# Low-Value Care: Background and Momentum


October 16 & 17, 2019

Detroit Airport Westin Hotel

VBIDHEALTH

# Welcome


JAMA | Special Communication
Waste in the US Healt
Estimated Co
William H. Shrank,
IMPORTANCE Th
costs approaching
approximately 30%
reduce overtreatme
waste in US health ca
OBJECTIVES To estimate
developed domains and t
One quarter of every U.S. healthcare dollar wasted
RE
Linda Carroll
(Reuters Health) -
About a quarter of the dollars spent on
analysis suggests.
Six types of waste in healthcare could
according to the study published in JA
The biggest source of waste is "admini
Dr. William Shrank, chief medical offic
insurance company based in Louisville
TheUpshot
THE NEW HEALTH CARE
The Huge Waste in the U.S. Health System
A study finds evid
large blind spot on
CBS NEWS
NEWS
SHOWS
LIVE
Wasted health care spending in the U.S. tops annual defense budget, study finds
BY MEGAN CERULLO
UPDATED ON: OCTOBER 11, 2019 / 4:10 PM / MONEYWATCH

# Agenda

| Thursday, October 17 | |
|---|---|
| **7:30 am** | **Breakfast**, *Wright Room, Convention Level* |
| **8:15 am** | **Welcome**, *Lindbergh A, Convention Level*<br>*Mark Fendrick, MD* |
| | **Introductions**<br>*Moderator: Cliff Goodman, PhD* |
| **Background & Momentum** | **Identify, Measure, Report, Reduce:**<br>**The Momentum Behind Low-Value Care**<br>*Michael Budros, VBID Health*<br><br>**Debrief Consumer-Oriented Satellite Meeting on Low-Value Care**<br>*John Rother, President and CEO of the National Coalition on Health Care* |
| | **Break,** *refreshments available* |
| **Momentum (cont'd.)** | **V-BID X Update: Implementing Low-Value Care in Benefit Design**<br>*Michael Chernew, PhD* |
| **Measure** | **Measuring Low-Value Care – Creating a Framework**<br>*Sameer Saini, MD MS, University of Michigan*<br><br>**Measuring Cost and Care Cascades of Low-Value Care**<br>*Ishani Ganguli, MD, Harvard University*<br><br>**Update on State APCD Health Waste Calculator Project**<br>*Michael Budros, VBID Health* |
| **Report** | **Quick Strike and report card updates**<br>*George Miller, PhD, and Beth Beaudin-Seiler, PhD* |
| **12:30 – 1:30 pm** | **Lunch**, *Wright Room, Convention Level* |

# Outline

1. What is low-value care and level-setting
2. Why is low-value care important
3. Review of Task Force approach
4. Updates on estimates of low-value care
5. Task Force in the news and current collaborations
6. Ongoing initiatives outside the Task Force

IDENTIFY.

MEASURE.

REPORT.

REDUCE.

# What is low-value care?

- Some (small) distinction between different definitions of “overuse” and “waste” or “unindicated” care – often used interchangeably

- “Waste” in general typically captures other inefficiencies
  - administrative (eg, system complexity)
  - operating waste (eg, duplicative services)
  - “30 percent of health spending” estimates usually include above

