

Summary

Doing Better by Doing Less: Approaches to Tackle Overuse of Services

Timely Analysis of Immediate Health Policy Issues

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This analysis presents what we know about the provision of medically inappropriate and unnecessary services that drive up health care spending without making a positive impact on patients' health outcomes. It also describes approaches that have already been used to address this issue—with limited success. We suggest that broader payment reforms are needed to minimize incentives to overdiagnose and overtreat and to better support the other approaches.

Introduction

Analysts have estimated that as much as a third of U.S. health care spending is unnecessary and wasteful. More than a quarter of all wasteful spending in health care—\$210 billion out of the estimated \$765 billion in wasteful spending in 2009—is attributed to overuse of services, which includes services that are provided more frequently than needed as well as higher-cost services that are no better than lower-cost alternatives. Health care services are considered inappropriate in situations where patients derive no medical benefit from them or when their potential harms exceed their potential benefits, but that determination requires a review of the clinical record.

Among different types of services, there is variation in the level of inappropriate use. A recent review of

the research literature found that the rates at which particular procedures, tests, and medications were performed or prescribed when clinically inappropriate ranged from a low of 1 percent to a high of 89 percent.

This overuse of services has implications for both health care costs and outcomes. One in every four patients admitted to the hospital is prescribed an inappropriate medicine, sometimes leading to adverse drug reactions, which are in turn responsible for 20 percent of inpatient deaths. Reducing the overuse of just seven services known to be subject to high rates of inappropriate use could save between \$33 billion and \$62 billion annually.

Sparse research

While research has produced some eye-catching statistics about the magnitude of savings that could be achieved by reducing overuse, relatively few studies have looked at the rate of inappropriate use of specific health care services. We also lack research on whether overuse of services varies by race or ethnicity, and we don't know what impact the overuse of services has on health care disparities.

The dearth of research on inappropriateness is in part due to methodological constraints. To assess appropriateness properly, researchers require clinical

information from medical records to be able to compare actual practice against evidence-based guidelines that define circumstances under which the service is appropriate. In practice, both the standards and the clinical information needed for assessment tend to be insufficient and costly to develop, given the spotty use of electronic health records and current lack of interoperability between data systems.

Further, while it is sometimes possible to label services as being clearly appropriate or inappropriate under certain circumstances, often the benefits of a service are unknown, unclear, or uncertain, leaving physicians and patients to navigate a vast gray area by relying on some combination of judgment, instinct, experience, and tradition. This gray area stymies both health services researchers in their efforts to assess the prevalence of inappropriateness and health policy-makers in their efforts to target the problem for reduction.

Targeted approaches to curb inappropriate service use

Efforts of policy-makers to tackle overuse in general and inappropriate service use specifically have been helpful but insufficient to date.



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Monitoring rates of inappropriate service use. Although measuring quality is becoming an increasingly common part of health care in the United States, measuring rates of inappropriate service use has not been the focus of these efforts. By one estimation, only four of the 39 quality measures in the 2011 Healthcare Effectiveness Data and Information Set (HEDIS) of quality measures that are commonly used by payers and other parties to assess care quality explicitly address overuse. Further, claims-based appropriateness measures generally can only be developed for services that fall into all-or-nothing categories of appropriateness, such as measures of whether individuals over the age of 74 received screening colonoscopies, which are not recommended for that age group. Indications for most services are not so black and white and require the review of medical records to determine if their provision was inappropriate.

Educating physicians. To help their members stay current with evolving medical knowledge, specialty societies have long developed evidence-based care guidelines that identify when performing diagnostic and treatment interventions is medically indicated. Some go further and also identify when an intervention is contra-indicated and therefore inappropriate. Although physicians have a duty to adhere to the professional standards established by evidence-based practice guidelines, it is clear that professionalism and the efforts of professional societies have not succeeded in substantially reducing inappropriate service use in the past. Recently, a new initiative known as the Choosing Wisely campaign was launched to identify five overused services of questionable benefit

across a number of specialties and educate both providers and patients to help reduce utilization. It remains to be seen whether this latest initiative will be more successful than past efforts.

Value-based benefit design. Value-based benefit designs in insurance policies increase cost-sharing for services of uncertain benefits and those prone to overuse (e.g., imaging) while reducing it for services that are viewed as high value under most patient circumstances (e.g., immunizations). But implementing such benefit designs has proved challenging, since most services are not uniformly appropriate or inappropriate and clinical detail is needed to determine value in particular circumstances.

Prior authorization. Prior authorization is the administrative approach most widely used by payers to try to reduce inappropriate service use. It involves having providers submit clinical information related to a particular intervention prior to its provision to a payer in order to determine whether the service is appropriate for the patient's clinical circumstance and will therefore qualify for payment. When applied selectively to high-cost, discretionary services where objective information can be reviewed by qualified third parties, prior authorization can play a role in reducing inappropriate services. However, given the administrative complexity involved, the changing clinical evidence of what works and when, and the large amount of uncertainty in the gray area, prior authorization's role in reducing inappropriate overuse is limited.

