



Health Reform 2010: Economics of a Reformed Health Workforce

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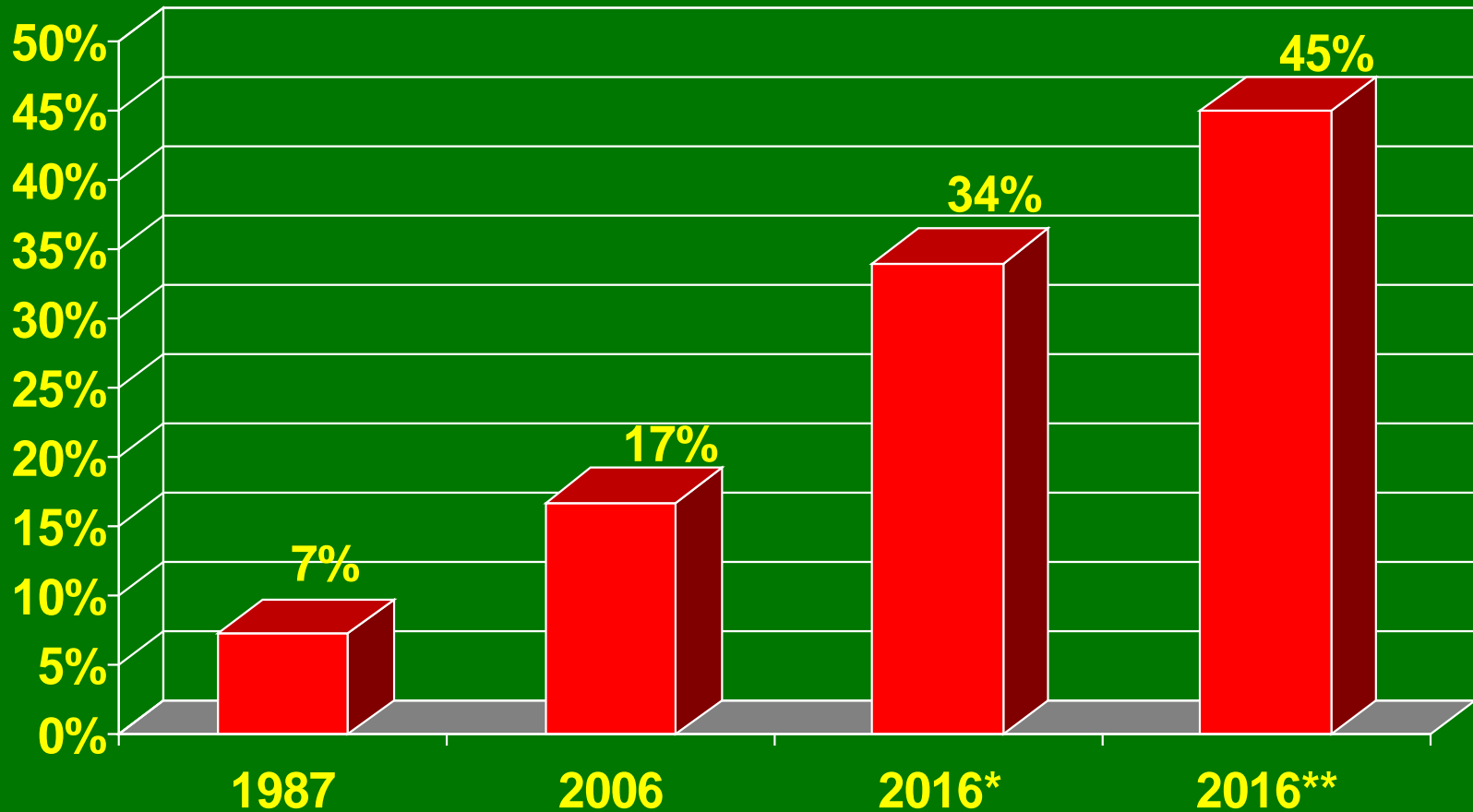
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Overview

