

NO PAY FOR SEXIST PERFORMANCE: HOW GENDER DISPARITIES IN HEALTHCARE HURT HOSPITALS' PAY FOR PERFORMANCE REIMBURSEMENTS

INTRODUCTION

Gender disparities and discrimination in healthcare treatment are vast.¹ Women in pain are deemed hysterical,² heart attacks in women are caught less frequently than in men due to symptom presentation differences,³ and women are screened less often than men for some cancers.⁴ Meanwhile, in order to be fully reimbursed for healthcare services, legislative reforms increasingly evaluate hospitals and physicians based on their performance as it relates to quality measurements, otherwise known as pay for performance.⁵ This particular method of reimbursement expanded after the Patient Protection and Affordable Care Act⁶ (ACA) enacted pay for performance standards, particularly for hospitals and physicians participating in Medicare.⁷

The pay for performance standards included in the ACA were a missed opportunity to explicitly name and address existing gender disparities in healthcare.⁸ For example, the ACA evaluates and potentially penalizes hospitals and doctors based on their quality standards with acute myocardial infarctions (commonly known as heart attacks).⁹ When hospitals actively fail to diagnose and to treat heart attacks in women, they may be losing

1. See Karen H. Rothenberg, *Gender Matters: Implications for Clinical Research and Women's Health Care*, 32 HOUS. L. REV. 1201, 1210–11 (1996).

2. See, e.g., Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29 J.L. MED. & ETHICS 13, 20 (2001).

3. See, e.g., Gabrielle R. Chairamonte & Ronald Friend, *Medical Students' and Residents' Gender Bias in the Diagnosis, Treatment, and Interpretation of Coronary Heart Disease Symptoms*, 25 HEALTH PSYCHOL. 255, 263–264 (2006).

4. See, e.g., Scott E. Woods et al., *The Influence of Gender on Colon Cancer Stage*, 14 J. WOMEN'S HEALTH 502, 504 (2005).

5. CTRS. FOR MEDICARE & MEDICAID SERVS., ICN 907664, HOSPITAL VALUE-BASED PURCHASING (2015) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_FactSheet_ICN907664.pdf [hereinafter HVBP FACT SHEET] [<https://perma.cc/QF5U-22JL>]. Quality measurements are utilized by programs such as the Medicare Hospital Value-Based Purchasing and the Hospital Readmission Reduction Program. See *infra* Part II.

6. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

7. See *infra* Part II.

8. See Patient Protection and Affordable Care Act, 42 U.S.C. § 1395ww(o) (2010) (demonstrating the statute fails to establish incentives addressing gender disparities in healthcare).

9. *Id.* The Secretary establishes a quality measures and hospitals receive compensation based on whether they meet these quality measures. *Id.*

reimbursement money under the ACA.¹⁰ However, the language of the ACA hides the gendered aspect of this loss.¹¹ Gender disparities and discrimination in healthcare negatively impact pay for performance reimbursements for both hospitals and physicians and result in hospitals losing reimbursement payments, especially via Medicare.¹²

To ensure better quality healthcare for female patients and maximum reimbursement levels for hospitals and physicians providing Medicare services, this Note will examine two categories of possible solutions: legislative and ground-based.¹³ First, Congress could amend the ACA and its Medicare provisions to explicitly call for reductions in gender-based healthcare disparities.¹⁴ Second, hospitals throughout the country could implement ground-based efforts such as unconscious bias training for all healthcare providers.¹⁵

This Note adopts feminist legal theory as a lens through which to view the problem of gender disparities in healthcare and pay for performance reforms by asking about gender implications of a law, thus asking “the woman question” (“Woman Question”).¹⁶ Specifically, this Note asks how and why the ACA fails to adequately address gender-based disparities in healthcare.¹⁷ This question presumes the current law is non-neutral¹⁸ and seeks to “expose those features and how they operate”¹⁹ before turning to potential solutions.²⁰ A non-neutral law may appear on its face to be neutral towards women and men, but affect women and men differently.²¹ Asking the Woman Question in the context of gender disparities and pay for performance reform reveals how women’s healthcare “reflects the organization of society rather than the inherent characteristics of women.”²² Analyzing the ACA through a feminist lens requires a look “beneath the

10. See *id.* (requiring hospitals to meet certain performance standards in order to receive reimbursement/incentive payments).

11. See *id.* (failing to require the Secretary to take sex or gender into account when establishing quality standards).

12. See *infra* Part III.

13. See *infra* Part III.

14. See *infra* Section III.A.

15. See *infra* Section III.B.

16. Katharine T. Bartlett, *Feminist Legal Methods*, 103 HARV. L. REV. 829, 837 (1990). Generally, scholars ask: “[H]ave women been left out of consideration? If so, in what way; how might that omission be corrected? What difference would it make to do so?” *Id.*

17. See *infra* Part II.

18. *Id.*

19. *Id.*

20. *Id.*

21. LESLIE FRANCIS & PATRICIA SMITH, *Feminist Philosophy of Law*, in THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta et al. eds., Winter 2017), [HTTPS://PLATO.STANFORD.EDU/ENTRIES/FEMINISM-LAW/](https://plato.stanford.edu/entries/feminism-law/) [<https://perma.cc/FMS2-BLG8>].

22. Bartlett, *supra* note 16, at 843.

surface” of the law to identify its gender implications.²³ Framing the analysis in this way does not necessitate a solution which favors women but requires a “decision . . . that is defensible in light of [gender] bias.”²⁴

Part I of this Note examines the existing gender disparities in healthcare, especially in the areas of cardiovascular disease, pain management, and cancer. Part II analyzes pay for performance reforms in the ACA. First, Part II looks at the Affordable Care Act generally. Then, Part II turns to the Medicare reforms in the ACA, focusing on the Hospital Readmissions Reduction Program and the Hospital Value-Based Purchasing Program. Part III integrates gender-based disparities in healthcare and pay for performance reforms, proposing solutions at both the legislative and ground-based levels. The Note argues that if hospitals prompted their physicians to consider, for example, the differences in how women and men present with heart attacks, the hospitals’ scores on pay for performance quality measures would rise.²⁵ This in turn would mean higher reimbursement for hospitals, many of which desperately need reimbursement funds to remain in business.²⁶

I. EXISTING GENDER DISPARITIES IN HEALTHCARE

Disparities plague the healthcare industry.²⁷ The National Institutes of Health defines health disparities “as differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups.”²⁸ Disparities in the healthcare industry appear across many demographics, including gender, sex, race, socioeconomic status, sexual orientation, and citizenship status.²⁹ Gender-based disparities³⁰ in the healthcare system are a vast and

23. *Id.*

24. *Id.* at 846.

25. *See infra* Part II.

26. *See infra* Part II.

