

## No Hospital Left Behind? Education Policy Lessons for Value-Based Payment in Healthcare

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Value-based payment systems have been widely implemented in healthcare in an effort to improve the quality of care. However, these programs have not broadly improved quality, and some evidence suggests that they may increase inequities in care. No Child Left Behind is a parallel effort in education to address uneven achievement and inequalities. Yet, by penalizing the lowest performers, No

Child Left Behind's approach to accountability has led to a number of unintended consequences. This article draws lessons from education policy, arguing that financial incentives should be designed to support the lowest performers to improve quality. *Journal of Hospital Medicine* 2016;11:62–64. © 2015 Society of Hospital Medicine

The United States is moving aggressively toward value-based payment. The Department of Health and Human Services recently announced a goal to link 85% of Medicare's fee-for-service payments to quality or value by 2016.<sup>1</sup> Despite the inherent logic of paying providers for their results, evidence of the effectiveness of value-based payment has been mixed and underwhelming. Recent reviews of pay-for-performance—reflecting the emerging understanding of the complexities of designing successful programs—have painted a more negative picture of their overall effectiveness.<sup>2,3</sup> One study of over 6 million patients found that the Medicare Premier Hospital Quality Incentive Demonstration had no effect on long-term patient outcomes including 30-day mortality.<sup>4</sup> At the same time, research suggests that lower performing providers tend to have a disproportionate number of poor patients, many of whom are racial and ethnic minorities. Value-based payment risks the dual failure of not improving health outcomes while exacerbating health inequities.

We have seen this movie before. In 2001, No Child Left Behind was enacted to improve quality and reduce inequities in K–12 education in the United States. Much like healthcare, education suffers from uneven quality and wide socioeconomic disparities.<sup>5</sup> No Child Left Behind attempted to address these problems with new accountability measures. Based on the results from standardized tests, No Child Left Behind rewarded the highest performing schools with

more funding while penalizing poor performing schools with reduced funding, and in some cases, forcing “failing” schools to cede control to outside operators.

In the aftermath of its implementation, however, it became clear that these incentives had not worked as intended. No Child Left Behind did not improve reading performance and was associated with improvements in math performance only for younger students.<sup>6</sup> These modest gains came at a high cost; consistent with “teaching to the test,” No Child Left Behind led to a shifting of instructional time toward math and reading and away from other subjects. It also led to widespread cheating, challenging the validity of observed performance improvements. Before No Child Left Behind was rolled out, the wealthiest school districts in the country spent as much as 10 times more than the poorest districts.<sup>5</sup> By penalizing the lowest performers, these gaps persisted. Schools were not given the support that they needed to improve performance.

The parallels to healthcare are striking (Table 1). Early results from Medicare's Hospital Value-Based Purchasing and Readmission Reduction Program show that hospitals caring for more disadvantaged patients have been disproportionately penalized.<sup>7</sup> Similar “reverse Robin Hood” effects have been observed in incentive programs for physician practices.<sup>8</sup> Over time, financial incentive programs may substantially decrease operating revenue for hospitals and physicians caring for low-income and minority communities. This could perpetuate the already large disparities in quality and health outcomes facing these populations. Although risk-adjusting for socioeconomic status may alleviate these concerns in the short term, allowing low-income or minority patients to have poorer health outcomes simply accepts that disparities exist rather than trying to reduce them.

How then is it possible to improve the quality of care at lower performing hospitals without simultaneously

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**TABLE 1.** Financial Incentive and Collaboration-Based Programs in Healthcare and Education

		Healthcare	Education
National incentive programs	Examples	Hospital Value-Based Purchasing Hospital Readmission-Reduction Program Hospital-Acquired Conditions Penalty Program Physician Value-Based Payment Modifier	No Child Left Behind
	Approach toward improving performance	Reimbursements are tied to quality and cost.  Bonuses are given to hospitals and providers that perform well on performance metrics.  Low performers are penalized with lower reimbursements.	Test-based accountability: Results of standardized tests are used to determine levels of federal funding. Schools failing to meet testing goals are penalized with reductions in funding. Takeover of failing districts: Districts failing to make adequate yearly progress for 5 years in a row must implement a restructuring plan that may involve changing the school's governance arrangement, converting the school to a charter, or turning the school over to a private management company.
	Unintended consequences	Gaming Ignoring or neglecting areas of care that are unincentivized. Avoiding high-risk or disadvantaged patients.	Cheating to boost test scores. Shift of instruction time toward math and reading. States intentionally making assessment tools easier. Stress among administrators, teachers, and students due to high-stakes testing.
Collaboration-based programs	Examples	Quality collaboratives Hospital engagement networks	Shanghai school system
	Approach toward improving performance	Improvement networks: High performing hospitals or providers are identified and work with other groups to improve patient treatment and the care process. Data sharing: Facilities collect and share data to monitor quality improvements and better identify best practices.	Pairing of districts: High-performing districts are paired with lower performing districts to exchange education development plans, curricula, and teaching materials. Commissioned administration: A high-performing school partners with low performers by sending experienced teachers and administrators to share successful practices and turn around their performance.
	Example of success	The Michigan Surgical Quality Collaborative was associated with a 2.6% drop in general and vascular surgery complications. Hospitals participating in the programs made improvements at a faster rate than those outside of the program.	Zhabei District No. 8 School, located in an area with high crime rates and low student performance, was transformed from one of the lowest performing schools in its district to ranking 15 out of 30. Approximately 80% of the school's graduates go on to study at universities compared to the municipal average of 56%.

