Hospital Value-Based Purchasing
Will Medicare’s New Policy Exacerbate Disparities?

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This fall, the Centers for Medicare and Medicaid Services (CMS) will embark on perhaps their most ambitious hospital quality improvement program yet—value-based purchasing (VBP). This program aims to transform Medicare from a purchaser of services to a purchaser of value, tying hospitals’ payments to a series of quality metrics including performance on processes of care and patient experience.1

Truly, pay for performance in Medicare has been a long time coming. More than a decade ago, in its landmark Crossing the Quality Chasm report, the Institute of Medicine highlighted the payment system as a cause of quality problems in health care and a barrier to reform.2 In the Medicare program, perverse incentives abound for clinicians to focus on doing more rather than doing better. Over the past decade, CMS has moved deliberately in the direction of a more value-based hospital payment system. In 2003, CMS spearheaded the Premier Hospital Quality Incentive Demonstration, a pay-for-performance pilot project involving more than 200 US hospitals.3 In 2005, Medicare launched Hospital Compare with public reporting of process measures of hospital quality, later extending reporting to clinical outcomes such as mortality rates.4 In 2009, Medicare altered its inpatient prospective payment system to prevent hospitals from receiving severity-adjusted payments for any of 9 hospital-acquired complications. Now, VBP takes these programs one step further—into a national, mandatory payment for quality.

While tying payment to performance rather than volume and intensity is conceptually desirable, we know there are many complications to any such effort. In this issue of Circulation: Cardiovascular Quality and Outcomes, Borden and Blustein5 illustrate one such complication: How do we encourage and reward good performance without excessively punishing the disadvantaged? This is both a fundamental and a difficult question, to which there is no simple or absolute “right” answer—but rather a set of tradeoffs, the magnitude of which we cannot expect to know precisely.

Almost surely, however, the CMS policy is imbalanced. The “elastic ruler” of the VBP formulas double-corrects against rewarding mediocrity by both setting a minimum performance level for any bonus and rewarding failure-rate reduction (the proportional reduction of the gap between baseline performance and maximum attainment) rather than absolute improvement. The risk here is real: the opportunity cost of this schema is under-rewarding improvement specifically among those with the most to gain. In the long run, we could see disparities increase if poor-performing institutions cannot bridge the gap because the resources required to move into bonus territory exceed the rewards for doing so.

Borden and Blustein offer a reasonable alternative—the “wooden ruler,” that would strike this balance differently for hospitals at the lower end of the scale by rewarding fixed increments of improvement. This approach has a number of appeals, not the least of which is that it is simple, straightforward, and objective. Additionally, given that baseline performance on nearly all of the measures in the initial phase of VBP is 90% or greater, this method makes improvement only relevant in the scoring for low performers, while high performers continue to be rewarded for achieving progressively higher scores even at the top end of the attainment scale. After all, when experts have specifically called for pay-for-performance programs to reward improvement, the notion was that doing so would primarily serve to encourage lower-performing providers to catch up. By design, the “most valuable player” and “most improved” awards almost always go to two different players.

Of course, all of the work that has been done on VBP thus far is simply a simulation analysis. In the real world, dynamics will matter—it remains to be seen whether disadvantaged hospitals will be able to effectively respond to the VBP incentives and rapidly close the gap between themselves and the high-performing hospitals. The process metrics in VBP have been included in Hospital Compare for many years, and many are beginning to demonstrate a significant ceiling effect; in this context, even the poor-performing hospitals may be able to “catch up” on these metrics in short order. Prior evidence suggests that significant improvement may be feasible; data from the United Kingdom demonstrated that within the first 3 years of a pay-for-performance program for general practitioners, practices scored more than 95% of available points; the worst performers—who served the most disadvantaged patients—improved at the fastest rate.6 Similarly, an analysis from the Premier program showed that hospitals caring for a disproportionate number of poor patients had worse quality at baseline but demonstrated greater improvement over time.7 We will need to closely track the

References


On a more fundamental level, what we still need to understand is exactly why disadvantaged hospitals perform more poorly, and what we can do to help them improve. Using incentives for this purpose may be justifiable if each hospital can determine how best to improve quality; on the other hand, if some hospitals do not know how to produce these results, lack the resources to do so, or if the easiest way for poor performers to improve outcomes is through undesirable means such as dumping patients or gaming the system, then we may need a different approach.

At the very least, we should strive to “do no harm” to the most vulnerable hospitals in the nation while simultaneously working to improve the performance of all hospitals. The Borden and Blustein “wooden ruler” would appear to bring VBP a step closer to this goal than the current formula. We should also recognize that we may need to go further to truly improve health outcomes for the people living in the deeply disadvantaged parts of the country that Borden and Blustein identify. Incentives to improve the quality of care may not ultimately be enough to overcome the types of obstacles—from poverty to human capital—that these hospitals face as they try to improve their performance. Perhaps even more importantly, we should not lose sight of the fact that while important, inpatient quality of care may be relatively far down the list of threats to health in persistently disadvantaged communities. Given scarce resources, Federal investments in health may be better made in support of community-building and public health than in efforts to gain one additional point on VBP metrics.

Disclosures
Dr Rosenthal is a paid member of the Voluntary Hospitals of America (VHA) Value-Based Purchasing Advisory Board.

References

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