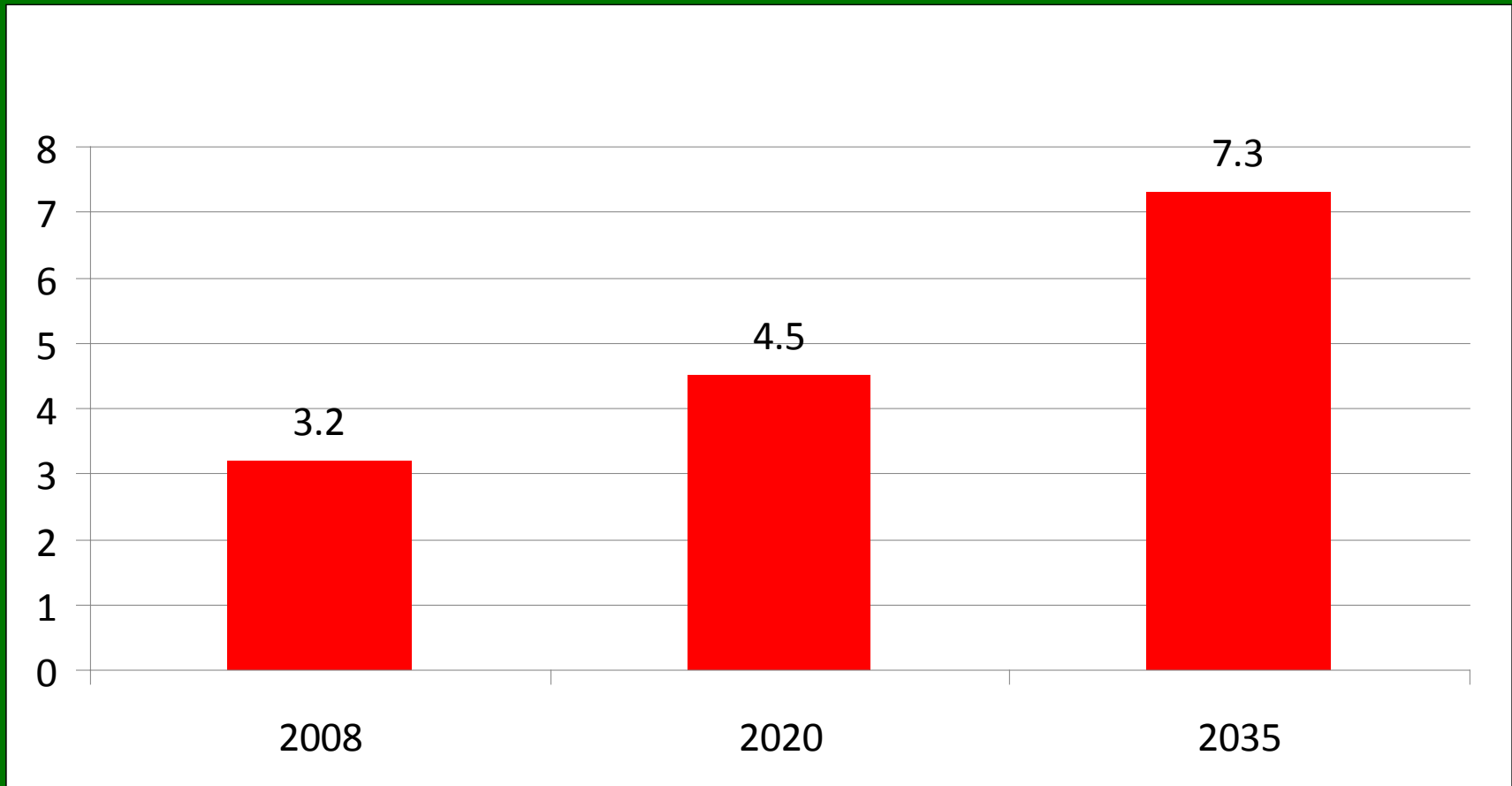
- Economics of Why
- Economics of the Core of the Reform Law
- Workforce Challenges
- How Reform will be made or broken

