Do providers give preference to more profitable patients?

Featuring Daniel Wiznia, MD.

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Bill: You're listening to the Health Disparities Podcast from Movement Is Life. Conversations about health disparities with people who are working to eliminate them. I'm Bill Finerfrock and today I'm discussing health disparities and health policy with Dr. Dan Wiznia, who is at Yale University. He is Assistant Professor of Orthopedics and Rehabilitation and Assistant Professor of Orthopedics and Rehab Joint Reconstruction and he also is an Assistant Professor of Mechanical Engineering. So, you have both an engineering background, as well as, being a physician. We're here to talk about health disparities and tell us a little bit about yourself, more than I've done, and how you got into this whole area of dealing with health disparities.

Dan: Thank you for having me. I am a total joint replacement surgeon. So, I treat patients who have end stage arthritis and I focus on hip arthritis and knee arthritis. So, in terms of how I became engaged in healthcare disparities, it was when I was a resident and we had a resident arthritis clinic and we would be really, the only resource in the New Haven, Connecticut community where these patients who had Medicaid insurance or did not have any insurance could go to seek care and it was very, very

surprising to me, just how large a demand there was for our clinic. I engaged in a study looking at total joint replacement access, given that the Affordable Care Act had just come into effect in 2014, I conducted a study across the nation looking at how patient access varied in terms of being able to obtain appointments to see orthopedic surgeons to have total joint replacement. It was very eye-opening to me how access for someone with Medicaid was such a struggle to be seen, while access for someone with private insurance, they were able to obtain an appointment very easily.

Bill: I've heard about that study. I think it's what sometimes is described as a Secret Shopper Study. Can you elaborate on that a little bit of how are you able to make the determination that the provider was making a distinction in creating or deciding to treat based on whether they were Medicaid uninsured or commercial insured? How does that work?

Dan: So, the Secret Shopper concept really its premise is a little deceiving. You call an office acting as though you're a patient and you try to see if you can obtain an appointment, and during the conversation, following a script, you are able to also record other variables and factors that may affect your access to obtain an appointment. So, for example, for this study where we're exploring whether patients who have arthritis, whether they could be evaluated for potentially, a total joint replacement, we would call, tell them

that we were told by our primary care doctor that we needed a total joint replacement. That we had end stage arthritis. We would tell the office that we either had private insurance, Medicare or Medicaid. Then, we would ask if we could schedule an appointment and the office would then, either say, yes, we can schedule an appointment or they would say, no, we don't accept your insurance and then, they would give us an actual date for the appointment, and this was important because we actually were trying to see if patients with Medicaid insurance were going to have longer wait times, more days between the request for an appointment and the actual appointment. And then, the office would also tell us what sort of requirements they had in terms of office notes from our primary care doctor or x-rays and, at the end of the call, we would always cancel the appointment, so, we wouldn't be taking a needed spot, but what we would learn is from the study was that Medicaid patients, their wait times were a bit longer to be seen.

Bill: So, let me see if I understand it. So, a person would call up the medical practice, describe the medical condition that they had been referred and say they were on Medicaid, and the practice would say, that's great. We can schedule you for an appointment in two weeks. And then, an hour later, another person calls up with the same medical problem and description, all the relevant information was very similar, and the practice would say, oh, great, we can see you tomorrow.

Dan: Exactly.

Bill: So, you're concluding from that, that the Medicaid, they're putting them off, versus the commercial insured individual is able to get in right away. Is that kind of the…?

Dan: That was one major thing was there was a delay, but the other big finding was that just there was a very low percentage of offices that would even see Medicaid patients, in the first place.

Bill: So, the Medicaid patient might told, I'm sorry, we don't have any time slots for you, but, again, the commercial insured patient would call up and they'd be, oh, yeah, we can see you. We can schedule you. So, it was even that disparate where they wouldn't tell them, we won't see you because you're on Medicaid, necessarily.

