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Data Brief

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

Health Care Opinion Leaders' Views on Vulnerable Populations in the U.S. Health System

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ABSTRACT: Virtually all leaders in health care and health care policy believe traditional safety-net institutions such as community health centers, public hospitals, and faith-based and mission-driven organizations will still fulfill critical roles in the U.S. health system after implementation of the Affordable Care Act, according to a Commonwealth Fund/ *Modern Healthcare* Health Care Opinion Leaders Survey. Nearly seven of 10 respondents believe the new law will effectively improve access and financial protection for vulnerable populations, and 70 percent support policies that would guarantee access to care for undocumented immigrants. Preferred strategies for improving the quality of care delivered by safety-net providers include ensuring access to enabling services, facilitating the adoption and spread of patient-centered medical homes, and moving toward tightly integrated models of care delivery. Approximately 80 percent feel the health system is currently unsuccessful in achieving equity across the specific domains of access, quality, and outcomes for vulnerable populations.

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OVERVIEW

The Commonwealth Fund Commission on a High Performance Health System believes that equity is a core goal of a high performance health system.[1] Yet in the United States, there are substantial disparities in health and health care for vulnerable populations such as people with low incomes, the uninsured, and minorities.[2] Ninety percent of respondents to the latest Commonwealth Fund/ *Modern Healthcare* Health Care Opinion Leaders Survey think the current health system is unsuccessful in achieving equity on the whole, and approximately 80 percent feel it is unsuccessful in achieving equity in terms of access, quality, and outcomes for vulnerable populations.

The Affordable Care Act represents a substantial step forward in addressing these shortcomings; surveyed leaders agree that the coverage expansion provisions included in the law will be helpful in closing the health care divide.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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Nearly seven of 10 respondents believe health reform will effectively improve access and financial protection for vulnerable populations. Seventy percent support policies that would guarantee access to care for undocumented immigrants who are currently ineligible for premium subsidies and expanded Medicaid coverage under reform.

Following implementation of the law, the number of patients without insurance will drop dramatically. Nevertheless, 98 percent of respondents believe traditional safety-net institutions such as community health centers, public hospitals, and faith-based and mission-driven organizations will still fulfill critical roles in the U.S. health system after 2014. To that end, the Affordable Care Act provides additional financial support to certain safety-net providers, including $11 billion for expanded and sustained investment in community health centers.[3] Both Medicaid and Medicaid disproportionate share hospital (DSH) payments—designed to offset some of the cost of providing care to low-income patients without insurance—are scheduled to be reduced in 2014. But they will not be eliminated, as hospitals will continue to provide care for the remaining uninsured.

There are provisions in the new law to test and promote the spread of delivery system reform within the safety net to better meet the needs of at-risk patients.[4] Respondents support policies like ensuring access to transportation and translation services, facilitating the adoption and spread of patient-centered medical homes, and moving toward tightly integrated models of care delivery. More than eight of 10 leaders support expanding opportunities for scholarships and loan forgiveness and providing positive incentives to private sector providers to encourage them to care for vulnerable populations.

Many of these views 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, particularly for vulnerable patients and their families.[5] The Commission has focused not only on policies that extend affordable insurance coverage to all, but also on ways to better organize and strengthen care delivery systems to deliver high-quality, efficient care for every American.[6]

