

In addition to serving as a General Surgery resident, I am currently pursuing a research fellowship and Masters degree in Health Services Research at the Boston University School of Public Health. My research focuses on the impact of value-based payment models for surgical care at safety-net hospitals. During the past decade, the Department of Health and Human Services (HHS) has sought to improve the cost and quality of health services through the promotion of value-based payment models. HHS has established a goal for Medicare to dispense half of its payments to providers through alternative models, such as accountable care organizations (ACOs) and episode-based or bundled payments. In both models, providers accept increased financial risk, often in exchange for bonuses. While ACOs strive to meet annual spending and quality targets, bundled payments motivate providers to achieve targeted spending and quality metrics for specific episodes of care.

I am concerned that safety-net hospitals may be unfairly penalized as a consequence of current payment models that set unattainable budget goals and rely on inadequately risk-adjusted quality metrics. One year after implementation of the Comprehensive Joint Replacement bundle model, over 40% fewer safety-net hospitals (versus non-safety-net hospitals) qualified for rewards because they did not meet either spending goals or quality targets (Thirukumaran CP et al, Health Aff, 2019). While many safety-net patients are uninsured, accounting for insurance coverage alone may be insufficient. For example, my recent study found that expanded Medicaid eligibility has no effect on important quality metrics in patients undergoing arteriovenous access creation, such as rates of tunneled catheter use or mortality. However, I have determined that other factors common in the safety-net population, like homelessness or institutionalization, are associated with increased length of stay, wound infections, and mortality after access creation (Levin SR et al, J Vasc Surg, forthcoming). I recommend that payors adjust quality targets for sociodemographic factors, such as housing status, and reward hospitals for improving outcomes among vulnerable populations. In this manner, safety-net hospitals may accrue the resources to increase their efficiency and quality of care, elevating the health of their communities.

I contend that surgeons are best positioned to advocate for realistic and achievable budget and quality measures that pertain to operations. Attending the ACS Leadership Conference and Advocacy Summit will prepare me to effectively promote equitable surgical payment reform that supports those who serve the most socioeconomically vulnerable patients.