Percent of median family income required to purchase family health insurance



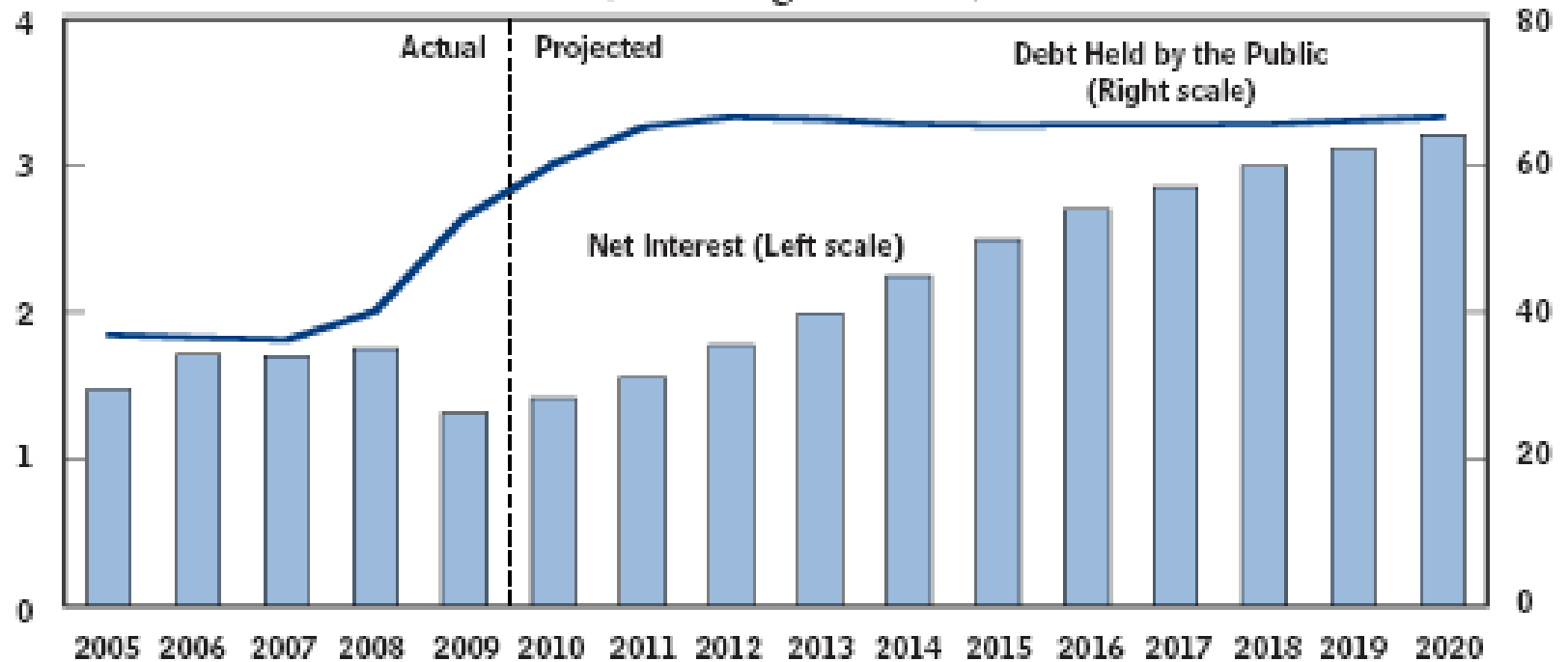
Source: Author's calculations, using KFF and AHRQ premium data, CPS income data, plus projections from Carpenter and Axteen, *The Cost of Doing Nothing*, 2008.

Medicare is unsustainable now (percent of GDP, projected)