27. *See, e.g.*, U.S. DEP’T OF HEALTH & HUMAN SERVS., HEALTH EQUITY REPORT 2017 10–14 (2017), <https://www.hrsa.gov/sites/default/files/hrsa/health-equity/2017-HRSA-health-equity-report.pdf> [<https://perma.cc/W8NB-FGRS>].

28. *NIH Announces Institute on Minority Health and Health Disparities*, NAT’L INSTS. HEALTH (Sept. 27, 2010), <https://www.nih.gov/news-events/news-releases/nih-announces-institute-minority-health-health-disparities> [<https://perma.cc/JNT3-HVJS>].

29. Petry Ubri & Samantha Artiga, *Disparities in Health and Health Care: Five Key Questions and Answers*, KAISER FAM. FOUND. 1 (Aug. 2016), <http://files.kff.org/attachment/Issue-Brief-Disparities-in-Health-and-Health-Care-Five-Key-Questions-and-Answers> [<https://perma.cc/D6DS-GYP7>].

30. There are distinct sociological differences between the terms gender and sex. *See* Candace West & Don H. Zimmerman, *Doing Gender*, 1 GENDER & SOC’Y 125, 125 (1987). Sex is a biological marker typically assigned at birth through the visible genitalia or chromosomal typing. *Id.* at 127. Gender, on the other hand, “is the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one’s sex category.” *Id.* The Note author acknowledges these distinct terms, but for the purpose of this Note will use the terms “sex” and “gender”

overlooked problem. A large body of work studies healthcare disparities based on race, ethnicity, and socioeconomic status.³¹ While this scholarship is useful in searching for and proposing solutions to gender-based healthcare disparities, this Note will isolate gender as much as possible.

Medical institutions and providers are not immune to perpetuating harmful gender stereotypes that are ingrained in American society.³² Gender bias “pervades medicine, beginning with medical-school admissions and education, encompassing research facilities and medical journals, and culminating in how women are treated as patients in clinics, hospitals, and physicians’ offices across the country.”³³ For example, society views women as much more emotional than men,³⁴ in some cases leading providers to classify pain not as a physical problem, but as a mental problem.³⁵ Society also views women as better-equipped to deal with pain, so healthcare providers may expect women to endure pain more easily than men.³⁶ The negative impacts of gender disparities hurt all players in the healthcare system, including patients, doctors, hospitals, and insurance providers. Gender disparities in healthcare are frequently seen in the treatment of cardiovascular disease, pain management, and certain cancers.³⁷

interchangeably to speak of biological indicia of sex. Accordingly, the terms “female,” “woman,” and “women” will also be used interchangeably.

31. See, e.g., INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (Brian D. Smedley et al. eds., 2003); Janny Scott, *Life at the Top in America Isn't Just Better, It's Longer*, N.Y. TIMES (May 16, 2005), <http://www.nytimes.com/2005/05/16/us/class/life-at-the-top-in-america-isnt-just-better-its-longer.html>. The author also acknowledges the importance of examining healthcare disparities via intersectionality although this goes beyond the scope of this Note.

32. See Rothenberg, *supra* note 1, at 1210.

33. *Id.* (quoting LESLIE LAURENCE & BETH WEINHOUSE, *OUTRAGEOUS PRACTICES: THE ALARMING TRUTH ABOUT HOW MEDICINE MISTREATS WOMEN* 7 (1994)).

34. See, e.g., Frank Newport, *Americans See Women as Emotional and Affectionate, Men as More Aggressive*, GALLUP (Feb. 21, 2001), <https://news.gallup.com/poll/1978/americans-see-women-emotional-affectionate-men-more-aggressive.aspx> [<https://perma.cc/459V-SG5Y>].

35. See Emalie Marthe, *Your Pain Is Not Real: How Doctors Discriminate Against Women*, BROADLY (Feb. 12, 2017, 7:21 AM), https://broadly.vice.com/en_us/article/8x4gwz/your-pain-is-not-real-how-doctors-discriminate-against-women [<https://perma.cc/CA9V-TEXZ>].

36. *Id.*

37. See, e.g., Esther H. Chen et al., *Gender Disparity in Analgesic Treatment of Emergency Department Patients with Acute Abdominal Pain*, 15 ACAD. EMERGENCY MED. 414, 415 (2008); Jodi R. Godfrey & JoAnn E. Manson, *Toward Optimal Health: Strategies for Prevention of Heart Disease in Women*, 17 J. WOMEN'S HEALTH 1271, 1271 (2008); Woods et al., *supra* note 4, at 504–05.

A. Cardiovascular Disease

“Cardiovascular disease³⁸ (CVD) . . . is the number-one killer of women”³⁹ and affects approximately 41.3 million women.⁴⁰ Despite that, many physicians perceive women to have a lower risk for cardiovascular disease compared to men.⁴¹ Women often experience heart attack symptoms differently than do men.⁴² While men tend to feel intense pressure in their chest, women “may experience shortness of breath, pressure or pain in the lower chest or upper abdomen, dizziness, lightheadedness or fainting, upper back pressure or extreme fatigue.”⁴³

When women do have chest pain, physicians often view their pain as an emotional or psychological problem rather than as a manifestation of heart attack.⁴⁴ Physicians also tend to be more influenced by a female patient’s psychological symptoms and rely on harmful, negative stereotypes of women when they present with symptoms of coronary heart disease.⁴⁵ Women with CVD tend to have a higher morbidity rate and experience more “impairment in [their] quality of life” compared to similarly situated men,⁴⁶ perhaps as a consequence of underdiagnosing CVD in women.

Gender disparities continue even after doctors diagnose a heart attack and begin treatment.⁴⁷ For example, “men are 6.5 times more likely to be referred for cardiac catheterization than women.”⁴⁸ Further, “26% of men

38. The terms ‘cardiovascular disease’ and ‘heart disease’ are interchangeable. *Heart Disease*, MAYO CLINIC (Mar. 22, 2018), <https://www.mayoclinic.org/diseases-conditions/heart-disease/symptoms-causes/syc-20353118> [<https://perma.cc/DQF6-HKAW>]. Generally, cardiovascular disease “refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke.” *Id.*

39. ELLEN J. STAUROWSKY ET AL., *HER LIFE DEPENDS ON IT II: SPORT, PHYSICAL ACTIVITY, AND THE HEALTH AND WELL-BEING OF AMERICAN GIRLS AND WOMEN* 9 (2009), <https://files.eric.ed.gov/fulltext/ED515841.pdf> [<https://perma.cc/8W7R-6MSX>]; *Women & Heart Disease*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 23, 2017) https://www.cdc.gov/dhds/dsp/data_statistics/fact_sheets/fs_women_heart.htm.

