

Levers to Reduce Use of Unnecessary Services: Creating Needed Headroom to Enhance Spending on Evidence-Based Care

Michael Budros, MPH, MPP, and A. Mark Fendrick, MD

A recent survey reported that three-quarters of Americans feel that our country doesn't get good value for what it spends on healthcare. The pervasive provision of medical care services that do not improve patient-centered outcomes is a major driver of inefficiency. Published estimates suggest that low-value care—patient care with no net benefit in specific clinical scenarios—costs patients, purchasers, and American taxpayers hundreds of billions of dollars every year.^{1,2} A recent *Health Affairs* study reported that more than \$500 million was spent in Virginia on 44 low-value health services in 2014.³ At worst, unnecessary care results in physical harm in the form of preventable morbidity and mortality. At best, spending on low-value care diverts scarce resources from higher-value services that benefit patients.

Given the potential for immediate savings for purchasers and an opportunity to create headroom for incremental investment in evidence-based care, stakeholders are paying greater attention to the identification and elimination of low-value care. The Choosing Wisely campaign is notable among many ongoing efforts.⁴ Scores of professional societies have published detailed lists of clinical services that are potentially overused and explicitly acknowledge that more care is not always better. The recognition by provider groups that commonly used services can be clinically unnecessary was a defining moment, motivating the development and implementation of strategies to enhance efficiency that do not sacrifice quality of care.

Despite the hard work of the Choosing Wisely campaign⁵ and its partners,⁶ awareness of the initiative remains limited⁷ and studies examining the effect of disseminating Choosing Wisely recommendations have reported small, if any, changes in the provision of low-value care.⁸ Deimplementation of routine care that no longer has evidence to support its use is often very slow, especially when an alternative service is not available as a substitute (ie, the clinical default is to do nothing).⁹ These disappointing findings illustrate the difficulties and challenges faced by the task of changing consumer and provider behavior, especially when the primary levers used by the Choosing Wisely campaign are educational and financial incentives were intentionally not included.⁸

“ THESE CLINICALLY NUANCED TACTICS ARE DESIGNED TO PRESERVE, OR INCREASE, SERVICES ESTABLISHED AS HIGH VALUE AND REDUCE ONLY THOSE SERVICES DEEMED CLINICALLY UNNECESSARY. ”

Several complex factors contribute to the undesirable level of low-value care and the slow pace of its removal, including patient expectations, cognitive heuristics, misaligned financial incentives, and payer or provider culture. Innovative efforts are urgently needed to translate research and guidelines into action. Health system leaders, policy makers, payers, and consumer advocates should aim to use multiple synergistic levers to increase the likelihood of success.

In this issue of *The American Journal of Managed Care*[®], Heekin and colleagues report on Cedars-Sinai Medical Center's experience using clinical decision support (CDS) to reduce specified low-value care services defined by Choosing Wisely recommendations.¹⁰ The CDS intervention resulted in improvements in numerous quality indicators, ranging from process measures (eg, adherence to clinical alerts) to clinically meaningful outcomes (eg, reduced complications and hospital readmissions). This study adds to promising evidence that CDS assists clinicians in making value-based clinical decisions and reducing the use of care that is not clinically indicated. Despite the benefits of CDS, Heekin et al found that only 6% of providers adhered to all alerts, suggesting there is significantly more work to be done. Additional comprehensive strategies that engage both providers and consumers are needed; the multistakeholder Task Force on Low-Value Care¹¹ has categorized a number of supply- and demand-side levers that, when used synergistically, have the potential to produce a greater impact on quality and cost of care than when information (or any single-lever strategy) is used in isolation (Table¹²⁻¹⁹).