The Health Care Opinion Leaders Survey

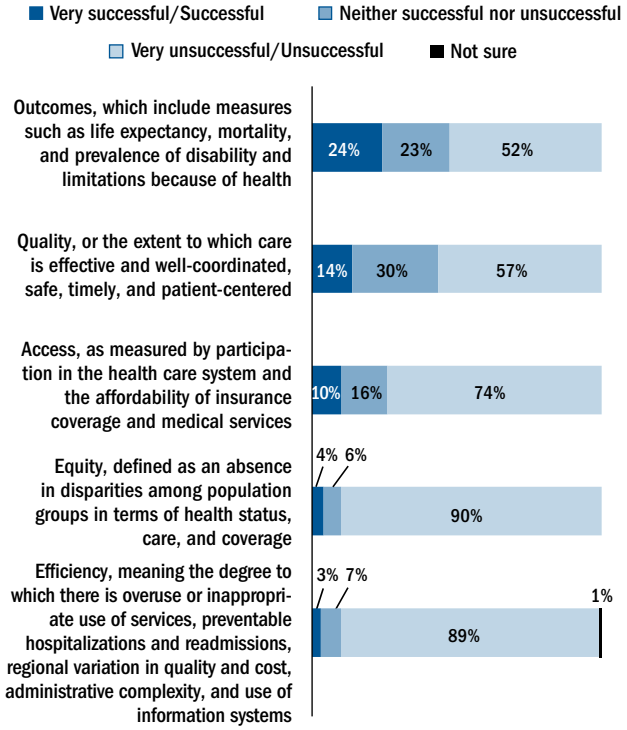
The Commonwealth Fund and *Modern Healthcare* recently commissioned Harris Interactive to solicit the perspectives of a diverse group of health care experts on vulnerable populations in the U.S. health system. The 186 individuals who took part in the survey—the 26th in a continuing series of surveys assessing the views of experts on key health policy issues—represent the fields of academia and research; health care delivery; business, insurance, and other health industries; and government, labor, and advocacy groups (see Methodology, Appendix A, for detailed demographic information). Respondents were asked for their perspective on vulnerable populations between June 14 and July 20, 2011.

About the Health Care Opinion Leaders Survey

The Commonwealth Fund/*Modern HealthCare* Health Care Opinion Leaders Survey was conducted online within the United States by Harris Interactive, on behalf of The Commonwealth Fund, between June 14 and July 20, 2011, among 1,302 opinion leaders in health policy and innovators in health care delivery and finance. The final sample included 186 leaders for a response rate of 14.3 percent. For analytic purposes respondents were grouped into four nonexclusive sectors: academic/research institutions (58%); health care delivery (22%); business/insurance/other health care industry (25%); and government/labor/consumer advocacy (9%). Data from this survey were not weighted. A full methodology is available in Appendix A.

Exhibit 1. Rating of U.S. Health System's Performance

"On the whole, how successful is the U.S. health system in achieving high performance on the following domains?"



Source: Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey, Aug. 2011.

Large majorities of leaders feel the U.S. health system as a whole has been unsuccessful in achieving equity.

Nine of 10 respondents believe the U.S. health system as a whole has been unsuccessful in achieving equity, defined as an absence in disparities among population groups in terms of health status, care, and coverage (Exhibit 1). Substantial majorities also report unsuccessful performance on domains of efficiency (89%) and access (74%), and more than half of leaders believe the health system has been unsuccessful in achieving high performance on quality (57%) and outcomes (52%). Leaders in health care delivery were less likely than other respondent categories to perceive poor performance on quality or outcomes (Table 1).

Approximately eight of 10 leaders believe the U.S. health system has failed to achieve equity for vulnerable populations on the specific domains of quality, access, and outcomes.

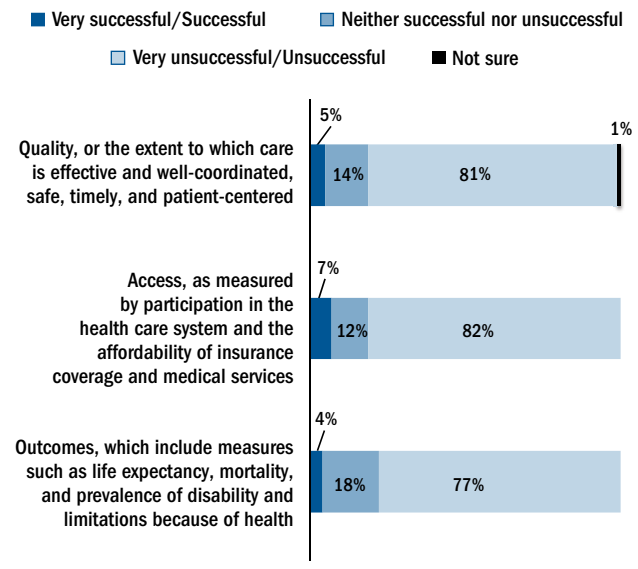
Opinion leaders were asked to indicate the degree to which the U.S. health system has been successful in achieving equity across several specific domains for vulnerable populations. More than eight of 10 leaders feel the health system has been unsuccessful or very unsuccessful in achieving equity for vulnerable populations in terms of quality (81%) and access (82%) (Exhibit 2). Seventy-seven percent of respondents report that the U.S. health system has been unsuccessful in achieving equity in outcomes for vulnerable populations. Leaders in health care delivery (66%) report poor performance on outcomes at lower rates than those in academic and research institutions (79%) and business, insurance, and other health care industries (78%) (Table 2).