40. STAUROWSKY ET AL., *supra* note 39, at 9.

41. Godfrey & Manson, *supra* note 37, at 1271.

42. *Heart Attack Symptoms in Women*, AM. HEART ASS’N (Mar. 30, 2018), http://www.heart.org/HEARTORG/Conditions/HeartAttack/WarningSignsofaHeartAttack/Heart-Attack-Symptoms-in-Women_UCM_436448_Article.jsp [<https://perma.cc/B6XX-JWDN>].

43. *Id.*

44. Chairamonte & Friend, *supra* note 3, at 263–64.

45. *Id.*

46. Godfrey & Manson, *supra* note 37, at 1271.

47. See Rothenberg, *supra* note 1, at 1210.

48. *Id.*

versus 14% of women receive clot-dissolving drugs after a heart attack.”⁴⁹ Moreover, women of all ages are more likely to be readmitted to a hospital following heart attacks.⁵⁰ Gender disparities in the diagnosis and treatment of CVD in women thus present a real and potentially life-threatening problem for the women they affect.⁵¹

B. Pain Management

Physicians tend to take women’s pain less seriously than they do men with similar symptoms.⁵² When doctors treat women’s pain, their treatment is consistently inadequate.⁵³ In one study, these differences were true “regardless of [the] provider[s] . . . gender, suggesting that an unconscious bias may exist.”⁵⁴ Research suggests that healthcare providers also tend to express disbelief towards women’s pain far more often than they do with men.⁵⁵

Disparate treatment of pain severely harms women.⁵⁶ For example, one study showed that women were less likely to receive opioid pain medication than men.⁵⁷ Further, the women in the study were forced to wait longer to receive pain medication than men, even when they rated their pain level the same.⁵⁸ Other studies articulate gender biases when women present with pain.⁵⁹ When experiencing pain, normatively physically attractive women are less likely to be taken seriously by physicians or treated appropriately for her pain.⁶⁰ Unsurprisingly, when healthcare providers do not take

49. *Id.*

50. *See, e.g.*, Rachel P. Dreyer et al., *Sex Differences in the Rate, Timing and Principal Diagnoses of 30-Day Readmissions in Younger Patients with Acute Myocardial Infarction*, 132 *CIRCULATION* 158, 164–65 (2015); Cashel O’Brien et al., *Sex Differences in Rates of 30-Day Readmission in Patients Discharged After Acute Myocardial Infarction in the United States*, 69 *J. AM. C. OF CARDIOLOGY* 2 (2017).

51. *See* Chairamonte & Friend, *supra* note 3; Dreyer et al., *supra* note 50.

52. *See* Hoffmann & Tarzian, *supra* note 2, at 21.

53. *See id.* at 17.

54. Chen et al., *supra* note 37, at 416.

55. *See* Hoffmann & Tarzian, *supra* note 2, at 17.

56. *See, e.g.*, Chen et al., *supra* note 37, at 415; Elizabeth Dougherty, *Racial Disparities in Opioid Prescriptions*, B.U. RES. (Oct. 4, 2016), <https://www.bu.edu/research/articles/racial-bias-opioid-prescribing/> [<https://perma.cc/2U5M-2TZL>]; Laura Kiesel, *Women and Pain: Disparities in Experience and Treatment*, HARV. HEALTH BLOG (Oct. 9, 2017, 10:30 AM), <https://www.health.harvard.edu/blog/women-and-pain-disparities-in-experience-and-treatment-2017100912562> [<https://perma.cc/8WJ5-V6MX>].

57. Chen et al., *supra* note 37, at 415. This gender bias may have unintended positive consequences in light of the opioid addiction crisis. *See* Dougherty, *supra* note 56. Researchers observed a similar phenomenon along racial lines. *Id.* Racial bias affects the number of opioids prescribed by physicians in some settings. *Id.* Some have speculated this bias has contributed to the high levels of opioid abuse by white people since they are able to more easily obtain opioids. *Id.*

58. Chen et al., *supra* note 37, at 415.

59. *See* Hoffmann & Tarzian, *supra* note 2, at 21.

60. *Id.*

women's pain seriously, physicians provide lower quality pain management methods to women than men.⁶¹

C. Cancer

Gender disparities in clinical decision-making have been shown in both colon cancer and lung cancer.⁶² Women are less likely than men to be screened for colon cancer.⁶³ By the time women are actually diagnosed with colon cancer, the disease is often at a more advanced stage and thus harder to treat.⁶⁴ When female and male smokers with equal risk factors for lung cancer were treated, men were “more likely to be referred for diagnostic testing for lung cancer than women.”⁶⁵ Given the shock and severity of any cancer diagnosis, these disparities are particularly concerning.

The gender disparities present in cardiovascular care, pain management, and cancer screening can neither be explained nor justified by medical science.⁶⁶ As such, health disparities based on gender deserve to be critically examined.⁶⁷ Moreover, hospitals and healthcare providers need to be encouraged to meaningfully reduce gender-based disparities.⁶⁸ Pay for performance programs may provide one such avenue for meaningful change.

II. PAY FOR PERFORMANCE

Pay for performance, or value-based purchasing, “is an umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care”⁶⁹ that utilize “financial incentives to hospitals, physicians, and other[s] . . . to carry out such improvements and achieve optimal outcomes for patients.”⁷⁰ In regards to the broad appeal for pay for performance, one author observed:

Because patients have a limited ability to observe the quality of care

61. See Kiesel, *supra* note 56. Another factor contributing to pain management disparities may be that most studies on pain are done on men. *Id.* For pain management, widespread gender disparities exist which “can have serious and sometimes fatal repercussions.” *Id.*

62. See Rothenberg, *supra* note 1, at 1210; Woods et al., *supra* note 4, at 504–05.

63. Woods et al., *supra* note 4, at 504–05.

64. *Id.*

65. Rothenberg, *supra* note 1, at 1210.

66. See generally Rothenberg, *supra* note 1 (stating disparate gender treatment partially originates from not including women in clinical research).

67. *Id.* at 1204.

68. See *infra* Part III.s

69. Julia James, *Pay-for-Performance*, HEALTH AFF. (Oct. 11, 2012), <https://www.healthaffairs.org/doi/10.1377/hpb20121011.90233/full/>, [<https://perma.cc/7US7-TA3B>].

