Low-Value Care Task Force:











Outline

- 1. What is clinical waste and low-value care
- 2. Why address low-value care
- 3. Identify: the Task Force Top Five services
- 4. Measure: existing tools to measure LVC
- 5. Reduce: overview of levers and some examples
- **6.** Resources and activities









What is "low-value care"?

- Some distinction between different definitions of "overuse" and "waste" – often used interchangeably
- "Waste" captures a number of inefficiencies
 - administrative (eg, system complexity)
 - operating waste (eg, duplicative services)
 - clinical waste (eg, utilizing unindicated services)
- Our focus: clinical waste



What is low-value care?

Clinical waste, aka low-value care

 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

Why address low-value care?

2012 Analysis:



grams, erode wages, and undermine the problem affects the private sector just as much as the public sector. Both need serious relief.

Obtaining savings directly—by simply services-seems the most obvious remedy. Programs designed to make cuts of this kind appear across the policy spectrum, from many, carefully sequenced provisions of the Patient Protection and Obama Administration, to draconian proposed shifts of Medicare costs to beneficiaries and reductions in payments to physicians and hospitals, favored by several Reducing Waste Republican congressional proponents. in Health Care Spending

The ACA, for example, gradually Here is a better idea: cut waste. That is nhases in well-warranted decreases in Some in Congress have proposed caps on federal Medicare payments (with beneficiaries picking up the differ-the elements of work that do not. ence). Many states, reeling from uning Medicaid benefits and payments.

©2012 American Medical Association. All rights reserved

both public and private payers. Commonly, programs to contain costs use cuts, such as reductions in payment levels, benefit structures, and eligib politics in the United States
ity. A less harmful strategy would reduce waste, not value-added have become, nearly every-one agrees that health care opportunity is immense. In just 6 categories of waste—overtrecosts are unsustainable. At almost 18% ures of care coordination, failures in execution of care proof the gross domestic product (GDP) trative complexity, pricing failures, and fraud and abuse in 2011, headed for 20% by 2020, 1,2 the est available estimates exceeds 20% of total health ca nation's increasing health care expen- actual total may be far greater. The savings potential ditures reduce the resources available tematic, comprehensive, and cooperative pursuit of for other worthy government procompetitiveness of US industry. Although Medicare and Medicaid are often in the limelight, the health care cost

JAMA. 2012;307(14):1513-1516

Published online March 14, 2012. doi:10.1001/jama.2012.367

The cost reductions in the ACA are seem k necessary and prudent, but if other exhau lowering payments or paying for fewer initiatives to cut spending are taken mates too far or too fast, they become risky. of these Vulnerable Medicaid beneficiaries and and Me seniors covered by Medicare with marginal incomes may find important care waste tha services out of reach, either because they lack of w Affordable Care Act (ACA), favored by the cannot afford the new cost-sharing, best care p withdrawn from local markets, or both

a basic strategy for survival in most in- between \$102 billion and \$ payments to Medicare Advantage plans. dustries today, ie, to keep processes, in wasteful spending in 2011. products, and services that actually help The opportunity for waste reduction

precedented budget deficits, are reducin health care is enormous. The literaAuthor Affiliations: RAND Corporation and Pardee RAND ture in this area identifies many potential sources of waste and provides a broad range of estimates of the magnitude of

shown to be effe

JAMA, April 11, 2012-Vol 307, No. 14 1513

2. Failures of Care Coordination

the waste that comes when patients fall

through the slats in fragmented care.

34% of spend wasted



2017 Physician Survey:



unneeded

21% of

care

article distributed under the terms of the Creative amons Attribution License, which permits

unrestricted use, distribution, and reproduction in

ry medium, provided the original author and

Data Availability Statement: All of our data is

access privileges to the data. The third party is

QuantiaMD and their contact information is

nfo@guantiamd.com or +1.800.773.4162.

owned by a third party. The authors had no special

Funding: This work was supported by the Richieon

Foundation - no grant number available (MM). The

funder had no role in study design, data collection

and analysis, decision to publish, or preparation of

that no competing interests exist.

source are credited.

