

Patient deaths: Unintended consequence of quality measurement?

By David Pittman • November 27, 2017

Doctors are avoiding some of the nation's sickest patients out of concern that deaths or other poor outcomes following treatment could cause Medicare or insurers to cut their payments or shame them with poor marks on their health care quality measures.

As the country struggles with its nearly \$3 trillion annual health care budget, policymakers have tried to tie payments to quality scores. They also publish the scores, to give patients choice and to nudge doctors toward better performance. In response, doctors and scholars say, many providers are avoiding patients who might make them look bad or cost them money.

"It breaks my heart because it's undermining engagement of physicians with their patients," said David Barba, **president of the American Medical Association**, who added **he often hears a colleague say he or she is avoiding a complex patient because it will "kill my scores."**

The 2015 MACRA law calls for tying up to nine percent of doctors' Medicare reimbursements to their quality scores and efficiency. The AMA pushed hard for the law but now wants Congress to delay implementing parts of it that would link payment to doctors' cost-cutting abilities.

Data on how MACRA is changing doctors' behavior are hard to come by since the program is so new. But a [recent study](#) found **doctors who served higher-risk patients under MACRA's precursor, the Value-Based Payment Modifier, had lower quality scores, giving them fewer bonuses and more penalties.**

"If people see that pattern happening, they will have a lot of incentive to stop caring for sick patients," said Karen Joynt, the study's author and physician at the Washington University School of Medicine.

"I don't think there's a single specialty where you can say risk aversion is absent," said Keith Nauheim, chief of cardiothoracic surgery and a professor at Saint Louis University School of Medicine.

Doctors, from his experience, worry that too many sick patients will lead to poor quality scores, which will make prospective patients think they are bad doctors.

Public reporting on hospital and doctor performance is not new; nor is gaming the system. When New York state implemented public reporting for bypass surgery in late 1980s, data showed more patients were being referred to Ohio and the respected Cleveland Clinic, where there was a spike in deaths — in patients who had been sent there from New York.

Philadelphia cardiologist Anish Koka recently [told the story](#) of a 54-year-old man he treated in the emergency department. The man needed surgery to treat an infected aortic valve, but no surgeon in the city would operate on him because his history of kidney and liver disease and prior open heart surgery gave him only a 50-50 chance of living six months.

A short time later, the man died in the hospital — his life possibly shortened by the fact that surgeons were afraid of having a death on their record.

"There isn't a serious person who does clinical medicine you can talk to who can, with a straight face, tell you that this has not changed things," Koka said. "It's to the detriment to our sickest patients. The ones who are feeling it are our least connected."

Sensing this might be an issue, Congress asked HHS to study risk-adjustment in health care programs. Last year, that report outlined several steps to avoid the unintended consequences of doctors shunning sick patients.

Among the [recommendations](#) was to think about ways to reward doctors for improving quality scores, rather than simply for posting good ones. **Policymakers should also come up with better ways to include social factors, like a patient's poverty level, into quality scoring.** The Trump administration hasn't responded to the report.

"If we pretend like these things don't matter," Joynt said, "we can really hurt people."

The Veterans Health Administration, under pressure from Congress to improve itself in the mid-1980s, began manipulating quality scores to make itself look better. Hospital administrators [often told him](#) to not bring certain patients into the operating room if they were likely to have a complication, says heart surgeon Michael Mann, who worked for the VA in San Francisco.

He remembers a lung cancer patient who administrators did not want him to operate on who died of pneumonia waiting for an operation. "In the end, it wasn't the other health problems that made his surgery risky that did him in, it was an administrative decision," Mann said.

Mann, a surgery professor at the University of California, San Francisco, was fired from the VA in 2011, he said, for questioning hospital administrators' decision to deny high-risk surgeries. These actions reflected an effort to manipulate quality scores, Mann said.

Deepak Bhatt, a cardiologist at Brigham and Women's Hospital, said he recently saw a patient transferred to his hospital after another refused to consider his case. The man, who was homeless with a long list of medical issues, ended up being helped by surgery, though he ultimately died.

"In those sorts of situations, risk scores and public reporting don't capture the full extent of risk," Bhatt said. "We could have just said we're not going to take this risk, but felt obligated to try to do something to help this patient."

Bhatt helped [publish research](#) earlier this month that **found an association between a drop in 30-day readmissions for heart failure at hospitals, and a spike in deaths. The study suggests that hospitals, fearing penalties from Medicare penalties for readmissions, may not be taking on very sick patients.** However, other research has contradicted this finding, Bhatt acknowledged.

CMS, in a [final rule](#) this month that outlined MACRA's requirements for next year, responded to worries about neglect of the sickest patients by adding a small bonus for doctors who treat a high number of complex patients. The bonus, CMS said, was partly to help "avoid placing ... clinicians who care for complex patients at a potential disadvantage."

In addition, health plans and Medicare are seeking to avoid some unintended consequences of hospital quality reporting programs by identifying the patients who were never going to live long despite having certain procedures.

But it's still hard to judge the actions of individual doctors. Since they have far fewer patients to account for than hospitals, risk adjustment is exponentially more difficult from a statistical perspective.

"At the individual physician level, one or two patients can make a difference," said Anders Gilberg, senior vice president of government affairs at the Medical Group Management Association

Reporting programs are like fireworks, said Greg Dehmer, chief of cardiology at Baylor Scott and White. Some think they are beautiful, some fear them, and "if you don't use them correctly, you can get hurt."

Programs like accountable care organizations offer a workable solution, since provider performance is based on how well they did in the past — not on their peers, who might be skirting sick patients, said Blair Childs, a spokesman for Premier, the health care management company.