70. *Id.*

that they receive, providers have lacked the incentive to provide sufficiently high-quality care, resulting in suboptimal quality across the health care system In response, numerous public and private payer initiatives have attempted to incentivize higher quality care through pay-for-performance programs.⁷¹

This portion of the Note will first look briefly at the goal of the ACA and some steps it took to increase the general quality of healthcare. The Note will then examine the ACA's Medicare reform, looking specifically at Medicare's Hospital Readmissions Reduction Program before turning to Medicare's Hospital Value-Based Purchasing Program. The Woman Question underlies each inquiry into the ACA and its Medicare reform as the Note searches for gender implications in each seemingly neutral reform.⁷² All of the recent healthcare reforms stimulates hospitals and providers to provide higher quality care for all patients but do not necessarily push providers to provide the *same* quality care to patients regardless of gender.⁷³

A. *The Affordable Care Act's Framing of Gender Disparities*

The primary goal of the ACA was to expand access to health insurance.⁷⁴ The ACA proved to be quite effective for reducing "the uninsured rate for low-income groups and people of color. . . ."⁷⁵ However, wide healthcare disparities still exist across various dimensions.⁷⁶ This has been especially true for those individuals in the eighteen states that chose not to expand Medicaid.⁷⁷

The ACA also aimed to develop an all-encompassing "national strategy to improve the delivery of health care services, patient health outcomes, and population health."⁷⁸ To do this, the ACA mandated more data collection, including reports on sex-based disparities.⁷⁹ The law established new requirements that the Secretary of Health and Human Services ("the Secretary") set forth provider-level outcome measures.⁸⁰ The provider-level

71. Andrew M. Ryan et al., *The Early Effects of Medicare's Mandatory Hospital Pay-for-Performance Program*, 50 HEALTH SERVS. RES. 81, 82 (2015) (citation omitted).

72. See *supra* notes 16 and 21 and accompanying text.

73. See *infra* Sections II.A–B.

74. *Summary of the Affordable Care Act*, KAISER FAM. FOUND. 1 (April 23, 2013) [hereinafter *Summary of the ACA*], <http://files.kff.org/attachment/fact-sheet-summary-of-the-affordable-care-act> [<https://perma.cc/82M8-CW6R>].

75. Ubrri & Artiga, *supra* note 29, at 6.

76. *Id.* at 1.

77. See *id.* at 6.

78. Patient Protection and Affordable Care Act, 42 U.S.C. § 280j (2010).

79. *Summary of the ACA*, *supra* note 74, at 10.

80. Patient Protection and Affordable Care Act, 42 USC § 299b-31 (2010).

outcome measures promulgated by the Secretary must generally include measures for acute and chronic diseases, in addition to outcome measurements for primary and preventative care.⁸¹ Tracking preventative care outcome measurements is a key part of the ACA's broad reforms impacting gender disparities, given, for example, the lesser amount of screening women receive for colon and lung cancers.⁸²

Expanding access to health insurance, increasing reporting on sex-based disparities, and provider-level outcome measures were all important ACA reforms. Importantly, meaningful change in gender-based disparities cannot be enacted without the ACA's tracking of these gender-based disparities, which enables a critical examination of provider-level outcome measurements.⁸³ However, the ACA's broad quality reforms did not create optimal incentives for providers to meaningfully change the *actual* quality of care provided to patients. These broad reforms failed to hit hospitals and providers where it hurts—their pocketbooks—to increase the quality of patient care.

B. Medicare

The ACA more substantively pulled on healthcare providers' purse strings via pay for performance in its Medicare reform.⁸⁴ Medicare is a huge player in the healthcare industry, as it is “the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease”⁸⁵

The ACA Medicare reforms utilized many tools intended to positively affect healthcare quality for individuals eligible for Medicare.⁸⁶ In order to

81. *Id.*

82. *See supra* Section I.C.

83. *See supra* notes 79–81 and accompanying text.

84. *What Are the Value-Based Programs?*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 9, 2017, 3:25 PM) [hereinafter *VBP Explanation*], <https://perma.cc/VEK3-SHGS>.

85. *What's Medicare?*, MEDICARE, <https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html> [<https://perma.cc/M949-DCKP>] (last visited Jan. 15, 2018). Medicare has two primary sections. Dig. Commc'ns Div., *Who is Eligible for Medicare?*, U.S. DEP'T HEALTH & HUM. SERVS. (Sept. 11, 2014), <https://www.hhs.gov/answers/medicare-and-medicare/who-is-eligible-for-medicare/index.html> [<https://perma.cc/D73B-SD59>]. Part A covers “inpatient care in hospitals, critical access hospitals, and skilled nursing facilities (not custodial or long-term care).” Assistant Sec’y for Pub. Affairs, *What is Medicare Part A?*, U.S. DEP'T HEALTH & HUM. SERVS. (Aug. 11, 2014), <https://www.hhs.gov/answers/medicare-and-medicare/what-is-medicare-part-a/index.html> [<https://perma.cc/FDA8-E7J8>]. Part B, on the other hand, covers medical services such as preventative “exams, lab tests, and screening[s]” Dig. Commc'ns Div., *What is Medicare Part B?*, U.S. DEP'T HEALTH & HUM. SERVS. (Sept. 16, 2014), <https://www.hhs.gov/answers/medicare-and-medicare/what-is-medicare-part-b/index.html> [<https://perma.cc/L89G-4B2F>].

86. *See infra* Sections II.B.1–2. In addition to the Readmissions Reduction Program and the Hospital Value-Based Purchasing Program, the ACA included subtler, but still important, quality control measures such as Hospital Compare data. *See About Hospital Compare Data*, MEDICARE, <https://www.medicare.gov/hospitalcompare/Data/About.html> [<https://perma.cc/P2SM-N3DJ>] (last

reach quality of care more directly, the ACA tailored specific reform measures, commonly referred to as value-based programs or pay for performance, as financial incentives.⁸⁷ Generally, “[v]alue-based programs reward health care providers with incentive payments for the quality of care they give”⁸⁸ Most of the value-based programs in the ACA were directed toward the Medicare program.⁸⁹ For purposes of addressing gender-based disparities in healthcare, the most pertinent of the ACA’s value-based programs are the Hospital Readmissions Reduction Program (RRP) and the Hospital Value-Based Purchasing Program (HVBP).⁹⁰ Both programs were enacted through the ACA and took effect in 2012.⁹¹

1. *Readmissions Reduction Program*

The ACA enacted the RRP as a value-based program targeting hospitals participating in Medicare.⁹² The aim of the RRP is to prevent hospital readmissions by providing better quality care up front.⁹³ The RRP originally monitored readmissions rates only for heart failure, heart attacks, and pneumonia.⁹⁴ As of 2017, the RRP also tracks diseases such as “chronic obstructive pulmonary disease (COPD), elective hip and/or knee replacement and coronary artery bypass graft (CABG).”⁹⁵ The RRP’s tracking of heart attacks and heart failure is especially notable, given the

visited June 16, 2018). The data collected concerns hospital performance and examines quality from the consumer, or patient, perspective. *Id.* This can be a useful tool for Medicare patients to compare the quality of care they may receive at one hospital or physician’s office versus another one in their same area. *See id.*

87. *See VBP Explanation, supra* note 84.

88. *See id.*

89. *See infra* Sections II.B.1–2.

90. *See VBP Explanation, supra* note 84. Other value-based programs enacted in the ACA include the End-stage Renal Disease Quality Incentive Program, Hospital Acquired Conditions Program, and the Value Modifier Program. *Id.* While important reforms in their own right, the impact of these programs on gender-based healthcare disparities is beyond the scope of this Note.

