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Changes in Health Care Financing & Organization (HCFO)

findings brief

What Is the Effect of Pay for Performance on Hospitals that Serve Poor Patients?

key findings

- After three years of participation in a CMS pay-for-performance initiative, hospitals that served a high number of poor patients realized gains in quality improvement measures on certain clinical conditions.
- The gains among these hospitals were greater than gains among other hospitals, allowing them to close the gaps seen prior to the onset of pay for performance.
- Hospitals that served a high number of poor patients started with lower baseline quality performance than other hospitals.

Pay-for-performance (P4P) initiatives typically provide hospitals or individual health care providers with a financial reward for meeting a set quality goal or realizing quality improvement. The aim of these initiatives is to incentivize high-quality care in a fee-for-service environment that traditionally rewards quantity rather than quality. The use of P4P has gained momentum in recent years with interest from private insurers, Medicaid, and Medicare. While there is general support for the aim of these initiatives, some critics fear that the programs will reward resource-rich hospitals that are able to invest in quality improvement and penalize hospitals that serve a high number of poor patients. Unintended consequences could include the inducement to avoid patients of lower health status, a reduction in income for physicians in poor minority communities, and the worsening of health care disparities.[1]

Study Overview

While there has been previous research examining the overall effectiveness of P4P programs in quality improvement, there was a gap in the literature around the impact of P4P on health care disparities. How do hospitals that serve high numbers of poor patients respond to financial incentives to improve quality as compared to other hospitals with a different patient mix? In a HCFO-funded study,[2] Ashish Jha, M.D., M.P.H., and colleagues attempted to answer this question. "We have all been worried that P4P may widen the gap between providers that care for the poor and others, potentially exacerbating health care disparities," said Dr. Jha.

In 2003 the Centers for Medicare & Medicaid Services (CMS) launched the Premier Hospital Quality Incentive Demonstration (hereafter "Premier program"), a large P4P demonstration to reward hospitals for high-quality care for five

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clinical conditions: acute myocardial infarction (AMI), congestive heart failure (CHF), pneumonia, coronary artery bypass graft surgery, and total knee or hip replacement. Dr. Jha and his colleagues used this program as a natural experiment to study the effects of financial incentives to improve quality on different types of hospitals. By comparing the hospitals that participated in the Premier program to a national sample of all hospitals, they sought to determine if hospitals that served large numbers of poor patients would be able to realize quality gains.

Analysis

Dr. Jha and his colleagues studied 251 hospitals from the Premier database and 3,017 other hospitals drawn from a national sample. To determine the number of poor patients that hospitals in both the national sample and the Premier program were serving, the researchers used the disproportionate share index. This measure accounts for both elderly Medicare patients eligible for Supplemental Security Income and nonelderly Medicaid patients.

The researchers ranked all hospitals in both groups by their disproportionate share index and obtained quality performance information from Hospital Quality Alliance data for two time periods—the fourth quarter of 2003 and the 12-month period between July 1, 2006 and June 30, 2007. They compared the change in the Premier hospitals' disproportionate share scores over the program's first three years with the change observed among non-participating hospitals. They then determined if the disproportionate share index varied on the basis of several organizational characteristics such as size or teaching status and whether these associations were different between the sample groups. The final analysis included quality measures for three clinical conditions for which data were publicly available—AMI, CHF, and pneumonia. The researchers determined the association between disproportionate share index and baseline quality performance, changes in performance over the study period, and terminal performance for these three conditions.

Key Findings

Dr. Jha and his colleagues found that among both Premier and non-Premier hospitals, providers that served more poor patients had lower baseline performance than did providers with fewer poor patients. However, the hospitals in the Premier program that served poor patients made significant gains in the quality of care for all three conditions and caught up to hospitals with fewer poor patients in three years. Hospitals in the national sample that served more poor patients continued to lag on quality measures for all three conditions.

Study Limitations

The researchers acknowledge several important limitations to their study. First and foremost, the hospitals participating in the Premier program were self-selected and benefits could be related to selection effects. In addition, the number of hospitals participating in Premier was relatively small, so analyses lack the precision to find small differences. Finally, there was no direct measure of how many poor patients were cared for in each hospital (only the proxy of the disproportionate share index) and the researchers lacked information on hospital characteristics, such as operating margin, which might have helped explain some of the differences in baseline performance.

Implications for Policy and Practice

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) calls for the Secretary of Health and Human Services to expand P4P projects. Additionally, the ACA established the Center for Medicare and Medicaid Innovation, which will be charged with developing new payment models to encourage higher quality care at lower costs.

The results of this study show that hospitals who serve large numbers of poor patients are able to respond to financial incentives to improve quality of care. These programs may have the potential to narrow rather than widen health disparities and the quality improvement initiatives of the ACA have promise for hospitals that serve poor patients. "These findings should offer solace to those who worry that P4P will reward the rich, punish the poor, and widen existing gaps in care," said Dr. Jha. "Our findings suggest that national policy initiatives to tie payment to better quality might actually narrow disparities in care."

Hospitals in the Premier program were self-selected, so even if they served large numbers of poor patients it is possible that they did have resources or an already present commitment to quality improvement that contributed to their gains under the program. Policymakers should identify barriers that prohibit hospitals from participating in P4P initiatives and work to lower them so that other facilities working with disadvantaged populations might participate and realize similar gains in quality.

Conclusion

P4P programs are likely to stay in the national spotlight as all payers look for ways to encourage high-quality care. The work of Dr. Jha and his colleagues shows that these programs seem to improve quality for hospitals that serve poor patients and may be a promising strategy for reducing disparities. "Our current system rewards more care over better care. P4P has the opportunity to change that," said Dr. Jha. "These findings suggest that there need not be any tradeoff between improving quality and ensuring equity in care."

For More Information

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Endnotes

1 Casalino, L.P. et al. "Will Pay-for-Performance and Quality Reporting Affect Health Care Disparities?," *Health Affairs*, Vol. 26, No. 4, May/June 2007, w405-w414.

2 For additional details on the analysis and complete findings see Jha, A.K. et al. "The Effect of Financial Incentives on Hospitals that Serve Poor Patients," *Annals of Internal Medicine*, Vol. 153, No. 5, September 7, 2010, pp. 289-306.