NATIONAL HEALTH POLICY
FORUM

# ANNUAL REPORT

## 2012

JANUARY 1 TO DECEMBER 31

## DIRECTOR'S MESSAGE

During its 40th anniversary year, the National Health Policy Forum remained true to its original mission of providing a safe haven for federal health policymakers to engage in thoughtful dialogue. While the specifics have changed as both federal and private-sector programs have grown more numerous and complex, many of the problems confronting policymakers in 1972 remain. Health care is still fragmented, expensive, and not always of the highest quality. And we are still searching for the most appropriate way to pay providers to ensure efficient, high-quality care and improved outcomes.

Not surprisingly, costs were a key focus of many of the Forum's activities in 2012. In one session, time was spent teasing apart the costs and characteristics of individuals dually eligible for Medicare and Medicaid, for example, to dispel the commonly held misconception that all duals are expensive, allowing policymakers to focus on those who truly do incur high costs. A similar session focused on high-cost Medicare beneficiaries. Both sessions pointed to the importance of targeting interventions to help ensure that cost savings are actually achieved, something that has been elusive in most demonstrations and initiatives to date.

The Forum also continued its dialogue about paying for physicians' services under Medicare, highlighted problems with other Medicare payment systems, and provided opportunities to learn about new payment approaches, such as bundling. Sessions on Medicaid managed long-term services and supports (MMLTSS) called attention to states' efforts to control their Medicaid budgets through expanded use of managed care. Whether MMLTSS will produce the desired results remains to be seen, but there is no shortage of concern about how consumers will fare under these new arrangements.

The importance of market dynamics in determining costs was another theme running through the Forum's work in 2012. We continued our series of "conversations with" sessions with expert speakers, this year including Ellen Zane, chief executive officer emeritus of Tufts Medical Center, and Robert S. Galvin, MD, chief executive officer of Equity Healthcare, The Blackstone Group, both of whom offered candid observations on how competition, consolidation, and provider reputation affect costs and the ability of purchasers and consumers to buy value. A session on spending trends in Medicare

and private insurance provided another lens for looking at the different forces that affect spending—volume, intensity, and population growth vs. provider competition and consolidation—and the levers these two purchasers can use to try to tame cost growth.

In addition to programming on cost-related issues, the Forum spent considerable time on perennial topics such as aging, chronic care, long-term services and supports, public health, the safety net, and the health care workforce. Non-medical determinants of health, a topic the Forum took up in 2008, featured prominently in several sessions. A site visit to locales in Washington, DC, provided an opportunity to bring safety net and public health issues together in an on-the-ground experience. Similarly, a one-day site visit to Arlington, Virginia, allowed participants to see the interaction between aging and home- and community-based services programs.

As this message is being written, the Forum has concluded another "Health Policy Essentials" briefing series for new and returning congressional staff. This basic education has become a core part of the Forum's mission and identity, and we look forward to working with another group of staffers new to health policy and the policy process.

Every year we thank our foundation and corporate sponsors for their support. This year is no different, and we especially appreciate continued support in the midst of many competing priorities. The value of a neutral venue for reflection and dialogue is hard to quantify, and the Forum's no press rule circumvents the publicity many sponsors seek. We are grateful that our sponsors continue to consider the Forum's work important and worthy of their support.

**Judith Miller Jones**
*Director*

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The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.

*"I rarely miss a NHPF [session] when I am in DC for the quality of information presented and the shared learning that occurs between diverse stakeholders from the program and ensuing discussions. As a long-time public health professional in the private sector, now in the public sector, I well recognize the value of the NHPF programs for engaging and fostering networking among us for more informed policy and realistic program efforts."*

*—Forum participant*

National Health Policy Forum

# The Year in Review – 2012

## An Executive Summary

In 2012, the National Health Policy Forum employed a variety of strategies to further its mission to inform the policymaking process on health policy issues. Forum sessions, in both large- and small-group settings, provided opportunities for congressional and executive branch staff to learn from and engage in dialogue with experts, state officials, providers, consumers, and others about a host of programmatic and policy issues. A variety of written products provided historical and contextual background on policies and programs and brought readers the latest evidence and thinking on key policy issues and emerging trends. Two local site visits allowed participants to see safety net and aging programs up close and personal.

As in prior years, some lines of programming focused on issues of immediate concern to the Forum's audience of federal health policymakers, such as payment policy, while others built on previous years' programming or highlighted emerging trends in how health care is organized and delivered. Several small-group sessions featured a key leader in the field who shared his/her personal insights into the how employer decisions and market dynamics are shaping the cost of care. Indeed, costs and improving the efficiency of health care delivery featured prominently in many of the sessions the Forum held in 2012, whether they looked at dual eligibles, Medicare-only beneficiaries, or subsets of the population served by the safety net.

Under the broad theme of **health care costs, Medicare, and market dynamics**, the Forum looked at a host of diverse but related issues. A session early in the year returned to the topic of physician payment and the adequacy of the data used to develop relative values (RVUs) that underlie the physician fee schedule. The role of the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in making recommendations to the Centers for Medicare & Medicaid Services (CMS) regarding fees for new services and changes to the fees of selected services was also highlighted. Bundled payment was the focus of a session in early spring. CMS

officials described the Center for Medicare & Medicaid Innovation (CMMI) Bundled Payment for Care Initiative (BPCI), while other speakers discussed the potential and the pitfalls of bundling. A Forum issue brief also looked at payment for post-acute services and the long-standing problems that have been identified by the Medicare Payment Advisory Commission.

The cost theme played out in several sessions, including one focused on high-cost Medicare beneficiaries and their characteristics. Speakers emphasized the importance of targeting interventions to help ensure that savings are achieved, while acknowledging the difficulty of doing so without better data. Following up on a discussion held in late 2011, proposals to eliminate first-dollar coverage and the relationship between Medigap insurance, which typically provides first-dollar coverage, and Medicare spending were explored in an issue brief. Two sessions, one in July and one in September, looked at the effects of rising health care costs on workers and retirees as well as on payors: Medicare, Medicaid, private insurers, and employers. Speakers noted that different forces—volume, intensity, population growth, economic conditions, provider competition, and consolidation—shape and contribute to cost growth and that solutions to the "cost" problem may be different depending on who is footing the bill. Throughout many of these meetings and in two small-group sessions, speakers and participants focused on market dynamics and the effects of provider reputation, consolidation, and competition on costs. An in-depth discussion of the Boston market was especially powerful in illustrating these points. Finally, several sessions looked at possible ways to help tame health care costs through simplifying administrative procedures, harnessing the power of information technology to improve care processes, and engaging consumers in managing their health and health care.

The Forum also continued to provide a significant level of programming on **aging, chronic care, and long-term services and supports (LTSS)**. Following up on programming begun in 2011, the Forum held a session early in the year to provide a more nuanced analysis of the population dually eligible for Medicare and Medicaid (duals) and an update on CMS duals initiatives. Not all duals are expensive and speakers urged CMS to carefully target its initiatives aimed at this population. Advocates also stressed the need to provide adequate consumer protections to these vulnerable individuals. This caution was reiterated in several meetings that described states' interests

and efforts to move individuals receiving Medicaid-financed LTSS into managed care arrangements.

The Forum rounded out its programming under this theme with sessions that described how some communities are breaking down silos of care by integrating social support services with health care delivery and how assisted living fits into an overall continuum of care. These sessions were supported by written documents describing assisted living, family caregiving, and aging programs supported by the Older Americans Act. A spring site visit to Arlington County, Virginia, featured many of the LTSS and aging programs the Forum has been discussing over the past two years and provided an opportunity for participants to see how these services can come together in an integrated approach.

On the **public health and safety net** front, the Forum looked at individual public health issues, the broader non-medical determinants of health and the role of public health in ameliorating negative influences, and the status and future of safety net providers. A spring meeting focused on the rising rate of caesarian sections and efforts of public and private sector partners to reduce rates and improve birth outcomes. A return to the "health in all policies" theme addressed in 2011 featured a session on food and the myriad policies that affect its production and consumption. This session served as an introduction to the connections between food and health and a foundation for future programming. Indeed, food came up again in a meeting on health at school, which included a discussion of new nutrition standards for the school lunch and breakfast programs. The session also looked at what policies local communities are pursuing in schools to promote better eating and more physical activity.