91. *Id.*

92. Patient Protection and Affordable Care Act, 42 U.S.C. § 1395ww(q) (2010); *Readmissions Reduction Program*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 20 2018), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html> [<https://perma.cc/4MSL-LB9P>].

93. Casey Ross, *The Hospital Readmission Conundrum*, WEEK (Dec. 29, 2017), <http://theweek.com/articles/744345/hospital-readmission-conundrum> [<https://perma.cc/TLT2-RYSW>]. Scholars largely agree that the program has worked to reduce readmissions overall, given the “wide body of evidence” showing a reduction in readmissions since 2012 when the program went into effect. *Id.*

94. *Readmissions Reduction Program, supra* note 92.

95. Cristina Boccuti & Giselle Casillas, *Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program*, KAISER FAM. FOUND. (Mar. 10, 2017), <https://www.kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/> [<https://perma.cc/BJJ4-GGNN>].

previously discussed gender disparities present in the treatment of cardiovascular disease.⁹⁶

Medicare considers *any* readmission into a hospital “within 30 days of discharge from an initial hospitalization”⁹⁷ a readmission for purposes of the RRP, regardless of reason.⁹⁸ Generally, reimbursement payments may be reduced for a readmission by “an amount equal to the product of . . . the base operating DRG [diagnosis related groups] payment amount . . . and the adjustment factor.”⁹⁹ The maximum penalty rate that can be entered against hospitals for readmissions following heart attacks and heart failure is 3% from the base payment on all Medicare inpatient admissions.¹⁰⁰ The average penalty actually assessed in 2017 was 0.74%.¹⁰¹ Since fiscal year 2013, the average percentage of hospitals penalized under the RRP has been between 64% and 79%, with the rate for the last three fiscal years (from 2015 to 2017) hovering around 78% to 79%.¹⁰²

While these numbers suggest the RRP works to reduce overall readmissions and encourage hospitals to provide better initial care, the impact on Medicare beneficiaries may be limited.¹⁰³ Proponents of the RRP suggest “that financial penalties encourage hospitals to implement activities designed to improve care quality and lower their rate of preventable readmissions . . . [benefiting] Medicare patients and the Medicare Program.”¹⁰⁴ However, critics of value-based programs note that many Medicare recipients are hospitalized in institutions that are penalized less than one percent, perhaps suggesting that the penalty is under-powered and too small to make a meaningful impact on institutional behavior.¹⁰⁵ Other critics argue that the RRP may be harming patients who might need to be readmitted by “keeping them out of the hospital” and further jeopardizing their health.¹⁰⁶

96. See *supra* Part I.

97. Boccuti & Casillas, *supra* note 95.

98. *Id.*

99. Patient Protection and Affordable Care Act, 42 U.S.C. § 1395ww(q)(1) (2010). The adjustment factor is equal to either the “ratio of the aggregate payments for excess readmission” and the “aggregate payments for all discharges” or the floor adjustment factor of 0.97 (whichever is greater). *Id.*

100. Boccuti & Casillas, *supra* note 95, at tbl.1.

101. *Id.*

102. *Id.*

103. Boccuti & Casillas, *supra* note 95.

104. *Id.* However, the counterargument to this is also compelling. Since the penalties have reduced reimbursement to lower-performing hospitals, teaching hospitals, rural hospitals, and hospitals with significant numbers of low-income patients, the programs may be negatively affecting the ability of these hospitals to give patients a high quality of care. *Id.*

105. *Id.* Due to concerns regarding penalties disproportionately impacting certain types of hospitals, beginning in fiscal year 2019, hospitals will be divided into peer groups with similar numbers of inpatients qualifying for both Medicare and Medicaid and will receive performance evaluations relative to other like hospitals. *Id.*

106. Ross, *supra* note 93.

Given the RRP's tracking of heart attacks and heart failure, the RRP is in a unique position to highlight gender-based healthcare disparities present in cardiovascular disease. One study found that in 2013 hospitals experienced higher rates of readmission for women than men in the thirty days following cardiovascular incidents.¹⁰⁷ Because of the higher readmission rates for women, under the ACA's RRP program, hospitals themselves are losing reimbursement payments for female Medicare patients.¹⁰⁸ Since the RRP does not explicitly encourage hospitals to ensure physician education regarding gender-based disparities, female patients are needlessly harmed and hospitals are needlessly losing Medicare reimbursement payments given their inability to address the issue.¹⁰⁹

2. Hospital Value-Based Purchasing Program

The ACA also established the Hospital Value-Based Purchasing Program (HVBP) for hospitals participating in Medicare.¹¹⁰ The HVBP “rewards hospitals with payments based on the quality of care provided to Medicare patients,” among other factors.¹¹¹ The Centers for Medicare and Medicaid Services (CMS)¹¹² may “make[] incentive payments to hospitals based on either: [h]ow well they perform on each measure . . . [or] [h]ow much they improve their performance on each measure compared to their performance during a baseline period.”¹¹³

Through the HVBP, CMS groups a set of measures into defined quality domains in order to assess the quality of care Medicare patients receive.¹¹⁴ For fiscal year 2018, the domains and their respective weights were: patient and caregiver-centered experience of care/care coordination (25%), safety (25%), clinical care (25%), and efficiency and cost reduction (25%).¹¹⁵ In fiscal year 2018, HVBP measures included the thirty-day mortality rate for acute myocardial infarctions.¹¹⁶ Pain management satisfaction was included through fiscal year 2017.¹¹⁷

107. Cashel O'Brien et al., *Comparison of 30-Day Readmission Rates After Hospitalization for Acute Myocardial Infarction in Men Versus Women*, 120 AM. J. CARDIOLOGY 1070, 1071, 1074 (2017).

108. See Boccuti & Casillas, *supra* note 95.

109. See *id.*

110. Patient Protection and Affordable Care Act, 42 U.S.C. § 1395ww(o) (2010).

111. HVBP FACT SHEET, *supra* note 5, at 3.

112. CMS is a department located within the Department of Health and Human Services. *About CMS, CTRS. FOR MEDICARE & MEDICAID SERVS.*, <https://www.cms.gov/About-CMS/About-CMS.html> [https://perma.cc/27QS-QCSK] (last visited Jan. 13, 2018).

113. HVBP FACT SHEET, *supra* note 5, at 3.

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.* at 4.