The response rate was 70.1%. Physicians reported that an interpolated median of overall medical care was unnecessary, including 22.0% of prescription medications tests, and 11.1% of procedures. The most common cited reasons for overtreatment of malpractice (84.7%), patient pressure/request (59.0%), and difficulty accessing media records (38.2%). Potential solutions identified were training residents on appropriateness of teria (55.2%), easy access to outside health records (52.0%), and more practice guidelines (51.5%). Most respondents (70.8%) believed that physicians are more likely to perform unnec essary procedures when they profit from them. Most respondents believed that de-emphasizing fee-for-service physician compensation would reduce health care utilization and costs.

From the physician perspective, overtreatment is common. Efforts to address the probler should consider the causes and solutions offered by physicians

Why address low-value care?

Best Care at Lower Cost

The Path to Continuously Learning Health Care in America

Mark D. Smith, MD, MBA, Study Chair



- National Academy of Medicine study found "unnecessary health spending" costs the US system \$750 billion in 2009.
- And most estimates of spending are conservative: they do not track the cascading downstream harm.
- Bottom line: care that provides little to not benefit is pervasive and costly.

Why low-value care?

- Both a financial imperative
 - Spending on low-value clinical care reduces 'headroom' for highvalue care
 - The savings are immediate + substantial
- And an ethical imperative
 - Patient harm



Why low-value care?

THE MILBANK QUARTERLY

A MULTIDISCIPLINARY IOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Original Investigation

Treating, Fast and Slow: Americans' Understanding of and Responses to Low-Value Care

MARK SCHLESINGER* and RACHEL GROB†

*Yale University; †University of Wisconsin (Madison)

Cascading downstream harm (and cost)

Opportunit **

'botherediness,

health disparities

Direct physical harm and worry

Harm to patients

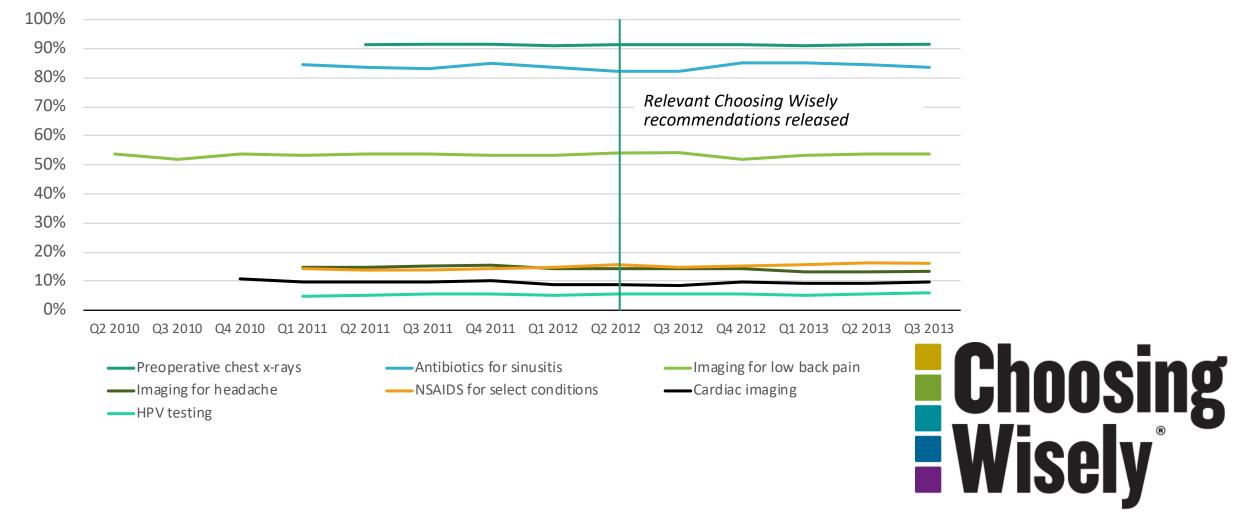
Out of of pocket costs

9

| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
|-------|-------|--------------------|-------|-------|---------------|----------------|--------|--------|-------|-------|-------|-------|-------------------|-------|-------|-------|-------|-------|-------|-------|-------------|-------|
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Do <u>n't</u> | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | D)n't | Port | Don't | Don't | 39 | Soc | Doi (t | Don't | D n't | | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | f ^{Dop't} | Don't | Don't | Don't | 201 Don't | Øn't † | Don't | Don't | Don't | Don't | Don't | D on't | Don't | Don't | Don't | Pon't | Don't | Don't | Don't | Don't | Don't |
| | | | | _ | | | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Reco |) Mar | ner | าฝลา | tlor | ∫ Son′t | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't 10 | Don't |
| Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't | Don't |

Minimal progress from information-only

Prevalence and Trends for Six Commonly Overused Services (2010-2013)



Building a Top Five List

Key Criteria

Unit PriceVolumeAggregate CostHarmPolitical SensitivityHigh Waste Index

Fruit below the ground

12

Background: Identify

5 Commonly Overused Services Ready for Purchaser Action



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

1. Unindicated Diagnostic Testing and Imaging in Low-Risk Patients Prior to Low-Risk Surgery



WHAT

Low-risk patients undergoing low-risk surgery do not need many commonly provided blood tests, imaging services, and more.