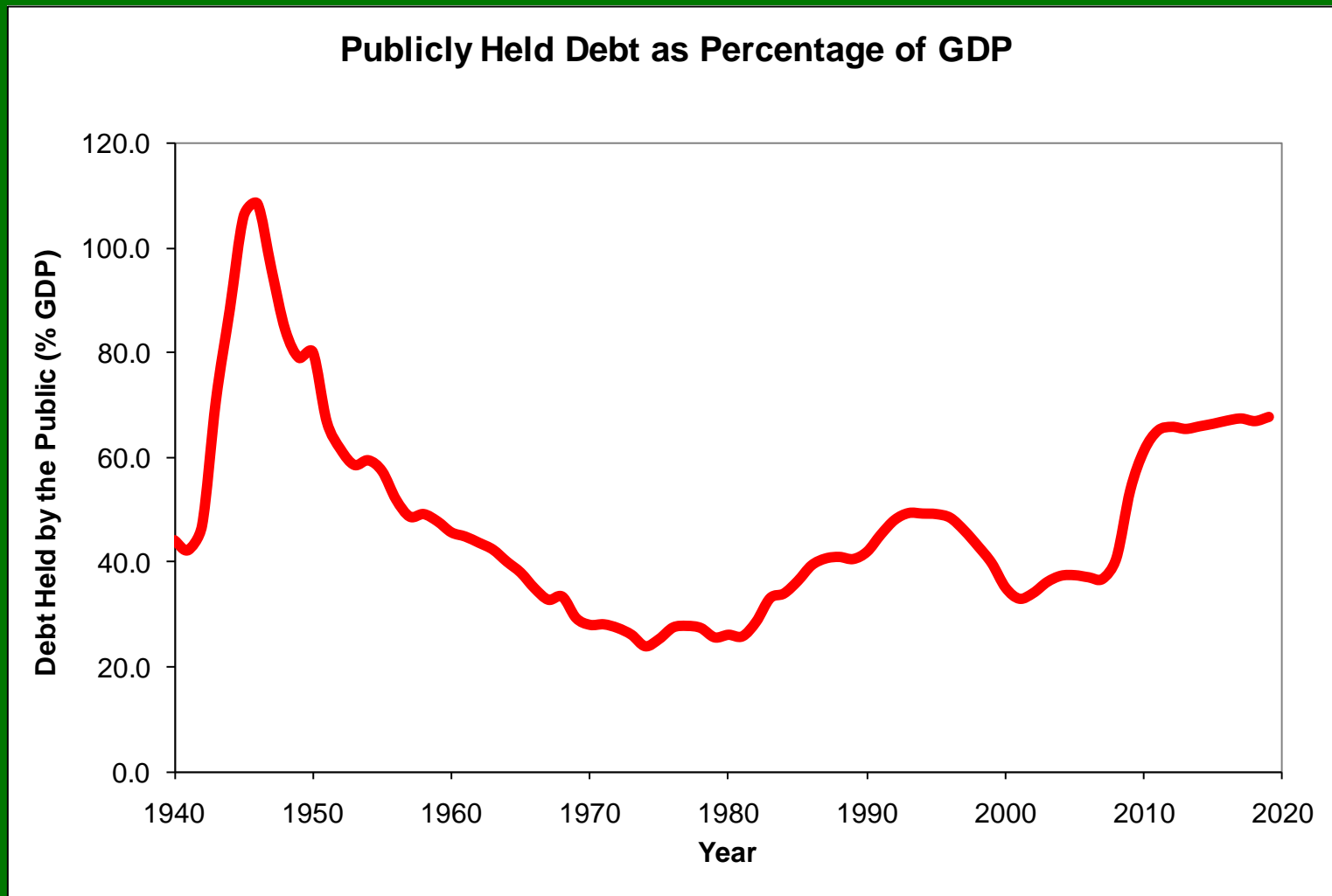


Source: Medicare Trustees Report, 2009.

Debt Held by the Public and Net Interest Payments (Percentage of GDP)



Source: CBO



Source: Council of Economic Advisors, CBO.

Why Not Just Cost Containment “First” ?

- Delivery system could not stand it
 - 3/4 of hospitals lose money on Medicare
 - Need embrace of new payment models, not circle the wagons in defense of the status quo
- Cost containment *with* coverage expansion is more likely to succeed
 - We’ve never promised to cover all Americans before
 - We have to pay the Chinese back (and we will)

What is Reform *REALLY* About?

