An Unintended Consequence of Payment Reforms: Providers Avoiding Nonadherent Patients

Jessica Mantel

Providers regularly encounter patients who fail to follow medical advice and recommendations for healthy living. Although sometimes providers fire nonadherent patients out of frustration or a belief that these patients waste precious medical resources,[1] most continue treating their nonadherent patients, doing their best to educate patients about the importance of adhering to recommended treatments and healthy lifestyles. However, payment models that link providers' reimbursements to patient outcomes and costs threaten to undermine providers' tolerance utilization for nonadherent patients. This commentary discusses how new payment models incentivize providers to avoid nonadherent patients and the potential consequences of providers doing so.

Rejecting Nonadherent Patients

Both private and public payors have shifted away from fee-for-service in favor of payment models that financially reward providers for improving patients' health outcomes and lowering costs, such as pay-for-performance, bundled payments, and shared savings.[2] When patients do not adhere to their providers' medical recommendations, they threaten providers' financial success under these new payment models. For example, patients who do not adhere to medication regimens are at higher risk of complications that may require costly emergency care, hospitalizations, or other treatments.[3] Those providers who care for these nonadherent patients may therefore have difficulty holding down costs and performing well on the quality metrics utilized under new payment models. Consequently, treating nonadherent patients may reduce a provider's payments and profits.[4] In response, some providers will refuse to treat nonadherent patients in an effort to protect their bottom-line.[5]

Current legal and ethical standards generally permit providers to fire their nonadherent patients or refuse to treat prospective patients deemed likely to be nonadherent. Providers may refuse to enter into a treatment relationship with a prospective patient for *any* reason, save for a few narrowly drawn exceptions.[6] Once the provider and patient have entered into a treatment relationship, the provider can terminate the relationship at any time subject only to anti-discrimination laws and common law patient abandonment rules that require giving a patient sufficient prior notice.[7] The medical profession's ethical guidelines echo these legal standards. For example, the AMA's Principles of Medical Ethics state that "[a]

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physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve . . .,"[8] and may terminate the physician-patient relationship with proper notice.[9] Providers who wish to avoid nonadherent patients in order to ensure greater success under the new payment models thus face few if any legal and ethical barriers to doing so.

The Consequences of Providers Avoiding Nonadherent Patients

The prospect of wide-spread avoidance of nonadherent patients by physicians raises fundamental policy and ethical concerns. First, when providers fire their nonadherent patients, they flout the medical profession's norms to act in their patients' best interests and do no harm.[10] When providers dismiss nonadherent patients, however, the resulting discontinuity in care leads to poorer health. Patients unable to promptly find a new source of care may experience unmet medical needs or a delay in care. Prescriptions may go un-refilled, diagnostics tests and medical procedures may be delayed, and medical counseling may be foregone.[11] Although nonadherent patients eventually may secure a new source of care, the quality of care initially received from the new provider may suffer until the new provider earns the patient's trust and accumulates a finer understanding of the patient's unique health needs.[12] Studies confirm that when the provider-patient relationship is terminated, the resulting discontinuity in care leads to poorer health for affected patients (as well as higher costs for the health insurers and government health programs that pay for their care).[13] Such actions hardly demonstrate a commitment to patients' well-being.

Second, legal and ethical standards that permit providers to reject nonadherent patients frustrate a key policy goal of the new payment models — giving providers financial incentives to improve patients' health. The new payment models have nudged providers to improve the coordination of care across clinical settings and address obstacles to treatment adherence and healthier living.[14] But the financial incentives to improve patients' health are weakened by legal and ethical standards that allow providers to avoid the financial penalties for poor patient outcomes by firing nonadherent patients. Rather than provide intensive support programs for patients struggling to quit smoking or diabetic patients with continuously high blood glucose levels, providers can refuse to treat these patients. Rather than adopt protocols that improve patients' medication adherence, providers can simply dismiss patients who do not take their medications as prescribed. Rather than screen and arrange for treatment of behavioral health problems, providers can fire patients with depression, substance abuse problems, or other behavioral health conditions that impair individuals' capacity to adhere to medical advice.

