Physicians at the Henry Ford Physicians Network in Michigan did something unusual in the last year—they held a friendly competition to promote ideas for *NOT* giving patients tests and procedures.

You didn’t misread that. The competition grew out of Choosing Wisely®, a campaign run by the [American Board of Internal Medicine (ABIM) Foundation](http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx)1 to promote a national dialog about inappropriate medical care. The ABIM Foundation asked medical societies to identify “tests or procedures commonly used in their field whose necessity should be questioned.” The societies made more than 300 recommendations, including:

* Don’t schedule elective, non-medically indicated inductions of labor or cesarean deliveries before 39 weeks, 0 days gestational age.
* Avoid imaging studies for acute low back pain unless there are red flags.
* Don’t order annual electrocardiograms or any other cardiac screening for low-risk patients without symptoms.

Choosing Wisely reflects a burgeoning movement to limit the “overuse” of medical care, which is generated both by physicians and patients. A [2014 survey](http://www.choosingwisely.org/wp-content/uploads/2015/04/Final-Choosing-Wisely-Survey-Report.pdf) of 600 physicians commissioned by the ABIM Foundation found that nearly three in four think the frequency of unnecessary tests and procedures in the healthcare system is a serious problem and guessed that the average physician prescribes an unnecessary test or procedure at least once a week. Nearly half said patients request an unnecessary test or procedure at least once a week.2

**The Problem of Overuse**

Overuse is coming under increasing scrutiny because it is a major source of waste. A 2011 study in the Journal of the American Medical Association pegged the cost of overuse at $158 to $226 billion a year. A [2013 investigation](http://www.washingtonpost.com/business/economy/spinal-fusions-serve-as-case-study-for-debate-over-when-certain-surgeries-are-necessary/2013/10/27/5f015efa-25ff-11e3-b3e9-d97fb087acd6_story.html) by the Washington Post concluded that of the more than 465,000 spinal fusions performed in the U.S. in 2011, “perhaps as many as half were performed without good reason.3”

Many experts blame overuse on the fee-for-service method used to reimburse doctors and other providers because it is volume-oriented; it pays based on the number of exams, tests and treatments they provide, without regard for how patients actually fare.

“We need to pay doctors and other providers in ways that not only encourage the right care, but also discourage inappropriate care,” says payment reform expert Suzanne F. Delbanco, executive director of [Catalyst for Payment Reform](http://www.catalyzepaymentreform.org/) (CPR), an independent non-profit employer coalition pushing for better value in U.S. healthcare.

The choices employers and their employees make can influence healthcare costs, and some purchasers are changing the way they pay for care because the predominant fee-for-service reimbursement system pays providers for the services they deliver regardless of necessity or outcome.

Below are three are three examples of payment strategies being used to curb inappropriate care.

**Payment Strategies to Limit Inappropriate Care**

**Maternity care.** Labor and delivery [account for nearly a quarter of all hospitalizations](http://www.catalyzepaymentreform.org/images/documents/maternity) for many employers. Although the American College of Obstetricians and Gynecologists recommends against deliveries before 39 weeks unless there is a medical indication, early elective deliveries via induction or cesarean remain a popular choice for many patients and providers.4 This is increasing costs and the incidence of complications among mothers and babies, with no evidence of improved outcomes.

Changing payment policies can dissuade unwarranted cesareans or elective inductions. One such policy is to offer a single, comprehensive, risk-adjusted payment for an entire “episode” of maternity care that covers all services—from prenatal office visits, to ultrasounds, to lab work, to delivery. This would encourage more full term, spontaneous deliveries.

Payers in South Carolina have taken an even harder line. The state’s Medicaid program and its largest commercial insurer, BlueCross BlueShield of South Carolina, stopped paying for early elective deliveries that are not medically indicated. The policy [saved Medicaid $6 million](http://www.catalyzepaymentreform.org/images/documents/birthoutcomes.pdf) in the first quarter of fiscal year 2013.5

**Imaging.** Some usage of diagnostic imaging also raises questions about overuse, such as cases in which patients with low back pain or headaches undergo imaging without symptoms or risk factors indicating a need for it. Self-referrals by physicians who own imaging equipment have also drawn attention to the issue.

Switching from fee-for-service to a global payment removes some of the financial incentives for overuse. One recent study examined the effect of Blue Cross Blue Shield of Massachusetts’ “Alternative Quality Contract” (AQC), which pays provider groups a risk-adjusted global payment for all the care they provide annually for each member. The study published in [*Healthcare: The Journal of Delivery Science and Innovation*](http://www.healthcareinnovation.us/journal/) in2013found thatspending on imaging services decreased by 6.1 percent for providers in the AQC program. About a third of the savings resulted from fewer tests being ordered.6

**Spinal surgery for lower back pain.** Atul Gawande’s article “Overkill” in the May 11 issue of [*The New Yorker*](http://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande)noted that the U.S. “spent more on spinal surgery than on any other operation—$13 billion in 2011.”7 Payers have taken note, and are changing benefits. Blue Cross and Blue Shield of North Carolina, for example, began requiring three months of non-surgical treatment, such as physical therapy, before approving surgery. The number of [procedures fell 30 percent](http://www.modernhealthcare.com/article/20140322/MAGAZINE/303229985) in the first year.8

Walmart Stores, Inc. has been at the forefront of a different approach to benefit redesign: it offers care with no out-of-pocket expenses for spinal procedures. There’s a catch, of course. Employees and dependents must use a limited network of hospitals designated by the company as “Centers of Excellence.” The 100-percent coverage also covers travel costs for the patient and a caregiver. The Centers of Excellence tend to be more conservative than local doctors. A senior Walmart official told Gawande that the centers are “finding that around 30 percent of the spinal procedures that employees were told they needed are inappropriate.”

1. American Board of Internal Medicine (ABIM) Foundation. “*Choosing Wisely*.” Accessed May 2015. *http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx*

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5. Catalyst for Payment Reform and Milbank Memorial Fund. “Using Education, Collaboration, and Payment Reform to Reduce Early Elective Deliveries: A Case Study of South Carolina’s Birth Outcomes Initiative.” November 2013. *http://www.catalyzepaymentreform.org/images/documents/birthoutcomes.pdf*

6. Song Z, Fendrick, A.M., et al. Global budgets and technology-intensive medical services. *Healthcare: The Journal of Delivery Science and Innovation*. 2013; 1(1-2): 15-21.

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# **Curbing Inappropriate Care: How Payment Reform Can Help**

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