WHY

Unneeded tests and imaging services:

- Rarely change patient management
- Identify clinically insignificant abnormalities
- Delay needed care (opportunity cost too)

BURDEN

Nationwide in 2014:

- About 19 million unneeded pre-surgery tests/images performed
- About \$9.5 billion in spending resulted

2. Population-based Vitamin D Screening



WHAT

Population-based screening for 25-OH-Vitamin D deficiency should be avoided.

WHY

Vitamin D deficiency is rare. If deficiency suspected, patients should simply be advised to take an over-the-counter supplement and increase sun exposure.

Nationwide in 2014:

- **BURDEN**
- About 6.3 million unneeded screening tests performed
- About \$800 million in spending resulted

3. Prostate-specific antigen (PSA) screening in men 75 and older



WHAT

In men 75 and older, screening for prostate cancer through the PSA blood test should almost never be performed.

WHY

BURDEN

- Over-diagnosis associated with serious harm
- Harms of screening in men 75+ unambiguously outweigh benefit

•

Nationwide in 2014:

- At least 1 million unneeded screenings in men 75+ performed
- Tests alone resulted in at least \$44 million in spending

4. Imaging for acute low-back pain for first six weeks after onset, unless clinical warning signs are present



WHAT

X-rays, computed tomography (CT), and magnetic resonance imaging (MRI) should be avoided during first six weeks of low-back pain, unless a specific clinical warning sign is present.

WHY

- Rarely changes patient management
- X-rays and CT expose patients to unneeded radiation
- Detects clinically insignificant abnormalities

Nationwide in 2014:

BURDEN

- About 1.6 million avoidable imaging services performed
- About \$500 million in spending resulted

5. Use of more expensive branded drugs when generics with identical active ingredients are available



WHAT

Branded medications should not be prescribed when less expensive, chemically identical generics are available. (This is distinct from therapeutic substitution, when non-equivalent medications are substituted for one another.)

WHY

Prescribing of more expensive, chemically identical medications buys no extra health per dollar.

BURDEN

Purchasers would have saved \$14.7 billion in 2016 had 100% of prescriptions with generics available been dispensed as generics

Tools to Measure Low-Value Care

- Milliman MedInsight <u>Health Waste</u>
 <u>Calculator</u>
- Altarum <u>PROMETHEUS Analytics</u>
- In-house claims analysis



Example: Health Waste Calculator

- Notable examples of implementation:
 - Washington Health Alliance
 - Virginia Center for Health Care Innovation
 - More about the states later
- What it does (in a nutshell)
 - Uses claims data
 - Wasteful, likely wasteful, necessary
 - Waste index
- Different than clinical variation analysis

Calculating Health Care Waste Over Time

Because some measures in the Health Waste Calculator were modified or added from Version 5 to Version 7, and because we added Medicaid data for this analysis, we re-ran results (using Version 7) for the "top 10" areas of waste noted in this report for the prior measurement year (July 2015 – June 2016). We did this to provide comparable data for the prior period and the current period (July 2016 – June 2017). Results are shown below. The level of waste remained remarkably similar for the two time periods, suggesting a strong practice pattern in these areas of care.