The potential of broad payment reforms

How providers are paid and the prices they are paid for different services have the potential to affect both the volume and mix of services physicians prescribe, particularly when the appropriateness of a service is uncertain.

Fee-for-service. There is a growing consensus that fee-for-service represents payment for volume, regardless of appropriateness, and needs to be replaced as the predominant method of paying for physician services. However, how physicians respond to fee-for-service incentives depends on whether or not a particular service is covered by a payer and how generous a fee is paid to providers for delivering it. Research on the precise effects of cutting fee-for-service payments is mixed. Some studies have found that physicians respond to reductions in fees for certain services by increasing the volume of those services. Other research suggests that physicians respond to fee reductions more like other economic actors do: if a service becomes less profitable, the incentive to produce it declines. Another study found that cutting payments leads to higher utilization when the targeted service accounts for a large share of a physician's income, but lower utilization if the services are a small share of income. Despite their different findings, these studies make clear that adjusting the generosity of payments can affect the volume of services.

Episode-based payments. With episode-based payment, providers face conflicting incentives. Since they take responsibility for providing all of a patient's needed services within a given episode of care in exchange for a flat-rate payment for

that episode, they have a greater incentive to provide only appropriate services within that episode. But at the same time, they also have an incentive to increase, if possible, the volume of such episodes, either by inducing demand for a procedure that triggers an episode, or by up-coding or up-diagnosing medical problems to qualify them for an episode payment. It may be possible to counter the latter incentive by requiring prior authorization, adherence to appropriateness guidelines, or shared decision-making in conjunction with payment.

Global payment. Global payment or global capitation is a population-based payment approach under which a fixed per-person, per-month prospective payment is made to an organization responsible for providing services to individuals who elect or are assigned to receive care from the providers in that organization. With global capitation, most of the services that comprise a payer's benefit package are included in the global payment, though sometimes prescription drugs, mental health benefits, and other specialized benefits are carved out. Global capitation fundamentally changes the fee-for-service incentives that reward provision of inappropriate services by making unneeded procedures and hospital stays cost centers instead of profit centers. But since global capitation mostly penalizes volume of services—whether appropriate or not—a major policy concern is that it may lead providers to underprovide services. Fortunately, most available quality measures address underservice, such as those for primary and secondary prevention services. But there remain measurement gaps in whether or not patients are receiving referrals for specialized expertise outside of the provider group's own clinicians.

Shared savings. Shared savings within an accountable care organization (ACO) is being promoted as a possible transition approach for organizations seeking to move from fee-for-service but are not willing or able to make the move to global or partial capitation. In such arrangements, groups of providers that form an ACO try to deliver care to a population of patients at a cost below a pre-set spending target. If their actual costs are below this spending target, the ACO and the payer share the savings that have been generated. In some of these arrangements, basic payment remains fee-for-service, with the possibility of a relatively small shared savings bonus layered on top. Depending on the structure of the ACO, individual providers may continue to respond mostly to their individual fee-for-service incentives to do more, rather than the ACO's collective incentive to reduce service use to generate shared savings.

Pay-for-performance. Pay-for-performance, in which providers receive small bonus payments or financial penalties based on their performance on a set of quality measures, has relatively limited potential to discourage the provision of inappropriate and unnecessary services, due to the small number of quality measures available to assess inappropriateness (as discussed earlier).

Conclusion

To find a solution to inappropriate service use, we need investment in research about what works under what circumstances and how alternative treatment approaches compare to one another. That information is sorely lacking, due to an underinvestment in research that is only beginning to be remedied.

But research alone will not suffice; there is a need for actors at all levels to step up efforts to make use of the available evidence. The best approaches need to be determined, whether they are campaigns to inform providers and patients, incentives to use clinical guidelines through benefit design and coverage decisions, or prior authorization rules for certain procedures with high rates of inappropriate use. New investments in electronic health records and tools for shared decision-making can also help by making information and evidence more accessible to providers and patients. Where possible, given the methodological constraints of measuring inappropriate service use, we need to amplify use of quality measurement and monitoring, and increase the amount of data given to providers that shows their provision of overused services relative to their peers.

For many services, particularly commonly used and relatively low-cost services for which prior authorization is infeasible, as well as for all services of unknown or uncertain benefit, administrative and policy tools will not suffice and could be counter-productive. In these cases, the incentives established through provider payments are likely to be of critical importance. Further, it is likely that the various educational efforts and administrative approaches will be more successful if coupled with altered payment incentives.

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