is contributing to the current problem because some areas, usually big cities and the surrounding regions, have more capacity than they need while other locales, particularly inner cities and rural areas, experience significant healthcare provider shortages. In those areas, known as federally designated health professional shortage areas, the Health Resources and Services Administration projects that an additional 7,000 physicians are needed right now. These issues can only be addressed by implementing significant changes in health workforce education and training.

The lack of a coordinated health care workforce is already a problem and it is anticipated to worsen. According to a recent report from the Congressional Research Service:

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Today’s health care provider shortages are projected to increase based on growing patient demand for services. HRSA estimates that by 2020 there will shortages in a number of physician specialties and nearly 67,000 too few primary care physicians. Additionally, a federal advisory group on the nursing workforce estimates that as of 2000 there was a 6% shortage of nurses and that this shortage is expected to grow to 20% in 2020. Enactment of PPACA is likely to further exacerbate health workforce shortages as the newly insured seek health care services.

The concern about increased workforce shortages is warranted based on the recent Massachusetts experience after it enacted similar legislation in 2006. Even with many measures implemented to increase access to health care services, Long and Stockley report that “In fall 2009, one in five adults in Massachusetts reported that they had not received needed health care, and one in seven reported an emergency department visit for a nonemergency condition." This news, combined with an aging population and an aging healthcare workforce, helps emphasize the importance of the healthcare workforce provisions in the PPACA.

Title V of the PPACA identifies 6 areas relating to the health care workforce. Each area is briefly described below:

Innovations in the Health Care Workforce

- A National Health Workforce Commission as well as a national and regional workforce centers will be created as a means to monitor the nation’s workforce needs.
- Grants will be available for states to conduct comprehensive workforce planning and create workforce development strategies
Increasing the Supply of the Health Care Workforce

- Improve and enhance federal student loan programs for a variety of health professions including primary care and geriatric physicians, nurses, allied health workers, public health workers and people working in underserved areas.

Enhancing Health Care Workforce Education and Training

- Training opportunities and grants for primary care, dental, mental health, nursing, public health, and direct care programs.
- Education and training grants for those working with individuals with disabilities
- Education and training grants for improved cultural competency across health professions
- Grants to improve the community health workforce
- Grants to improve the rural health workforce

Supporting the Existing Health Care Workforce

- Increased scholarship support for minority applicants for health professions
- Primary care extension program to educate providers about evidence-based therapies, health promotion, chronic disease management, and mental health

Strengthening Primary Care and Other Workforce Improvements

- Gives the HHS Secretary increased discretion to redistribute unfilled residency positions and modifies rules for residency training programs
- Increases funding for primary care residency programs at teaching health centers
- Establishes a demonstration program to increase graduate nurse training

Improving Access to Health Care Services

- New and expanded funding for federally qualified health centers
- States and medical schools will be eligible for grants to support the improvement and expansion of emergency medical services for children
- New funding for coordinated and integrated services through primary and specialty care in community-based mental health settings.
- Creates a Key National Indicator System and Commission

ANTICIPATED ISSUES OF HEALTH CARE REFORM IMPLEMENTATION

Although much of the legislation pertaining to workforce issues appears straightforward, states have a very difficult task as they seek to address their deficiencies in health care workforce planning and implementation. The biggest barrier to effective planning is the current lack of reliable estimates of the current healthcare workforce. There have been repeated calls for national, regional, or state databases that would contain up-to-date information about the workforce that could be analyzed and then used for planning purposes. This would include information about all health professionals and also direct care workers, along with family
caregivers. Without this information it is extremely difficult to accurately determine future health workforce needs.

Another challenge for states will be to leverage all of the opportunities for grants and federal assistance while facing tough economic circumstances that have likely decreased their capacity for this very type of endeavor. Put another way, there are legitimate concerns about states’ capability to apply for the available assistance, and if they receive funding whether they will have the infrastructure in place to implement effective policies and programs.

THE PIPELINE: RECRUITING AND TRAINING FUTURE HEALTHCARE WORKERS

Connecting young people to careers in healthcare is critical for youth and for society. A flourishing and employed youth sector is a vital customer base, an economic development stimulus, and a check on further declines in poverty in low-income neighborhoods. A landscape of economically-pressured families with young people who lack the skills to drive economic growth is an untenable picture of life in America.

To make communities healthy — places where people want to work, live, and play — some policy advocates recommend the dual goal of promoting economic self-sufficiency among disconnected youth and of creating viable employment opportunities. The healthcare sector is vital to achieving this goal. It can offer many and varied opportunities for training in both entry level and advanced educational settings for young people.