A strong majority of respondents feel the Affordable Care Act will be effective in improving access and financial protection for vulnerable populations.

Key provisions in the Affordable Care Act expand eligibility for Medicaid to individuals or families earning up to 133 percent of the federal poverty level, offer premium subsidies for private insurance to families earning up to four times the poverty level, and establish an essential benefits package that limits patient

Exhibit 2. Rating of U.S. Health System's Achievement of Equity for Vulnerable Populations

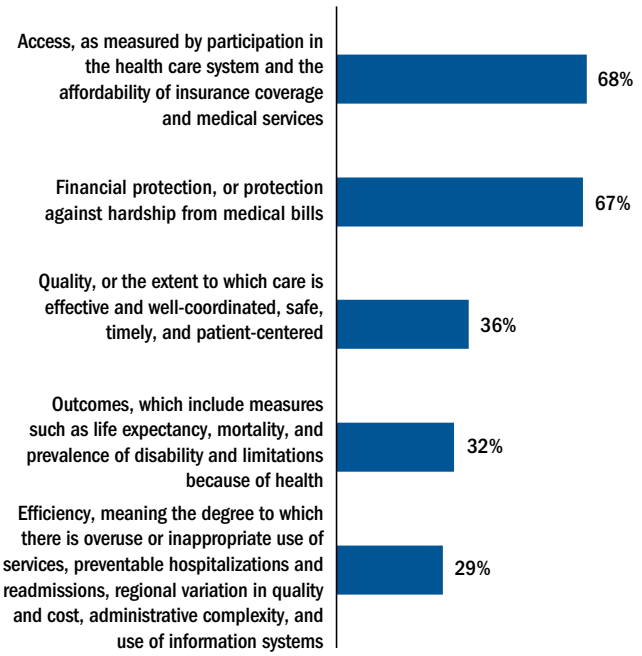
"How successful is the U.S. health system in achieving equity on the following domains for vulnerable populations?"



* Percentages may not add up to 100% because of rounding.
Source: Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey, Aug. 2011.

Exhibit 3. The Affordable Care Act and Vulnerable Populations

"How effective do you feel the Affordable Care Act will be in addressing the following issues for vulnerable populations?"



Source: Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey, Aug. 2011.

liability and out-of-pocket costs. As a result of the coverage expansions, the number of uninsured Americans is projected to diminish substantially. In 2009, there were an estimated 51 million uninsured Americans.[7] Following full implementation of health reform, Medicaid is expected to cover an additional 17 million low-income, nonelderly people by 2021.[8] It is also estimated that health insurance coverage will expand to an additional 24 million nonelderly people by 2021 through subsidized health insurance options.[9]

Strong majorities of leaders believe the law will be effective in improving access to the health system (68%) and offering financial protection (67%) for vulnerable populations (Exhibit 3). Respondents were more skeptical that the law would effectively improve quality (36%), outcomes (32%), or efficiency (29%) for at-risk groups.