- Focus: **clinical waste**

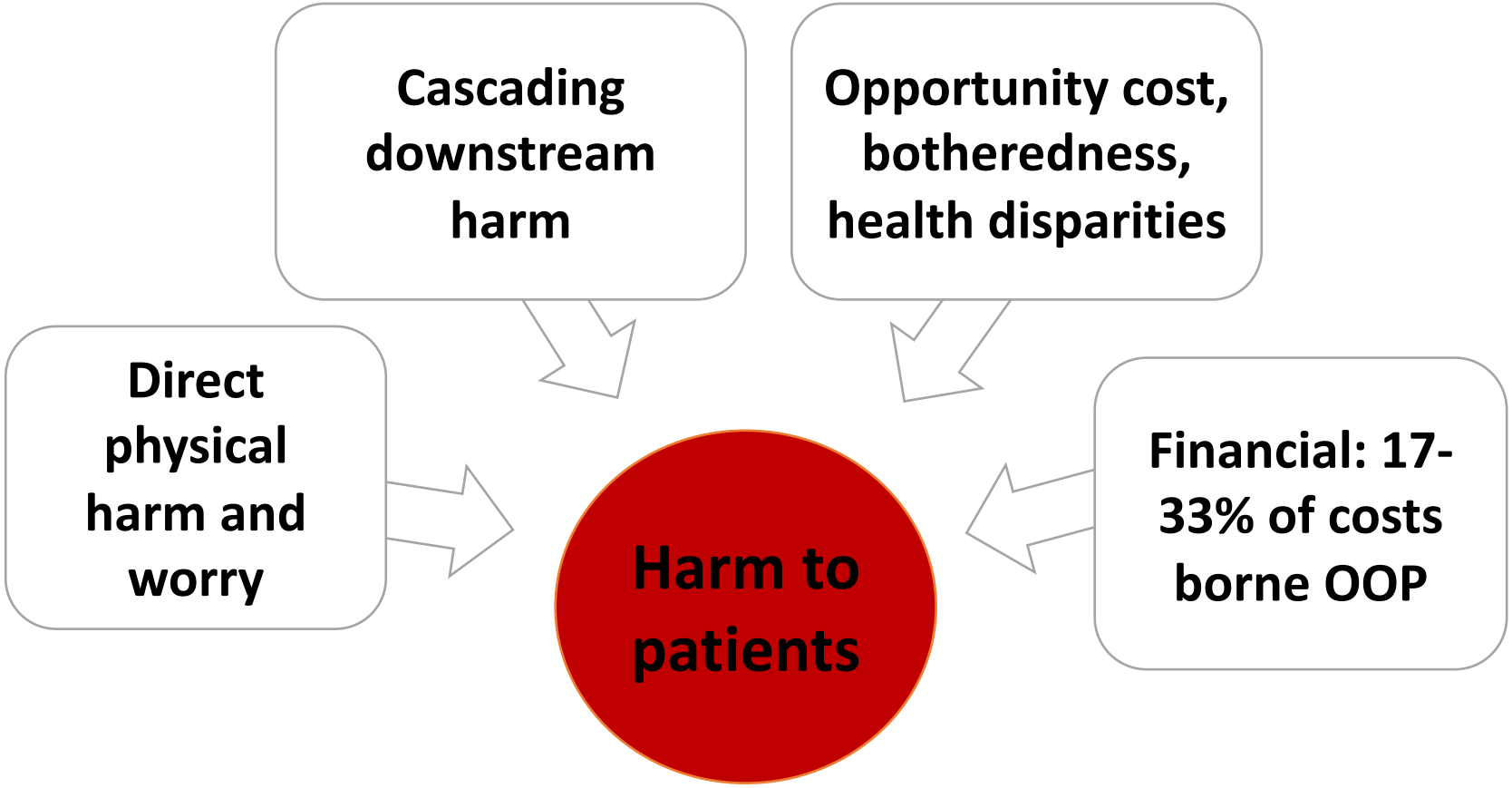
Bentley TGK, Effros RM, Palar K, Keeler EB. Waste in the U.S. Health Care System: A Conceptual Framework. *Milbank Q*. 2008;86(4):629-659.
OECD. *Tackling Wasteful Spending on Health*. Paris: OECD Publishing; 2017.

# What is low-value care?

## Clinical waste

- Medical care that is harmful or the harms outweigh the benefits
- Care that offers no benefit over less costly alternatives
- “Low-value care” recognizes clinical nuance: services differ in value depending on patient, provider, and when received

# Why is low-value care important?



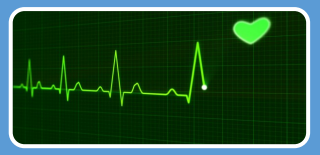
# Background: The Task Force approach

- Conceived to engage diverse stakeholders in a conversation about purchaser-led reductions in low-value care

- Our framework: **start with the lowest hanging, most actionable fruit**
  - Not necessarily the most harmful
  - Not the largest spend
  - Not the most controversial


- Purchaser community can help build momentum, catalyze a broader movement to reduce all low-value care, and ultimately, achieve meaningful results.

