Health disparities have been defined as the differences in the quality of care received and the health outcomes based on patients’ race/ethnicity and socioeconomic status; health care leaders have recognized the need to better understand the association between payment models and these disparities.¹ Hsu and colleagues² tackle this important issue in their article.

Using health care–associated infection rates from 2013 to 2018 reported by 618 US hospitals, Hsu and colleagues² applied to their investigation a rigorous interrupted time-series design that controlled for variation in health care–associated infection definitions, which were established and revised by the National Healthcare Safety Network of the Centers for Disease Control and Prevention over time. The investigators found that no association existed between value-based incentive programs (VBIPs) and changes in disparities in health care–associated infection rates. That is, health disparities persisted, with safety-net hospitals reporting worse outcomes than other hospital types and with VBIP implementation neither improving nor exacerbating these disparities.

These findings have important policy implications. Safety-net hospitals provide care for individuals regardless of their insurance status and offer services that other hospitals in the community may not have, such as trauma care, burn care, or inpatient behavioral care. As Hsu and colleagues² pointed out, the reasons for the persistent health disparities at safety-net hospitals are not fully understood and are likely associated with multiple factors, including increased clinical risk, social, and health care environmental (or structural) factors. However, current methods of adjusting for case mix, as the authors stated, do not adequately control for the differences in patient outcomes.

Safety-net hospitals operate on small margins. Other researchers have found that these hospitals are forced to rely on non–patient care revenues to offset high Medicare penalties.³ These non–patient care funds, which are likely to be volatile, may come from communities and could be used for other activities such as health-related programs for the homeless, local health promotion, and other community benefit initiatives. In addition, the intent of VBIP is to promote the delivery of high-quality care; however, the financial work-arounds that safety-net hospitals must use to be financially viable may undermine the intent of the VBIP. That is, high penalties may diminish these hospitals’ financial viability and thus make it necessary to make operational cuts that could jeopardize quality. Mixed payment models that encourage health systems to reduce disparities with specific equity accountability measures have been suggested.¹ We need to find payment models that decrease, not contribute to, health disparities.

Within the context of the coronavirus disease 2019 pandemic, the popular press has told stories of how important safety-net hospitals are to communities. For example, the Brookdale University Medical Center, a safety-net hospital in Brooklyn, was one of the first hospitals to reach capacity in New York City.⁴ However, before the pandemic, New York state’s health care budget showed a $38 million reduction in funding to Central Brooklyn hospitals, which serve many of the working class and low-income individuals living in the borough.⁵

Safety-net hospitals play an important role in the US health care system. Clearly, the federal VBIPs that penalize these hospitals for underperforming on health care–associated infection metrics are not working. The solutions to this problem must come from both the state and federal levels.
ARTICLE INFORMATION
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