Finally, when providers reject their nonadherent patients, disparities in health between vulnerable populations and the general population may worsen. Members of vulnerable populations disproportionately face social and environmental circumstances that hinder their adopting healthier lifestyles and adhering to their physicians' medical advice.

Third, when providers refuse treatment to nonadherent patients, they undermine patients' trust in the medical profession. Patient trust promotes patients sharing with their providers sensitive and confidential information that may be crucial to the effective diagnosis and treatment of patients' health conditions.[15] Yet nonadherent patients fearful of being fired may withhold important information from their providers, including their self-care shortcomings (e.g., medication nonadherence, poor diet).[16] In addition, patients fired by providers may lose trust in the medical profession generally, causing them to approach new providers with wariness or avoid the health care system altogether.[17] Consequently, diminished trust between nonadherent patients and providers will lead to even poorer health among nonadherent patients.

Finally, when providers reject their nonadherent patients, disparities in health between vulnerable populations and the general population may worsen.[18] Members of vulnerable populations disproportionately face social and environmental circumstances that hinder their adopting healthier lifestyles and adhering to their physicians' medical advice. For example, lower average family income and lack of paid sick leave contribute to individuals from vulnerable groups delaying or foregoing needed care.[19] Lower income families also have difficulty affording healthier foods that support improved weight management and general health, as these foods typically are more expensive

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than less healthy foods.[20] Racial and ethnic minorities, those with lower levels of educational attainment, and those living in poverty also have lower rates of health literacy,[21] that is, they have less "capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[22] These disparities in the social determinants of health and health literacy contribute to higher rates of nonadherence among vulnerable groups relative to other groups.[23] Consequently, members of vulnerable groups are more likely to be refused treatment by providers seeking to avoid nonadherent patients.

Conclusion

Nonadherent patients, with their poorer health outcomes and higher costs, threaten providers' financial success under new payment models that reward quality improvements and reduced health costs. Providers can escape this predicament by firing or otherwise refusing to treat nonadherent patients, actions permitted under current legal standards and the medical profession's ethical guidelines. Regulators and payors therefore should closely monitor whether the shift away from fee-for-service to these new payment models leads to the unintended consequence of providers avoiding nonadherent patients. If so, society should consider the merits of reforming the relevant legal and ethical standards so as to limit providers' ability to reject nonadherent patients. In addition, in recognition of the challenges inherent in addressing patient nonadherence, regulators and payors should adopt policies that will support providers' efforts to improve patients' adherence to medical advice and adoption of healthier lifestyles.

Note

The author has no conflicts to declare.

