Team effort
Addressing patient noncompliance

BY AMY LYNN SORREL  Last year, when Almas Mecklai, MD, noticed an influx of patients streaming in with wellness forms to get their physicals, she was delighted to discover their employers offered a financial bonus to get healthy.

The Houston family physician’s enthusiasm waned, however, when most of those patients declined to return to follow up after she discovered ailments from high blood pressure and cholesterol to diabetes.

Some cited their high-deductible health plans and medication costs as barriers to getting the care they needed. Others worried about missing work; some had no reason at all.

But Dr. Mecklai also found patients’ noncompliance presented a barrier to her efforts to improve their health.

“My priority is to get patients in to follow up in the office so they can have more cost-effective care and better quality of life, instead of landing in the emergency room with strokes and heart attacks. But there is a limit to what doctors can do,” she said.

Yet an increased emphasis on care quality and physician performance has Sugar Land internist and Harris County Medical Society President Elizabeth Torres, MD, concerned about the impact patient noncompliance could have on how payers purport to grade and ultimately pay physicians based on their patients’ health.

For example, Dr. Torres uses a patient registry to report certain quality measures under Medicare’s Physician Quality Reporting System. She wonders about the future financial impact on her practice if, for example, half of her patients don’t take their medications or get their lab tests done, as recommended, and she is unable to hit the quality targets.

“I will receive a decrease in payment because I didn’t fulfill the requirements. One of our worst fears is that we are going to be penalized for something we really have no control over,” Dr. Torres said.

Because private health plans typically follow Medicare’s path, Dr. Torres suspects commercial pay-for-performance programs aren’t far behind.

Drs. Mecklai’s and Torres’ concerns prompted an informal survey by the Texas Medical Association Council on Health Care Quality. It shows private health plan policies vary in how they address patient noncompliance and whether they factor it into emerging pay-for-performance programs. TMA continues to advocate for protections for physicians from quality-of-care measures in Medicare and commercial programs that don’t account for variablenes in patient populations, including chronically ill or noncompliant patients.

Health plans, meanwhile, point to an industry-wide shift to tackle a problem they, too, agree has a direct impact on health care quality and costs.

“This really is the first global attempt to raise the level of health care by population,” said Rene Vega, MD, chief executive officer of Aetna’s Medicaid managed care organization, Aetna Better Health of Texas. When it comes to noncompliance, “we [health plans] know physicians can’t do this by themselves, and patients have some responsibility. And our responsibility is getting providers as much information as we can to get gaps in care closed,” he said.

Arming physicians with data
For example, Aetna Better Health has case management programs to identify patients with high-risk conditions and help set up follow-up primary care appointments or arrange transportation or medical supplies. Using claims data, the health plan notifies physicians of patients who frequently visit the
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egency department or fail to pick up their medication at the pharmacy, for example.

Aetna also tracks whether patients might have missed certain preventive services, such as mammograms and immunizations, as recommended by national quality measures from the National Committee for Quality Assurance and the Healthcare Effectiveness Data and Information Set.

Dr. Vega says Aetna doesn’t financially penalize physicians for patient non-compliance. Rather, Aetna factors it into certain quality improvement programs in the form of an incentive.

For example, Aetna offers bonus payments in two pilot programs to physicians who get children to complete their regular checkups through the Medicaid Texas Health Steps program (www.dshs.state.tx.us/thsteps) and pregnant women to get routine care. Dr. Vega says the pilots aim to address what he describes as “under-usage” of certain services, like immunizations and Pap smears. Practices could use the pool of money to hire a part-time nurse or assistant, for instance, to help manage patients.

“This is more of a carrot than a stick. The stick is the physician’s own responsibility to that patient and [to avoid] missing an opportunity to give the member services to help patients avoid an illness or a trip to the emergency room,” Dr. Vega said.

He acknowledges that such quality measurement programs don’t directly address patients’ role in the equation, which can be difficult. Any number of financial or social factors can play into patients’ inability to follow through on their care, he says.

“We do [quality measurement] as a proxy for noncompliance, and that’s the weakness of all these programs. We look to providers to manage someone else’s health, when really members also should be incented in some fashion to take care of themselves,” he said.

In the commercial world, Dr. Vega says employers are providing that push for their workers. The same strategy fails short, he says, for a Medicaid population that typically does not have stable work to access such incentives.

Health plans agree with physicians that costs, including high deductibles, can pose financial barriers to patients’ ability to follow doctors’ orders. But it’s typically employers that dictate plan design features, such as deductible levels, based on their business needs and financial constraints, says Cigna’s Mark Netoskie, MD. He is medical director for the South Texas and Louisiana region.

**Coding for noncompliance**

Meanwhile, health plans appear to be exploring other approaches. TMA’s survey reveals that while many insurers are employing data analysis and case management tools, some also are considering whether coding for noncompliance can help gather information for use in reaching out to patients to address gaps in care.

Whereas ICD-9 includes just one general code for “noncompliance with medical treatment,” ICD-10 expands the list to eight more specific codes that address patients’:

- Noncompliance with dietary regimen;
- Intentional underdosing of medication regimen due to financial hardship;
- Intentional underdosing of medication regimen for other reason;
- Unintentional underdosing of medication regimen due to age-related debility;
- Unintentional underdosing of medication regimen for other reason;
- Other noncompliance with medication regimen;
- Noncompliance with renal dialysis; and
- Noncompliance with other medical treatment and regimen.

Health plans generally don’t require such coding as a condition of payment, according to TMA’s survey; nor do physicians regularly use it.

But Cigna’s Dr. Netoskie says using the more detailed codes could create an opportunity for health plans to identify potential areas of collaboration with physicians on patients’ noncompliance.

Like Aetna, Cigna’s main strategy is arming physicians with as much information as possible from claims data and other patient programs, he says, adding that noncompliance does not directly affect physician pay, largely because most of its participating doctors are still in fee-for-service payment arrangements.
Incentivizing patients

Although the Affordable Care Act no longer allows health plans to discriminate against patients with certain conditions, Dr. Torres expresses concern the additional coding could unfairly penalize patients in the form of more expensive insurance costs. She adds patient incentives, such as reduced copays and deductibles, are a more promising approach than penalties to encourage positive health behaviors.

TMA officials also caution against dismissing noncompliant patients without heeding Texas Medical Board rules on patient abandonment. (Read “Firing Patients,” May 2012 Texas Medicine, pages 37–40, or visit www.texmed.org/firing.)

While physicians welcome the additional data health plans can provide, the barrage of reports can result in what Dr. Torres describes as data overload. The regular notices she receives about medication reviews, follow-up testing, or preventive exams health plans say patients need are already “things we do daily in each patient visit. When we go back to review the patient’s chart, we have found that these issues have already been addressed by us.”

Dr. Torres says she recognizes addressing patient noncompliance requires a team effort but says physicians increasingly must do more with limited resources.

“If I could afford additional personnel in my office to monitor patients’ preventive care and follow-up tests ordered, that would be helpful. Health plans sending me letters is not,” she said.

She also has yet to see evidence that health plan case management programs have made a significant impact on her patients’ care, adding that insurance companies are missing an important piece of the puzzle that only physicians can provide.

“Physicians depend on the trusting relationship we have with our patients to effect change. Patients do not have that trust with their insurance carrier,” Dr. Torres said.