Hospital pay for performance incentives may backfire among safety-net hospitals

14 May 2008

The same government-backed incentive programs aimed at improving the care all Americans receive in hospitals may be widening the gap between poor, underserved patients and those who are insured or can afford to pay for their own care, according to a new study led by a University of Pennsylvania School of Medicine physician.

“Though public reporting and pay for performance are designed to improve quality of care, the smaller performance gains at safety-net hospitals will be very harmful to these hospitals, damaging their reputations and finances,” says lead author Rachel M. Werner, MD, PhD, assistant professor in Penn’s Division of General Internal Medicine. “Ultimately, this could widen existing disparities between hospitals, with rich hospitals getting richer and poor hospitals becoming poorer.”

Werner and her colleagues from the University of California at San Francisco analyzed how well “safety-net” hospitals – facilities that serve large populations of low-income, minority and Medicaid patients – delivered care compared to non-safety-net hospitals. The findings, published this week in JAMA, show that safety-net hospitals had significantly smaller gains in care improvement over time, and were less likely to be among the top-ranked facilities recognized for providing high-quality care.

The researchers used data from the Centers for Medicare and Medicaid Services (CMS) public reporting Web site, Hospital Compare, to evaluate hospital performance. Since 2004, some U.S. hospitals have received pay-for-performance bonuses based on their record in providing recommended care for several key conditions including heart attack, heart failure and pneumonia. Hospitals that didn’t meet performance standards faced financial penalties. Werner found that under this pay for performance system, safety-net hospitals would have received smaller bonus payments and been more likely to be financially penalized – a hit she theorizes may ultimately damage their reputations and lead to cash shortfalls that leave them unable to invest in quality improvements like nurse staffing or information technology such as electronic health records.

“Many of these hospitals are already plagued by financial problems,” she says. “They are least prepared to absorb the hit of a financial penalty, which only puts them further behind the 8-ball for making quality improvements, and ultimately penalizing the patients who rely on safety-net hospitals for their care.”

Werner and her colleagues propose that to level the playing field, pay for performance programs be redesigned to provide bonuses each time hospitals deliver appropriate care, rather than only when they achieve targets that may be unrealistic for their payer mix. The researchers also suggest providing subsidies to fund quality improvements in safety-net hospitals, a model that has already been used successfully among some federally qualified health centers.

Source: University of Pennsylvania