



Data Brief

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

Health Care Opinion Leaders’ Views on Payment System Reform

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ABSTRACT: The 16th Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey asked a diverse group of experts about health care payment system reform. Survey participants are fundamentally dissatisfied with the way health care is paid for in the United States, with more than two-thirds reporting the fee-for-service system is not effective at encouraging high-quality, efficient care and more than three-quarters preferring a move toward bundled per-patient payment. Shared accountability for resource use was favored as a means for improving efficiency, and at least two-thirds supported realigning provider payment incentives to improve efficiency and effectiveness, increasing payments for primary care under Medicare, and paying for transitional care services. Opinion leaders also supported Medicare negotiation of pharmaceutical prices and competitive bidding for durable medical equipment. A majority expressed support for creation of a Medicare “health board” to make Medicare payment and benefit decisions, subject to congressional guidelines.

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Overview

The fee-for-service payment system in the United States reimburses individual services—such as physician visits, procedures, and tests—rather than paying for the most appropriate care over an episode of illness or a year-long period. This system creates incentives to provide the maximum number of complex services, even when there may be better, simpler, and lower-cost ways to treat a condition. Follow-up care after a hospital discharge can, for example, reduce readmissions, which are not good for the patient and are costly for the system. However, hospitals receive no reimbursement for the costs incurred during follow-up care, and there is no mechanism for ensuring a smooth transition from the hospital to the community provider.¹

To determine the best strategies for moving the health care system toward high performance, the latest Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey asked leaders in health care and health policy about

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payment system reform. Survey respondents voiced resounding dissatisfaction with the current fee-for-service payment system. Almost all preferred alternatives to fee-for-service payment; only a small percentage think the current system is very effective at encouraging high-quality, efficient care. Opinion leaders also call for fundamental provider payment reform, with broader incentives to provide better, more efficient care over time.

The American public has reported first-hand experiences of the excesses caused by the fee-for-service system. In a recent survey, nearly 33 percent said they had received care they regarded as unnecessary or duplicative.² Moreover, nearly half reported inefficiencies within the system, including delays receiving test results or coordination problems between physicians and specialists. These experiences suggest that moving to greater accountability for care over the course of an illness or over time would be beneficial for patients.

These views on health care payment system reform are in line with the recommendations of the Commonwealth Fund Commission on a High Performance Health System, which has a mission to promote better access, improved quality, and greater efficiency across the U.S. health care system. The Commission has recommended simultaneously embracing five key strategies for change: ensuring affordable coverage for all, aligning incentives and

effective cost control, providing accountable and coordinated care, aiming higher for quality and efficiency, and creating accountable leadership on the national level and public-private collaboration.³

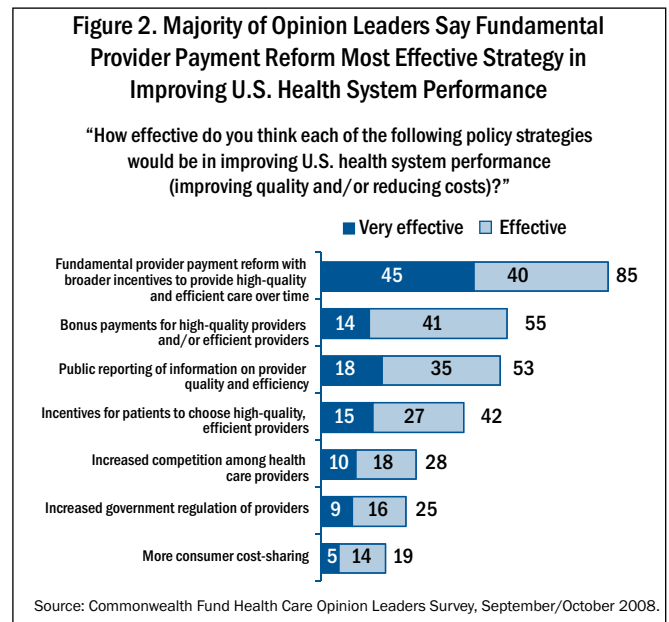
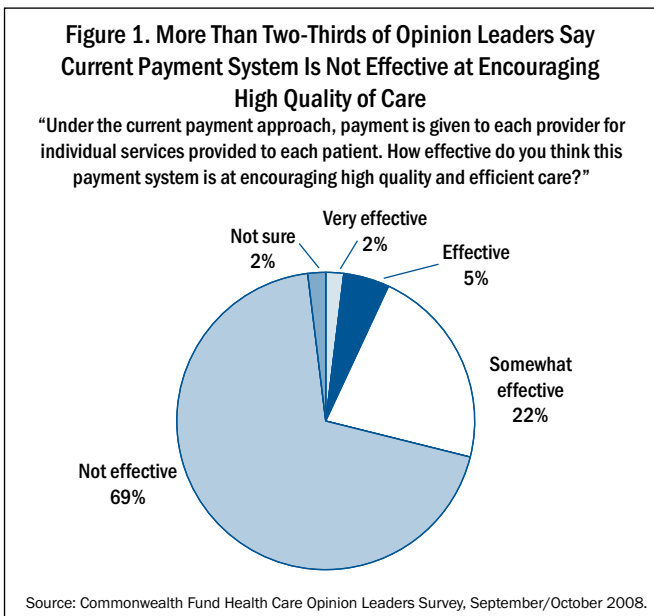
THE HEALTH CARE OPINION LEADERS SURVEY