| | | Current Period 2016 – June 2 | | Prior Period (July 2015 – June 2016) | | | | |
|---|------------------------------|---------------------------------|----------------|---|------------------------------|----------------|--|--|
| | # of Services Examined | # of Wasteful Services | Waste Index | # of Services Examined | # of Wasteful Services | Waste Index | | |
| Opiates for acute low back pain | 248,790 | 232,824 | 93.6% | 267,494 | 251,528 | 94.0% | | |
| Antibiotics for URI and ear infection | 197,871 | 197,758 | 99.9% | 202,094 | 202,020 | 99.9% | | |
| Annual EKG/cardiac screening | 693,071 | 196,123 | 28.3% | 655,440 | 195,160 | 29.8% | | |
| Imaging tests for eye disease | 199,928 | 137,070 | 68.6% | 190,751 | 136,248 | 71.4% | | |
| Pre-op lab studies, low-risk procedures | 151,960 | 129,360 | 85.1% | 152,376 | 129,411 | 84.9% | | |
| Two or more concurrent antipsychotic meds | 488,477 | 118,015 | 24.2% | 447,199 | 108,521 | 24.3% | | |
| PSA-screening for prostate cancer | 92,111 | 79,347 | 86.1% | 89,299 | 76,702 | 85.9% | | |
| Cervical cancer screening for women | 254,510 | 52,594 | 20.7% | 252,161 | 58,231 | 23.1% | | |
| Screening for Vitamin D deficiency | 136,629 | 40,049 | 29.3% | 145,214 | 43,033 | 29.6% | | |
| NSAIDS for hypertension, heart failure, CKD | 58,341 | 39,027 | 66.9% | 54,766 | 37,641 | 68.7% | | |

2018 Virginia Health Value Dashboard



2

Low-value care levers



Reduce: Levers for low-value care

TABLE. Tools to Target Low-Value Care 12

| Provider Facing | Patient Facing |
|--|--|
| Coverage policies 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. | Network design 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 |
| Payment rates and payment models Adjust allowed amounts to reduce incentives to provide commonly overused/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 | Utilization management 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 |
| Provider profiling information • Distribute reports benchmarking the practice patterns of a clinician or practice against those of your peers. 15 | Value-based insurance designs 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.

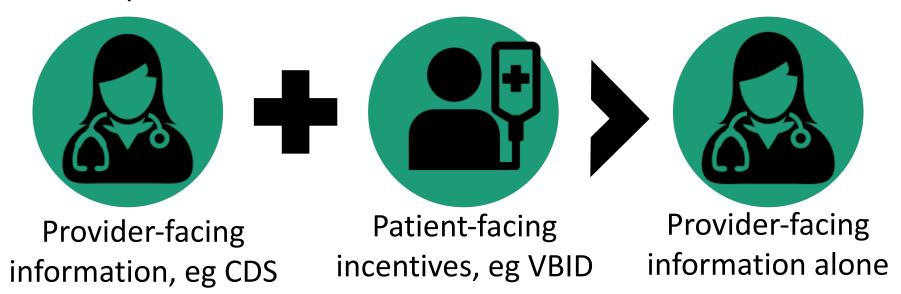


Blog: "Tackling Low-Value Care: A New "Top Five" for Purchaser Action" Buxbaum, Mafi, Fendrick

Levers work best in combination

Multiple and "synergistic" interventions work better than in isolation

For example...







ACA Sec 4105: Modify or Eliminate Coverage of Certain Preventive Services

SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

- (a) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:
- "(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

"(1) modify—

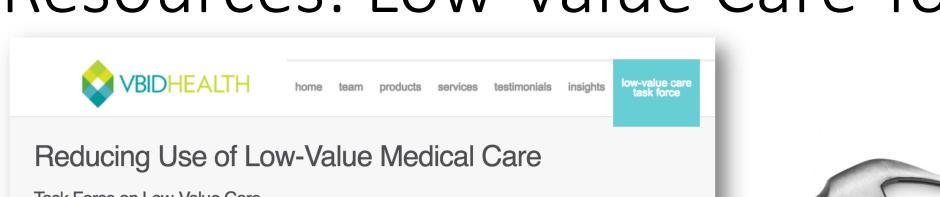
- "(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and
- "(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and
- "(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.".
- (b) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

The ACA grants HHS the authority to eliminate coverage for USPSTF 'D' Rated Services in Medicare

Other Low-Value Care Activities and Resources



Resources: Low-Value Care Toolkits



Task Force on Low-Value Care

Problem of Overspending and Underperforming in the United States

The US spends more on health care per capita than any other country but does not achieve outcomes commensurate with that spending.

A substantial share of this spending is devoted to services that buy no additional health, and in some instances, expose patients to serious harm. Experts estimate that between \$158 and \$226 billion is spent on low-value care every year (2011 dollars). Private payers bear the cost of between \$90 and \$140 billion of this amount. And there is reason to believe even the upper estimates of low-value care are too conservative.