A second nexus of programming centered on the health care safety net and its role in meeting the health care needs of vulnerable populations, especially as the implementation of health care reform moves ahead. The financial viability of the safety net and efforts to improve coordination through integration were two topics addressed in Forum sessions. An end-of-the-year background paper laid out these issues in greater detail for federally qualified health centers and community health centers. Finally, a one-day site visit to safety net institutions in Washington, DC, provided an opportunity to observe programs in person and to discuss how the integration of services can help improve the health of low-income individuals, families, and communities.

The Forum added to its growing body of work on the **health care workforce** with several sessions and written products in 2012. A basic summarized and pulled together in one place the educational requirements and professional obligations of the various professions, and an issue brief focused on community health workers and how they might be used to augment the work of other primary care professionals. The paper described what these workers do, how they are trained, and the challenges for developing the profession further. Educating nurses for the 21st century was the focus on a one-on-one session with Marla Salmon, a respected leader in nursing education and former director of the division of nursing in the Health Resources and Services Administration's Bureau of Health Professions. A former dean of nursing at the University of Washington, Dr. Salmon shared her views on nursing education and nurses' role in providing primary care services. Physician education was up next with a November discussion of how physician practice has changed over the past several decades and what concomitant changes might be needed in undergraduate and graduate medical education.

All together, the Forum conducted 24 general meetings, small-group sessions, and workshops in 2012. Not included in this total were numerous brown bag and other informal meetings with researchers, market experts, program officials at state and local levels, and others who helped inform the Forum's programming throughout the year. Forum staff also met periodically with representatives of the foundations and corporations that support the Forum. Written products, which numbered 10, included issue briefs, background papers, basics, and a site visit report. Two site visits were completed during the year. Short descriptions of each meeting and product are provided below, organized by theme. A chronological list of Forum activities is also provided.

## HEALTH CARE COSTS, MEDICARE, AND PRIVATE MARKETS

*Throughout the year, a number of Forum sessions and papers touched on a set of broad themes related to health care costs and spending and how rising costs affect public programs, employers, and consumers. Several meetings addressed specific aspects of Medicare payment policy, including the*

*development of the physician fee schedule, payment for post-acute services, and the bundled payment initiative of the Center for Medicare & Medicaid Innovation. A session on the characteristics of high-cost Medicare beneficiaries looked at the importance of targeting in developing interventions to improve quality and reduce spending. Market dynamics—especially provider consolidation and the power of branding in price setting—and their effects on costs were explored in several small-group meetings. Sessions also looked at strategies that have been suggested to reduce costs, including simplifying administrative procedures, harnessing health information technology to improve care, and greater engagement of consumers in managing their health and health care.*

**Forum Session** [February 17]

### Assessing Progress on Improving the Data Behind Medicare's Physician Fee Schedule

*Manager – Kathryn Linehan*

Medicare's physician fee schedule distributes over $60 billion annually and is a critical determinant of individual physicians' incomes, beneficiaries' access to health care services, and Medicare spending, as well as the basis for physician fees used by many private payers. The fee schedule is based on relative values (RVUs) assigned each service reflecting the resources required to produce that service in comparison to all other services. The Centers for Medicare & Medicaid Services (CMS) is responsible for Medicare's fee schedule and relies heavily on the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), an independent group of physicians, to provide recommendations on fees for new services and changes to the fees of selected services. Although both CMS and the RUC have updated and improved the data and methods for developing the values assigned physician services, concerns remain about the adequacy and validity of the data, the transparency of the processes, involvement of medical specialty societies, and CMS's oversight. To address ongoing concerns about potentially misvalued services on the physician fee schedule, the Patient Protection and Affordable Care Act (PPACA) directed the Secretary to examine specific categories of services to improve RVU accuracy and to establish a process to validate RVUs under the fee schedule. In this Forum session, speakers discussed the data underlying Medicare's physician fees, the process for developing

*"Very good overview of the problems with current payment approach and why it does not result in our using public dollars to produce the workforce we need."*

the relative values assigned to physician services, progress on implementing provisions in PPACA, and recent changes to the processes and composition of the RUC. Speakers also described and assessed current and past efforts to improve the accuracy of the physician fee schedule and highlighted areas for future improvement.

**Forum Session** [February 24]

### Mission Possible II: Reducing Health Care Costs Through Administrative Simplification

*Manager – Michele J. Orza, ScD*

Most proposals for solving the nation's economic woes assume that health care costs can be tamed by reducing the estimated 30 percent of health care spending that is wasted in that it does not serve to improve health and may even be harmful. The Institute of Medicine Roundtable on Value & Science-Driven Health Care describes several categories of wasted spending: unnecessary services, excessive administrative costs, inefficiently delivered services, prices that are too high, medical fraud, and missed prevention opportunities. Excessive administrative costs, the second largest category of waste, are driven by the complexities of dealing with varying documentation requirements from multiple payers and other entities. Streamlining these could result in the largest amount of savings of all the options the Roundtable identified—an estimated $181 billion annually (39 percent of the total savings achievable if all options were fully implemented). A previous Forum session provided an overview of excess health costs, causes identified, and possible solutions to wasteful health spending, with a focus on that attributable to unnecessary health care services. This Forum session explained excessive administrative costs and proposals for streamlining and featured the perspectives and initiatives of physician practices, hospitals, and insurers.

**Issue Brief No. 845** [February 24]

### Recent Proposals to Limit Medigap Coverage and Modify Medicare Cost Sharing

*Author – Kathryn Linehan*

As policymakers look for savings from the Medicare program, some have proposed eliminating or discouraging "first-dollar coverage" available through privately purchased Medigap policies. Medigap

coverage, which beneficiaries obtain to protect themselves from Medicare's cost-sharing requirements and its lack of a cap on out-of-pocket spending, may discourage the judicious use of medical services by reducing or eliminating beneficiary cost sharing. It is estimated that eliminating such coverage, which has been shown to be associated with higher Medicare spending, and requiring some cost sharing would encourage beneficiaries to reduce their service use and thus reduce program spending. However, eliminating first-dollar coverage could cause some beneficiaries to incur higher spending or forego necessary services. Some policy proposals to eliminate first-dollar coverage would also modify Medicare's cost sharing and add an out-of-pocket spending cap for fee-for-service Medicare. This paper discusses Medicare's current cost-sharing requirements, Medigap insurance, and proposals to modify Medicare's cost sharing and eliminate first-dollar coverage in Medigap plans. It reviews the evidence on the effects of first-dollar coverage on spending, some objections to eliminating first-dollar coverage, and results of research that has modeled the impact of eliminating first-dollar coverage, modifying Medicare's cost-sharing requirements, and adding an out-of-pocket limit on beneficiaries' spending.

**Forum Session** [March 2]

### Beacon Communities: Signaling Success in Health Information Exchange?

*Manager – Lisa Sprague*

The electronic exchange of health information is a key element in the collective vision of a transformed American health system, contributing to both higher quality and greater efficiency in service delivery. The electronic health record (EHR) is a first step, but a means of making patient data available to a variety of authorized providers, payers, and the patient himself is also necessary. This kind of health information exchange (HIE) is one of the three main components of "meaningful use" of health information technology (IT). A number of incentive programs have been devised to encourage the development of HIE. Among these is the Office of the National Coordinator of Health IT's Beacon Community program. This program provides funding to 17 selected communities around the country that had, in ONC's words, already made progress in the development of secure, private, and accurate systems of EHR adoption and HIE. This Forum session considered the goals of HIE implementation and the kind of

progress the country is making toward them. It looked at the role of incentive programs in fostering HIE initiatives, and how robust those initiatives may be expected to remain once grant funding is exhausted. Two Beacon communities, Greater Cincinnati and Southeastern Minnesota, were featured.