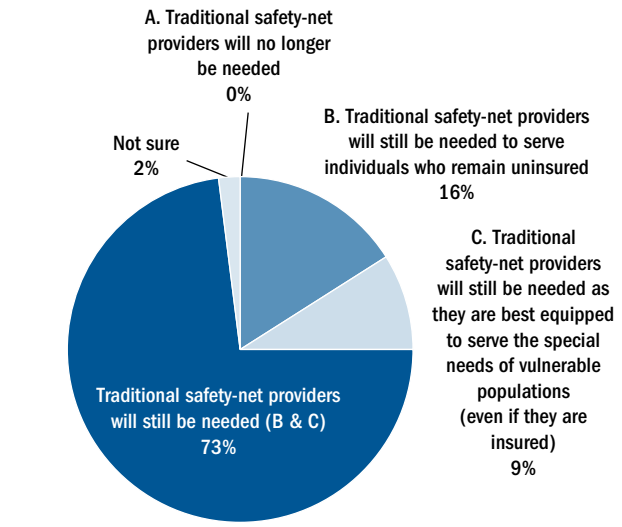
Ninety-eight percent of leaders believe traditional safety-net providers will still fulfill critical roles after implementation of the Affordable Care Act.

Despite the gains in coverage projected under the Affordable Care Act, 23 million nonelderly Americans are expected remain uninsured in 2021 (about 8% of U.S. residents), many of whom may rely on traditional safety-net institutions for care.[10] Furthermore, it is likely that many uninsured patients who gain coverage through Medicaid and subsidized private health insurance options will continue to seek out community providers who are uniquely qualified to meet their needs.

Opinion leaders were asked for their view on the post-reform role of traditional safety-net institutions such as community health centers, public hospitals, and faith-based and mission-driven organizations. Ninety-eight percent (98%) of leaders feel traditional safety-net providers will still be needed to serve individuals who remain uninsured after 2014 and/or to meet the special needs of at-risk groups even if they are insured (Exhibit 4). No leaders believe that traditional safety-net providers will no longer be needed.

Exhibit 4. Post-Reform Role of Traditional Safety-Net Providers

"Assuming that the coverage expansion initiatives included in the Affordable Care Act are implemented as scheduled in 2014, which of the following comes closest to your view regarding the post-reform role of traditional safety-net providers such as public hospitals and Federally Qualified Health Centers?"



Source: Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey, Aug. 2011.

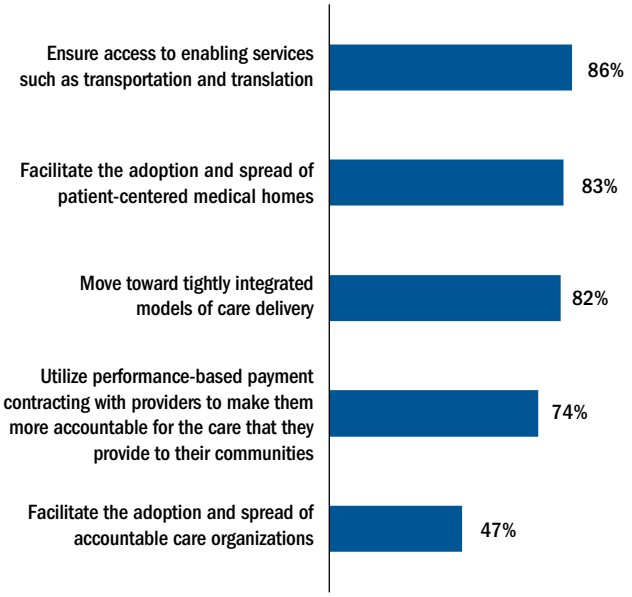
Large majorities of respondents support policies that ensure access to enabling services, facilitate the adoption and spread of patient-centered medical homes, and move toward tightly integrated models of care delivery.

Several provisions in the Affordable Care Act test and promote the spread of delivery system reforms to improve the quality of care delivered within the safety net and across the entire health care system. The law provides grants to states for establishing community health teams that provide support and funding for enhanced reimbursement to primary care sites designated as health homes for Medicaid patients with chronic conditions. Health reform also provides integrated health care services for low-income populations through community-based collaborative care networks. Clinical integration of services across settings is essential to delivering high-quality, coordinated, and efficient care, especially for vulnerable populations who tend to be sicker and have complex medical and behavioral needs.[11]

Exhibit 5. Improving the Quality of Care Provided by Safety-Net Providers

"Please indicate the degree to which you support the following strategies to improve the quality of care vulnerable populations receive from safety-net providers such as community health centers, public hospitals, and faith-based and mission-driven community service facilities."

Percent reporting "Strongly support/Support"



Source: Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey, Aug. 2011.