# The Task Force approach



**1.** Diagnostic Testing and Imaging Prior to Surgery

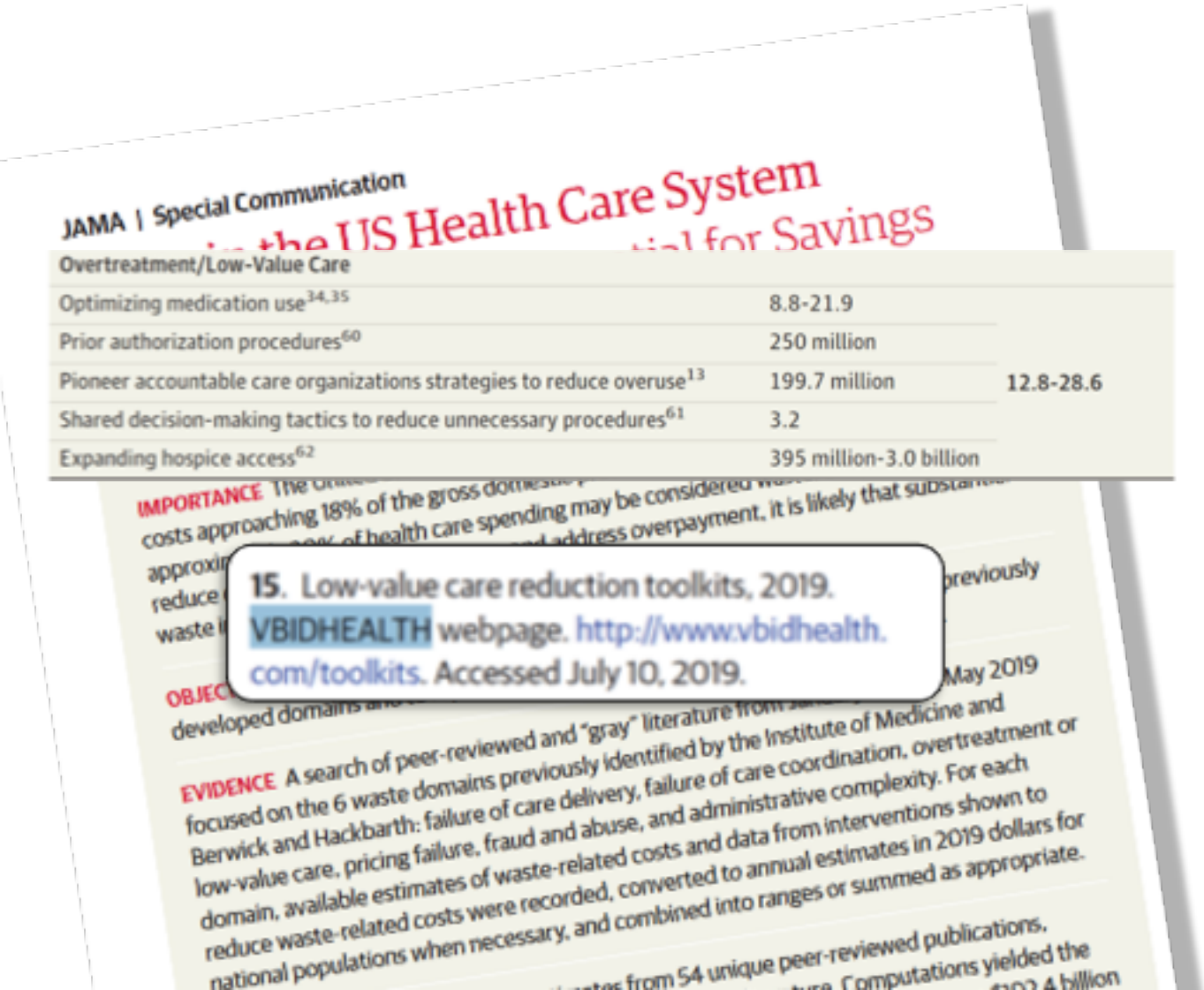
**2.** Vitamin D Screening

**3.** PSA Screening in Men 75+

**4.** Imaging in First 6 Weeks of Low Back Pain

**5.** Branded Drugs When Identical Generics Are Available

# How much is there?



JAMA | Special Communication

...the US Health Care System ...for Savings

| Overtreatment/Low-Value Care | | |
|---|---|---|
| Optimizing medication use[34,35] | 8.8-21.9 | |
| Prior authorization procedures[60] | 250 million | |
| Pioneer accountable care organizations strategies to reduce overuse[13] | 199.7 million | 12.8-28.6 |
| Shared decision-making tactics to reduce unnecessary procedures[61] | 3.2 | |
| Expanding hospice access[62] | 395 million-3.0 billion | |

IMPORTANCE ... costs approaching 18% of the gross ... of health care spending may be considered ... address overpayment, it is likely that substa...

15. Low-value care reduction toolkits, 2019. VBIDHEALTH webpage. http://www.vbidhealth.com/toolkits. Accessed July 10, 2019.

OBJEC... developed domains ... May 2019

EVIDENCE A search of peer-reviewed and "gray" literature from ... focused on the 6 waste domains previously identified by the Institute of Medicine and Berwick and Hackbarth: failure of care delivery, failure of care coordination, overtreatment or low-value care, pricing failure, fraud and abuse, and administrative complexity. For each domain, available estimates of waste-related costs and data from interventions shown to reduce waste-related costs were recorded, converted to annual estimates in 2019 dollars for national populations when necessary, and combined into ranges or summed as appropriate.

...tes from 54 unique peer-reviewed publications. ... Computations yielded the ...

- October JAMA review:

**Up to $101 billion of low-value care or overtreatment**

- More conservative than previous Berwick estimate: $226 billion
- Still: do not include the cascading downstream harm
- Highlights weak success of value-based programs thus far to address complexity or clinical inefficiencies