**Forum Session** [March 9]
*Related to Forum Session, January 27*

### Targeting High-Cost Medicare Beneficiaries to Improve Care and Reduce Spending: Finding the Bull's-Eye

*Manager – Sally Coberly, PhD*

*"I very much appreciated having the 'on-the-ground' voice there, as well as an academic perspective."*

In 2011, Medicare spent approximately $551 billion to provide health insurance coverage to 49 million elderly and disabled beneficiaries; the Congressional Budget Office (CBO) projects that by 2020, Medicare spending will grow to $903 billion. Given concerns about the federal deficit, it is not surprising that policymakers continue to search for ways to reduce costs and make the Medicare program more efficient. The Patient Protection and Affordable Care Act (PPACA) of 2010 created a new Center for Medicare & Medicaid Innovation to conduct demonstrations/pilots aimed at reducing costs and improving care. Several of these approaches are the latest in a long line of care coordination and disease management demonstrations and pilots that have targeted selected groups of beneficiaries. According to several analyses, including a recent CBO report, however, previous efforts have had relatively little success in producing savings. One possible explanation is that these demonstrations were not sufficiently targeted to individuals for whom cost savings were most likely to be achieved. New research suggests that the most expensive Medicare beneficiaries are those who have multiple chronic conditions and functional impairments. These findings suggest that current targeting criteria may be inadequate for identifying beneficiaries for whom coordination may both improve quality of care and achieve cost savings. This Forum session described the characteristics and spending patterns of high-cost Medicare beneficiaries and their implications for targeting care coordination and other interventions, examined the track record of targeting within Medicare demonstrations and pilots and lessons learned regarding how to make those criteria more effective, and profiled the experience of one health system's efforts to target and manage high-cost Medicare beneficiaries enrolled in Medicare Advantage plans.

**Small-Group Session** [March 16]

## Employers and Today's Health Care Marketplace: Between a Rock and a Hard Place?

*Managers – Sally Coberly, PhD & Judith Miller Jones*

Employers provide health insurance to over 160 million Americans, giving them a considerable stake in the costs of health care. Yet after over two decades of efforts by large employers to both tame costs and improve the quality and value of care delivered to their employees, the costs of providing health benefits continue to rise at rates exceeding the growth in wages. This has occurred despite the expectation that large employers would be able to leverage their purchasing power—at least in some markets. Of course, many large employers continue to support initiatives to contain costs, such as value-based benefit design and disease management or health promotion programs, and to steer employees to more efficient providers through the use of tiered networks and centers of excellence. The primary cost-containment tool today, however, appears to be shifting more of the costs to employees through increased premiums, deductibles, and cost sharing. Moreover, while many employers say they will continue to offer health insurance to remain competitive in the labor market, the prospect of employees eventually being able to purchase policies through an exchange raises questions about the future of employer-sponsored insurance.

Given the changes in the organization and delivery of health care that have occurred over the past two decades, what role can employers play in controlling costs and obtaining greater value for the money they and their employees spend? Can employers leverage their purchasing power in markets where providers have consolidated? Where insurers have consolidated? Are there new approaches on the horizon that will be more successful in taming costs? Are employers in it for the long haul, or will some get out of the business of providing health insurance if the circumstances are right? To explore these and related questions, Robert S. Galvin, MD, chief executive officer of Equity Healthcare, The Blackstone Group joined us for a small-group discussion. Prior to joining Blackstone in 2010, Dr. Galvin was executive director of Health Services and chief medical officer for General Electric.

*"Loved his perspective—we don't hear it often enough in DC."*

*"Great background on the underlying issues of bundling and future outlook for implementing programs."*

**Forum Session** [April 20]

## Bundled Payment in Medicare: Promise, Peril, and Practice

*Manager – Kathryn Linehan*

Fee-for-service Medicare is blamed for a number of inefficiencies in the delivery of care including service duplication, the provision of unnecessary care, failure to coordinate services for the patient, and resulting excess spending and poor quality. Bundled payment models, which aim to pay for more comprehensive episodes that may encompass multiple provider types are one alternative to fee-for-service payment that has the potential to promote more efficient, coordinated care across providers or settings. Establishing a bundled payment system presents several critical design choices that must balance fairness to providers with promoting responsibility for an entire episode at a price that is adequate to ensure access. In addition, operational challenges facing payers and providers, even those who are highly motivated to participate in new payment models, must be addressed. Understanding the risks can help to design bundled payment programs with features that may mitigate some of those risks and establish realistic expectations for what bundling can achieve in the Medicare program.

The Center for Medicare & Medicaid Innovation (CMMI) in the Centers for Medicare & Medicaid Services (CMS) is currently in the process of implementing the Bundled Payments for Care Improvement (BPCI) initiative. Under this initiative, CMMI has received (and continues to receive) applications from eligible participants for four broadly defined bundled payment models that will combine payments for multiple services (depending on the model) during an episode of care. Among the goals of the BPCI are fostering quality improvement while decreasing the cost of an episode of care, giving providers flexibility to redesign care to meet the needs of their community, and removing barriers and provide opportunity for partnerships among providers and other stakeholders.

This Forum session described the rationale for Medicare to move toward episode or bundled payment; examined the policy and operational challenges that a bundled payment approach presents for providers and payers, particularly Medicare, and ways those could be addressed; and provided the audience with an understanding of CMMI's (BPCI) initiative.

## Small-Group Session [July 13]

### We've Seen the Future: Insights About the Real Dynamics of Marketplace Competition

*Manager – Judith Miller Jones*

In this small group session, Ellen Zane, chief executive officer emeritus of Tufts Medical Center, shared insights into the dynamics of health care markets and how those dynamics might affect the implementation of health reform and efforts to reduce costs and get better value for the dollars spent on health care. Some of the topics addressed during the discussion included:

- how leverage is used by providers and insurers in ways that are mostly unseen to those outside the system and how it creates perverse incentives and results,
- how market realities and public policy goals do not necessarily intersect as we would like,
- how the lack of "sunshine" on various provider and insurer transactions harms consumers and employers,
- how inequities can drive costs and inefficiencies in the market, and
- what "having skin in the game" really means for consumers and providers.

## Forum Session [July 20]

### Is Health Care Eating Our Lunch? The Impact of Cost Trends on Workers and Retirees

*Manager – Sally Coberly, PhD*

Aware that health care costs consume a large share of current spending and contribute to the nation's long-term fiscal problems, policymakers have been preoccupied with containing health care costs. But employers and workers also feel the pinch, as health care cost growth continues to outpace growth in gross domestic product and consumes a larger and larger share of wages. Health care is also a significant expense for retirees, especially those age 80 and older. This Forum Session provided an overview of how rising health care costs and the changing nature of insurance are affecting today's workers and retirees. It also looked at projected retirement income adequacy

*"I found this session very useful because I was not familiar with the material. Thanks for directing me to new sources of information/data."*

for Baby Boomers and Gen Xers and the ability of these future retirees to finance health care in retirement. Finally, participants heard first-hand about the role health care expenses play in the financial difficulties experienced by individuals and families seeking credit counseling services.

**Forum Session** [September 21]

### Technologies, Games, Incentives: Patient Engagement and Cost Containment

*Manager – Lisa Sprague*

*"Speakers were very engaging and presented concrete examples of ways to motivate patient behavior."*

Patient engagement has become a kind of rallying cry in health care circles. It is hard to measure how many patients on their own seek to become better informed and to participate more actively in managing their health. Increasingly, though, they have help from others with a stake in keeping patients well informed and well behaved. Both health plans and employers benefit from a healthy, productive population that consumes fewer (and cheaper) health care services. This Forum session looked at how patient-engagement initiatives are structured, what really works to motivate behavior change, how to recognize and reward success, how employee preferences are factored in, and how today's game may become tomorrow's cost reduction.