The Commonwealth Fund and *Modern Healthcare* recently commissioned Harris Interactive to solicit the perspectives of a diverse group of health care experts on issues related to health care payment system reform. The 222 individuals who took part in the survey—the 16th in a continuing series of surveys assessing the views of experts on key health policy issues—represent the fields of academics and research; health care delivery; business, insurance, and other health industries; and government, labor, and advocacy groups (see Methodology, Appendix A).

The survey questions were developed to solicit health care opinion leaders’ thoughts on the current fee-for-service payment system and various proposals for reform. For the purposes of the survey, a fee-for-service payment system is defined as payment given to each provider for individual services provided to each patient.

Fundamental Dissatisfaction with the Current Health Care Payment System

More than two-thirds (69%) of health care opinion leaders think the current fee-for-service payment



approach is not effective at encouraging high quality and efficient care (Figure 1). Only 2 percent view the system as very effective.

Respondents overwhelmingly favored fundamental provider payment reform, including broader incentives to provide high-quality, efficient care over time (85%). Majorities cited bonus payments for high-quality providers (55%) and public reporting of information on provider quality and efficiency (53%) as effective or very effective policy strategies in improving health system performance (Figure 2). Support for fundamental reform was strong across all sectors (Table 2). Majorities of leaders in business, insurance, health care delivery, and other health care industries thought bonus payments for high-quality and/or efficient providers (62% and 62%, respectively) and public reporting of information on provider quality and efficiency (51% and 52%, respectively) were effective or very effective policy approaches. A majority of government, labor, and consumer advocacy leaders also thought bonus payments (58%), public reporting (58%), and incentives for patients to choose high-quality, efficient providers (54%) were effective or very effective. None of the listed policy strategies received similar support from a majority of those in academia and research.

A Blend of Modified Fee-for-Service and Bundled Payment Systems Perceived Effective

Sixty-two percent of opinion leaders believe that a blend of modified fee-for-service and bundled per-patient payment would be effective or very effective in facilitating a more efficient health care system. Fifty-one percent felt bundled per-patient payment—defined as a single payment for all services provided to the patient during the year, with bonuses based on quality—would be effective or very effective (Figure 3). Only 23 percent of respondents believed a modified fee-for-service system that included bonus payments for high quality and efficiency would be effective or very effective in facilitating a more efficient health care system.

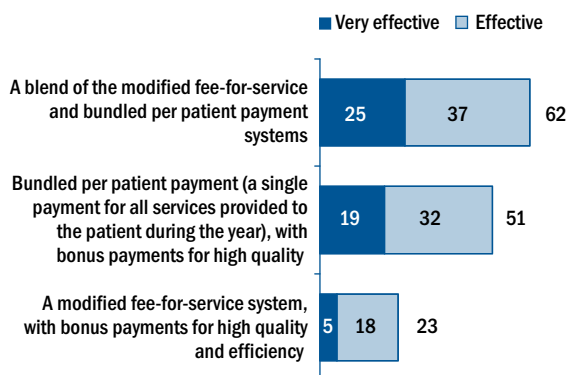
More than six of 10 health care delivery (68%) and business leaders (62%) perceive a blend of the modified fee-for-service and bundled per-patient payment systems as effective or very effective (Table 3). Although a majority of every group felt similarly, support for a blended approach was somewhat less strong among leaders in government (58%) and academia and research (54%). A modified fee-for-service system with bonus payments for high quality and efficiency was seen much less favorably in every group, with 14 percent of academic and research leaders rating such an approach as effective or very effective in increasing efficiency, while 15 percent of government leaders, 25 percent of business leaders, and 32 percent of health care delivery leaders did so.

