Clin Orthop Relat Res (2014) 472:32–34 / DOI 10.1007/s11999-013-3315-x

Clinical Orthopaedics and Related Research®
A Publication of The Association of Bone and Joint Surgeons®

Published online: 12 November 2013
© The Association of Bone and Joint Surgeons® 2013

On Patient Safety

The Patient Protection and Affordable Care Act: Better Coverage, Worse Access. Will It Really Improve Patient Safety?

Michael J. Lee MD

In this era of healthcare reform, there is plenty of discussion regarding the expansion of healthcare coverage in the United States. While healthcare coverage is an improvement from no coverage, an equally, if not, more important discussion has yet to take proper shape: what are we doing about healthcare access? Broader healthcare coverage does not ensure broader healthcare access.

Access to healthcare is not just a convenience; it is a patient safety issue. Consider any access-challenged patient who must wait an extended period of time to see a physician. Progression of any disease, whether it is spinal stenosis, carpal tunnel syndrome, fracture, hip arthritis, or an ACL tear, results in more complicated treatment, and many studies suggest [3, 4, 6] inferior clinical results.

Access is already an issue for the Medicaid population. The majority of physicians in the United States currently do not see Medicaid patients [11]. But in January 2014, as a direct result of the Patient Protection and Affordable Care Act (PPACA), millions more patients will have health insurance through the expansion of Medicaid [7]. Americans earning less than 133% the poverty level will then be eligible for Medicaid services. Collins et al. [1] supported the PPACA, arguing that the expansion of health insurance coverage in the United States provided by the Affordable Care Act will “narrow if not eventually eliminate the profound inequity that currently characterizes the healthcare system.” [1] While the PPACA will improve coverage, what about access?

Another core component of the PPACA is the Hospital Value Based Purchasing Program [7]. Under this program, payments are linked to outcome measures such as high rates of 30-day readmission or hospital acquired conditions, including surgical site infections and deep venous thrombosis. As was the focus of one of my earlier columns [10], these metrics do not consider patient comorbidity or complexity of care rendered. Importantly, these metrics also fail to consider socioeconomic risk factors. Penalties for these complications represent a disincentive for physicians to provide care to those with risk factors for these complications, namely the sick and the poor.

Whether we like it or not, Medicaid status is associated with higher complication rates and a higher cost of care. In the orthopaedic literature, a recent

Note from the Editor-in-Chief: We are pleased to publish the next installment of “On Patient Safety” *to the readers of* Clinical Orthopaedics and Related Research®. *The goal of this quarterly column is to explore a broad range of topics that pertain to patient safety. We welcome reader feedback on all of our columns and articles; please send your comments to eic@clinOrthop.org.*

The author certifies that he, or any members of his immediate family, has no funding or commercial associations (eg, consultancies, stock ownership, equity interest, patent/licensing arrangements, etc) that might pose a conflict of interest in connection with the submitted article.
All ICMJE Conflict of Interest Forms for authors and *Clinical Orthopaedics and Related Research®* editors and board members are on file with the publication and can be viewed on request.
The opinions expressed are those of the writers, and do not reflect the opinion or policy of *CORR®* or the Association of Bone and Joint Surgeons®.

M. J. Lee MD (✉)
Department of Sports Medicine and Orthopaedic Surgery, University of Washington Medical Center, 1959 NE Pacific St., Seattle, WA 98195, USA
e-mail: mjl3000@uw.edu

On Patient Safety

study [2] from the University of Washington significantly linked Medicaid status with higher 30-day readmission rates. Another study from the University of Washington [5] (using a separate data registry), observed significantly higher complication rates after spine surgery in the Medicaid population.

There are several reasons as to why a lower socioeconomic status may predispose a patient to a higher complication rate, including limited access as already noted, a minimal supportive social network, different education levels, and competing social forces. A single parent working two jobs may miss a followup or two because she was at risk for losing one of her jobs. Postsurgical wound care may be compromised by of a lack of supportive social structure. Patients seen in the emergency department with injuries may have experienced suboptimal or untimely care because they were unable to find a physician who would accept Medicaid.

If Medicaid patients have higher rates of complications and worse outcomes, and reimbursement is directly linked to complications and outcomes, what happens next? Two things can happen, and neither is favorable for the Medicaid population.