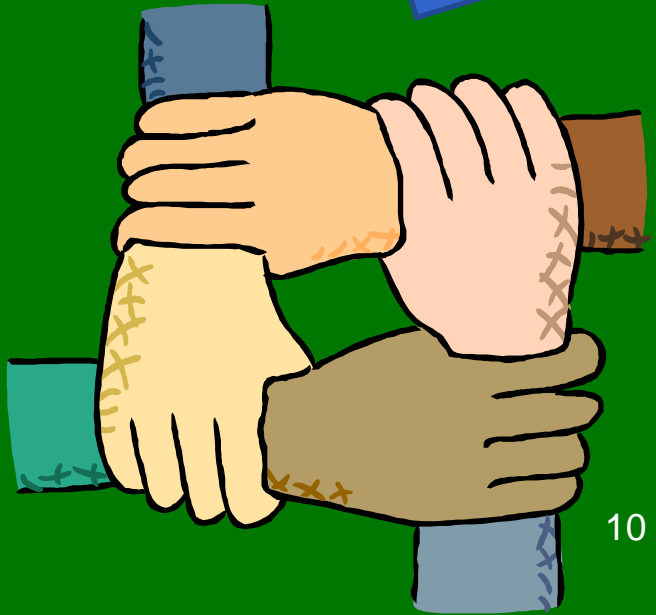
- Signalling that “Business As Usual” is over
 - We are going to expand access
 - We are going to make the system sustainable
- Changing obsolete business models
 - Risk Selection → helping *all* find value
 - FFS pay for volume → pay for value

Aligned Incentives





Aligned Incentives!



This Will Not All Be Smooth Sailing



Close Up of Not Smooth Sailing



Dovetailing with Delivery Reform

- Pressure to deliver value, not just volume, will intensify over time
 - We have to pay the Chinese back
 - BAU is over, and incentives will be changed
 - Exchanges + insurance market reforms lead to larger, more organized and focused buyers
 - Excise tax on high cost plans, limits on MLRs will force payers to focus even more on value
 - Payment reforms, if successful, will spread potential for value delivery
 - Emphasis on primary care should also help set tone
 - “Trust but verify” culture, plus increased information and cost sharing, could make patients more open to new delivery models than ever before

Workforce Challenges

- We cannot afford business as usual
- Current workforce pipelines will not meet “need” as we project it today
- Physicians are key, but part of “team”
- Hawaii data (per HRSA) strongly suggest undersupply and underuse of nurses, NPs, PA s
- You have to attract and deploy more docs, NPs and PA s than you are currently growing

Overwhelming Need for Efficiency Demands Workforce Change

- Reduce/eliminate low value care/expense
 - Administrative simplification
 - Malpractice reform
 - Coordinated care with information flows
 - Much “excess” today
- Leverage scarce assets of advanced training
 - Teams
 - Technology