A Blend of Modified Fee-for-Service and Bundled Payments Systems Preferred

When asked to pick a preferred system of payment, only 1 percent of opinion leaders prefer the current fee-for-service approach, while just over one-half (53%) prefer a blend of the modified fee-for-service and bundled per-patient payment systems (Figure 4). An additional 23 percent of respondents preferred bundled per-patient payment, indicating that more than three-quarters favor a move toward more bundled payment.

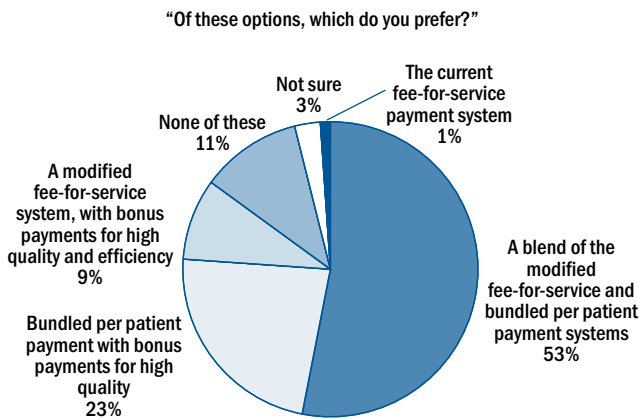
Figure 3. Blend of Modified Fee-for-Service and Bundled Per Payment Systems Perceived as Most Effective for Efficient Health Care System

“How effective do you think each of the following payment approaches would be in facilitating a more efficient health care system?”



Source: Commonwealth Fund Health Care Opinion Leaders Survey, September/October 2008.

Figure 4. Slightly Over Half of Opinion Leaders Prefer a Blend of Modified Fee-for-Service and Bundled Per Payment Systems



Source: Commonwealth Fund Health Care Opinion Leaders Survey, September/October 2008.

Support for a blended approach is strongest among health care delivery leaders (63%) and weakest among business leaders (44%) (Table 4). Support for bundled per-patient payment with bonuses for quality is comparable among leaders in the academic and research (29%) and business sectors (30%), while relatively low among respondents in government (19%) and health care delivery (15%). Meanwhile, a modified fee-for-service system with bonus payments for quality and efficiency is preferred by 13 percent of health care delivery leaders and 9 percent of all respondents.

Majority of Opinion Leaders Say Shared Accountability for Resource Use Effective

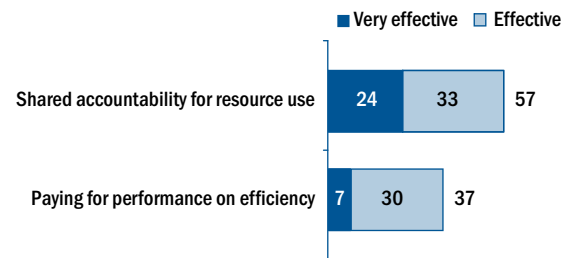
Opinion leaders were asked to rate the effectiveness of two alternative approaches for improving efficiency: paying for performance on efficiency and shared accountability for resource use. Pay-for-performance means providing bonus payments for high performance on measures of efficiency. Shared accountability for resource use involves holding health care providers accountable for the use of resources in the care of their patients over time and sharing a portion of any savings with them. Both approaches have been promoted in the policy community as methods to reward providers for the efficient delivery of care.

Fifty-seven percent of respondents reported that shared accountability for resource use would be effective or very effective in improving efficiency, while 37 percent believed the same about paying for perfor-

mance on efficiency (Figure 5). Support for shared accountability was comparable across the academic and research (57%), health care delivery (62%), and business (63%) communities, but lower among government leaders (42%) (Table 5). Meanwhile, the perceived effectiveness of paying for performance on efficiency was higher among the leaders in business (46%) and health care delivery (42%), relative to those in government (35%) and academics and research (30%).

Figure 5. Nearly Three of Five Opinion Leaders Say Shared Accountability Is Effective In Improving Efficiency

“Two approaches for encouraging improved efficiency are “paying for performance on efficiency” (providing bonus payments for high performance on measures of efficiency) and “shared accountability for resource use” (holding health care organizations including hospitals and physicians accountable for use of resources in care of patients over time and sharing a portion of any savings with the accountable care organizations). How effective do you believe each of these approaches would be in improving efficiency?”