Dan: Oh, no, they would.

Bill: They were honest about it.

Dan: They would say, we don't accept Medicaid. We would have a follow-up question. Well, do you know who might accept Medicaid? Some offices

would forward us to an academic practice or a state institution or a city institution. Some couldn't. But, then, just the requirements that they place on these Medicaid patients was a lot higher. A lot of them required a referral from the primary care doctor and a lot of them required the last note from the primary care doctor and x-rays. And, for someone with limited means, coordinating all of those extra barriers to care can be challenging, if you don't have access to a fax machine. If you don't have a phone to be able to arrange for your primary care to send all those documents over.

Bill: And, those same requests weren't made of an individual who had commercial insurance?

Dan: Exactly. Someone who had commercial insurance didn't have to bring any of that.

Bill: Wow, fascinating. If somebody wanted to gain access or look at your study, where could they find it?

Dan: This study was published in the Journal of Arthroplasty.

Bill: So, if you can Google the Journal of Arthroplasty and just put in your name?

Dan: Yes, it'll come up.

Bill: That's fascinating. So, one of the things that we've been talking with folks about is how they're changing some of the payment models, that, right now, as a surgeon, you're paid, basically, on what's called a "fee for service" basis. You do a surgery, you get paid for what you're doing, but they're moving to more of what, now, are called bundled payments. Can you talk a little bit about that? What does a bundled payment mean first, and then, we'll kind of maybe talk a little bit more about that and what the implications are?

Dan: So, the whole concept behind the bundled payment is to try to have one sort of central fiscal manager of the care.

Bill: Which doesn't seem like a bad idea.

Dan: No, because, then, at least, someone is in control of how the care is being administered. So, in most cases, it's a hospital and the hospital will be given a lump sum and from that lump sum, it has to cover the surgeons fee. It has to cover the cost of doing the surgery. So, that's the admission, the operating room time, the implants, the medical device implant costs, all the nursing care the patient receives, the medication,

and then, subsequently, also included in that would be, therapy after the surgery and any care, up to 90 days after the surgery. So, the bundled payment has really placed the hospital system sort of at the forefront of trying to coordinate all of those services and costs and their incentivized because whatever isn't spent, they get to keep.

Bill: So, why is that a bad thing or what are some of the potential dangers, maybe, of that type of a payment model?

Dan: The major concern is that you're going to have institutions that will cherry pick patients who are healthier and who are perhaps less of a surgical risk and you won't allow care or you're making challenging for patients who, perhaps, don't meet those criteria.

Bill: Can you give an example of what a patient of greater surgical risk might look like compared to someone who is less of a surgical risk?

Dan: So, for example, the average patient who's having a total joint replacement is around the age of 70. If you have a patient who is obese or has diabetes, they have a higher risk for a complication after the surgery. Now, a hospital, if they're just being paid this lump sum, they don't want to be also beset with the expenses of that patient being readmitted with an infection and being readmitted and perhaps needing

another surgery. If that occurs during the 90-day period, that comes out of their bundled payment. So, the hospital is accepting, sort of, that risk of that, potentially, happening. So, there's an incentive to try to only operate on the healthiest patients, so, you don't have those complications.

Bill: So, that's not an uncommon occurrence. I've seen that with regard, for example, insurance companies have long argued and been successful at getting risk adjusted payments. That if they have a disproportionate higher percentage of individuals choose a particular health plan, the system has a mechanism to adjust for that and say, "Okay, you're going to have sicker patients. We'll pay you a little bit more." So, are you saying that these bundled payments don't do the same thing for the provider, the hospital the doctor, and make those same kinds of risk adjustments?

Dan: That's correct. So, the way that Medicare has setup these bundled payments, right now, is it does not make those risk adjustments. So, what's happening is you'll have patients who are higher risk for surgery. A lot of these patients are within these underserved populations who have less healthcare knowledge and resources and financially have faced a lot of challenges in terms of optimizing themselves for surgery and these patients tend to be, from those backgrounds, tend to not be as healthy. So, by instituting this bundled payment system, you may, actually, be disadvantaging these patients and creating healthcare disparities.