**Forum Session** [September 28]

### Spending Trends in Private Insurance and Medicare: Variations on a Theme

*Managers – Sally Coberly, PhD & William J. Scanlon, PhD, Consultant*

*"This information will provide us with a better perspective on the drivers of health care costs as we look at policy proposals this winter."*

The most recent analysis and projections of health care spending in the United States contain both good news and bad news. The good news is that the rate of growth of health care costs has slowed since 2002. The bad news is that even at slower rates of growth, health care expenditures still outpaced growth in gross domestic product (GDP), and are expected to do so indefinitely. Taming health care costs is easier said than done. The forces that shape and contribute to cost growth vary from payer to payer, health service to service, and market to market. Rising costs in Medicare are due largely to growth in the volume and intensity of services rather than increases in payment rates or growth in the number of beneficiaries. In contrast, provider competition and consolidation play a large role in determining the

prices paid by employers and private insurers. This Forum session provided an overview of spending trends in the private sector and in Medicare, teased apart some of the factors that contribute to spending growth for each payer, and explored some of the opportunities and challenges associated with taming costs for both Medicare and private payers.

**Issue Brief No. 847** [December 7]

### Medicare's Post-Acute Care Payment: A Review of the Issues and Policy Proposals

*Author – Kathryn Linehan*

Medicare spending on post-acute care provided by skilled nursing facility providers, home health providers, inpatient rehabilitation facility providers, and long-term care hospitals has grown rapidly in the past several years. The Medicare Payment Advisory Commission and others have noted several long-standing problems with the payment systems for post-acute care and have suggested refinements to Medicare's post-acute care payment systems that are intended to encourage the delivery of appropriate care in the right setting for a patient's condition. The Patient Protection and Affordable Care Act of 2010 contains several provisions that affect the Medicare program's post-acute care payment systems and also includes broader payment reforms, such as bundled payment models. This issue brief describes Medicare's payment systems for post-acute care providers, evidence of problems that have been identified with the payment systems, and policies that have been proposed or enacted to remedy those problems.

## AGING, CHRONIC CARE, AND LONG-TERM SERVICES AND SUPPORTS

*The Forum continued to explore issues related to the organization and delivery of care to older adults, with a special emphasis on long-term services and supports (LTSS). A session on the individuals dually eligible for Medicare and Medicaid (duals) focused on differentiating the needs—and associated costs—of this population and targeting interventions appropriately. Several sessions examined the growing trend among states to deliver Medicaid-financed LTSS through managed care arrangements. These sessions also addressed issues*

*in planning and implementing such arrangements, including those related to network adequacy and beneficiary choice. Programming also looked at the integration of social support services with health care delivery and the role of assisted living facilities in the continuum of care. Basics on the Older Americans Act programs and spending for LTSS were updated to reflect the most recent information available. A one-day site visit to Arlington, Virginia, provided an opportunity for participants to learn about one county's efforts to integrate community aging programs and home- and community-based LTSS services for its older adults. A background paper on family caregivers described the important role that family and friends play in coordinating and delivering care to functionally impaired older adults.*

**Forum Session** [January 27]
*Related to Forum Session, March 9*

### Improving Care for Dual Eligible Medicare-Medicaid Beneficiaries: One Size Does Not Fit All

*Manager – Carol V. O'Shaughnessy*

*"This was a very strong panel. Very knowledgeable and having a CMS leader provide information on specific activities combined with lessons learned from the field brought the topic home.*

Providing appropriate and efficient care for the 9 million people enrolled in both Medicare and Medicaid—the "dual eligibles"—is a major policy challenge. Dual eligibles represent a small proportion of each program's enrollees but account for a disproportionate share of health care costs. Often overlooked, however, is the heterogeneity of health care needs and spending of the dual eligible population and the potentially different approaches to addressing care delivery and costs for specific subgroups. Some dual eligibles are in relatively good health and do not account for significant spending. Others, however, account for significant Medicare spending for acute and chronic medical care costs. Many of these dual eligibles have significant disabilities and incur high Medicaid spending for long-term services and supports (LTSS), primarily in the form of institutional care. This Forum session explored the diverse group of individuals who are eligible for both Medicare and Medicaid. Speakers discussed initiatives by the Centers for Medicare & and Medicaid Services (CMS) to integrate financing streams, improve service delivery, and reduce overall health care costs for this population; examined some of the challenges in serving diverse high cost patient groups; and considered consumer protections that should be in place for those who participate in integrated care models.

**The Basics** [February 23]

### Older Americans Act of 1965: Programs and Funding

*Author – Carol V. O'Shaughnessy*

This document offers a basic description of the Older Americans Act of 1965. The Act is considered the major vehicle for promoting the delivery of social services to the aging population. The Act's seven titles and multiple programs are described, along with a chart showing fiscal year 2012 federal appropriations.

**The Basics** [February 23] *(updated February 1, 2013)*

### National Spending for Long-Term Services and Supports (LTSS)

*Author – Carol V. O'Shaughnessy*

Long-term services and supports (LTSS) for the elderly and younger populations with disabilities are a significant component of national health care spending. In 2010, spending for these services was $207.9 billion (8 percent of all U.S. personal health care spending), most of it paid by the federal-state Medicaid program. This publication presents data on LTSS spending by major public and private sources.

**Site Visit** [April 13]

### Long-Term Services and Supports (LTSS): Arlington County's Integrated Approach

*Managers – Carol V. O'Shaughnessy & Lisa Sprague*

The National Health Policy Forum sponsored a local site visit looking at community-based aging programs and long-term services and supports (LTSS) in Arlington County, Virginia. Arlington County human services are integrated under an umbrella agency in the Department of Human Services (DHS) which administers multiple programs for the elderly and people with disabilities. These include the Older Americans Act services, Medicaid LTSS, transportation services, a nursing case management program, and mental health services for those living in nursing homes and assisted living facilities. Arlington County integrates its aging and disability programs under the auspices of an Administration on Aging-funded Aging and Disability Resource Center (ADRC) and emphasizes the "no wrong door" approach for client entry into service programs. The site visit focused on learning about the integration of community aging programs and home- and

*"I knew that we would learn about how Arlington County provides services for individuals as they age in the community, but it was a much more comprehensive and in-depth look than I expected."*

community-based LTSS, how the programs are administered and coordinated, and how services are delivered. Tours were arranged for site visit participants, who were also able to talk to administrators of an adult day care program, assisted living facilities, and an Older Americans Act congregate nutrition site, as well as the director of DHS and the area agency on aging, staff of the nursing case management program and the mental health support team, and consumers of services. A report on participants' impressions was published on June 8, 2012.

**Forum Session** [May 11]
*Related to Forum Session, October 5*

### Medicaid Managed Long-Term Services and Supports (MMLTSS): Increasing State Interest and Implications for Consumers, Quality of Care, Providers, and Costs

*Manager – Carol V. O'Shaughnessy*

*"I left with greatly enhanced knowledge of the topic which I can apply directly to my work."*

By many accounts, state interest in initiating Medicaid managed care for long-term services and supports (MMLTSS) is growing at a rapid pace. To date, MMLTSS arrangements have been confined to a handful of states with limited enrollment and expenditures. A number of factors are causing more state Medicaid agencies to consider managed LTSS, including objectives to balance the availability of home- and community-based services with institutional care; slow the rate of spending growth and establish some predictability in Medicaid LTSS costs; and better integrate LTSS with primary, acute, and chronic care. Some observers predict that, over the next few years, fee-for-service under Medicaid for LTSS will gradually disappear in many states. Whether or not this is the case, increased state interest in moving to MMLTSS has stirred objections and fears among some consumers and providers. Some caution that states should learn from other states' experiences with MMLTSS programs when planning implementation and also ensure that effective consumer protections and quality oversight procedures are in place. Further, some are concerned about the impact that capitated financing will have on the traditional LTSS community provider system. This Forum session explored lessons learned from state experiences with MMLTSS, evidence of its effect on cost savings and quality outcomes, actions being taken by the Centers for Medicare & Medicaid Services (CMS) to help states interested in moving to MMLTSS, and consumer protections to be considered.