designing an incentive system that hurts them? Lessons from the education policy are again instructive. Every 3 years the Organization for Economic Cooperation and Development ranks countries by the performance of their 15-year olds on a standardized test called the Program for International Student Assessment.<sup>9</sup> For the past 2 sets of rankings, Shanghai, China has topped the list. Like many attempts to generate international rankings, this one has its flaws, and Shanghai's top position has not been without controversy. For one, China is not ranked at the country-level like other nations; yet, due to the city's status as a wealthy business and financial center, Shanghai certainly cannot be considered representative of the Chinese education system. Nevertheless, the story of how Shanghai reformed its education system and achieved its high position has important implications.

Prior to implementing reforms, Shanghai's rural outer districts struggled with less funding, high teacher turnover rates, and low test scores compared to wealthier urban districts. To reduce education disparities within the city's schools, the government of Shanghai enacted a number of policies aimed at bringing lower performers up to the same level as schools with the highest degree of student achievement.<sup>10</sup> The government gives schools a grade of A, B, C, or D based on the quality of their infrastructure and student performance. It then uses several programs to

facilitate the exchange of staff and ideas among schools at different levels. One program pairs high-performing districts with low-performing districts to share education development plans, curricula, teaching materials, and best practices. Another strategy—called commissioned administration—involves temporary contracts between schools to exchange both administrators and experienced teachers. In addition to these approaches, the government sets a minimum level of spending for schools and transfers public funds to indigent districts to provide them with assistance to reach this level.

The notion that the very best can help the weak requires a sense of solidarity. This solidarity may falter in environments in which hospitals and physicians are in cutthroat competition. Though there will always be some tension between competition and collaboration, in most markets, competition between hospitals does not rule out collaboration. Policies can either relieve or reinforce the natural tension between competition and collaboration. This suggests that adopting reforms with the same intent as the Shanghai system is still possible in healthcare, especially through physician and other provider networks. The healthcare workforce has a rich history of cross-organizational collaboration through mentorships, the publication of research, and participation in

continuing medical education courses. The Centers for Medicare and Medicaid Services' Hospital Engagement Networks, a program in which leading organizations have helped to disseminate interventions to reduce hospital acquired conditions, are an example of this approach. Quality collaboratives—groups of providers who collaborate across institutions to identify problems and best practices for improvement—have similarly shown great promise.<sup>11</sup> Similar approaches have been used by the Institute for Healthcare Improvement in many of their quality improvement initiatives.

Such collaboration-based programs could be harnessed and tied to financial incentives for quality improvement. For instance, top-performing hospitals could be incentivized to participate in a venue where they share their best practices with the lower performers in their field. Low performers, in turn, could be provided with financial assistance to implement the appropriate changes. Over time, financial assistance could be made contingent on quality improvements. By providing physicians and other providers with examples of what success looks like and assisting them with garnering the resources to reach this level, improvement would not only be incentivized, it might also become more tangible.

Although some hospitals and physicians may welcome changes to incentive systems, implementation of collaboration-based programs would not be possible without a facilitator that is willing to underwrite program costs, provide financial incentives to providers, and develop a platform for collaboration. Large insurers are the most likely group to have the financial resources and widespread network to develop such programs, but that does not mean that they would be willing to experiment with this approach. This may especially be the case if cost savings and measurable improvements in quality are not immediate. Even though the results of collaboration-based efforts have been promising, the implementation of these programs has been limited, and adoption in different contexts may not yield the same results. Collaboration-based programs that have already shown success can serve as models, but they may need significant adaptations to meet the needs of providers in a given area.

Despite its promise, collaboration-based strategies alone will not be enough to improve certain aspects of quality and value. Although providing physicians with knowledge on how to reduce unnecessary care, for example, could help limit overutilization, it is not suf-

ficient to overcome the incentives of fee-for-service payment. In this case, broader payment reform and population-based accountability can be paired with programs to encourage collaboration. For instance, the Blue Cross and Blue Shield of Massachusetts' Alternative Contract has used a combination of technical assistance, shared savings, and large quality bonuses to improve quality and reduce medical spending growth.<sup>12</sup> Collaboration-based strategies should be seen as a complement to these broad, thoughtful reforms and a substitute for narrow incentives that encourage myopia and destructive competition.

Evidence from education and healthcare shows that penalizing the worst and rewarding the best will not shift the bell curve of performance. Such approaches are more likely to entrench and expand disparities. Instead, policy should encourage and incentivize collaboration to expand best practices that improve patient outcomes. Lessons from education provide both cautionary tales and novel solutions that might improve healthcare.

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