# How much is there? Editorial responses

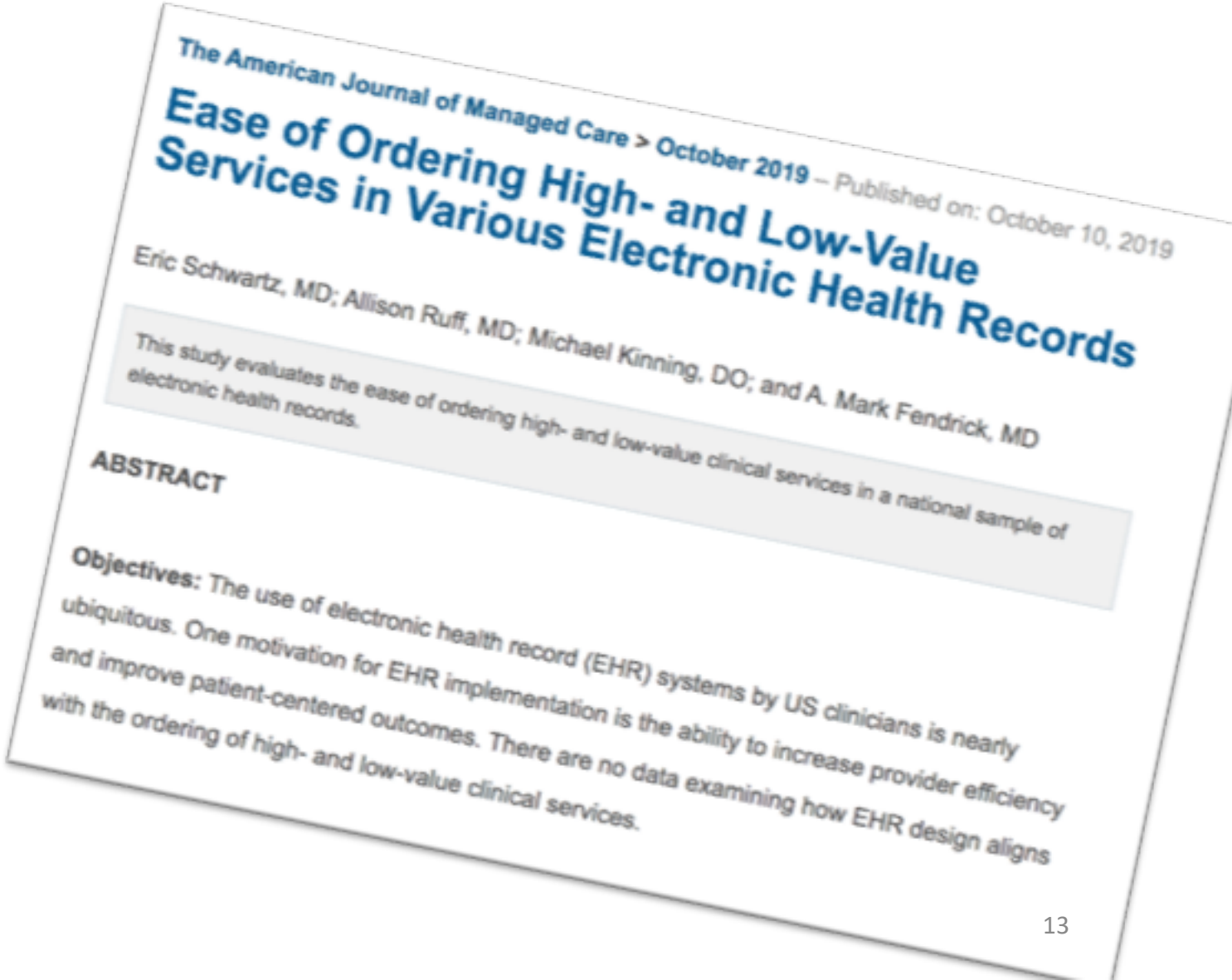
- Berwick: “Even 5% of [total health expenditures] is more than $150 billion per year (almost 3 times the budget of the US Department of Education).”

- Maddox and McLellan: Major policy initiatives have led to limited financial savings because …
  1. current value-based and alternative payment models are generally complex,
  2. current models are inadequately aligned across payers
  3. no sustainable business case for truly redesigning care in “mixed” payment system
  4. there has been inadequate clinician buy-in to these programs and
  5. the cost of implementing interventions to reduce waste remains large [and largely unknown – Shrank et al did not include these costs into estimates]

# Low-Value Care: In the News/Literature

# Electronic Health Records – AJMC article

- No correlation was found between the ease of EHR ordering and the value of the clinical service.
- Three of the 5 services that were easiest to order were low value, and 3 high-value services were among the most difficult to order.
- (more to come on EHRs)



The American Journal of Managed Care > October 2019 – Published on: October 10, 2019