Opinion leaders were asked to indicate their support for strategies designed to improve the quality of care vulnerable populations receive from safety-net providers. Eighty-six percent of those surveyed support policies that ensure access to enabling services such as transportation and translation for patients (Exhibit 5). Large majorities also support facilitating the adoption and spread of patient-centered medical homes (83%), moving toward tightly integrated models of care delivery (82%), and utilizing performance-based payment contracting with providers (74%). There was less support (47%) for the adoption and spread of the specific model of accountable care organizations.

More than eight of 10 leaders support expanding opportunities for scholarships and loan forgiveness and establishing positive incentives for private sector providers to encourage them to care for vulnerable populations.

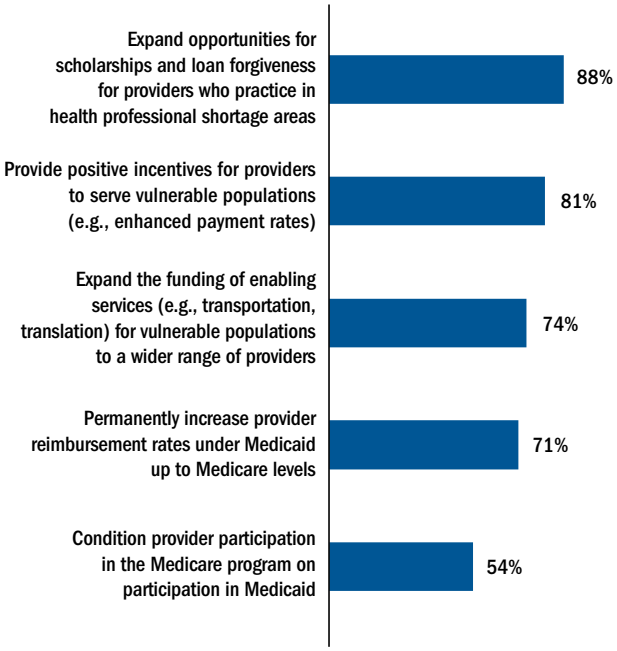
The Affordable Care Act has numerous provisions to train and provide financial incentives for medical professionals to serve in underserved communities. One provision authorizes $1.5 billion between 2011 and 2015 for the National Health Service Corps to provide scholarships and loan forgiveness for primary care physicians, nurse practitioners, and physician assistants practicing in health professional shortage areas. Another expands training programs under Title VII, Section 747 of the Public Health Services Act, which encourages health care workers to practice in underserved areas. In addition, Medicaid reimbursement rates will be brought up to Medicare levels in 2013 and 2014 for certain evaluation and management services provided by primary care physicians.

More than eight of 10 survey participants support expanding opportunities for scholarships and loan forgiveness for providers who practice in health professional shortage areas (88%) and establishing positive incentives for providers to serve vulnerable populations (81%) (Exhibit 6). A large majority also support expanding funding of enabling services to a wider range of providers (74%) and permanently increasing

Exhibit 6. Encouraging Private Sector Providers to Care for Vulnerable Populations

"Please indicate your support for or opposition to the following approaches that have been proposed to encourage private sector providers to serve vulnerable populations."

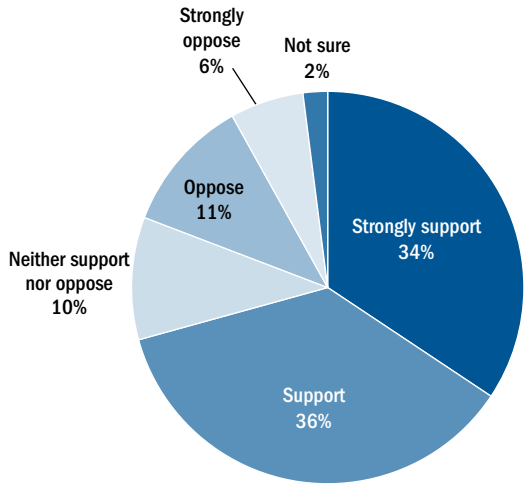
Percent reporting "Strongly support/Support"



Source: Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey, Aug. 2011.