Workforce Tools in the Reform Law

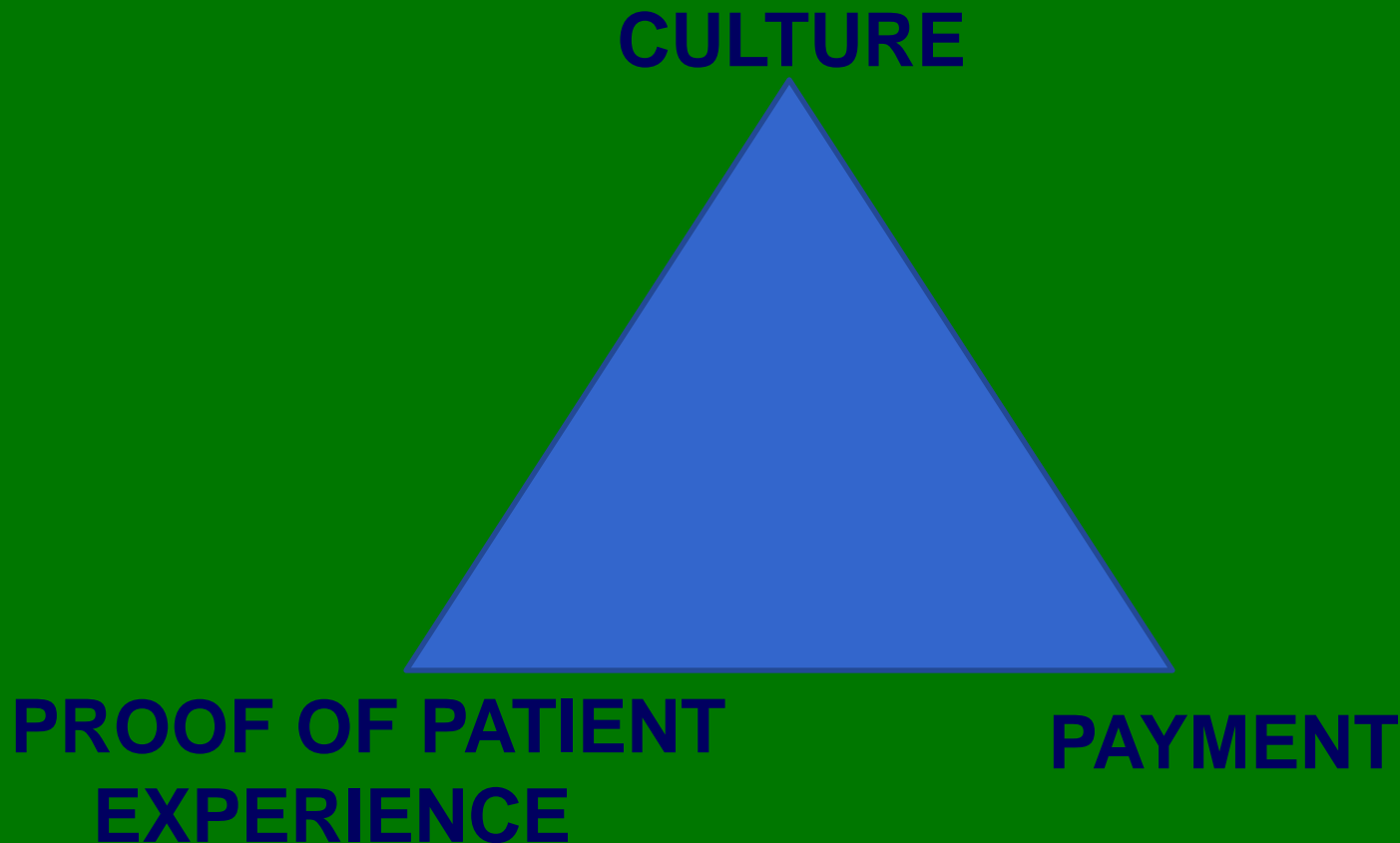
- National Health Care Workforce Commission and state development grants
- Loan forgiveness for primary care choice
 - **NOT!** (casualty of partisanship)
- Reallocation of residency slots
- Teaching Health Centers
- Nursing Loan expansion and targeting
 - Faculty, non-profit and public settings, advanced practice, family practice demos
- Grants for Nurse-managed health clinics
- Payment reforms ?

Payment Reform Models

- Pay for performance
 - Specific models in place today mostly 1.0
 - Paying for value = reward quality, cost, and patient experience/satisfaction in combo
- Medical Home
- Bundling
- Accountable Care Organizations
- Remember: Potential is huge, since much spending does not increase health

Remember:

- PAYMENT REFORM ALONE IS NOT ENOUGH

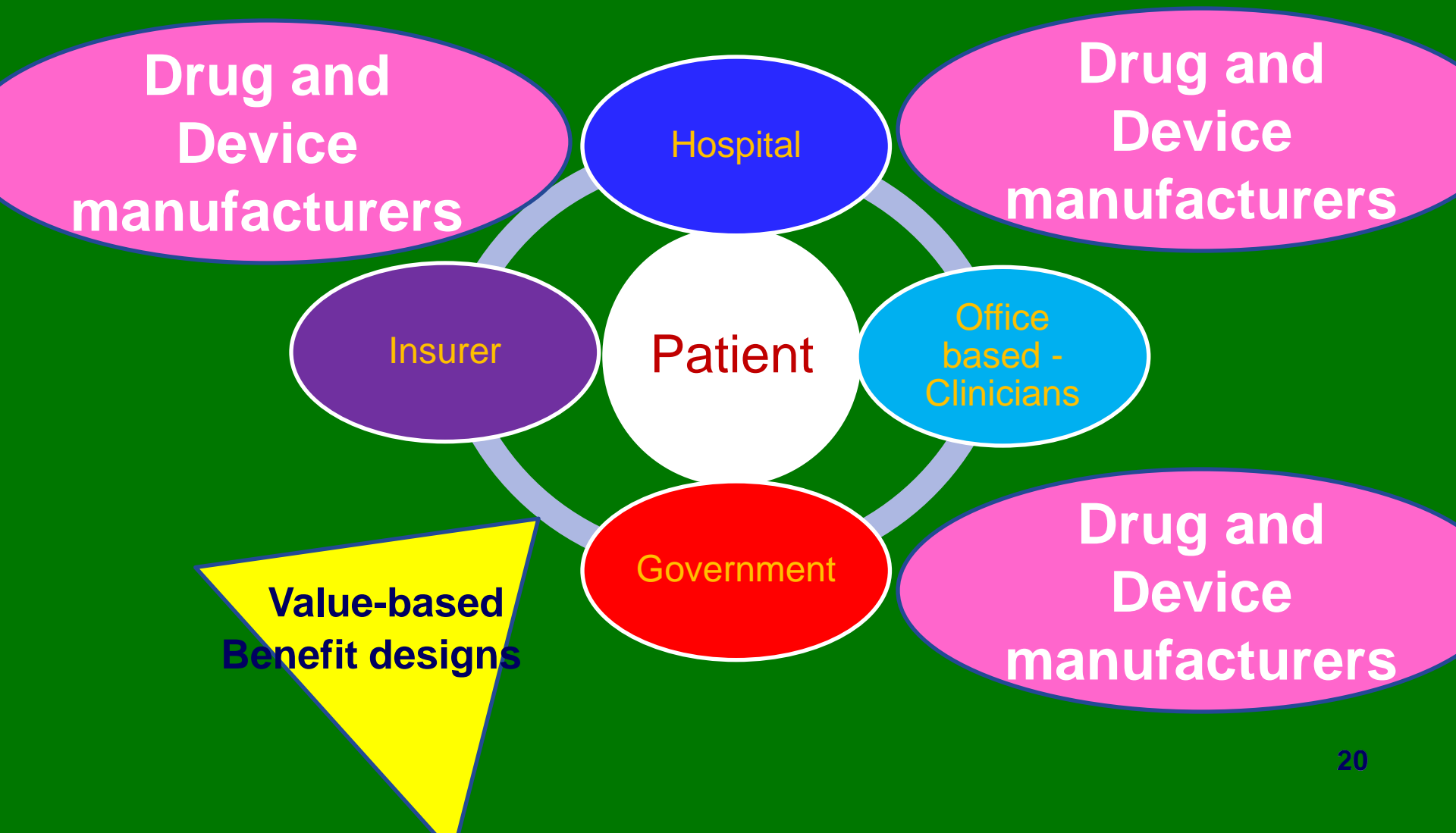


Who is at the Center of the Health Care System?

