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**“Never Pay Events”: Informing Patients and Improving
Care Delivery**

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Many experts view changing the payment system as the critical first step in improving the quality and value of healthcare delivery. A recent report by the Medicare Payment Advisory Committee stated that provider payment should be a direct signal for what we value in our health care system. Truth be told, however, the current system of payment often is not reflective of purchaser or consumer health care values at all.

Health care purchasers and consumers want health care that is high quality, cost-efficient and enhances diagnosis or treatment to make a significant difference in a patient's outcome; follows clinical practice guidelines; considers the goals and preferences of the patient; and leverages a care team that has aligned competencies and objectives. Yet, the current fee-for-service payment system does little to encourage the behaviors sought and nothing to encourage better results. Rather, it creates perverse incentives by recognizing providers for how much care they deliver, not the quality of care they provide. It rewards providers more for expensive forms of treatment such as procedures and hospital stays, than for prevention and care coordination. Quality in the U.S. remains variable while nearly thirty percent of the \$2.3 trillion in national health expenditures result from wasteful care that adds little to no value to the patients.¹

It is no surprise then that purchasers and policymakers have rallied behind the need to change payment systems, even they recognize that such reforms must be incremental given the many entrenched interests affected. Changes in payment systems entail significant political and practical challenges. Examples of these challenges include the status quo which benefits many providers and payers that have legacy claims systems built on the fee-for-service chassis that would require costly modifications if payments were to be restructured. As a result, early payment reforms have focused on changes at the margins, including pay-for-performance (P4P) programs and non-payment for "never events."

Early Efforts: Pay-For-Performance and "Never Events"

More than 160+ pay-for-performance programs exist in the marketplace today, all of which seek to provide financial rewards to providers identified as delivering higher quality health care. Early analyses of these programs demonstrate mixed results in improving quality of care, which many have credited to the fact that few have offered rewards large enough to influence meaningful change. In addition to P4P programs, non-payment for hospital acquired infections and never events have also been an early focus of national efforts to reform payment. Never events as defined by the National Quality Forum (NQF) are 28 errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Examples include: surgery

¹ The Implications of Regional Variations in Medicaid Spending, Part 1: The Content, Quality, and Accessibility of Care. *Annals of Internal Medicine*, 2003.

on the wrong body part, foreign body left in a patient after surgery, mismatched blood transfusion, or major medication error.² The movement to align patient safety and payment has generated a lot of energy; however, implementation challenges, including effective risk adjustment, reporting and coding issues persist. Even so, the Centers for Medicare and Medicaid Services (CMS), payers and many hospitals are coalescing around the idea that providers should not be paid for these events. CMS is now implementing payment changes and private payers are following closely behind to phase in non-payment policies over the coming years.

Future payment changes will require the development of a national framework for reform that recognizes the complexities of the payment system and the interests of its many stakeholders. Some of these changes must be fundamental and far-reaching, including bundled payments, shifting rewards for primary care and fostering aligned coordinated care.³ The purpose of this brief paper is to explore the development of a framework to identify additional potential incremental reforms that build upon the successes of recent past efforts and provide important signals of how what behaviors and results should indeed be rewarded.

“Never Pay Events”: A Conceptual Framework

As consumers and purchasers continue to feel the impact of rising health care costs, reform is garnering public interest that compares to the days of the Clinton-era reforms nearly 15 years ago. But as economic woes and energy prices have dampened the hopes of broad-based reforms, incremental changes become all the more attractive. The early success of aligning stakeholders behind measurement, reporting and non-payment for never events could be leveraged to give rise to more focused attention to other perverse incentives endemic in the current payment system. Future reforms aimed at improving quality and efficiency of care could initially concentrate on payment policies that include non-payment or reduced payment for health care services that deliver little-to-no value to patients. These value-absent or value-limited services could be broadly defined as “never pay events,” and categorized into four broad areas:

Never Pay Event Type 1: Avoidable harm caused.

In 1999, the Institute of Medicine (IOM) estimated that as many as 98,000 deaths a year were attributable to medical errors. Another study examining 18 types of medical events concluded that medical errors might account for 2.4 million extra hospital days, \$9.3 billion in excess charges (for all payers), and 32,600 deaths.⁴ These studies became the basis for the development of the 28 NQF-identified “never events,” or errors in medical care that are clearly identifiable, preventable, and serious in their consequences

² Never Events Fact Sheet, The Leapfrog Group, March 2008.

³ Beyond Pay for Performance – Emerging Models of Provider-Payment Reform, Merideth B. Rosenthal, PhD. NEJM, September 18, 2008.

⁴ Centers for Medicare and Medicaid Services, Press release, May 2006.

for patients, and indicate a real problem in the safety and credibility of a health care facility.

Public and private sector payment reforms aimed at improving quality and efficiency of care should require reporting, public disclosure and non-payment for all instances where avoidable harm was caused, expanding to include all of the 28 currently recognized “never events” and assessing how to go beyond these to other avoidable events. The crux of this expansion will be to develop an effective system of identifying those events that were indeed not preventable while not, at the same time, fostering a feeding frenzy for attorneys that could drive these incidents underground.