The process of scoring hospital performance is incredibly complex. At its most basic level, hospitals receive a Total Performance Score (TPS) out of one hundred points which is derived from the four domains and their relative weights.¹¹⁸ HVBP scores the TPS out of one hundred points, with the relative weights of the domains in place; however, a hospital who scores in just three of the four domains will have their scores “proportionately re-weighted to the scored domains.”¹¹⁹ For fiscal year 2017 and beyond, the HVBP is funded by a 2% reduction in a hospital’s base diagnosis-related group payments.¹²⁰ HVBP redistributes leftover funds as incentive payments to hospitals based on their TPS.¹²¹ Hospitals may earn back a percentage “that is less than, equal to, or more than the applicable reduction for that [fiscal year].”¹²²

One study isolated the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) portion of the patient and caregiver-centered experience of care/care coordination TPS domain.¹²³ The HCAHPS is a survey which “measures . . . the patient experience of care.”¹²⁴ HCAHPS points are awarded to hospitals across two different variables—achievement and improvement.¹²⁵ Prior to fiscal year 2018, one part of the

118. *Total Performance Score Information*, MEDICARE, <https://perma.cc/CE8P-DEEQ> (last visited Jan. 18, 2018).

119. *Id.*

120. Patient Protection and Affordable Care Act, 42 U.S.C. § 1395ww(o)(7) (2010); CTRS. FOR MEDICARE AND MEDICAID SERVS., HOSPITAL VALUE-BASED PURCHASING, (Oct. 31, 2017) [hereinafter HVBP MOST RECENT], https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf [<https://perma.cc/QF5U-22JL>]. Diagnosis related groups (DRG) are the foundation of hospital reimbursement through Medicare. CTRS. FOR MEDICARE & MEDICAID SERVS., DESIGN AND DEVELOPMENT OF THE DIAGNOSIS RELATED GROUP (DRG) 1, [https://www.cms.gov/ICD10Manual/version34-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_\(DRGs\)_PBL-038.pdf](https://www.cms.gov/ICD10Manual/version34-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs)_PBL-038.pdf) [<https://perma.cc/MV8G-5JAE>]. DRGs “are a patient classification scheme which provides a means of relating the type of patients a hospital treats . . . to the costs incurred by the hospital.” *Id.* DRGs are based on principal and secondary diagnoses, age, sex, procedure, and discharge status. *Id.* at 13.

121. HVBP MOST RECENT, *supra* note 120. “The hospital’s TPS is converted to a value-based incentive payment adjustment factor, and that factor is then multiplied by the base operating DRG payment amount for each Medicare fee-for-service discharge in a fiscal year to calculate the adjusted payment amount that applies to the discharge for that fiscal year.” *Hospital VBP Program Aggregate Payment Adjustments*, MEDICARE, <https://www.medicare.gov/hospitalcompare/data/payment-adjustments.html> [<https://perma.cc/A53X-LQP2>] (last visited May 29, 2018).

122. HVBP MOST RECENT, *supra* note 120.

123. Marc N. Elliot et al., *Understanding the Role Played by Medicare’s Patient Experience Points System in Hospital Reimbursement*, 35 HEALTH AFF. 1673 (2016).

124. *Id.* at 1673.

125. HVBP MOST RECENT, *supra* note 120, at 6.

patient-experience-of-care domain included pain management,¹²⁶ an area where gender-based healthcare disparities often exist.¹²⁷

The improvement points portion of HCAHPS has been shown to better performance in lower-performing hospitals.¹²⁸ Given this finding, some scholars suggest that increasing the weight given to improvement points might be a useful tool to decrease socioeconomic and racial and ethnic disparities.¹²⁹ If CMS decides to reintroduce a pain management axis,¹³⁰ the HVBP scheme could be utilized to indirectly reduce the gender-based disparities in pain management. Since women are less likely to receive opioid pain medication than men and are forced to wait longer to receive pain medication than men,¹³¹ it is fair to speculate that their responses on the HCAHPS are reducing the number of bonuses given to hospitals. Even if the pain management axis is not directly reintroduced, CMS will continue to collect important data on pain management via the Hospital Inpatient Quality Reporting Program¹³² which should be used as an impetus for more equal pain management between women and men.

The HVBP Program has been controversial and is certainly not without its critics.¹³³ The intent of HVBP was always to increase the quality of care without furthering any health disparities.¹³⁴ However, the first study to evaluate HVBP implementation found no evidence of quality improvement when compared to hospitals not under HVBP provisions.¹³⁵ The study did find that, when assuming the impact of HVBP began three years before the financial incentives, there was an “improvement on clinical process performance” for hospitals under HVBP.¹³⁶ Critics of HVBP also note that pay for performance may fail to decrease, and may even exacerbate,

126. HVBP MOST RECENT, *supra* note 120, at 4. “Due to potential confusion about the appropriate use of the Pain Management dimension questions,” CMS removed the domain and is reformulating its questions. 81 Fed. Reg. 79562, 79857 (Nov. 4, 2016). There is some likelihood the dimension will return. *Id.* at 79856.

127. *See supra* Section II.B.

128. Elliot et al., *supra* note 123, at 1677.

129. *Id.* at 1679.

130. 81 Fed. Reg. 79562, 79856 (Nov. 4, 2016).

131. *See* Chen, *supra* note 37, at 416.

132. 81 Fed. Reg. 79562, 79859 (Nov. 4, 2016).

133. *See, e.g.,* Ryan et al., *supra* note 71; Jordan Rau, *Doctor-owned Hospitals Prosper under Health-Care Law*, WASH. POST (April 13, 2013), https://www.washingtonpost.com/national/health-science/doctor-owned-hospitals-prosper-under-health-care-law/2013/04/13/d25888f0-a45a-11e2-82bc-511538ae90a4_story.html [<https://perma.cc/93U7-2B2J>] (stating that physician-owned hospitals may cherry-pick the healthiest, wealthiest patients allowing for inflated performance on quality measurements).

134. Elliot et al., *supra* note 123, at 1674, 1678-79; *see also* Ryan et al., *supra* note 71, at 92.

135. *See also* Ryan et al., *supra* note 71, at 92.

136. *Id.* The study used a three year assumption since “hospitals may have anticipated the start of HVBP and begun to improve quality performance” *Id.* at 89.

disparities if they “reward only high levels of absolute performance.”¹³⁷ These critics say that HVBP is harmful because it disproportionately penalizes healthcare organizations serving “disadvantaged populations [who are] already less likely to receive recommended care.”¹³⁸ These critiques, while valid, can be addressed by more closely tailoring HVBP domains to align with the disparities that they explicitly wish not to exacerbate.¹³⁹ Another way to make HVBP more effective is to increase the financial penalty to more forcefully prompt hospitals to comply with quality standards.¹⁴⁰ Regardless, due to the potential for an adverse effect on disparities, the HVBP must be closely monitored and evaluated and should be allowed to change and grow over time.¹⁴¹

On its face, the ACA, including its Medicare reforms such as the RRP and HVBP, does not facially discriminate against women in any way.¹⁴² In fact, the ACA reforms pull on various policy levers intended to improve the quality of care for all people regardless of gender.¹⁴³ However, asking the Woman Question shows that the ACA is non-neutral because gender-based disparities in healthcare persist despite the ACA’s attempts to improve quality.