(1) The already access-challenged patient population becomes even more access-challenged. Medical centers and providers may choose to cherry pick patients so as to optimize their quality grades and minimize their financial penalties. To some extent, this practice is already being done; the majority of physicians in the United States do not see Medicaid patients [11]. The PPACA policies may serve to worsen the preexisting disparity in health care access.

(2) The "safety net" institutions that disproportionately care for the Medicaid populations (often county hospitals, tertiary care centers, or academic hospitals) will get hit with financial penalties. As these penalties are expected to grow, this could result in substantial financial strain for these hospitals endangering their viability. If these hospitals go under, the patients they serve will lose access to care.

This is already happening [8, 9]. *Kaiser Health News* [9] reported that hospitals with large numbers of low-income patients were more likely to receive a penalty. Academic medical centers were more likely to be fined [8], and these penalties are only expected to increase with time.

The PPACA will certainly increase healthcare coverage in the United States in 2014. The Hospital Value Based Purchasing Program makes it more likely that healthcare access will be reduced for the lower income population. It is ironic that the net effect of the PPACA, despite being touted to narrow inequity in healthcare, may ultimately be to worsen the access, and subsequently the safety, of the population it is seeking to assist.

There is no easy solution. The likelihood of Medicaid increasing its reimbursement to encourage physicians to care for this population is close to nil. The likelihood of physicians embracing the care of this challenging, high-risk, and under-insured population while also assuming additional liability without adequate compensation, also is close to nil. Yet it is incumbent upon us, and our political representatives, to work together to prevent things from getting worse, and perhaps even make them better.

The structure of this program should be modified; currently, it incentivizes providers to avoid caring for a population in need of care. This is in no one's best interest. Even if funding cannot be found to improve reimbursement rates, the penalties need to be mitigated, particularly for safety-net institutions. Regulatory interventions should be considered to spread the burden of care more equally across all capable providers and care centers.

References

1. Collins SR, Robertson R, Garber T, Doty MM. The income divide in health care: how the Affordable Care Act will help restore fairness to the

On Patient Safety

U.S. health system. Issue brief. *Commonw Fund*. 2012;3:1–24.

2. Dailey EA, Cizik A, Kasten J, Chapman JR, Lee MJ. Risk factors for readmission of orthopaedic surgical patients. *J Bone Joint Surg Am*. 2013;95:1012–1019.
3. Emery SE, Bohlman HH, Bolesta MJ, Jones PK. Anterior cervical decompression and arthrodesis for the treatment of cervical spondylotic myelopathy. Two to seventeen-year follow-up. *J Bone Joint Surg Am*. 1998;80:941–951.
4. Ghodadra N, Mall NA, Karas V, Grumet RC, Kirk S, McNickle AG, Garrido CP, Cole BJ, Bach BR Jr. Articular and meniscal pathology associated with primary anterior cruciate ligament reconstruction. *J Knee Surg*. 2013;26:185–193.
5. Hacquebord J, Cizik AM, Malempati SH, Konodi MA, Bransford RJ, Bellabarba C, Chapman J, Lee MJ. Medicaid status is associated with higher complication rates after spine surgery. *Spine (Phila Pa 1976)*. 2013;38:1393–1400.
6. Hantes ME, Karidakis GK, Vlychou M, Varitimidis S, Dailiana Z, Malizos KN. A comparison of early versus delayed repair of traumatic rotator cuff tears. *Knee Surg Sports Traumatol Arthrosc*. 2011;19:1766–1770.
7. How does the healthcare law protect me? Available at: https://www.healthcare.gov/how-does-the-health-care-law-protect-me/. Accessed Aug. 21, 2013.
8. Kaiser Health News. Hospitals treating the poor hardest hit by readmission penalties. Available at: http://www.kaiserhealthnews.org/Stories/2012/August/13/hospitals-treating-poor-hardest-hit-readmissions-penalties.aspx. Accessed Aug. 21, 2013.
9. Kaiser Health News. Readmission penalties by state: year two. Available at: http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-medicare-hospitals-year-two.aspx. Accessed Aug. 21, 2013.
10. Lee MJ. Quality: a process or an outcome? It's not what you may think… *Clin Orthop Relat Res*. 2013;471:1097–1099.
11. Rath L. More spine surgery complications for Medicaid patients. Available at: http://www.arthritistoday.org/news/spine-surgery-complications-288.php. Accessed: Aug. 5, 2013.