References

1. See M. Wicclair, "Dismissing Patients for Health-Based Reasons," *Cambridge Quarterly of Healthcare Ethics* 22, no. 3 (2013): 308-318 (discussing reasons why physicians fire a patient); D.B. Resnik, "The Patient's Duty to Adhere to Prescribed Treatment: An Ethical Analysis," *Journal of Medicine & Philosophy* 30, no. 2 (2005): 167-188 ("[I]f the pattern of nonadherence continues despite the doctor's concerted efforts to help the patient implement the treatment, the doctor may feel that he or she is wasting time and society's resources… Non-adherence eventually takes its toll. At some point, many doctors decide that they would rather not treat non-adherent patients.").
2. Under pay-for-performance, providers who perform well on selected quality and efficiency measures receive higher payment rates or bonuses while those who perform poorly often receive lower payments. Risk-based alternative payment models such as bundled payments and shared savings hold providers accountable for the cost of care by shifting financial risk to providers. See C.L. Damberg et al., *Measuring Success in Health Care Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions* (2014), *available at* <http://www.rand.org/content/dam/rand/pubs/research_reports/RR300/RR306/RAND_RR306.pdf> (last visited November 2, 2018): at xi.
3. See M.E. McGrady and K.A. Hommel, "Medication Adherence and Health Care Utilization in Pediatric Chronic Illness: A Systematic Review," *Pediatrics* 123, no. 4 (2013): 730-740 (reporting that a systematic review found that nine of ten studies demonstrated a relationship between medication nonadherence and increased health care use among children and adolescents with chronic medical conditions); M.C. Sokol et al., "Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost," *Medical Care* 42, no. 6 (2005): 521-530 (finding that for patients with diabetes and hypercholesterolemia, a high level of medication adherence was associated with lower disease-related medical costs, including lower hospitalization rates); L.R. Martin et al., "The Challenge of Patient Adherence," *Therapeutics & Clinical Risk Management* 1, no. 3 (2005): 189-199 (explaining that medication nonadherence is a risk factor for a variety of subsequent health outcomes, including hospitalizations and even death).
4. See J. Mantel, "Refusing to Treat Noncompliant Patients is Bad Medicine," *Cardozo Law Review* 39, no. 1 (2017): 127-195. Because providers who treat patients who are sicker on average could perform worse on quality utilization and cost metrics due to patient factors that are not under the provider's control (e.g., age, severity of illness), payors use risk adjustment to adjust scores on quality measures and ensure that comparisons are fair across providers. See Centers for Medicare & Medicaid Services, *Fact Sheet: Risk Adjustment* (2015), *available at* <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Risk-Adjustment-Fact-Sheet.pdf> (last visited November 2, 2018); E. Schone and R.S. Brown, Robert Wood Johnson Foundation, *Risk Adjustment: What Is the Current State of the Art, and How Can It Be Improved?* (2013): at 1. Risk adjustment, when done properly, thereby deters providers from avoiding sicker patients. Risk adjustment, however, does not account for differences in the extent to which a provider's patients comply with medical advice or adopt healthier behaviors. See, e.g., Centers for Medicare & Medicaid Services (describing the factors CMS takes into account when performing risk adjustment under the Physician Value-Based Payment Modifier program). Consequently, risk adjustment does not account for the impact of patient nonadherence on providers' quality and cost metric scores.
5. See Mantel, *supra* note 4 (summarizing physician surveys indicating that new payment models will lead some physicians to reject noncompliant patients).
6. See generally *id.* Anti-discrimination laws prevent providers from refusing to treat patients on the basis of the patient's race, gender, religion, national origin, age, disability, and sexual orientation. Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241, 252–53 (codified as amended at 42 U.S.C. §§ 2000d–d-4 (2012)); 20 U.S.C. § 6101 et seq. (age); 20 U.S.C. § 1681 et seq. (sex); 42 U.S.C. § 12181 (2012); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557, 124 Stat. 119 (2010) (codified at 42 U.S.C. § 18116 (2012)). The Emergency Medical Treatment and Active Labor Act (EMTALA) requires physicians to screen and stabilize any individual with an emergency condition accessing a hospital's emergency department. 42 U.S.C. § 1395dd(a)–(b) (2012). Finally, the Hill-Burton Act, enacted in 1946, requires all hospitals and other facilities that received federal subsidies for construction and modernization to make their services available on a nondiscriminatory basis. See J.F. Blumstein, Court Action, "Agency Reaction: The Hill-Burton Act as a Case Study," *Iowa Law Review* 69, no. 5 (1984): 1227-1261.
7. See Mantel, *supra* note 4.
8. See American Medical Association, Code of Medical Ethics (2016) [hereinafter Code of Medical Ethics]: at 1.

