AHCCCS Payment Modernization
Blog # 9

Unnecessary Medical Care

May 29, 2015

In a recent article, physician Atul Gawande discussed unnecessary medical care. He points to numerous examples of procedures with little value, the prescribing of ineffective drugs, and use of unnecessary tests. He revisits McAllen, Texas which he had previously shown to have extremely high utilization, and which now with increased transparency and implementation of value based provider contracts, costs were down and outcomes had improved. Some worry that a trend to more conservative care could lead to inadequate care. But Gawande counters

> *Right now, we're so wildly over the boundary line in the other direction that it's hard to see how we could accept leaving health care the way it is. Waste is not just consuming a third of health-care spending; it's costing people's lives.*

In fact, it is estimated that at least 20% of U.S. health care is unnecessary, with spending in

> *6 categories of waste—overtreatment, failures of care coordination, failures in execution of care processes, administrative complexity, pricing failures, and fraud and abuse*

There are multiple factors contributing to the provision of unnecessary care described by Gawande and others. Perhaps the most significant he cites is the fee for service model.

> *Our piecework payment system—rewarding doctors for the quantity of care provided, regardless of the results—was a key factor. The system gives ample reward for overtreatment and no reward for eliminating it.*

Others note that like all of us, physicians have habits, and evidence is frequently ignored. Research on lowering blood pressure in the elderly is one of many examples. While it may be appropriate in younger persons, lower BP in older adults was shown to be harmful, but

> *It is surprising that among frail elderly patients with a systolic blood pressure less than 130 mm Hg (20 percent of the studied group), the use of multiple antihypertensive drugs was continued, because few evidence-based data support this approach.*

Screening tests with limited or no value is another common area of unnecessary care. A recent JAMA study describes the frequent use of cancer screening for persons with very high mortality risk.

> *A substantial proportion of the US population with limited life expectancy received prostate, breast, cervical, and colorectal cancer screening that is unlikely to provide net*

> *benefit. These results suggest that overscreening is common in both men and women, which not only increases health care expenditure but can lead to net patient harm.*

Another often cited contributor is uncoordinated care delivered in silos exemplified in this description

> *I have a congenital arrhythmia and osteoarthritis. These problems are treated by different sets of specialists: electrophysiologists and orthopedic surgeons. These doctors work in different clinics: mine actually work in different hospitals. Neither group's records are accessible to the other. My primary care doctor works for a third hospital and—of course—she can't access the records of either group of specialists.*

As Gawande points out, sometimes getting limited care or no care is the best care. Often, physicians are more concerned with doing too little than too much and patients must be their own advocate.

> *Doctors generally know more about the value of a given medical treatment than patients, who have little ability to determine the quality of the advice they are getting. Doctors, therefore, are in a powerful position. We can recommend care of little or no value because it enhances our incomes, because it's our habit, or because we genuinely but incorrectly believe in it, and patients will tend to follow our recommendations.*

What can be done short of changing the health care payment and delivery system? Many believe a good place to start is Choosing Wisely, a physician run organization which lets providers know what experts from their specialty boards recommend based on evidence to reduce unnecessary care. With the increasing prevalence of value based models, there is a strong business case to be made for utilizing this resource. Even policy experts previously skeptical of Choosing Wisely's value, are now advocating its use as the resource has become more robust.

Value Based Cancer Care- UPDATE

May 29, 2015

In the last PM Blog the need for, and challenges to development of value based care and payments models for treating cancer in the U.S. was discussed. Since then, the American Society of Clinical Oncology announced a new proposal which would

> *fundamentally restructure the way oncologists are paid for cancer care in the United States by providing sufficient payment to support the full range of services that cancer patients need and removing the barriers created by the current payment system to delivering high-quality, affordable care.*

The Patient- Centered Oncology Payment (PCOP) model which the ASCO proposes would require participating practices to provide evidenced based care and avoid unnecessary expenses. The model has three payment approaches

1. **Basic**:

Oncology practices would receive four supplemental, non-visit-based payments to support diagnosis, treatment planning, and care management. Oncology practices would bill payers for four new service codes:

- *New Patient Treatment Planning: $750 payment for each new patient*
- *Care Management during Treatment: $200 payment each month for each patient*
- *Care Management during Active Monitoring: $50 payment each month for each patient during treatment holidays and for up to six months following the end of treatment*
- *Participation in Clinical Trials: $100 per month payment for each patient while treatment is underway and for six months afterward*

Practices would continue to be paid as they are today for services currently billable under the Medicare Physician Fee Schedule, including Evaluation & Management services, infusions of chemotherapy, and drugs administered or provided to patients in the practice setting.

In return, practices would *take accountability* for avoidance of ED visits and hospital admissions, appropriate use of drugs, labs, and imaging, high quality end of life care, and a commitment to "care consistent with standards of quality defined by ASCO". "*Accountability*" is not defined.

2. **Consolidated Payment for Oncology Practice Services**:
   This system would replace existing Evaluation & Management and infusion payments with three new consolidated sets of billing codes that provide oncology practices with even more flexibility to determine exactly how to deliver effective services to patients. This option provides monthly payments matched to resources needed at various stages of the patient's treatment. It reduces the 58 CPT codes oncology practices currently use to bill for services and replaces them with fewer than a dozen new payment codes. These new payment codes fall into three major categories:
   - *New Patient Payment*
   - *Treatment Month Payment*
   - *Active Monitoring Month Payment*

3. **Bundled Payment for Oncology Practice Services**:
   This payment approach would set a target spending level to cover not only the services delivered by the oncology practice but also one or more other categories of services, such as hospital admissions, laboratory tests, imaging studies, and/or drugs. Oncology practices would have greater flexibility to redesign the way they deliver care to patients without the restrictions imposed by the fee-for-service system.

ASCO has estimated that, under PCOP, oncology practices would receive a <u>significant increase in payments</u> for patient services compared to what they receive today, yet overall spending on cancer care would decrease because patients would avoid expensive hospitalizations and unnecessary tests and treatments.

This begs the question, why are unnecessary tests and treatments being provided currently?