



Speakers discuss solutions for health care inequalities and the bundled payment system

By Casey Tingle - October 3, 2017

As CMS continues to transition from a fee-for-service to a value-based delivery and payment model, providing the same quality of care to all patients has been a challenge. Physicians may feel incentivized by hospitals to not provide care for patients with complex medical needs and demographic challenges to reduce the cost of the episode of care and the risk of penalties for readmissions.

“The challenge is that patients who still need our care, desperately need our care, are being marginalized by the payment models that we have developed to drive value,” Mary I. O’Connor, MD, chair of Movement is Life and director of the Center for Musculoskeletal Care at Yale School of Medicine, said in a webinar on health disparities in Medicare bundled payments hosted by Movement is Life. “This is an unintended consequence, in my opinion, of how we have approached driving value and improving health care in this country. We need risk stratification to recognize that all patients are not the same.”

The phenomenon known as cherry-picking and lemon-dropping, in which physicians will choose to treat healthier patients rather than sicker patients, may be encouraged with the gainsharing aspect of bundled payment models, O’Connor said. She noted that publications are now appearing which support that hospitals in bundled payment models are operating on healthier patients.

Risk stratification

To help provide care for more complex patients, especially those in lower income areas, Andrew M. Slavitt, former acting administrator at CMS, noted hospitals should receive more investment dollars to provide a better level of care. However, he added that quality should be measured the same across all hospitals to avoid creating a two-tiered quality system.

“The minute we start saying we have one set of standards of quality for one people and another set of standards for quality for another set of people, ... that is not what we want,” Slavitt said. “Maybe it is going to take a little extra effort to get readmissions lower for people who have more challenges, but that is why we are going to invest more and allow you to invest more in those populations, but you have to hit the same standard.”

However, O’Connor noted that not every hospital is the same and that measuring all hospitals equally will not solve the problem of cherry-picking and lemon-dropping that is experienced in a bundled payment setting. According to Stacy Sanders, federal policy director at Medicare Rights Center, one way around the issue of a two-tiered system while treating patients equally is to measure hospitals that serve the same patient populations against one another instead of measuring every hospital at the same level.

“I like the concept of comparing my safety-net hospital to other safety-net hospitals,” O’Connor said. “Do not compare my hospital to the hospital from the affluent suburb. These are different patient groups.”

Creating change

Both O’Connor and Slavitt stressed the importance of physicians and hospitals making themselves available to patients instead of waiting for patients to come to them.

“We see safety-net providers and safety-net hospitals providing the care to higher risk and lower socioeconomic patients. Providers in a non-safety net environment, more of a private practice environment, they often — not everybody but a significant number of them — do not see many of these individuals in our communities,” O’Connor said.

Research has also shown that hospitals with good leadership have led to high performance, even in areas with high proportions of racial and ethnic minorities, noted Thomas A. LaVeist, PhD, chair of the Milken Institute School of Public Health at the George Washington University.

“Each of these hospitals had a leader that simply said, ‘We will be a higher-performing hospital. It does not matter who walks through those doors and if you cannot do that, you will not work here,’” LaVeist said. “They were able to get that idea permeated throughout the organization and those hospitals were high-performing hospitals, in spite of the fact that they had patients that we claim we cannot provide good-quality care for.”

Standing together

However, for more patients to receive more care, hospitals cannot do it alone. Laini Jarrett, project manager at North Carolina Quality Center/North Carolina Hospital Association, noted hospitals and communities need to partner together to reach a greater number of patients.

“The hospitals cannot do it all, but the communities cannot do it either,” Jarrett said. “It requires the partnership necessary and that means that you design your programming around domestic abuse issues; you design your programming around children’s issues; you make sure that the basic needs that are impacting why they are not seeking care are being met so that they will feel more comfortable and have access.”

Overall, O’Connor noted that more conversations are needed on how to make patient care better and more widely available.

“These are the kinds of conversations that we need to have,” O’Connor told [Healio.com/Orthopedics](https://www.healio.com). “We are not talking enough about these challenging issues with individuals who are part of think tanks and who create policy. Bringing the perspective of physicians and orthopedic surgeons and, as I describe myself, someone in the trenches to these conversations is critical because we still ultimately have to advocate. Our primary role as physicians is to advocate for our patients and serve our patients.” – by Casey Tingle