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9. The AMA's Code of Medical Ethics provides as follows: "Physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients. When considering withdrawing from a case, physicians must notify the patient (or authorized decision maker) long in advance to permit the patient to secure another physician… " *Id.*, at 12. See also L. Snyder, "American College of Physicians Ethics Manual: Sixth Edition," *Annals Internal Medicine* 156, no. 1 pt. 2 (2012): 73-104.
10. See E. Martin, *Concise Medical Dictionary* (8th ed.) (2010) (defining beneficence and nonmaleficence).
11. See J.E. DeVoe et al., "A Medical Home Versus Temporary Housing: The Importance of a Stable Usual Source of Care Among Low-Income Children," *Pediatrics* 124, no. 5 (2009): 1363-1371; M.A. Smith and J.M. Bartell, "Changes in Usual Source of Care and Perceptions of Health Care Access, Quality, and Use," *Medical Care* 42, no. 10 (2004): 975-984.
12. See J.M. Gill et al., "The Effect of Continuity of Care on Emergency Department Use," *Archives Family Medicine* 9, no. 4 (2000): 333-338; Mantel, *supra* note 4.
13. See P.S. Hussey et al., "Continuity and the Costs of Care for Chronic Disease," *JAMA* 174, no. 5 (2014): 742-748; M. Raddish et al., "Continuity of Care: Is It Cost Effective?" *American Journal of Managed Care* 5, no. 6 (1999): 727-734 (finding that increasing the number of primary care or specialty care providers a patient saw was significantly associated with increased prescriptions and prescription costs, more outpatients visits, and increased hospital admissions); J.M. Gill et al., "The Effect of Continuity of Care on Emergency Department Use," *Archives of Family Medicine* 9, no. 4 (2000): 333-338 (finding that Medicaid patients with high provider continuity make fewer emergency department visits).
14. See J. Mantel, "Taking Aim at the Social Determinants of Health: A Central Role for Providers," *Georgia State University Law Review* 33, no. 2 (2017): 217-284. Providers also have taken steps to more effectively identify their patients' behavioral health problems and integrate primary care and behavioral health care. In addition, providers also have implemented intensive patient education interventions that target smoking and other risky behaviors among high-need patients, and have addressed poor medication adherence by prescribing less complex medication regimens or sending automated reminders to patients who have not refilled their prescriptions. See Mantel, *supra* note 4. In addition, examples abound of providers targeting the social and economic barriers to good health, including patient's transportation, income and food insecurity needs. See Mantel, *supra* note 14.
15. See M.A. Hall, "Law, Medicine, and Trust," *Stanford Law Review* 55, no. 2 (2002): 463-527; D. Orentlicher, "Health Care Reform and the Patient-Physician Relationship," *Health Matrix* 5, no. 1 (1995): 141-180.
16. See L. Shepherd, "HIV, the ADA, and the Duty to Treat," *Houston Law Rev*iew 37, no. 4 (2000): 1055-1100 (arguing that only patients "[s]ecure in the knowledge that they cannot be legally denied medical care" will then "reveal those aspects about themselves that doctors need to know").
17. See Mantel, *supra* note 4.
18. The Centers for Disease Control and Preventions defines disparities in health as observed differences in health outcomes or health determinants between populations. *See* Centers for Disease Control & Prevention, *CDC Health Disparities and Inequalities Report United States, 2013* (2013): at 3, *available at* <https://www.cdc.gov/mmwr/preview/ind2013_su.html#HealthDisparities2013> (last visited November 2, 2018) [hereinafter "CDC Health Disparities and Inequalities Report 2013"].
19. See J.T. Kullgren et al., "Nonfinancial Barriers and Access to Care for U.S. Adults," *Health Services Research* 47, no. 1 pt 2 (2007): 462-485 (reporting the results of a survey finding that "barriers in the affordability dimension were the most common reasons for unmet need or delayed care"); K. Miller et al., Inst. For Women's Policy Research, *Paid Sick Days and Health: Cost Savings from Reduced Emergency Department Visits* (2011): at iii, 7–8 (finding that workers with paid sick days are less likely to delay seeking care for themselves and their families). Racial and ethnic minorities are more likely than whites to have annual incomes below the federal poverty level. See CDC Health Disparities and Inequalities Report 2013, *supra* note 18, at 16. Racial and ethnic minorities and lower income workers also are less likely to have paid sick days. See Inst. for Women's Policy Research, *Paid Sick Days Access and Usage Rates Vary by Race/Ethnicity, Occupation, and Earnings* (2016), *available at* <https://iwpr.org/wp-content/uploads/wpallimport/files/iwpr-export/publications/B356.pdf> (last visited November 2, 2018): at 2, 5.
20. See A. Drewnowski and P. Eichelsdoerfer, "Can Low-Income American Afford a Healthy Diet?" *Nutrition Today* 44, no. 6 (2010): 246-249.
21. See R. Rudd et al., Educational Testing Service, *Literacy and Health in America* (2004): at 3-4; M. Kutner et al., American Institutes for Research, *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy* (2006): at v, 9–14.
22. C. Selden et al., *Health Literacy*, *Nat'l Insts. Health* (Feb. 2000), *available at* <https://www.nlm.nih.gov/archive//20061214/pubs/cbm/hliteracy.pdf> (last visited November 2, 2018): at vi.
23. See generally Mantel, *supra* note 4 (summarizing studies finding greater nonadherence among vulnerable populations relative to other groups).

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