**Ease of Ordering High- and Low-Value Services in Various Electronic Health Records**

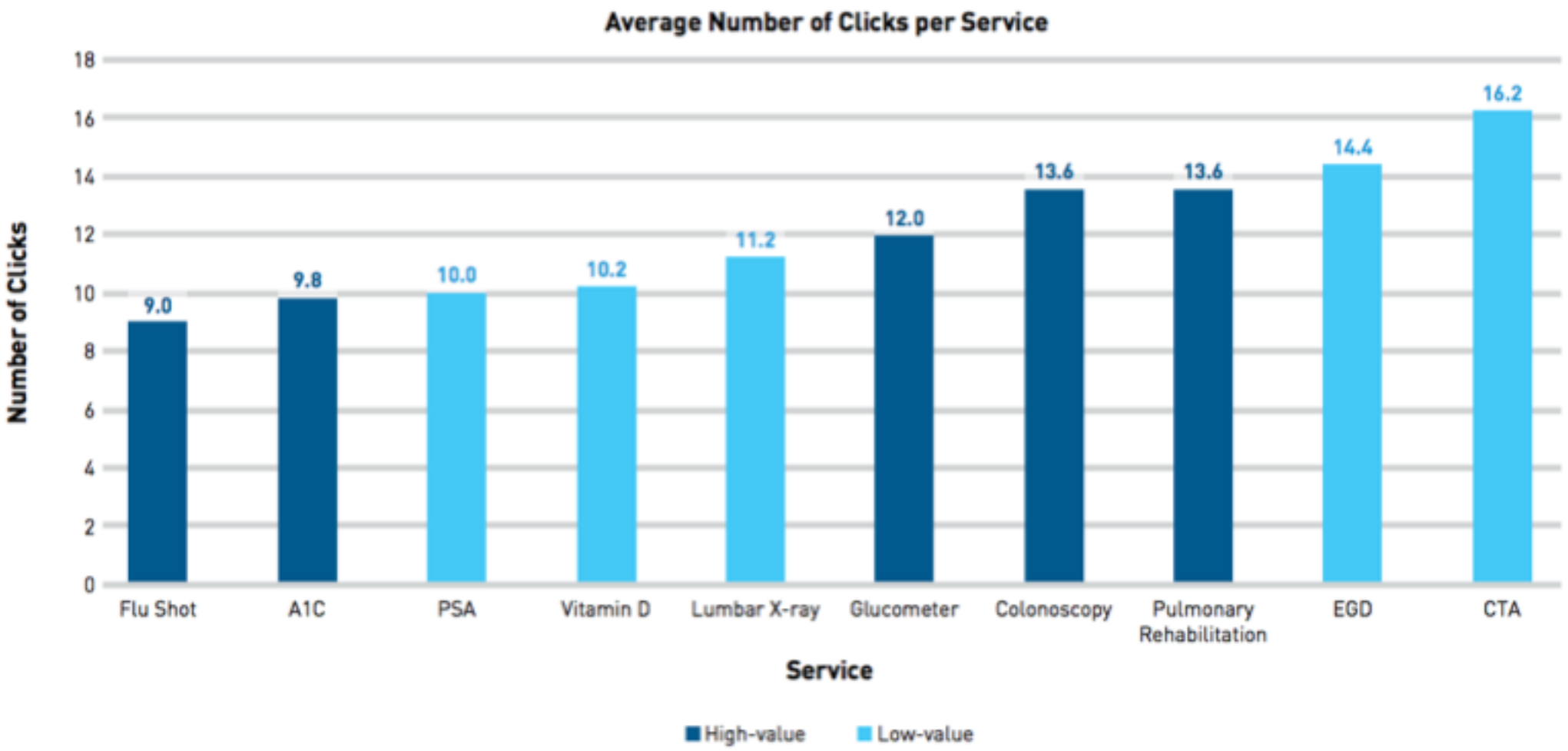
Eric Schwartz, MD; Allison Ruff, MD; Michael Kinning, DO; and A. Mark Fendrick, MD

This study evaluates the ease of ordering high- and low-value clinical services in a national sample of electronic health records.

**ABSTRACT**

**Objectives:** The use of electronic health record (EHR) systems by US clinicians is nearly ubiquitous. One motivation for EHR implementation is the ability to increase provider efficiency and improve patient-centered outcomes. There are no data examining how EHR design aligns with the ordering of high- and low-value clinical services.

**FIGURE.** Order of Services by Clicks



# US Preventive Services Task Force – clinically nuanced BRCA rating

**Recommendation Summary**

| Population | Recommendation | Grade (What's This?) |
|---|---|---|
| Women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with *BRCA1/2* gene mutation | The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (*BRCA1/2*) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing. | B |
| Women whose personal or family history or ancestry is not associated with potential harmful *BRCA1/2* gene mutations | The USPSTF recommends against routine risk assessment, genetic counseling, or genetic testing for women whose personal or family history or ancestry is not associated with potentially harmful *BRCA1/2* gene mutations. | D |

- "B" rating ensures covered at no cost-sharing per ACA
- "D" rating means harms outweigh the risks
- Difference: population based on non-claims-based factors (e.g., family history)

# Health Reform:  Medicare For All debate should include a discussion about low-value care.

- a growing body of evidence shows that blunt efforts to increase “high-value care”, eg. PCP access, can also lead to increases in low-value care.
- Medicare covers a number of (expensive) treatments with little clinical benefit. MedPAC has shown low-value care spending in the billions for Medicare FFS.