Bill: The things that you just talked about, socioeconomic status, the neighborhood, the environment in which an individual comes from, those aren't medical conditions. It's easy to identify and say, okay, we know you have diabetes, we know you have hypertension, but these other factors that I think are sometimes referred to as social determinants of health, can you talk a little bit about that? I think it somewhat ties back to your Medicaid example and research of how social determinants of health affect, potentially, the desirability of a physician or a hospital to see a particular patient and why that's important.

Dan: So, patients who come from these disadvantaged backgrounds, they tend to be not as healthy and part of that is based on the neighborhoods and communities, and they don't have the resources that wealthier communities have. For example, we're looking at a study, right now, where we're finding that most of these health centers are located in wealthy neighborhoods and the health centers aren't located in these more indigent communities. So, these patients who don't have the financial wherewithal to be able to travel outside of their neighborhoods are really stuck sort of in a healthcare desert in some sense. Then, because of this, they develop these more complex health conditions. So, what you're, ultimately, doing is you're creating this vicious cycle where

these social determinants are actually leading to these healthcare disparities.

Bill: I was talking with a doctor recently and it was an interesting example of that. She had it wasn't a patient but a friend of hers who was dealing with some weight issues and she said, well, one of the simple things you can do is just walk like every night go out and walk a mile, or whatever you can do and add to it. The individual said, "Doctor, you don't understand. You don't walk in my neighborhood." Because of crime, because of drugs and other things of where she happened to live, the notion of just going out and walking wasn't a realistic option. And so, that, in essence, contributed to her ultimate need for surgery because she wasn't able to do some of the things that many of us might think of as just routine activities to be able to combat what she was experiencing, in terms of her weight gain. Are those the kinds of things you're talking about?

Dan: Exactly. So, these patients, they don't have access to healthy eating choices. They don't have access to grocery stores that have produce, so that they can have meals with plenty of fruits and vegetables in their diet. That places them at increased risk of gaining weight. They don't have safe places to be physically active. That places them at increased risk of gaining weight. Extra weight places extra forces through the joints. For every extra pound that you have, the knee actually feels five pounds. So,

if you're 20 pounds overweight, the knee is actually experiencing a hundred extra pounds of force, and that extra force creates damage to the cartilage. So, cartilage is the surface that lines the ends of the bones that allows the bones to glide against each other. You'll see that at the end of chicken bones, that white glistening substance, that's cartilage and it's a very delicate tissue. It can't really withstand those extra forces and over time it gets worn down and decays. So, it's an enormous challenge for these patients and the weight places them at risk for, unfortunately, this disability.

Bill: Is there anything we can do to maybe adjust the bundled payment? My sense in talking with folks is that the physicians and hospitals don't, necessarily, mind being held accountable for the things that you can control but it's when you are suddenly being, basically, held accountable for things that are outside your control. So, are there things that we can do in how we design these models, these bundled payments to say, okay, we accepted bundled payment as not a bad policy, but any thoughts or ideas on what we might be able to do to try to prevent the kinds of things, cherry picking you mentioned, from happening?

Dan: I think one thing that would really, help is if Medicaid was more universally accepted and, currently, depending on the state you're in, the Medicaid reimbursement rates vary a little bit but, overall, they're significantly lower

than Medicare reimbursement rates and those patients really, struggle to gain access to care because of this, and if those patients had access to care a lot of these medical comorbidities might actually be improved. Second, the bundled payment system that Medicare has really does need to take into account these additional risk factors because it is, in some sense, creating a bias in terms of which patients are going to be treated.

Bill: So, the social risk factors and the medical risk factors both need to do that. I know there's been some effort to look at, can we build those into the models at the frontend, rather than waiting and looking at the results and going, gee, we've got a problem here. Maybe we can do a better job in how we design those models. Is that kind of part of the message here?