Low-Value Care Toolkits cover a wide scope of resources

Organized background information and resources

- LVC white paper,
- LVC infographic,
- LVC one pager,
- References to other resources (eg, IHA and WHA/drop the pre-op)

New business case templates

- Template with background and headers for any service
- Template example with low back pain

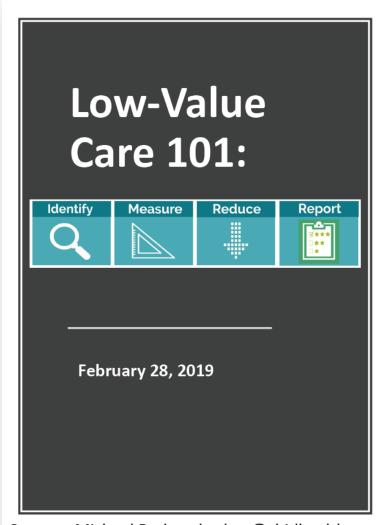
Updated measurement information

- Health Waste Calculator information, and others
- Updated data specifications for in-house analyses

New Top Five resources

- RFI language and expanded talking points
- One-pagers for each Top Five

Low-Value Care 101 Webinar











- Mark Fendrick + Beth Bortz
- What is LVC and IMRR
- Opportunity for state engagement in LVC specifically
- 378 registrants, 203 unique visitors

Contact: Michael Budros, budros@vbidhealth.com

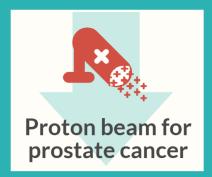


Low-Value Care in Benefit Design: V-BID X

Increased cost-sharing on low-value services reduces spending...



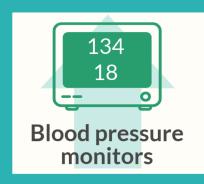






...and allows for lower cost-sharing and increased spending on high-value services









Research Consortium on Health Care Value Assessment: Untapped opportunity for state leadership



CONCEPT PAPER NO. 1 | FEBRAURY 2019

Improving Health by Reducing Low-Value Care

THE BURDEN AND IMPLICATIONS OF LOW-VALUE CARE

Affordability in health care is best achieved by aligning spending with value. Traditional approaches to reducing health care spending often seek to reduce costs by indiscriminately eroding coverage for care, frequently targeting new technologies, rather than reducing spending though improved efficiency. By failing to take a holistic perspective on all sources of costs and value, reduced spending on health is all too often at the expense of patient outcomes and overall health system performance.

Low-value care, or health services that provide no or minimal benefit to a patient, is a major driver of inefficiency in health care and an untapped opportunity to increase quality and reduce spending. The

STATES ARE UNIQUELY POSITIONED TO ADDRESS THESE INEFFICIENCIES

As states continue to feel pressure to contain health care spending, it is tempting to reduce care of any kind. However, this type of short-sighted budgeting decision will not lead to lasting reforms that improve patient health. Accurate measurement and stakeholder champions armed with data can instead focus attention and direct action to increase efficiency in the health care system. All-payer claims data in combination with tools like the Health Waste Calculator, which help identify low-value care from these data, will make states a likely source of leadership on low-value care reduction. Better engaging state stakeholders to precisely measure the magnitude of low-value care will substantially advance systematic efforts.

Research Consortium for Health Care Value Assessment

- States are interested in containing costs.
- Cost containment should address inefficiencies.
- Low-value care is a major driver of inefficiency.
- Low-hanging fruit exist in state APCD data.
- State stakeholders measuring low-value care will substantially advance efforts.

Low-value Care in the News



Health services research Research

Measuring 21 low-value hospital procedures: claims analysis of Australian private health insurance data (2010–2014) 8

Kelsey Chalmers^{1, 2}, Sallie-Anne Pearson³, Tim Badgery-Parker^{1, 2}, Jonathan Brett³, Ian A Scott^{4, 5}, Adam G Elshaug¹

Author affiliations +



Low-value Care in the News



AHN to push doctors to follow guidelines for reducing unneeded medical tests



APR 13, 2018 9:27 AM

Low-value Care in the News



FEB 01

MORE ON PATIENT ENGAGEMENT

Patients with primary care doctors receive more high-value healthcare, study finds

Policymakers and health system leaders seeking to increase value should consider increasing investments in primary care.