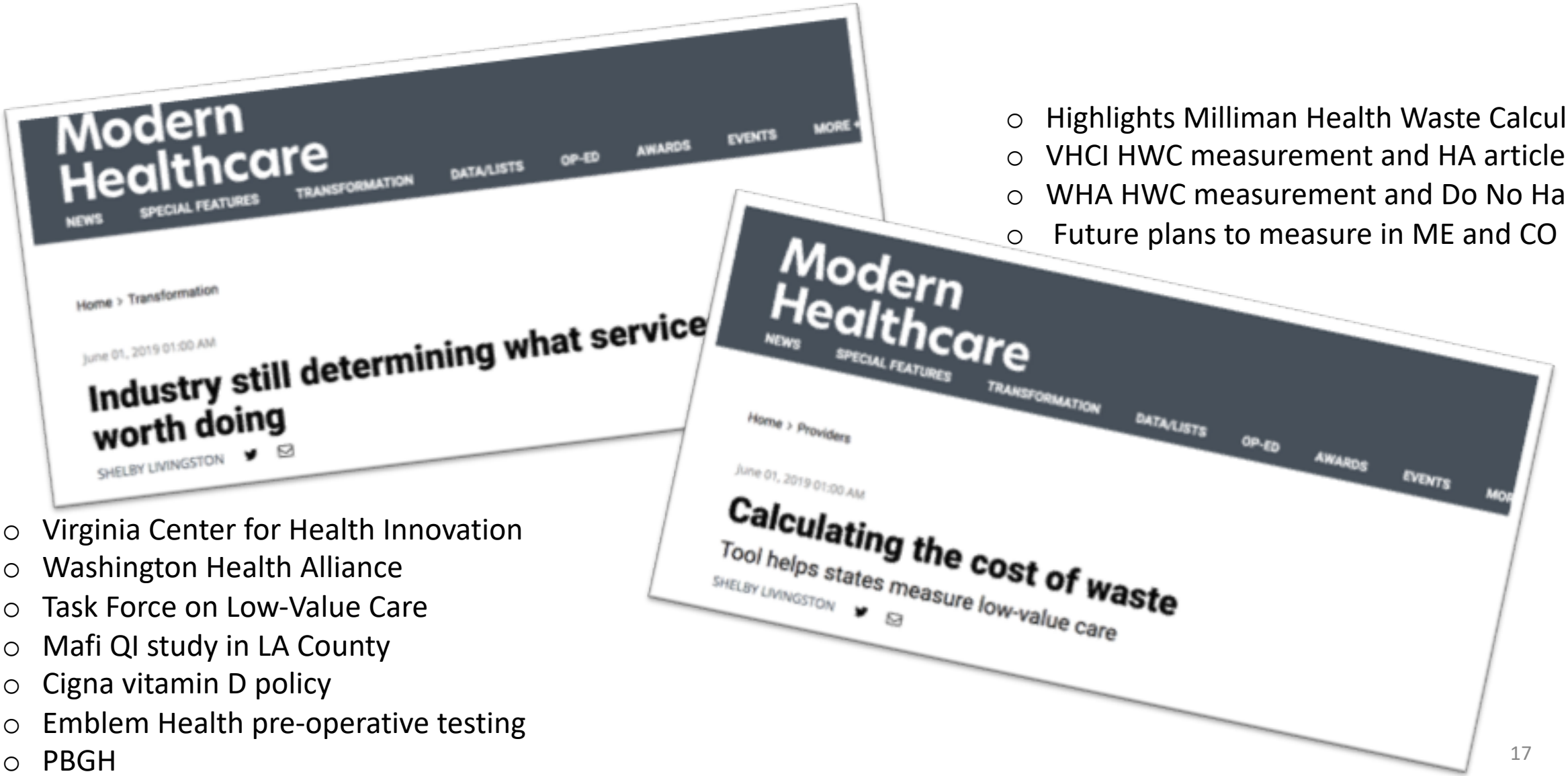

TheUpshot

THE NEW HEALTH CARE

A Question Rarely Asked: What Would Medicare for All Cover?

If it followed the path of traditional Medicare, it would end up paying for a lot of coverage that has little medical value.