**Background Paper No. 84** [July 20] *(updated January 11, 2013)*

### Family Caregivers: The Primary Providers of Assistance to People with Functional Limitations and Chronic Impairments

*Author – Carol V. O'Shaughnessy*

An extensive body of research conducted over the past several decades has documented that family or other unpaid caregivers provide the majority of care to people who need assistance because of functional limitations or multiple and complex chronic conditions. Families play a central role not only in assisting impaired family members with personal care needs, but also in helping them coordinate health care and supportive services, and, increasingly, providing and/or supervising home-based medical care. This paper presents background information on family caregiving, briefly describes federal programs that provide direct assistance to caregivers, and discusses possible future policy and practice directions.

**Forum Session** [October 5]

*Related to Forum Session, May 11*

### Medicaid Managed Long-Term Services and Supports (MMLTSS): Lessons from Three States

*Manager – Carol V. O'Shaughnessy*

*"Useful to hear what states are doing and the challenges they perceive in implementation as well as where they think they've made strong, successful policy and implementation choices."*

In recent years, more states have begun implementing Medicaid managed long-term services and supports (MMLTSS), garnering attention from national organizations and consumer advocacy groups that promote quality LTSS for people with functional limitations. A recent report for the Centers for Medicare & Medicaid Services (CMS) indicates that 26 states will have MMLTSS programs by 2014, up from 8 states in 2004 and from 16 states in 2012. In the second of two meetings on MMLTSS, this Forum session explored issues in planning and implementing programs and discussed the experiences of three state Medicaid agencies. Arizona, a veteran of MMLTSS, began its Arizona Long-Term Care System (ALTCS) in 1988. ALTCS operates on a statewide basis and enrolls about 52,000 people. Star+Plus in Texas began in 1998 and operates in part of the state. Texas has about 401,000 people enrolled and is expanding its program to other regions of the state. Delaware, a newcomer to the field, began implementation of Delaware Diamond State Health Plan-Plus (DSHP-Plus) in April 2012. The program is statewide and has 4,800 people enrolled. Key

program designs, oversight of network and beneficiary choices, and lessons learned regarding state budgets and cost savings were among the issues addressed.

**Forum Session** [October 19]

**Breaking Down Silos of Care: Integration of Social Support Services with Health Care Delivery**

*Manager – Carol V. O'Shaughnessy*

*"My work connects community-based activities and programs to health care—so this session was directly relevant to my work."*

Many patients with complex chronic illnesses and/or functional impairments face not only managing the medical care necessitated by their conditions, but also finding ways to access supportive services that help them live independently in their homes and communities. Access to supportive services can be difficult for anyone with complex conditions, and social and economic patient characteristics can complicate the task. The absence or insufficiency of home care support; assistance in hospital-to-home transitions; follow-up medical coaching; and access to transportation for medical appointments, adequate nutrition, and mental or behavioral health services act as barriers to positive health care outcomes. Theoretically, models of care, such as health homes, that aim to improve outcomes for people with complex chronic conditions may help fill these gaps. But how far these initiatives will go beyond the traditional medical model of care remains to be determined. This Forum session, a continuation of the Forum's programming on serving populations with complex conditions, explored barriers to effective coordination of social support and health care services and discussed opportunities for service integration.

**The Basics** [November 9] *(updated January 29, 2013)*

**Assisted Living: Facilities, Financing, and Oversight**

*Author – Carol V. O'Shaughnessy*

This publication briefly describes assisted living facilities that provide long-term services and supports to people with functional or cognitive impairments who do not need the level of skilled nursing care offered in nursing homes but cannot live independently. It also describes selected resident characteristics, reviews cost and financing arrangements, and reviews state responsibilities for regulation and oversight of assisted living facilities.

**Forum Session** [November 30]

*Related to The Basics, November 9, updated January 29, 2013*

## Assisted Living Facilities and Their Growing Role in Long-Term Services and Supports (LTSS)

*Manager – Carol V. O'Shaughnessy*

Assisted living facilities increasingly play an important role in providing long-term services and supports (LTSS) for many people with functional and cognitive impairments who do not need the level of care provided in nursing homes but cannot live independently. The market for assisted living facilities has grown substantially in recent years in response to consumer demand for home-like supportive housing. Individuals and families usually pay for assisted living arrangements out-of-pocket. For those with limited income and assets, Medicaid (at the option of each state) can finance some of the supportive services provided in assisted living facilities, excluding room and board. Unlike nursing homes, for which the federal government and states share responsibility for oversight and enforcement of federal standards, states have total responsibility for development of regulations and licensure requirements as well as oversight of assisted living facilities. During the past decade, various national provider organizations have promoted adoption of improved quality of care standards by states and providers, including protections for consumers. This Forum session described the assisting living market, including resident and facility characteristics, based on findings of a recent major survey undertaken by the U.S. Department of Health and Human Services (HHS). The meeting also discussed the growth and evolution of the assisted living market from several viewpoints, including those of a state long-term care ombudsman, an educator of assisted living personnel, and an assisted living multi-state provider. Areas discussed included sources of financing and state regulation and oversight of quality of care provided to residents.

## THE HEALTH CARE SAFETY NET AND PUBLIC HEALTH

*The Forum's work on safety net issues focused primarily on the status and future of safety net providers, especially community health centers and hospitals, in a reforming health care system. Two sessions addressed these topics: one focused on the financial status of safety net providers and the other examined efforts to more fully integrate safety net services to improve both access and efficiency. An issue brief at the end of the year provided an in-depth look at how federally qualified health centers and community health centers are likely to respond to new challenges and opportunities created by the Affordable Care Act. On the public health side, Forum sessions looked at rising caesarian section rates, and their effect on costs and quality; the connections between food and health; and opportunities to improve health at school through better nutrition, opportunities for physical activity, and access to clinical and behavioral health services. The role of public health in reducing the need for health services and improving the health and productivity of the U.S. workforce was the focus of another Forum session. A one-day site visit to several locations in Washington, DC, featured programs attempting to integrate health, social, and legal services to improve health for some of the city's most vulnerable residents.*

**Forum Session** [March 30, 2012}

### Caesar's Ghost: The Effect of the Rising Rate of C-Sections on Health Care Costs and Quality

*Managers – Jessamy Taylor & Michele J. Orza, ScD*

*"Excellent speakers who illustrated specific strategies as well as the 'so what.'"*

Delivering babies is big business in the United States, with childbirth-related hospital costs totaling $27.6 billion in 2009—7.6 percent of all inpatient hospital costs. The rate of delivery by cesarean section (c-section) has risen steadily over the past 15 years, and now roughly one-third of all births are by c-section. This increase is of concern because, while all deliveries have risks, c-sections are associated with substantially greater risks to the mother and baby. And c-sections are more costly: in 2009, the average cost for an uncomplicated vaginal delivery was $2,962 but an uncomplicated c-section was $5,351. Medicaid pays for a large proportion of all maternal childbirth-related hospital stays, and in 2009 paid for 42 percent of all c-sections at a total cost of $3.1 billion.

A number of factors have been suggested to explain the high rate of c-sections: maternal choice, physician practice patterns, liability concerns, convenience, guidelines that have discouraged vaginal birth after a previous birth by c-section, and payment incentives. Although debate continues about the optimal rate of c-sections, and rates vary widely across the states, there is agreement that on average the rate is too high. Healthy People 2020 goals include a 10 percent reduction in c-section rates. Efforts involving numerous private and public partners are under way nationally, in states, and in communities to achieve these reductions in rates.

This Forum session explored the rising rate of c-sections: its drivers and consequences and public- and private-sector initiatives to achieve a more optimal rate.