TABLE. Tools to Target Low-Value Care¹²

Provider Facing	Patient Facing
<p>Coverage policies</p> <ul style="list-style-type: none"> Do not reimburse for services that are clearly inappropriate given data from claims and enrollment files. Ensure medical policies do not require unneeded services in order for patients to receive coverage of medically unnecessary services. 	<p>Network design</p> <ul style="list-style-type: none"> Steer patients to providers and plans that minimize the use of inappropriate medical services, including through tools such as shared decision making, which has been shown to reduce unnecessary care.¹⁶
<p>Payment rates and payment models</p> <ul style="list-style-type: none"> Adjust allowed amounts to reduce incentives to provide commonly over-used/potentially harmful services. Use a composite measure of low-value care in pay-for-performance programs, such as has been suggested for the Medicare Merit-based Incentive Payment System.¹³ Accelerate adoption of new payment models that reduce incentives for overuse, such as ACO programs with downside risk.¹⁴ 	<p>Utilization management</p> <ul style="list-style-type: none"> Consider narrowly targeted PA programs.¹⁷ Minimize the administrative burden through tools such as electronic PA for a select number of services and with a seamless user-friendly interface.¹⁸
<p>Provider profiling information</p> <ul style="list-style-type: none"> Distribute reports benchmarking the practice patterns of a clinician or practice against those of your peers.¹⁵ 	<p>Value-based insurance designs</p> <ul style="list-style-type: none"> Align patients' out-of-pocket cost sharing with the value of the underlying service. For example, high-value chronic disease care, such as blood pressure medications, should be free. For commonly overused services, selectively allow increases in cost sharing to serve as "speed bumps."¹⁹

ACO indicates accountable care organization; PA, prior authorization.

A wide range of strategies are available to reduce low-value care.²⁰ From a payment perspective, alternative payment models, such as reference pricing and accountable care organizations (ACOs), have shown some promise for reducing low-value care beyond alerts and recommendations alone.¹⁴ These strategies are particularly valuable because they limit administrative burden; neither ACO models nor global budgets require administrative data to specifically target low-value care. Risk-based payment models provide an organization-wide financial rationale to act upon known guidelines.

Recent work in the field of behavioral economics has demonstrated early success by using intrinsic motivators,²¹ such as an accountable justification (ie, gentle shaming by prompting physicians to publicly justify inappropriate use). However, this tool might prove overly burdensome if deployed for too many clinical scenarios.

Harnessing the potential of the electronic health record (EHR) can be a valuable means of improving practice patterns without disrupting workflow. Successful examples include making generic medications the default choice in the EHR, which in 1 study substantially increased rates of generic prescribing,²² and requiring clinicians to explicitly indicate an evidence-based clinical rationale for a vitamin D screening, which dramatically reduced overuse of this test, more so than the existence of a Choosing Wisely recommendation alone.²³

Although provider profiling is likely to be valuable in a broader strategy, available published evidence suggests that benchmarking used in isolation is unlikely to have a substantial aggregate impact. Similar concerns exist regarding CDS, as it is unclear that provider feedback can consistently improve performance with respect to low-value care—especially if changing practice patterns could threaten significant revenue streams.

Moving to a value-based system requires a change in both how we deliver care and how we engage consumers. Establishing synergies

between supply- and demand-facing efforts that simultaneously consider quality and cost is a critical step to reallocate spending. As providers are held increasingly accountable to deliver more high-value services and less low-value care, more patient-facing approaches, such as networks that steer patients to high-performing providers and value-based insurance designs that align a patient's cost sharing to the value of the underlying service, are needed. These clinically nuanced tactics are designed to preserve, or increase, services established as high value and reduce only those services deemed clinically unnecessary.²⁴

Although there is no agreed-upon formula to precisely reduce low-value care, several promising strategies are available for implementation and evaluation. Importantly, these approaches should be pragmatic, adaptive, and results-driven; engage clinicians and patients alike; and carefully watch for unintended consequences. Reducing low-value care is one of the few patient-centered solutions that directly addresses the tension between the need to control the rate of growth of aggregate healthcare expenditures and the societal desire to devote more resources to underused, high-value clinical services that improve individual and population health. ■

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Address Correspondence to: A. Mark Fendrick, MD, University of Michigan, 2800 Plymouth Rd, Bldg 16, Fl 4, 016-400S-25, Ann Arbor, MI 48109-2800. Email: amfen@med.umich.edu.

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