Dan: I think that's part of it. I think we also have to look at which institutions are really, being very aggressive in terms of their patient selection and examine how they're making those decisions and whether those decisions are being made based off of the patient's medical comorbidities or if there are actually other factors that may be influencing whether these patients are ultimately treated.

Bill: Yes, I mean, it seems to me as you're talking, that one of the concerns you'd have is hospital or surgeon who is doing that kind of cherry picking is going to come out and have great scores. "Oh, look at what a great

institution we are. Look at what a great surgeon I have, great quality scores," without recognizing that part of the reason for that is that you're self-selecting the patients and you're dealing with a healthier community and, meanwhile, what's not showing up in the quality scores is the whole community that's not even getting care.

Dan: So, let me give you an example. In New Haven, we have a nonprofit hospital and we have a hospital that's a private hospital and the nonprofit hospital, the physicians that operate there will accept patients with all types of insurance including Medicaid and even free care. At this private hospital, they'll only see patients who have insurance and, actually, won't see patients with Medicaid. So, at this nonprofit hospital, the patient population is very different because you have a lot of indigent patients and that puts a lot of, that does affect the complexity of the cases and the ultimate outcome of those patients. While, at this private hospital, they have these sorts of barriers to care, and they're able to select the healthiest patients and, if they have patients that are more complex, they, frequently, will refer the patient to the nonprofit hospital. So, they have this setup in their institution so that if you aren't a straightforward simple case, we're going to send you to this nonprofit hospital, and this is a hospital that is underfunded. Is trying to do the best it can to serve a population, which it is being reimbursed less for but that is medically more complex and socially more complex.

Bill: Yes, I mean, you can easily see where it becomes really, deteriorates over time, either from a financial perspective, the public hospital makes it harder and harder to exist financially, and then, the public perception. When the government comes out, for example, and says, “Oh, we’re going to give you our star ratings,” and Hospital A, whose the private hospital, get a five-star rating and Hospital B, gets a three-star rating, the impression in the community is oh, well, if you want to get good care, go to the five-star hospital, not the three-star hospital and it even causes greater self-segregation, if you will because, now, the insured population says, well, okay, I have the choice, but I’m going to go to the five-star. So, that even exacerbates itself.

Dan: But the reality is you probably do get better care at the three-star hospital because this is where the most complex cases are being done, and this is where the specialist who really can take on those cases are, where the folks who are doing all the simple cases, you know, they’re at the five-star hospital.

Bill: It’s outside the space you’re in, in orthopedics, but a few years ago, when they started to do this with hospitals, they found that some of the leading cancer hospitals got low ratings because they had a high mortality rate. A lot of patients died. They looked at other hospitals and they said, “Oh,

look. Their cancer mortality rate is much, much lower." But when they went in and looked, they said, "Well, wait a minute, the cancer hospitals, they're dealing with the most challenging cases, and they're actually the best place to go to, but the way you're measuring it and the way you're reporting it makes it appear that they're not as good and I think that's the same thing you're saying here that the hospital with the lower rating may actually be a better hospital because they're dealing with those more challenging cases, but it's just not showing up because of how we structured the rating process.

Dan: Exactly, exactly and, unfortunately, those star ratings create a perception that the hospital is of poor quality when, in fact, it may actually be even better given the expertise of the specialists there who are taking on those cases.

Bill: Well, Dr. Wiznia, I really appreciate you taking some time to talk with us today. This has been fascinating. I wish you great luck. I look forward to some of the additional research and analysis you're going to do in this space and just really want to encourage you to stick with it. It really helps from the public policy standpoint to have that kind of analysis to help educate people who are making those decisions that there are some things out there, some problems that they may not be aware of. So,

appreciate everything you're doing and look forward to working with you moving forward. So, thank you.

Dan: Thank you so much for having me. I really appreciate it.

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