Source: Commonwealth Fund Health Care Opinion Leaders Survey, September/October 2008.

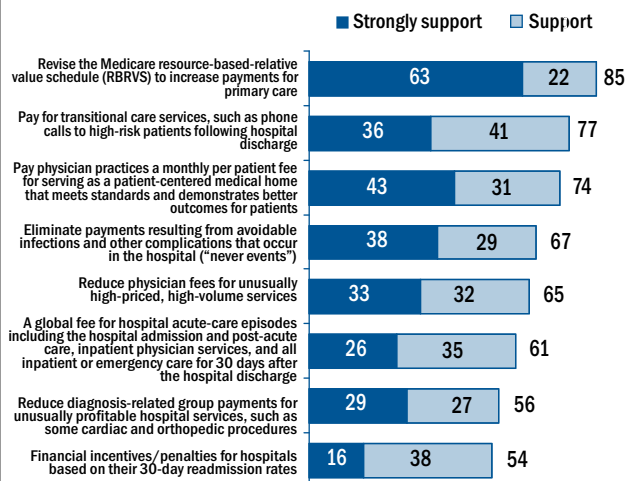
Overwhelming Support for Revisions to Medicare Fee Schedule and Payment for Transitional Services

Opinion leaders were asked to indicate their level of support for various policies designed to realign provider payment to improve the efficiency and effectiveness with which health care is delivered. An overwhelming number of opinion leaders (85%) reported they either support or strongly support revising the Medicare resource-based relative value schedule (RBRVS) for physician services to increase payments for primary care (Figure 6). Respondents also voiced support for realigning the system to pay for transitional care services (77%), paying physician practices a monthly per patient fee for serving as a medical home (74%), and eliminating payments resulting from avoidable infections and other complications that occur in a hospital, also known as “never events” (67%).

Revising the RBRVS was supported or strongly supported among a large majority of every group of leaders, ranging from 83 percent of those in academia and research to 90 percent among those in health care delivery. Support for realigning the current system to pay for transitional care services, such as phone calls to high-risk patients following hospital discharge, was highest among respondents in the health care delivery field (82%) and lowest among those in business, insurance, and other health care industries (63%) (Table 6). Support for paying physician practices a monthly per-patient fee for serving as a patient-centered medical home also was strong across groups, with 70 percent of opinion leaders in academia and research and 82 percent of leaders in health care delivery supporting or strongly supporting medical homes. Similarly, support for eliminating payments resulting from “never events” varied from 58 percent of opinion leaders in health care delivery to 71 percent of those in business, insurance, and other health care industries.

Figure 6. Opinion Leaders Support Revision of Medicare RBRVS to Improve Efficiency and Effectiveness of Health Care Delivery

“Several approaches to realigning provider payment have been suggested to improve the efficiency and effectiveness with which health care is delivered. Please indicate your level of support for each.”



Source: Commonwealth Fund Health Care Opinion Leaders Survey, September/October 2008.

Three-Quarters of Opinion Leaders Support Negotiating Pharmaceutical Prices and Competitive Bidding for Durable Medical Equipment

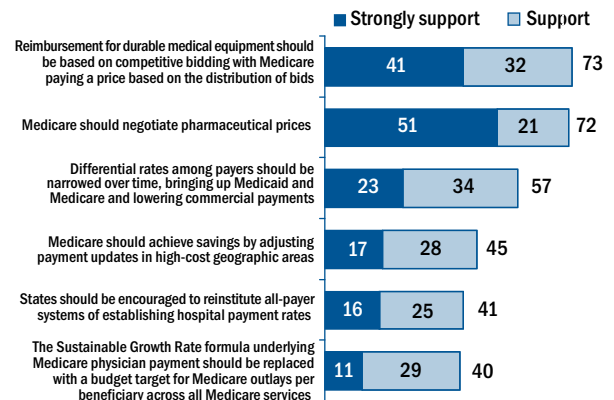
Opinion leaders believe Medicare should negotiate pharmaceutical prices and engage in competitive bidding for durable medical equipment to reduce the growth of health care costs, with 72 and 73 percent, respectively, supporting or strongly supporting those strategies (Figure 7). Support for negotiation of pharmaceutical prices is highest among respondents in the academic and research (77%) and health care delivery (78%) fields while lower among respondents in business (63%) (Table 7). Competitive bidding for durable medical equipment was supported by 79 percent of respondents in academia and research and 65 percent of health care delivery leaders.