# Modern Healthcare



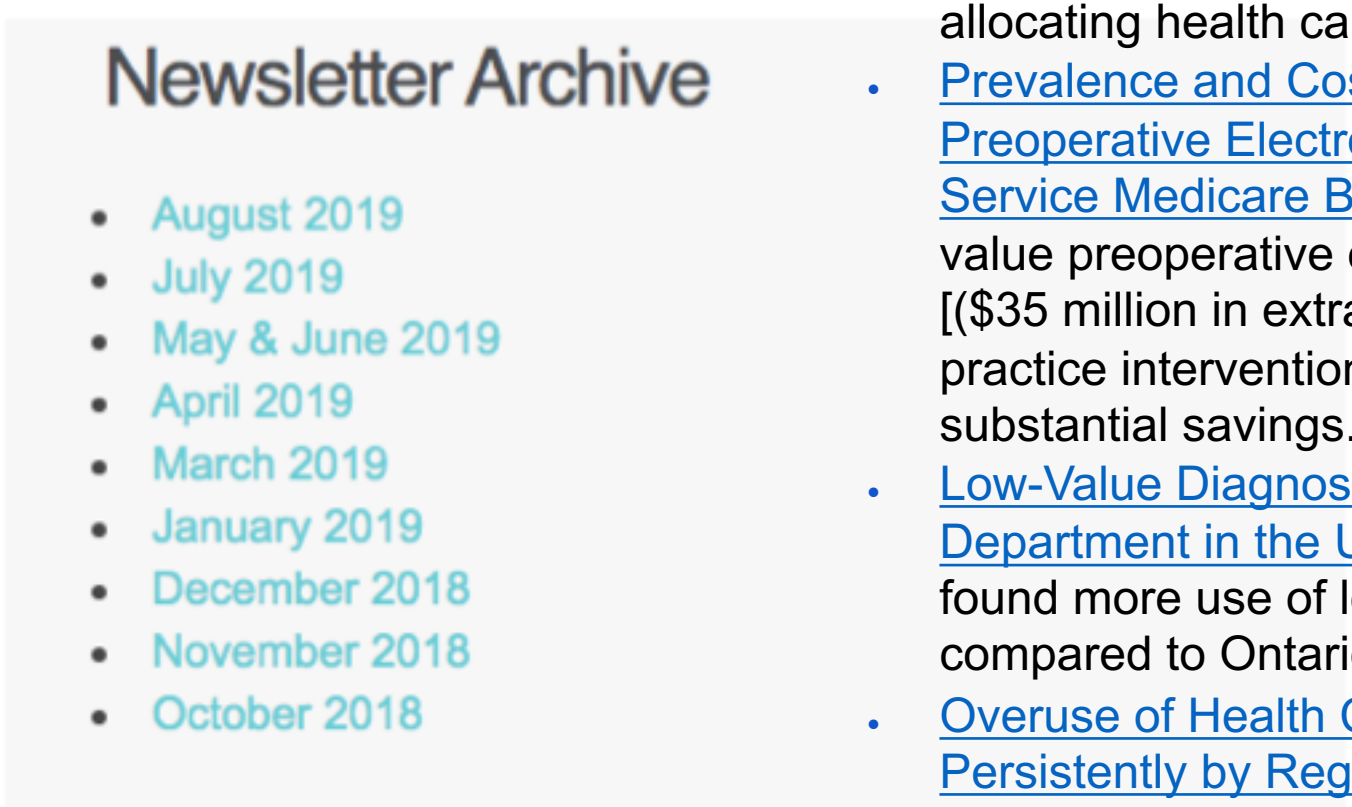

- Virginia Center for Health Innovation
- Washington Health Alliance
- Task Force on Low-Value Care
- Mafi QI study in LA County
- Cigna vitamin D policy
- Emblem Health pre-operative testing
- PBGH

- Highlights Milliman Health Waste Calculator
- VHCI HWC measurement and HA article in 2017
- WHA HWC measurement and Do No Harm repo
- Future plans to measure in ME and CO

The Commonwealth Fund

- **Key Findings:** Reducing the use of high-cost, low-value drugs could lead to $63 million in annual savings across the 15 plan sponsors. This represented 3 percent to 24 percent of overall pharmacy spending, depending on a number of factors.
- **Conclusion:** Plan sponsors could lower drug spending and out-of-pocket costs for enrollees by reducing the use of high-cost, low-value drugs on formularies. Savings could be achieved by improving pharmacy benefit design and management.

# Visit the Task Force newsletter archive




- Using the Task Force's Top Five list, the Value Consortium released a research brief detailing spending on Top Five low- and high-value services, as an indicator of progress towards better allocating health care resources.
- Prevalence and Cost of Care Cascades After Low-Value Preoperative Electrocardiogram for Cataract Surgery in Fee-for-Service Medicare Beneficiaries (JAMA): "Care cascades after low-value preoperative electrocardiograms are infrequent yet costly [($35 million in extra care after $5 million in initial tests)]; policy and practice interventions to mitigate such cascades could yield substantial savings.
- Low-Value Diagnostic Imaging Use in the Pediatric Emergency Department in the United States and Canada (JAMA): this study found more use of low-value diagnostic imaging in the United States compared to Ontario, with no difference in outcomes.
- Overuse of Health Care by Commercially Insured Adults Varies Persistently by Region (NIHCM): Systemic overuse of health care follows regional patterns that are highly persistent over time, according to a new study of commercial health insurance claims from 2010 to 2015.