Vocational education, career and technical education, tech-prep, youth entrepreneurship, school-to-work transition activities, apprenticeships, academies, internships, charter schools with a career focus – these are all separate yet similar strategies for connecting vocational sectors (such as health) with classroom and worksite education. One particular model that has been well documented by the NYC-based MDRC is Career Academies. These small ‘schools within schools’ can be found in over 2500 high schools in America. In addition to work-based learning and traditional educational practices, each school is focused on a sector. The healthcare sector comes in along with other career foci such as business, finance, hospitality, or computer technology.

OPPORTUNITIES TO LEVERAGE HEALTH CARE FOUNDATION INVESTMENTS

There are numerous examples of the PPACA’s connection to the education and training of healthcare workers:

- PPACA’s primary concerns are quality and safety, and therefore, we can expect a greater focus on a better prepared workforce, a diversity of continuous learning opportunities, a sharp focus on preventable medical errors, new training technology deployed to all tiers of medical and health workers, and work redesign initiatives. Recommendation: Medical error training and use of new training technologies are just a few areas in which foundations might play a role strengthening training and incumbent worker career paths. Grantmakers In Health funding partners have
acquired a deep understanding of appropriate foundation roles through previous experience with business groups, local coalitions, providers and in some cases, the human resources/training units of employer/providers. These lessons might be summarized and examined against the backdrop of PPACA to guide future development of foundation roles.

- PPACA is also focused on safety net challenges. There is funding, for example, for creating a ladder of career development opportunities for community health workers. This influx of funding and support will become increasingly important, especially as new immigrant groups and others seek advancement in the healthcare sector. One brief example of this “safety net” challenge is a study by the Center for the Health Professions at the University of California, San Francisco. This research examines the role of medical assistants (MA) in community clinics where the utilization of MAs has been growing. Improvements in clinic operations (for example moving people through the centers) are documented, but the study also notes training challenges that were barriers to expanding utilization of MAs. The authors report that traditional MA education and training does not adequately prepare MAs for clinical database management or roles in patient education; and, as a consequence, the career paths for the MAs are compromised. Foundations can find many roles to play in assisting neighborhood health centers and healthcare personnel with the new demands from technology and other sources under PPACA.

- PPACA addresses work and career development in other ways. For example, through state legislation, the Act allows localities to build training and licensing for certain employees which would ultimately support and contribute to the central functions of comprehensive primary care centers. Foundations should monitor state policy efforts around licensing and encourage, as needed, inclusion of new competencies promoted by the PPACA.

- PPACA is encouraging comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute. Foundations can both influence and benefit from this type of patient outcomes research. For example the new group’s agenda might involve studies that measure the impact of work design and training initiatives on patient outcomes. Pilot programs and demonstration are also cited in the Act with at least five pilot projects and 30 demonstrations mentioned. There are opportunities to ensure that quality and safety concerns, the nature of work settings, and on-the-job-training are considerations in the patient-centered outcomes agenda.

- PPACA offers grants to states to conduct comprehensive workforce planning and create workforce development strategies. Many foundations have an extensive background in this area and could supplement federal resources in order to ensure that states are able to maximize their resources and create lasting infrastructure to support long-term planning efforts.
• Much of the PPACA legislation explicitly or implicitly requires data that will need to be analyzed in order to identify needs at the state-level. In many cases it may be beneficial for foundations to partner with states to identify, collect, analyze, and disseminate this data in a timely manner.

• Despite its extensive set of reforms, PPACA is somewhat limited in its attempts to address the family caregiver component of home and community health care. This did not appear to be a primary concern as part of this legislation, but the importance of family caregivers cannot be understated. There is an opportunity for foundations to examine ways to better integrate these individuals into the new models of care.

• Funders can benefit from learning about prior attempts by philanthropic organizations to shape the health care workforce. One such history can be found at the Robert Wood Johnson Foundation, which has worked to shape the health care workforce for over two decades. A key lesson learned is that any vision must be clear and all goals should be apparent and concise and take into consideration the variability of local and regional labor markets. For any PPACA component that offers the opportunity for Foundation involvement there must be reasonable and specific pathways that can be articulated in a manner that avoids confusion and offers the best possible chance for success.

Although the focus of this paper is the PPACA, other legislation needs to be noted for its direct connection to the health workforce field. The Health Information Technology for Economic and Clinical Health (HITECH) amends the current Public Health Act by adding new funding opportunities to advance health information technology. Under HITECH, millions of dollars will be directed toward community colleges to help prepare young people on new technological advances as they are trained to work in the healthcare sector. Recommendation: with the support of foundations, high schools and community colleges have an opportunity to renew models of healthcare training and redesign to build on modern IT application in health settings.

This background paper was prepared by Andrew Hahn, PhD and Jeffrey Sussman, MPH, PhD Candidate.

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