Support for Medicare Health Board Strong Across All Groups

Recently, there has been policy interest in creating a “Medicare health board” that would enable Medicare to innovate within broad guidelines established by Congress. Congress would establish the board, appoint full-time members with long terms (e.g., nine years), and empower it to make Medicare payment and benefit decisions, subject to guidelines. Congress would also delegate to the board the authority to set specific

Figure 7. Half of Opinion Leaders Strongly Support Medicare Negotiating Drug Prices and Engaging in Competitive Bidding

“Please indicate your level of support for each of the following strategies to reduce the growth of health care costs.”



Source: Commonwealth Fund Health Care Opinion Leaders Survey, September/October 2008.

payment methods and rates and address other payment and coverage issues.

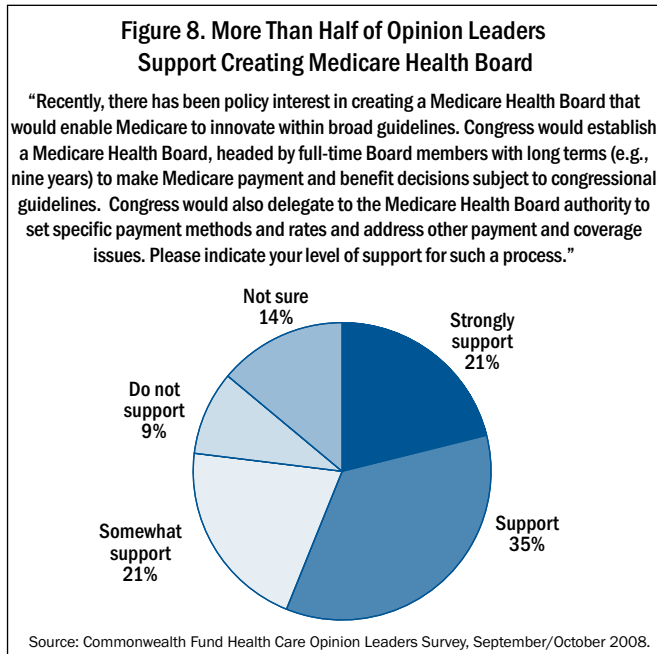
More than half (56%) of health care opinion leaders support or strongly support the creation of a Medicare health board, while only 9 percent indicated that they did not support such action (Figure 8). Support was high across respondents' employment positions and settings, with more than half of the respondents in academia, health care delivery, and business, insurance, or other health care industries supporting or strongly supporting the process; only among government leaders was there less than majority support (Table 8).

MOVING TOWARD A HIGH PERFORMANCE HEALTH SYSTEM

The Commonwealth Fund Commission on a High Performance Health System has defined a high performance health system as one that helps everyone, to the extent possible, lead longer, healthier, and more productive lives.⁴ Currently, although health spending in the United States is far higher than any other country, the health system falls short of what should be achievable levels of performance.⁵ In order to move toward high performance, the United States must improve the value it obtains for its health care dollars.

The Commission believes that efficient, high-value care cannot be achieved without fundamental provider payment and delivery reform to slow the growth in health care costs and encourage high quality.⁶ Specific strategies toward that end include:

- rewarding both high quality of care and prudent stewardship of resources, including minimizing waste through more efficient and effective health care delivery;
- moving away from the current reliance on fee-for-service payment and toward shared provider accountability for the total care of patients; and
- correcting the imbalance in payments that rewards specialty care more highly than primary and preventive care, and procedural services more highly than cognitive services.



These strategies all receive strong support from the health care opinion leaders, as evidenced by their responses to the survey.

The Commission also recommends exploring the establishment of a national board to ensure coordination of practices and policies that cut across public programs and private sector activities.⁷ The creation of a similar but more limited entity for Medicare was endorsed by over half of the health care opinion leaders in the current survey. The Commission has noted several interesting models that currently exist at the community and state levels, in which health care leaders from multiple sectors—government, business, consumer, health insurance, and care delivery—have forged coalitions to improve accountability and coordinate public and private policies and practices that are required for a high performance health system.

Important lessons are likely forthcoming from these models as well as others from non-health sectors of the U.S. economy and from around the world.

The Commission's payment policy recommendations and the options presented in this brief reflect substantial consensus among stakeholder groups on many key payment system reform issues. Health care opinion leaders—as well as the American people—agree that fundamental change is required in the way health care is paid for in the United States.⁸ The new administration and Congress that take office in January 2009 must respond to the call for change and capitalize on the broad political and popular will that exists for enacting substantive reform. Doing so will go a long way toward attaining a high performance health care system.