**Forum Session** [May 4]
*Related to Forum Session, June 15*

### Food Glorious Food: Supply, Consumption, and Consequences for Health

*Managers – Michele J. Orza, ScD & Jessamy Taylor*

*"Excellent information on important topic and timely topic. Good to have industry and consumer points of view represented. Helps advance the dialogue."*

To say "we are what we eat" may be overstating matters, but the connections between food and health are numerous and significant and, increasingly, a major concern of those seeking to improve health. The topic of food and health involves a wide array of local, state, and federal agencies and policies; provides numerous examples of intersections among nonmedical determinants of health; and illustrates the complexities inherent in a broad "health-in-all-policies" approach to tackling such determinants. The variety of recent legislation related to food and health currently being implemented includes the Healthy, Hunger-Free Kids Act of 2010, the FDA Food Safety Modernization Act of 2011, and even the American Recovery and Reinvestment Act and the Patient Protection and Affordable Care Act. At the moment, many eyes are on what is commonly referred to as the Farm Bill (the Food, Conservation, and Energy Act of 2008), due for reauthorization in 2012. With its potential to affect everything from farming livelihoods to the food supply to the environment, many in the public health community view it as a major piece of health legislation. Discussions of food and health in the policy arena range widely from food safety to school lunch to menu labeling requirements, engage myriad perspectives from multiple sectors and walks of life, and

demand from policymakers a broad knowledge base. This Forum session was intended as an introduction to the connections between food and health and a foundation for future Forum activities focused on selected policy issues under this rubric. The speakers described and discussed emerging food science, trends in the supply and consumption of food and in food-related health conditions, the drivers of these trends, and proposals for addressing them.

**Forum Session** [May 18]
*Related to Issue Brief No. 848, December 18*

### Examining the Condition of the Health Care Safety Net: Time to Re-Cast?

*Manager – Jessamy Taylor*

*"Good analysis of forward-looking options. Liked look at safety net from different perspectives and parts of U.S."*

Millions of people who would otherwise have little or no access to care rely on the safety net for health care services. This includes the uninsured, those who have low incomes and are underinsured, Medicaid beneficiaries, and other disadvantaged populations made vulnerable by poverty or poor health status. The safety net is difficult to define nationally because the providers and funding streams that constitute it vary from community to community. Safety net providers spend a lot of energy scraping together funds from multiple streams, including local, state, and federal governments and private sources, to pay for the care they provide. However, the financial complexity and status of safety net providers varies greatly. The varied types of funding, differing levels of payment, and range of local expertise and capacity to acquire funding mean that safety net capacity across the country is uneven, leaving significant gaps in access to care in many places. This Forum session explored the current status of the health care safety net. A health policy researcher along with representatives from a federally qualified health center and an academic medical center discussed how safety net providers have fared through the economic downturn and shared strategies for strengthening financial performance while expanding access to care and improving patient outcomes. The session also considered their future plans, given the uncertain fate of the health reform law, and the many ways its reversal or upholding would affect them.

**Forum Session** [June 15]
*Related to Forum Session, May 4*

## Among School Children: Opportunities to Improve Health at School

*Manager – Michele J. Orza, ScD*

When they are not at home, most children spend the bulk of their time at school. The school environment can significantly impact their health and well-being, which in turn can affect their educational outcomes. Although some people may equate it simply with the nurse's office, school health now encompasses a wide range of policies and activities. Indeed, the Elementary and Secondary Education Act (last reauthorized as the No Child Left Behind Act of 2001) includes dozens of provisions concerning everything from physical education program requirements to access to quality mental health care to healthy, high-performance school buildings. Further, the Child Nutrition and Women Infants and Children (WIC) Reauthorization Act of 2004, the Healthy, Hunger-Free Kids Act of 2010, and new nutrition standards for the National School Lunch and School Breakfast Programs all address facets of health in schools, from local wellness policies to aligning school meals with current science. With so many opportunities concerning children's health, schools are fertile ground for the health-in-all-policies approach promoted by public health leaders. But school health and wellness mandates are among many with which school districts must contend, and they compete for attention and resources with numerous other educational priorities. And, like public health entities, schools operate at the intersection of federal, state, and local policy and grapple with similar challenges to working across multiple levels and sectors. This Forum session built on previous sessions on health-in-all-policies approaches and food and health. Speakers provided overviews of school clinical and behavioral health services, school nutrition, and a comprehensive approach to health and well-being embodied in a variety of healthy school acts around the country. They also provided specific examples of initiatives and results from the state of Louisiana; the Jackson, Mississippi, school district; and the District of Columbia.

*"The perspective from people working directly for the school systems was particularly useful. Too often policy discussions are too disconnected from what is actually happening."*

*"It's always useful to connect what we see on paper with the people who are actually working in the programs."*

**Site Visit** [July 20]

### Pulling Together to Improve Health: Integrating Health, Social, and Legal Services in DC

*Managers – Jessamy Taylor & Michele J. Orza, ScD*

This one-day site visit in Washington, DC, was designed to expose congressional and federal health policy staff to programs that integrate medical, social, and legal services to improve the health of low-income individuals, families, and communities. Site visit participants toured the children's health center at the Children's National Medical Center and Mary's Center, a federally qualified health center (FQHC). The Medical Legal Partnership program situates legal staff in clinical settings and seeks to provide patients with legal services they might need to deal with their health conditions. An analogous program, called Health Leads, also locates largely volunteer staff in clinics and in the community to connect patients and their families to needed social services. These programs focus on addressing the circumstances that may have led to a child's medical condition and that may continue to exacerbate it even after proper medical treatment. The Home Visiting program for mothers and their children uses early and continuous intervention to improve children's overall well-being and to reduce child abuse and neglect. Together these programs seek to improve the efficacy of primary care by connecting people with supports and services to deal with aspects of their lives that may be contributing to poor health, but that are generally either seen as outside the traditional bailiwick or beyond the resources of the health care system. Most of these efforts are funded through philanthropic donations and therefore sustainability is a concern. It was suggested that covering these services under Medicaid could be a solution. Others noted national budgetary concerns and the need for more program specific data collection and evaluation.

**Forum Session** [October 12]

### Healthy People for a Healthy Economy: The Promise of Public Health

*Managers – Michele J. Orza, ScD & Judith Miller Jones*

For the past several years, the U.S. public health enterprise has been in the process of reinventing itself. Most recently, it has begun to take advantage of market dynamics and opportunities presented by health reform to turn its focus from serving as a last-resort provider

of health care services and toward being a primary force for reducing the need for health care. The current emphasis is on tackling the nonmedical determinants of health—such as behavior, socioeconomic status, and environment—to prevent poor health from developing in the first place. These efforts could help the struggling U.S. economy in two ways: by reducing the burgeoning health care spending that is devouring public, private, and family budgets and by improving the ability of the U.S. population to compete in the global economy. This session examined a trio of recent Institute of Medicine (IOM) reports focused on what is needed—especially regarding data needs, legal frameworks, and financial stability—to implement this new public health agenda. Given the reports' emphasis on partnerships with private organizations and public entities, the session featured the perspectives of a major corporation and one state's (Arkansas) department of public health.

**Forum Session** [December 7]
*Related to Issue Brief No. 848, December 18*

### Safety Net Integration: Tackling Fragmentation While Improving Access to Care and Efficiency

*Manager – Jessamy Taylor*

The lack of coordination across providers and settings in the U.S. health care system negatively affects health care costs, quality, and patient satisfaction. All providers face challenges with this, but primary care safety net providers, like federally qualified health centers (FQHCs), often struggle to gain access to specialty and inpatient care for their uninsured patients and many of their Medicaid patients. Becoming part of a more coordinated and integrated safety net system could help these providers improve access to care and the overall quality of that care and system efficiency. The Patient Protection and Affordable Care Act of 2010 (ACA) includes provisions to encourage delivery system integration including accountable care organizations, Medicaid health homes, Medicare avoidable hospital readmission penalties, and an FQHC patient-centered medical home demonstration for Medicare enrollees. While integration with other safety net providers holds promise for expanding access to care, improving care quality, and controlling costs, participation also comes with potential concerns and risks. This Forum session explored various types of integration among safety net providers, the challenges and

opportunities of attaining it, and federal policies that may influence integration or fragmentation.