Exhibit 7. Undocumented Immigrants and Access to Care

"Under the Affordable Care Act, undocumented immigrants to the U.S. are ineligible for premium subsidies and expanded Medicaid coverage. Please indicate the degree to which you support policies that would guarantee access to preventive, primary, and acute care for undocumented immigrants."



Source: Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey, Aug. 2011.

provider reimbursement rates under Medicaid up to Medicare levels (71%). However, respondents were less enthusiastic about conditioning provider participation in the Medicare program on participation in Medicaid.

Seventy percent of respondents support policies that would guarantee access to care for undocumented immigrants.

Under the Affordable Care Act, undocumented immigrants are ineligible for premium subsidies and expanded Medicaid coverage. Of the 23 million nonelderly Americans projected to remain uninsured in 2021, approximately one-third will be undocumented immigrants.[12] Seventy percent of opinion leaders support or strongly support policies that would guarantee access to preventive, primary, and acute care for undocumented immigrants (Exhibit 7). Only 17 percent of respondents oppose or strongly oppose such policies.

THE PATH TO A HIGH PERFORMANCE HEALTH SYSTEM

The majority of health care opinion leaders report that the U.S. health system is unsuccessful in achieving equity on the whole, and many believe it is largely unsuccessful in achieving equity across the specific domains of access, quality, and outcomes for vulnerable populations. This is consistent with decades of research that demonstrate that vulnerable populations such as low-income people, the uninsured, and minorities are at higher risk for poor health and health outcomes.

The Affordable Care Act represents a substantial step forward in addressing the needs of vulnerable populations, and a strong majority of leaders believe the law will effectively improve access and financial protection for such groups. Despite significant expansion of health insurance coverage after 2014, virtually all respondents believe traditional safety-net providers will still be needed. Leaders support policies to continue to improve the quality of care delivered by safety-net providers. These include models with a strong evidence base, like patient-centered medical homes and tightly integrated models of care delivery. There is also strong support for policies that encourage the private sector to serve vulnerable populations. Furthermore, 70 percent of respondents support guaranteeing access to care for undocumented immigrants.

Equity is a core goal of a high performance health system, and we need to pay attention to how well the U.S. health system serves the most vulnerable populations across the dimensions of access, quality, and efficiency. Ensuring that everyone has access not only to affordable insurance coverage but also to care, promoting more coordinated and organized care delivery through medical homes and clinically integrated health systems, and improving the quality of care delivered by all providers serving vulnerable populations will help us provide equal opportunities for all to lead healthy and productive lives. An analysis of the Affordable Care Act indicates that the significant insurance and delivery reform provisions included in the law utilize many of these strategies and have the potential to place the nation on a path to a high performance health system that works for all Americans.

Notes

[1] The Commonwealth Fund Commission on a High Performance Health System, *Framework for a High Performance Health System for the United States* (New York: The Commonwealth Fund, Aug. 2006).

[2] H. Mead, L. Cartwright-Smith, K. Jones et al., *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook* (New York: The Commonwealth Fund, March 2008); K. Davis and K. Stremikis, "A Five-Step Plan for Eliminating Inequality in Health Care," *Pathways: A Magazine on Poverty, Inequality, and Social Policy*, Winter 2009:14–18; K. Davis, C. Schoen, and K. Stremikis, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally 2010 Update* (New York: The Commonwealth Fund, June 2010); 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); Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2010* (Washington, D.C.: AHRQ, March 2011); and Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: National Academies Press, 2003).

[3] Patient Protection and Affordable Care Act (PPACA, P.L. 111–148), as amended by the Affordable Care and Education Reconciliation Act (ACERA, P.L. 111–152). For details on provisions see: Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111–148 and 111–152), http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

[4] K. Davis, *A New Era in American Health Care: Realizing the Potential of Reform* (New York: The Commonwealth Fund, June 2010); K. Davis, S. Guterman, S. R. Collins, K. Stremikis, S. Rustgi, and R. Nuzum, *Starting on the Path to a High Performance Health System: Analysis of the Payment and System Reform Provisions in the Patient Protection and Affordable Care Act of 2010* (New York: The Commonwealth Fund, Sept. 2010).