NOTES

¹ Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington: Medicare Payment Advisory Commission, June 2007).

² S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions*, (New York: The Commonwealth Fund, August 2008).

³ The Commonwealth Fund Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, November 2007).

⁴ The Commonwealth Fund Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, November 2007).

⁵ The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008).

⁶ A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, August 2008).

⁷ The Commonwealth Fund Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (New York: The Commonwealth Fund, November 2007).

⁸ S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions*, (New York: The Commonwealth Fund, August 2008).

METHODOLOGY

This survey was conducted online by Harris Interactive on behalf of The Commonwealth Fund among 222 opinion leaders in health policy and innovators in health care delivery and finance within the United States between September 15, 2008, and October 13, 2008. Harris Interactive sent out individual e-mail invitations to the entire panel containing a password-protected link, and a total of four reminder emails were sent to those that had not responded. No weighting was applied to these results.

The initial sample for this survey was developed using a two-step process. The Commonwealth Fund and Harris Interactive jointly identified a number of experts across different professional sectors with a range of perspectives based on their affiliations and involvement in various organizations. Harris Interactive then conducted an online survey with these experts asking them to nominate others within and outside their own fields whom they consider to be leaders and innovators in health care. Based on the results of the survey and after careful review by Harris Interactive, The Commonwealth Fund, and a selected group of health care experts, the sample for this poll was created. The final list included 1,246 individuals. In 2006, The Commonwealth Fund and Harris Interactive joined forces with *Modern Healthcare* to add new members to the panel. The Commonwealth Fund and Harris Interactive were able to gain access to *Modern Healthcare's* database of readers. The Commonwealth Fund, Harris Interactive, and *Modern Healthcare* identified readers in the database that were considered to be opinion leaders and invited them to participate in the survey. This list included 1,467 people. At the end of 2006, The Commonwealth Fund and Harris Interactive removed those panelists who did not respond to any previous surveys. In 2007, recruitment for the panel continued with *Modern Healthcare* recruiting individuals through their *Daily Dose* newsletter. In addition, Harris Interactive continued to recruit leaders by asking current panelists to nominate other leaders. The final panel size for the Health Care Delivery System Reform survey included 1,078 leaders.

With a pure probability sample of 222 adults, one could say with a 95 percent probability that the overall results have a sampling error of +/- 6.6 percentage points. However, that does not take other sources of error into account. This online survey is not based on a probability sample and therefore no theoretical sampling error can be calculated.

The data in this brief are descriptive in nature. They represent the opinions of the health care opinion leaders interviewed and are not projectable to the universe of health care opinion leaders.

ABOUT THE AUTHORS

Kristof Stremikis is research associate for the president of The Commonwealth Fund. Previously, he was a graduate student researcher in the School of Public Health at the University of California, Berkeley, where he evaluated various state, federal, and global health initiatives while providing economic and statistical support to faculty and post-doctoral fellows. He has also served as consultant in the director's office of the California Department of Healthcare Services, where he worked on recommendations for a pay-for-performance system in the Medi-Cal program. Mr. Stremikis holds three undergraduate degrees in economics, political science and history from the University of Wisconsin at Madison. In May 2008, he received a Masters in Public Policy from the Goldman School at the University of California, Berkeley. He can be e-mailed at ks@cmwf.org.

Stuart Guterman is assistant vice president and directs the Program on Medicare's Future at The Commonwealth Fund. His prior positions include: director of the Office of Research, Development, and Information at the Centers for Medicare and Medicaid Services; senior analyst at the Congressional Budget Office; principal research associate in the Health Policy Center at the Urban Institute; and deputy director of the Medicare Payment Advisory Commission (and its predecessor, the Prospective Payment Assessment Commission); and chief of institutional studies in the Health Care Financing Administration's Office of Research.

Karen Davis, Ph.D., is president of The Commonwealth Fund. She is a nationally recognized economist with a distinguished career in public policy and research. In recognition of her work, Ms. Davis received the 2006 AcademyHealth Distinguished Investigator Award. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also held an appointment as professor of economics. She served as deputy assistant secretary for health policy in the Department of Health and Human Services from 1977 to 1980, and was the first woman to head a U.S. Public Health Service agency. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna Award in 1991. Ms. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books *Health Care Cost Containment*; *Medicare Policy*; *National Health Insurance: Benefits, Costs, and Consequences*; and *Health and the War on Poverty*. She can be e-mailed at kd@cmwf.org.

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