Never Pay Event Type 2: Clinically inappropriate services.

Today’s health care system is fraught with inappropriate use of health care services and procedures. Appropriateness of care can be broadly defined by those services where the expected health benefits exceed the expected health risks as defined and determined by a well-informed patient. Long-standing studies by the RAND Corporation over the past decade have demonstrated that nearly one-third or more of all procedures performed in the United States are of questionable benefit.

Because measuring appropriateness of care for a given procedure remains a challenge at the individual level, requiring non-payment for such services may not yet be ready for prime time. In the absence of non-payment policies, requirements could be established for the assessment and disclosure to potentially affected patients of the “odds” that a specific procedure for a given condition may be inappropriate, particularly in cases of preference-sensitive care.

Never Pay Event Type 3: Ethically challenged services.

Ethically challenged services include a range of services, including those delivered without a patient’s consent or with “uninformed” consent, and care with undisclosed perverse incentives or conflicts of interest that would reasonably sway a provider or institution to recommend using a particular drug, device or treatment. Today, many providers have financial relationships with the makers of drugs, devices or diagnostic equipment. These common ties can range from the acceptance of meals to the receipt of large sums of money in theory for consulting, speaking, or conducting research – where decision-making related to specific procedures and products can be directly influenced by the potential to generate income.⁵ Similarly, many providers have equity stakes in facilities and directly benefit from self-referral.

⁵ Disclosure of Industry Payments to Physicians, New England Journal of Medicine, August 7, 2008.

Many of these arrangements are supported by the claim that they further research aimed at improving patient care or make delivery of care more convenient to patients; however, one could argue that where these financial ties are “hidden” from the consumer, it is impossible for a patient to make fully informed care decisions. Last June, Senator Charles Grassley introduced S. 2029, or the “Physician Payments Sunshine Act.” Fueled by the revelation that some relationships have generated an excess of \$1 million a year in revenues for some physicians, the purpose of the Act is to make physician payments and financially beneficial referrals transparent to the public-at-large. Electronic reporting and disclosure of payments from drug, device and medical supply companies to any physician or medical practice would be required by March 2011 if the bill was signed into law.⁶ The bill has met significant resistance by industry advocating that the public disclosure of certain relationships could undercut protection of trade secrets and reduce the impact of clinical trials. Such challenges have prompted the bill’s authors to scale back the requirements posed in the original legislation. The scaled back bill now has the endorsement of notable medical societies, including the American Academy of Medical Colleges, the American Medical Association, as well as those very organizations that represent the main payers of the suspect payments such as PhRMA, and the Advanced Medical Technology Association (AMTA). These endorsements greatly increase the likelihood that some public reporting with penalties for non-reporting is imminent, but they also call to question how far-reaching the provisions are. There needs to be a discussion of both how to make disclosure robust and meaningful, as well as what sorts of financial relationships are so toxic that the “disinfectant of sunshine” alone is insufficient and non-payment policies should be enacted.

Never Pay Event Type 4: Financially inappropriate services.

Financially inappropriate services could be defined as “price gouging” or charging much more than the market value for a given procedure (e.g., charging in excess of two times the national average for a service). Such practices are not at all uncommon. A recent public report by the New York Comptroller’s Office identified a large medical practice operating a urological facility that was acting as an out-of-network billing intermediary for its affiliated physicians (who were actually participating providers with certain health plans) in order to bill at non-participating rates. The non-participating rates were 5 times higher than participating rates, generating approximately \$4 million in additional payments from the State’s employee health program alone. The Comptroller’s Office ultimately required the excess payments to be recovered and that all payments be suspended until appropriate controls were put in place by the affected health plans. Future payment reforms should consider reporting, penalties, and in the most egregious cases, non-payment for financially inappropriate services, such as those outlined above. Clearly there will be challenges in defining what is “too much” when in the market

⁶ Information available from Senate Finance Committee and public comments of Senator Charles Grassley as of July 2008.

system the general rule is to seek to collect whatever the market will bear, and in health care many providers candidly note that they must overcharge some payers or for some services to cost-shift and cover underpayments from public payers or for some services.

In each of the potential Never Pay Events, there will be both technical and political challenges. Now is the time to leverage the widespread agreement that the current payment system is a problem – the Institute of Medicine, the Medicare Payment Advisory Committee, Presidential candidates, public officials, employer and consumer coalitions, and even medical societies themselves (e.g., American Academy of Family Practitioners, American College of Physicians) acknowledge the fact that care today is unacceptable and are recommending changes and implementing pilots. While reforms are possible, political and operational challenges will result in aggressive advocacy for the status quo from many quarters. At a minimum, payers and policymakers should leverage the success of recent payment reforms to implement reporting and public disclosure of the four types of never pay events outlined in this paper. Irrespective of any proposed payment policy, consumers have a right to know about inherent conflicts that might impact their care. And, wherever possible, payers and policymakers should take the additional step of moving to non-payment for Never Pay Events because it is not on the right thing to do, but because it would provide impetus for the broader payment reforms we need.