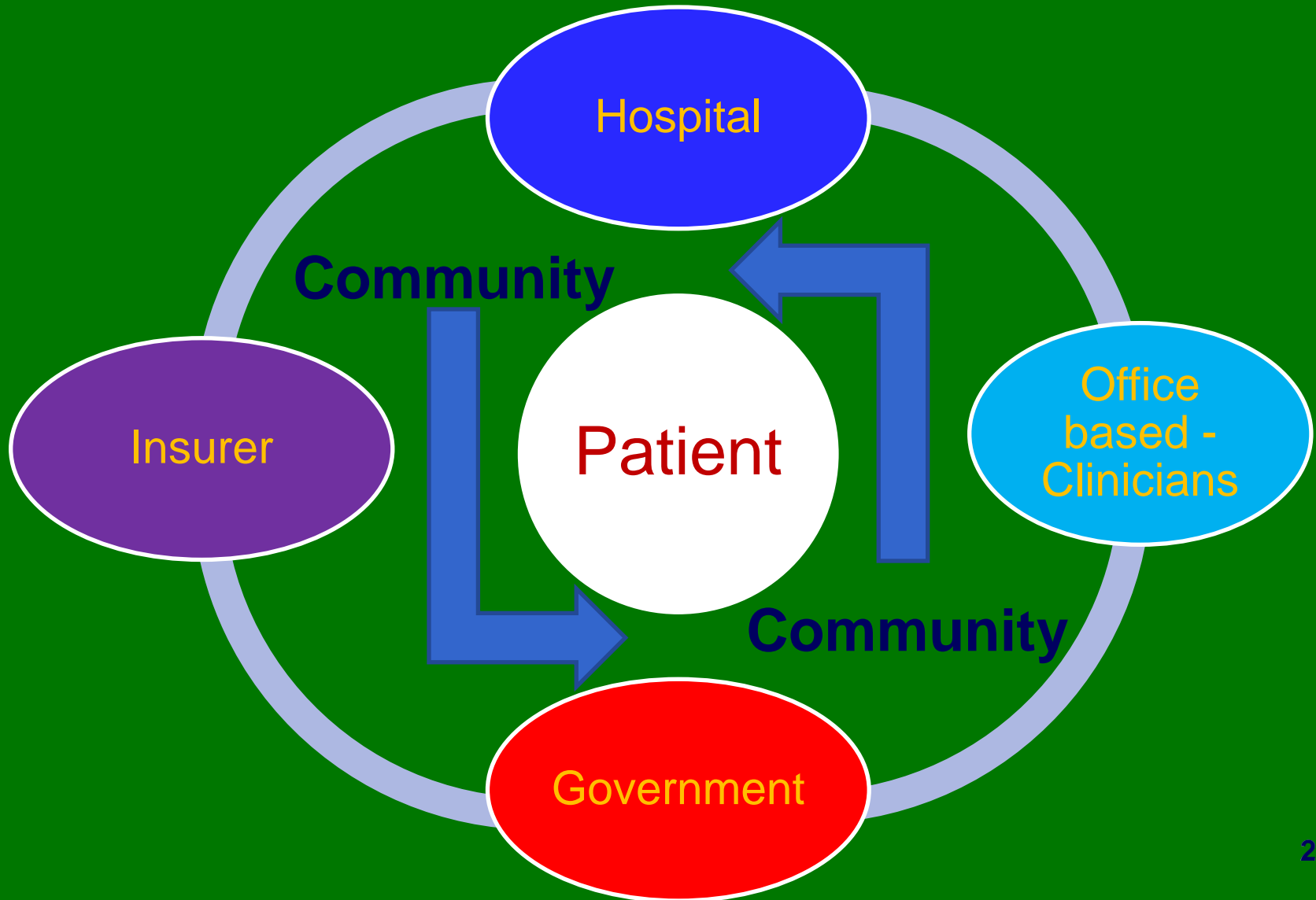
- Hospital?
- Primary Care Medical Home?
- Specialists?
- Drug and Device manufacturers?
- Insurers?

- Patients?

Reform Restructures Relationships



Reform Restructures Relationships



Better Health and Care Requires:

- Information
- Incentives
- Coordination
- Management and Leadership
- Patient engagement
- Employer buy-in to force multi-payer cooperation
 - *Successful reform is a participation sport*
 - *Most important unit is the ... Community*

Reform Process is in Transition

- Congress → HHS, states, and private sector; Legislation → regulations and pilots
- Worries:
 - HHS understaffed
 - Prolonged POLITICS prolongs bad behavior
 - Communication is hard enough when elites agree
 - Timelines sub-optimal
 - High risk pool deadline is VERY soon
 - IPAB not until 2014, CMMI 2011, excise tax 2018
 - Not Enough primary care clinicians

Where Do Academic Medical Centers Fit Into Reform?

- Acknowledge that Business as Usual is Over
 - National Commission on Workforce Needs
- Elevate value of primary care excellence
 - Train primary care teams, help THCs
- Teach value, not just quality
- Value enhancing the science of care delivery
 - Quality, outcomes and patient acuity adjustment research
 - Comparative Effectiveness Research
- Diversity recruitment and training

Most Important Parts of Reform Legislation

- Signals it sends
 - To Insurers
 - To Providers
 - To Patients
 - To our Politics