III. POSSIBLE SOLUTIONS TO GENDER DISPARITIES AS A PAY FOR PERFORMANCE ISSUE

Since the ACA is non-neutral, healthcare stakeholders must search for solutions to adequately address gender-based disparities. Gender-based disparities in healthcare affect the quality measurements utilized under the ACA to determine pay for performance.¹⁴⁴ However, given the prevalence and harm of these disparities, the ACA fell short with programs like the RRP or the HVBP. By adjusting the incentives available through these programs, the ACA could decrease gender-based disparities in healthcare. There are legislative solutions available, and hospitals should seek their own solutions to gender-based disparities from the ground up.

A. *Legislative Solutions through the Affordable Care Act and Healthcare Reform Efforts*

137. Elliot et al., *supra* note 123, at 1674.

138. Tingyin T. Chee et al., *Current State of Value-Based Purchasing Programs*, 133 CIRCULATION 2197, 2203 (2016).

139. *Id.*

140. *Id.* at 2201.

141. *Id.* at 2203.

142. See Bartlett, *supra* note 16; *supra* text accompanying note 18.

143. See, e.g., Patient Protection and Affordable Care Act, 42 U.S.C. §§ 1395ww, 208j (2010).

144. See *supra* Part I.

The ACA includes a built-in mechanism for financially penalizing hospitals for under-performing on quality-of-care measures.¹⁴⁵ However, nowhere in the ACA pay for performance system, which includes the RRP and the HVBP, are disparities explicitly mentioned.¹⁴⁶ The HVBP program include items like the thirty-day mortality rate from acute myocardial infarctions and, until fiscal year 2018, pain management.¹⁴⁷ These domains track where cardiovascular and pain management disparities exist, but the legislation itself is silent on the actual disparities present.¹⁴⁸

This inattention to disparities likely hurts hospitals' bottom lines as well as female patients. Since the ACA fails to explicitly provide incentives aimed at decreasing gender-based disparities, the disparities remain invisible and excluded from the priority list for hospitals.¹⁴⁹ However, if the ACA encouraged hospitals and their physicians to consider, for example, the differences in the ways in which women and men present with heart attacks, the hospital's scores for clinical process domains would likely rise and the rate of readmissions following heart attacks would likely decrease. This would mean *higher* reimbursements for the hospitals, many of which desperately need Medicare reimbursement to remain in business.¹⁵⁰

When considering how to address gender disparities in healthcare, it may be useful to follow the lead of studies looking at racial and ethnic disparities in healthcare.¹⁵¹ The National Quality Forum (NQF)¹⁵² suggests that pay for performance tools could more effectively decrease disparities if the measurements are based on explicitly lowering disparities themselves, instead of "paying for higher-quality performance applied generally to all patients."¹⁵³ Moreover, the NQF suggests pay for performance could also be "based [specifically on] improving quality of care for minority populations."¹⁵⁴

145. See *supra* notes 84 and 86 and accompanying text.

146. *VBP Explanation*, *supra* note 84.

147. See HVBP FACT SHEET, *supra* note 5 and accompanying text.

148. HVBP FACT SHEET, *supra* note 5.

149. See *supra* Part II.

150. AM. HOSP. ASS'N, FACTSHEET: RURAL AND SMALL HOSPITALS, <https://www.aha.org/system/files/content/16/fs-ruralsmall.pdf> [<https://perma.cc/875H-L6G5>]. The American Hospital Association has called for relief from Medicare regulations, or, at a minimum, consideration of the unique circumstances of rural hospitals, given their heavy reliance on Medicare reimbursement. *Id.*

151. See, e.g., NAT'L QUALITY FORUM, HEALTHCARE DISPARITIES AND CULTURAL COMPETENCY CONSENSUS STANDARDS 7 (Sept. 2012), https://www.qualityforum.org/Publications/2012/09/Healthcare_Disparities_and_Cultural_Competency_Consensus_Standards_Technical_Report.aspx [hereinafter CULTURAL COMPETENCY] [<https://perma.cc/W5HW-SVS4>].

152. The National Quality Forum is a "not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare." *About Us*, NAT'L QUALITY F. (2018), http://www.qualityforum.org/About_NQF/ [<https://perma.cc/T8FE-RJRN>]. The organization works to "enhance healthcare value, make patient care safer, and achieve better outcomes." *Id.*

153. CULTURAL COMPETENCY, *supra* note 151, at 7.

154. *Id.*

When creating future healthcare reforms, either direct changes to the ACA or any other attempt at reform, lawmakers must make disparities explicit within pay for performance models.¹⁵⁵ By raising the expectations of healthcare institutions and providers and demanding they address any gender disparities—or racial, ethnic, or socioeconomic disparities—head-on, they will be on notice that such disparities exist and be encouraged to make substantive, meaningful change for their patients.¹⁵⁶ Not only will female patients benefit, but healthcare institutions and physicians will see better quality outcomes, and thus greater levels of reimbursement and payment, when treating patients suffering from cardiovascular disease, pain management issues, and cancer prevention or any other area in which gender disparities exist.

Making gender-based disparities in healthcare explicitly visible through the RRP may prove challenging. For example, it is untenable and undesirable for a multitude of reasons to consider penalizing hospitals more for a woman's readmission than a man's.¹⁵⁷ However, for the HVBP, a "reduction in healthcare disparities" domain could be added.¹⁵⁸ This domain could be further broken down into subsections—like the clinical care domain already is—along gender, socioeconomic status, and racial and ethnic groups.¹⁵⁹ The score in this domain could then become part of an institution's TPS score and utilized to calculate the reimbursement rate in the usual manner.¹⁶⁰ Explicitly identifying disparities could encourage healthcare institutions and providers acknowledge disparities and work to reduce them.¹⁶¹ As previously discussed, not only will these changes improve outcomes for female patients, but the hospitals could increase the rates of reimbursement from TPS payments bolstering their bottom lines.¹⁶²

B. Hospital-Based Solutions

Because their net revenue is directly impacted, hospitals have stronger incentives to address gender disparities in their own facilities than Congress, and they can certainly do so more quickly. Simply by raising awareness of gender-based disparities, hospitals can encourage their healthcare providers

155. See Chee et al., *supra* note 138, at 2203.

156. See CULTURAL COMPETENCY, *supra* note 151.

157. Nor should a solution based on asking the Woman Question be about finding solutions which only benefit women. See Bartlett, *supra* note 16, at 846.

158. See HVBP FACT SHEET, *supra* note 5 and accompanying text.

159. *Id.*

160. See Total Performance Score Information, *supra* note 118 and accompanying text.

161. See *supra* notes 151 and 154 and accompanying text.

162. See Total Performance Score Information, *supra* note 118 and accompanying text.

to implement changes in the way they diagnose patients, thus increasing quality of care and, with it, Medicare reimbursements.