**Issue Brief No. 848** [December 18]
*Related to Forum Sessions, May 18 & December 7*

### Changes in Latitudes, Changes in Attitudes: FQHCs and Community Clinics in a Reformed Health Care Market

*Author – Jessamy Taylor*

The Patient Protection and Affordable Care Act of 2010 and the Supreme Court's related decision have significantly shifted the health care landscape for safety net providers. Federally qualified health centers (FQHCs) are a mainstay of primary care for the uninsured and those with limited access to care. This paper focuses on the impact of health reform on FQHCs given the significant federal investment in them through grants, Medicaid, and Medicare reimbursement. Where noteworthy, the effect on non-FQHC community clinics is also discussed. The implications of Medicaid coverage expansions (or lack thereof in states that choose not to expand), Medicaid disproportionate share hospital program cuts, discretionary budgets and sequestration, Medicare payment changes, contracting with qualified health plans in state health insurance exchanges, and delivery system reforms are explored.

## THE HEALTH CARE WORKFORCE

*Workforce issues continued to be a focus for the Forum in 2012. Efforts included a summary of the educational requirements and professional obligations of various health professionals, a session focused on nursing education and the role of nurses in providing primary care, an issue brief on community health workers and their potential to deliver primary care services, and a session that examined the evolution of physician practice and the concomitant need for a new approach to physician education.*

**The Basics** [April 30]
*Related to Forum Session, June 8*

### Health Professions Education and Professional Obligations

*Author – Lisa Sprague*

While there are differences in academic degree and length of time spent preparing to practice, all health professionals must meet certain requirements to commence and remain in practice in the United States. This Basic outlines the educational requirements of the various professions and the processes designed to demonstrate continuing competence in practice.

**Forum Session** [June 8]
*Related to The Basics, April 30*

### Starting with the Public Good: Nursing Education for 21st Century Care

*Manager – Lisa Sprague*

A virtual consensus exists about the need for reforming health care to promote higher quality and efficiency and to prepare for the demographic tidal wave of aging Baby Boomers. Popular concepts in 2012 health care delivery discussions, such as the patient-centered medical home and interprofessional team-based care, recognize that different health professions each have strengths and skills to bring to patient care. Nurses play a critical role at all levels of care. Unlike with other health professions (at least in modern times), there are different educational tracks for various kinds of nurses. Licensed practical and vocational nurses provide basic nursing care following a non-degree training program. A registered nurse (RN) may have a diploma or a degree at the associate's, bachelor's, master's, or doctoral level. The nursing profession itself seems to be moving toward expecting higher levels of education. For example, the American Association of Colleges of Nursing is committed to making a doctorate rather than a master's degree the necessary entry credential for advance practice nursing.

Others in the profession question the wisdom of this course not in terms of the highly skilled practitioners that would emerge, but its suitability to efficiently produce the nursing workforce needed for the future. Among them is Marla Salmon, until recently the Robert G. & Jean A. Reid Endowed Dean in Nursing at the University of Washington, former director of the division of nursing in the Health

Resources and Services Administration's Bureau of Health Professions, and a respected leader in nursing education. In this Forum session, Dr. Salmon shared her views on nursing education and nurses' role in providing primary care services.

**Issue Brief No. 846** [September 17]

**Community Health Workers: A Front Line for Primary Care?**

*Author – Lisa Sprague*

Among the potential changes invoked in discussions on health system transformation, a need to revitalize primary care remains paramount. One way of doing this, most agree, is to move more in the direction of team-based care. Professionals such as physician assistants and nurse practitioners may be able to ease some of the physician's clinical care load, but some populations also need help accessing services and basic health education in a familiar setting. Enter the community health worker (CHW), known by many titles and playing a variety of roles, who comes from the community he or she is serving and therefore can interact with and effectively motivate clients. This paper examines what CHWs do, how they are trained, and the outlook for their incorporation into mainstream health care, as well as the challenges for developing the profession further.

**Forum Session** [November 16]

**Training Tomorrow's Physicians: Science Alone Is Not Enough**

*Manager – Lisa Sprague*

Anchored in projections of population growth, illness burden, and the "right" ratio of clinicians to consumers, the numbers and skills of physicians and other health care professionals necessary to care for a growing and aging population remain a matter of debate. Some analysts suggest that other variables also come into play, such as the mix of health professionals, their ability to function as teams, and whether they are taught the skills that will allow them to deliver high-quality care cost-effectively.

But defining and inculcating the skills of 21st century physicians is a challenge in this time of change in medical practice. Physicians are less likely to anticipate hanging up the traditional shingle as employment by a hospital, health system, or medical group becomes more common.

In response to changing times, medical education has made some curriculum adjustments, for example adding course material related to leadership, patient safety, population health, and information technology. New teaching methods, notably the use of simulation, have appeared. Some institutions have made strides toward interprofessional education. For the most part, however, it is safe to say that practice has evolved at a more rapid clip than education.

Some leaders in medical education call for a revamping of the education process beginning in medical school and continuing through residency programs, incorporating a mix of experiences (for example, hospital and community care, didactic learning, and team exercises), and building rapid-learning mechanisms and expectations at all levels. These leaders also endorse a change in basic orientation, suggesting that health professions training programs should understand the needs of their communities and aim to produce a workforce that can meet them. Some further suggest that academic health centers should be held accountable for training students to deliver care that is both high in quality and cost-effective.

This Forum session considered ways in which medical education can and should evolve to meet the requirements of 21st century practice. Speakers offered examples of changes under way and their thoughts on further strategies for aligning education and community needs.

## OTHER

In addition to the work described above, the Forum facilitated a small-group session with several states and federal officials responsible for implementing the exchange provisions of the Affordable Care Act.

## MEETINGS, SITE VISITS, AND PUBLICATIONS: CHRONOLOGICAL LIST

Forum Session — January 27

Improving Care for Dual Eligible Medicare-Medicaid Beneficiaries: One Size Does Not Fit All

*Manager: Carol V. O'Shaughnessy*

www.nhpf.org/library/details.cfm/2882

Forum Session — February 17

Assessing Progress on Improving the Data Behind Medicare's Physician Fee Schedule

*Manager: Kathryn Linehan*

www.nhpf.org/library/details.cfm/2883

The Basics — February 23 *(updated February 1, 2013)*

National Spending for Long-Term Services and Supports (LTSS)

*Author: Carol V. O'Shaughnessy*

www.nhpf.org/library/details.cfm/2783

The Basics — February 23

Older Americans Act of 1965: Programs and Funding

*Author: Carol V. O'Shaughnessy*

www.nhpf.org/library/details.cfm/2626

Issue Brief No. 845 — February 24

Recent Proposals to Limit Medigap Coverage and Modify Medicare Cost Sharing

*Author: Kathryn Linehan*

www.nhpf.org/library/details.cfm/2885

Forum Session — February 24

Mission Possible II: Reducing Health Care Costs Through Administrative Simplification

*Manager: Michele J. Orza, ScD*

www.nhpf.org/library/details.cfm/2884

Forum Session — March 2

Beacon Communities: Signaling Success in Health Information Exchange?

*Manager: Lisa Sprague*

www.nhpf.org/library/details.cfm/2886

Forum Session — March 9

Targeting High-Cost Medicare Beneficiaries to Improve Care and Reduce Spending: Finding the Bull's-Eye

*Manager: Sally Coberly, PhD*

www.nhpf.org/library/details.cfm/2887

Small-Group Session — March 16

Employers and Today's Health Care Marketplace: Between a Rock and a Hard Place?

*Managers: Sally Coberly, PhD & Judith Miller Jones*

www.nhpf.org/library/details.cfm/2888

Forum Session — March 30

Caesar's Ghost: The Effect of the Rising Rate of C-Sections on Health Care Costs and Quality

*Managers: Jessamy Taylor & Michele J. Orza, ScD*

http://www.nhpf.org/library/details.cfm/2889

Site Visit — April 13

Long-Term Services and Supports (LTSS): Arlington County's Integrated Approach

*Authors: Carol V. O'Shaughnessy & Lisa Sprague*

www.nhpf.org/library/details.cfm/2893

Forum Session — April 20

Bundled Payment in Medicare: Promise, Peril, and Practice

*Manager: Kathryn Linehan*

www.nhpf.org/library/details.cfm/2890

The Basics — April 30

Health Professions Education and Professional Obligations

*Author: Lisa Sprague*

www.nhpf.org/library/details.cfm/2892

Forum Session — May 4

Food Glorious Food: Supply, Consumption, and Consequences for Health

*Managers: Michele J. Orza, ScD & Jessamy Taylor*

www.nhpf.org/library/details.cfm/2891

Forum Session — May 11

Medicaid Managed Long-Term Services and Supports (MMLTSS): Increasing State Interest and Implications for Consumers, Quality of Care, Providers, and Costs

*Manager: Carol V. O'Shaughnessy*

www.nhpf.org/library/details.cfm/2894

Forum Session — May 18

Examining the Condition of the Health Care Safety Net: Time to Re-Cast?