[5] Commonwealth Fund Commission, *Framework,* 2006.

[6] The Commonwealth Fund Commission on a High Performance Health System, *Keeping Both Eyes on the Prize: Expanding Coverage and Changing the Way We Pay for Care Are Essential to Make Health Reform Work for Families and Businesses* (New York: The Commonwealth Fund, Nov. 2009).

[7] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2010.

[8] Congressional Budget Office, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," Statement of Douglas W. Elmendorf, Director, before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 30, 2011, http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf.

[9] Ibid.

[10] Ibid.

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

[12] Congressional Budget Office, "CBO's Analysis," 2011.

Appendix A. Methodology

This survey was conducted online by Harris Interactive on behalf of The Commonwealth Fund among 186 opinion leaders in health policy and innovators in health care delivery and finance within the United States between June 14 and July 20, 2011. Harris Interactive sent out individual e-mail invitations to the entire panel containing a password-protected link, and a total of five reminder e-mails 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 result 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 Vulnerable Population survey included 1,302 leaders. With this survey, we are using a new definition of the panel. One hundred eighty-six of these panelists completed the survey, for a 14.3 percent response rate.

With a pure probability sample of 186 adults one could say with a 95 percent probability that the overall results have a sampling error of +/– 7.18 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. It represents the opinions of the health care opinion leaders interviewed and is not projectable to the universe of health care opinion leaders.

About the Authors

Kristof Stremikis, M.P.P., M.P.H., is senior 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 postdoctoral 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 a master of public policy degree from the Goldman School at the University of California, Berkeley, and a master of public health degree from the Columbia University Mailman School of Public Health. He can be e-mailed at ks@cmwf.org.

Julia Berenson, M.Sc., is the research associate to The Commonwealth Fund's executive vice president for programs. In this role, she provides written, analytical, and research support to the executive vice president for programs and program staff. Before joining the Fund, Ms. Berenson was a program associate at the Center for Health Care Strategies, where she worked on initiatives that enhance the organization, financing, and delivery of health systems aimed at improving the quality of care and reducing disparities among Medicaid beneficiaries. Ms. Berenson received a master's degree in health policy, planning, and financing jointly awarded by the London School of Economics and the London School of Hygiene and Tropical Medicine.

Anthony Shih, M.D., M.P.H., rejoined The Commonwealth Fund in January 2011 as executive vice president for programs. In this role, Dr. Shih serves as a member of the Fund's executive management team and is responsible for all of The Commonwealth Fund's grants programs. From 2006 to 2008, Dr. Shih directed the Fund's Program on Quality improvement and Efficiency. He left The Commonwealth Fund in 2008 to serve as chief quality officer and vice president of strategy for IPRO, one of the nation's leading independent, nonprofit health care quality improvement organizations. In addition to guiding the overall growth and strategy of IPRO, Dr. Shih led IPRO's Health Care Transparency Group, a leader in public reporting of health care performance information. Dr. Shih first joined IPRO in 2001, and held a variety of executive management positions there. Earlier in his career, he was assistant medical director for a community-based mental health organization serving immigrant and refugee populations in Oakland, California. Dr. Shih is board-certified in public health and preventive medicine, and holds an M.D. from the New York University School of Medicine and an M.P.H. from the Columbia University Mailman School of Public Health.

Pamela Riley, M.D., M.P.H., joined the Fund in July 2011 as program officer of the Vulnerable Populations program. Dr. Riley is a pediatrician with a longstanding commitment to improving the health of low-income, medically underserved populations. Dr. Riley previously served as clinical instructor in the Division of General Pediatrics at the Stanford University School of Medicine. In 2010, Dr. Riley became a program officer at the New York State Health Foundation, where she focused on developing and managing grantmaking programs in the areas of Integrating Mental Health and Substance Use Services, the Initiative for Returning Veterans and Their Families, and the Diabetes Campaign's faith-based initiative. Dr. Riley received an M.D. from the UCLA David Geffen School of Medicine in 2000, and an M.P.H. from the Harvard School of Public Health as a Commonwealth Fund/Harvard University Minority Health Policy Fellow in 2009.

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