# Upcoming Events

- **"Imagining a World Without Low-Value Care: What Will It Take?"** on Monday October 21st from 9:00 am-5:00 pm at the KP Center for Total Health

- **The Next Generation of Value Assessment: Including the Patient Voice** on November 12, 2019 from 10:00 AM - 4:00 PM at the Ronald Reagan Building and International Trade Center

# Recent Collaborations:

- Research Consortium on Health Value Assessment
  - Framework paper
  - ”Quick Strike” projects – Top 5 low-value care and Top 5 high-value care
  - Reporting and visualization tool*
- Cigna Vitamin D policy appeals rate paper
- National Coalition on Health Care: Low-Value Care and Consumers*
- Ballad Health Business Health Collaborative toolkit presentation*
- Smarter Health Care Coalition: Section 4105 letter to Secretary Azar*
- PhRMA/ State Collaboration Health Waste Calculator Report*



* = discussed today

# Collaborations:
# Toolkit Presentation at Ballad Health's Employer Health Collaborative

http://vbidhealth.com/toolkits

**Contents of toolkit review**

- General information on low-value care, literature, burden, etc.
- Overview of levers to reduce low-value care
- Resources specific to the Top Five
- RFI language for TPAs or carriers
- Case studies (where applicable, on Top Five)
- Business case templates
- Measurement tools: Health Waste Calculator, claims-based analysis help

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# Feedback

- Low survey results but a few e-mails & phone calls
- More information about the costs of reducing
- Brokers (new stakeholder) sought more information about specifications
- Resources for other stakeholders would be helpful to see and understand
- Talking points were useful but need more direction on how to talk with TPA
- Differences in tools for self-insured versus fully-insured employers
- Tools/levers for employers seem indirect

# Missing tools and topics, limitations of toolkit

- Technical assistance/resources for site of care changes
- Low-value care library of academic literature and current events
- How V-BID X could apply to employers
- Case studies outlining employer challenges (hoping to gather more)

# Collaborations:
# Low-Value Care Letter to Secretary Azar

SmarterHealthCareCoalition

August 21, 2019

The Honorable Alex M. Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, SW Room 600E
Washington, DC 20201

Dear Secretary Azar:

The Smarter Health Care Coalition (the Coalition) represents a broad-based, diverse group of health care stakeholders, including consumer groups, employers, health plans, life science companies, provider organizations, and academic centers.[1] Our goal is to better align health care spending with value, improve the patient experience, and lower health care costs by supporting innovative benefit design that encourages the use of high-value care, and discourages the use of low-value care.

Value-based insurance design (V-BID) is one method to better align health care spending with

**Highlights:**

- Section 4105 of the ACA permits the Secretary of HHS to cancel payments for USPSTF D-rated service
- HHS/CMS has yet to exercise authority
- HHS response: we worry that USPSTF recommendations are not appropriate for Medicare population

# The Role of Consumers in Addressing Low-Value Care

National Coalition on Health Care
October 2, 2019
NCQA, Washington DC


# Purpose and motivation

- convene small meeting, exclusively consumer-oriented organizations to provide a platform for discussion
- discuss the potential impact of efforts to identify, measure, reduce, and report “low-value care” on patients and consumer (especially issues/concepts of headroom, value, clinical nuance)
- receive feedback on waste-removal agenda, framework, and future policy endeavors (e.g. Section 4105)
- **Goal: establish agreement that we shouldn’t buy low-hanging fruit**

# Attendance

- **AARP**
- **Altarum Healthcare Value Hub**
- **Georgetown CHIR**
- **Alliance of Community Health Plans**
- **NCQA**
- **Medicare Rights Center**
- **Patient-Centered Primary Care Collaborative**
- **Lown Institute**
- **National Coalition on Health Care**

# Key outcomes and lessons learned

1. **Identifying Audience, Framing Message, Using Effective Language, and Trusted Messengers**

2. **Supply-Side Levers are Preferred Over Demand-Side Levers to Discourage Low-Value Care**

3. **Recommendations for How to Engage in Plan Design and Policy Changes to Lower Low-Value Care without Risking Consumer Backlash**

# Concluding thoughts

- Messages should vary according to the target audience
  - Public and press need to understand that value varies, and that there are risks to overtreatment
  - Physicians need to hear that low value services should be discouraged due to possible harm or unnecessary cost, D list services
  - Insured individuals – ask your doctor about possible side effects
  - Health policy makers – importance of trade-offs in budget neutrality context

- LVC better addressed via technical, expert processes rather than political ones

# PhRMA/ State Collaboration HWC Project

**Background and motivation**

- Despite growing interest: *robust (multi-stakeholder) action on low-value care has been limited*
  - And limited results from value-based strategies to improve clinical quality
- Data (hopefully) leads to action


- Low-hanging fruit exist among these

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# PhRMA/ State Collaboration HWC Project

**Project Aim**

- Compare spending & utilization of 47 LVC measures in four states with all payer claims databases (APCDs) using the Health Waste Calculator
  - How much waste, where, and how does waste spending & use differ ?

- States: Virginia, Washington and Colorado, Maine
  - Commercial, Medicare, Medicaid, Medicare Advantage

- Timeframe: 3 calendar years (2015, 2016, 2017)

# PhRMA/ State Collaboration HWC Project

**Plans for final report**

- Highlight total spending, cost-sharing, waste index, top 10, etc.
- Within-state geographic variation possible for at least 2 states
- All 3 years of spending/utilization to show trends, in appendices
- Include Washington data

**Limitations**

- Reporting and comparing costs by case versus line
- 47 is a small sample of total unindicated services
- Differing APCD reporting requirements within states
- Relative numbers look small compared to $100 billion