*Manager: Jessamy Taylor*

www.nhpf.org/library/details.cfm/2895

Forum Session — June 8

Starting with the Public Good: Nursing Education for 21st Century Care

*Manager: Lisa Sprague*

www.nhpf.org/library/details.cfm/2897

Forum Session — June 15

Among School Children: Opportunities to Improve Health at School

*Manager: Michele J. Orza, ScD*

www.nhpf.org/library/details.cfm/2896

Small-Group Session — July 13

We've Seen the Future: Insights About the Real Dynamics of Marketplace Competition

*Manager: Judith Miller Jones*

www.nhpf.org/library/details.cfm/2899

Forum Session — July 20

Is Health Care Eating Our Lunch? The Impact of Cost Trends on Workers and Retirees

*Manager: Sally Coberly, PhD*

www.nhpf.org/library/details.cfm/2898

Site Visit — July 20

Pulling Together to Improve Health: Integrating Health, Social, and Legal Services in DC

*Managers: Jessamy Taylor & Michele J. Orza, ScD*

www.nhpf.org/library/details.cfm/2901

Background Paper No. 84 — July 20 *(updated January 11, 2013)*

Family Caregivers: The Primary Providers of Assistance to People with Functional Limitations and Chronic Impairments

*Author: Carol V. O'Shaughnessy*

www.nhpf.org/library/details.cfm/2900

Issue Brief No. 846 — September 17

Community Health Workers: A Front Line for Primary Care?

*Author: Lisa Sprague*

www.nhpf.org/library/details.cfm/2907

Forum Session — September 21

Technologies, Games, Incentives: Patient Engagement and Cost Containment

*Manager: Lisa Sprague*

www.nhpf.org/library/details.cfm/2902

Forum Session — September 28

Spending Trends in Private Insurance and Medicare: Variations on a Theme

*Managers: Sally Coberly, PhD & William J. Scanlon, PhD, Consultant*

www.nhpf.org/library/details.cfm/2903

Forum Session — October 5

Medicaid Managed Long-Term Services and Supports (MMLTSS): Lessons from Three States

*Manager: Carol V. O'Shaughnessy*

www.nhpf.org/library/details.cfm/2904

Forum Session — October 12

Healthy People for a Healthy Economy: The Promise of Public Health

*Managers: Michele J. Orza, ScD & Judith Miller Jones*

www.nhpf.org/library/details.cfm/2905

Forum Session — October 19

Breaking Down Silos of Care: Integration of Social Support Services with Health Care Delivery

*Manager: Carol V. O'Shaughnessy*

www.nhpf.org/library/details.cfm/2906

The Basics — November 9 *(updated January 29, 2013)*

Assisted Living: Facilities, Financing, and Oversight

*Author: Carol V. O'Shaughnessy*

www.nhpf.org/library/details.cfm/2909

Forum Session — November 16

Training Tomorrow's Physicians: Science Alone Is Not Enough

*Manager: Lisa Sprague*

www.nhpf.org/library/details.cfm/2908

Forum Session — November 30

Assisted Living Facilities and Their Growing Role in Long-Term Services and Supports (LTSS)

*Manager: Carol V. O'Shaughnessy*

www.nhpf.org/library/details.cfm/2910

Forum Session — December 7

Safety Net Integration: Tackling Fragmentation While Improving Access to Care and Efficiency

*Manager: Jessamy Taylor*

www.nhpf.org/library/details.cfm/2911

Issue Brief No. 847 — December 7

Medicare's Post-Acute Care Payment: A Review of the Issues and Policy Proposals

*Author: Kathryn Linehan*

www.nhpf.org/library/details.cfm/2913

Issue Brief No. 848 — December 18

Changes in Latitudes, Changes in Attitudes: FQHCs and Community Clinics in a Reformed Health Care Market

*Author: Jessamy Taylor*

www.nhpf.org/library/details.cfm/2914

(Does not include a workshop on exchange provisions of the Affordable Care Act.)

## Budget Summary
[January 1–December 31, 2012]

*These figures have been compiled from National Health Policy Forum records. This is not a certified accounting. A complete audited accounting for the entire University, including expenditures of the Forum, is presented in the University's annual report.*

| | AP* | Blue Shield† | CHCF‡ | Kaiser§ | Kellogg | Kresge | Macy | Packard | RWJF | SCAN | General | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Salaries | $133,324 | $110,882 | $56,535 | $80,926 | $109,141 | $132,866 | $63,935 | $0 | $384,091 | $198,402 | $74,824 | **$1,344,926** |
| Wages | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 900 | **900** |
| Fringe Benefits | 33,331 | 27,721 | 14,134 | 20,232 | 27,285 | 33,217 | 15,984 | 0 | 96,023 | 49,601 | 18,759 | **336,287** |
| Meetings | 6,941 | 3,713 | 2,007 | 6,826 | 2,712 | 6,840 | 2,748 | 1,966 | 28,567 | 31,757 | 4,172 | **98,249** |
| Speaker Travel | 1,473 | 3,089 | 2,227 | 4,674 | 2,545 | 3,325 | 2,520 | 330 | 11,319 | 10,814 | 0 | **42,316** |
| Staff Travel | 1,189 | 1,952 | 75 | 226 | 151 | 267 | 135 | 0 | 1,140 | 974 | 242 | **6,351** |
| Postage | 21 | 0 | 11 | 11 | 0 | 57 | 18 | 0 | 81 | 24 | 85 | **308** |
| Telephone | 1,181 | 960 | 617 | 991 | 0 | 2,002 | 763 | 0 | 4,199 | 2,345 | 1,497 | **14,555** |
| Books/ Subscriptions | 58 | 619 | 120 | 849 | 0 | 1,160 | 195 | 0 | 381 | 1,167 | 132 | **4,681** |
| Leasing/ Maintenance | 1,365 | 1,552 | 681 | 1,256 | 0 | 1,825 | 1,108 | 0 | 6,573 | 2,739 | 632 | **17,731** |
| Supplies | 1,058 | 416 | 602 | 778 | 0 | 1,593 | 521 | 0 | 4,096 | 2,090 | 1,804 | **12,958** |
| Services | 1,462 | 954 | 854 | 901 | 0 | 3,287 | 749 | 0 | 10,330 | 1,908 | 102,516 | **122,961** |
| Rent | 25,390 | 24,006 | 14,235 | 18,940 | 0 | 33,178 | 14,817 | 0 | 101,343 | 37,692 | 25,737 | **295,338** |
| Indirect Costs | 0 | 26,380 | 13,814 | 20,492 | 21,275 | 43,923 | 10,349 | 0 | 77,777 | 40,741 | 0 | **254,751** |
| **TOTAL EXPENSES** | **$206,793** | **$202,244** | **$105,912** | **$157,102** | **$163,109** | **$263,540** | **$113,842** | **$2,296** | **$725,920** | **$380,254** | **$231,300** | **$2,552,312** |

* *The Atlantic Philanthropies* † *Blue Shield of California Foundation* ‡ *California HealthCare Foundation* § *Kaiser Permanente*

## SPONSORS

*The following is a list of current sponsors and those whose grants or contributions were in effect during any part of the period January 1 to December 31, 2012.*

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- W.K. Kellogg Foundation
- The Josiah Macy, Jr. Foundation
- California HealthCare Foundation

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- The Alliance of Community Health Plans
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NATIONAL HEALTH POLICY
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# ANNUAL REPORT 2012

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