As previously discussed, many of the gender-based disparities in healthcare stem from harmful, and frequently unconscious, gender stereotypes and biases. “Unconscious biases are social stereotypes about certain groups of people that individuals form outside their own conscious awareness.”¹⁶³ These biases exist along many axes including gender, sexual orientation, religion, weight, race, socioeconomic status, and ethnicity.¹⁶⁴ Examples of such biases include the perception that women are significantly more emotional than men—causing providers to classify women’s pain as a mental problem—or conversely, viewing women as inherently more capable of dealing with pain—causing providers to undertreat female pain.¹⁶⁵ One way to minimize these biases might be to require unconscious bias training for any healthcare provider in the hospital.¹⁶⁶ Unconscious bias training, while somewhat controversial,¹⁶⁷ has evidence supporting its efficacy.¹⁶⁸

Unconscious bias training is vital for healthcare professionals, as it may help to make it easier to recognize unconscious bias and to mitigate the harm of the biases.¹⁶⁹ Educating healthcare providers on the subtle forms, manifestations, harms, and consequences of stereotypes and bias gives them the knowledge and opportunity to work on minimizing biases and stereotypes in their own work with patients.¹⁷⁰ In so doing, the providers may be more likely to recognize the symptoms of heart attacks and heart disease in women.¹⁷¹ They may be more receptive toward women feeling intense pain and treat the pain more appropriately, thereby potentially increasing their score in the patient and caregiver-centered experience of the

163. *Unconscious Bias*, U.C., S.F. OFF. DIVERSITY & OUTREACH, <https://diversity.ucsf.edu/resources/unconscious-bias> [https://perma.cc/G88P-YBHB] (last visited Jan. 18, 2018).

164. *Id.*

165. Marthe, *supra* note 35.

166. The Association of American Medical Colleges (AAMC) offers limited opportunities for health professionals to receive training on unconscious biases. See *Unconscious Bias Training for the Health Professions*, ASS’N AM. MED. COLLS., <https://www.aamc.org/initiatives/diversity/322996/lab-learningonunconsciousbias.html> [https://perma.cc/KLE7-QTPU] (last visited May 29, 2018). In 2017, the AAMC offered an “Every Day Bias Workshop for the Health Professions” and an “Unconscious Bias Train-the-Trainer Program for the Health Professions.” *Id.*

167. See Jessica Nordell, *Is This How Discrimination Ends?*, ATLANTIC (May 7, 2017), <https://www.theatlantic.com/science/archive/2017/05/unconscious-bias-training/525405/> [https://perma.cc/7ZHY-CUPZ].

168. Patricia G. Devine et al., *Long-Term Reduction in Implicit Race Bias: A Prejudice Habit-Breaking Intervention*, 48 J. EXPERIMENTAL SOC. PSYCHOL. 1267, 1277 (2012).

169. ASS’N OF AM. MED. COLLS., *supra* note 166.

170. This may be especially important for healthcare providers as “biases may be more prevalent when multitasking or working under time pressure.” U.C., S.F. OFF. DIVERSITY & OUTREACH, *supra* note **Error! Bookmark not defined.**

171. See Godfrey & Mason, *supra* note 37.

care/care coordination domain.¹⁷² Similarly, they may become aware of the need to screen men and women for cancer at equal rates, especially when there is no medical evidence that men and women need to be screened at different rates.¹⁷³

Hospitals are well-situated to make more immediate, and perhaps more impactful, reductions in gender-based healthcare disparities than Congress by providing ground-level training on the unconscious biases all people carry. Such a solution has some appeal, given the relative ease, speed, and low cost of implementing unconscious bias training.¹⁷⁴ While legislative reform to the ACA and its Medicare reform might create stronger financial incentives for institutions, hospital-based solutions might appeal more to providers seeking a successful reduction in healthcare disparities at the local level in a relatively short amount of time.¹⁷⁵ Additionally, hospital-based solutions are not subject to the numerous political barriers and typically slow pace inherent in legislative healthcare reform.¹⁷⁶

CONCLUSION

This Note examined the ways in which gender disparities and value-based programs interplay in the healthcare system. The Note explained some of the most common and most concerning gender-based disparities, showing that these disparities are seen in areas such as cardiovascular disease, pain management, and cancer.

This Note then provided an overview of different value-based programs in existence while using feminist legal theory to ask the Woman Question. It first explained the broad measures found within the ACA to increase access and improve quality. The Note proceeded to examine the ACA's Medicare reform programs, including the RRP and the HVBP. It showed

172. See *supra* Sections I.B, II.B.1.

173. See *supra* Section I.C.

174. See *Unconscious Bias Train-the-Trainer for Healthcare Professionals*, COOK ROSS INC., <https://cookross.com/product/unconscious-bias-train-trainer-healthcare-professionals/> [<https://perma.cc/E59N-TV3X>] (last visited Feb. 3, 2018). Cook Ross Inc. partnered with the AAMC to provide a four-day training program for \$3,995.00. *Id.*

175. See, e.g., *Statistics and Historical Comparison*, GOVTRACK, <https://www.govtrack.us/congress/bills/statistics> [<https://perma.cc/K47S-7Z4U>] (last visited Feb. 4, 2018) (stating that only 3% of proposed bills became enacted law between 2015 and 2017).

176. See, e.g., Paige Winfield Cunningham, *The Health 202: There Are Plenty of Health-Care Issues at Stake in the Government Spending Fight*, WASH. POST (Jan. 4, 2018), https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/01/04/the-health-202-there-are-plenty-of-health-care-issues-at-stake-in-the-government-spending-fight/5a4d24b430fb0469e883fee3/?utm_term=.7d382506976f [<https://perma.cc/4HRL-BS6G>]; David Weigel, *McConnell Says Effort To Repeal Affordable Care Act Is 'Probably' Over*, WASH. POST (Dec. 21, 2017), <https://www.washingtonpost.com/news/powerpost/wp/2017/12/21/mcconnell-says-effort-to-repeal-affordable-care-act-is-probably-over/> [<https://perma.cc/S5HG-ZYBY>].

how these programs may or may not be effective in highlighting and solving gender-based disparities in healthcare.

Finally, this Note proposed solutions to the ACA's lack of neutrality which would both increase the quality of healthcare received by women and increase the reimbursement payments to hospitals under the various pay for performance programs. Potential solutions include legislative reforms to the RRP or the HVBP. Solutions may also include more ground-up reforms from hospitals themselves such as unconscious bias training.

Gender disparities in healthcare treatment are clearly pay for performance issues that impact Medicare, hospitals, and physicians. By failing to include comprehensive gender disparity resolutions in the quality measures hospitals use, hospitals are penalizing themselves under the legal guidelines of the ACA and Medicare reform.

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