Task Force on Low-Value Care

Model Language Specific to Low-Value Care for Use in
Purchaser-Issued Health Plan Requests for Information (RFIs)

Version: January 16, 2018

This draft material may be copied or adapted. Please share suggestions for improvement by e-mailing buxbaum@vbidhealth.com.

The following questions relate to health plans' policies and procedures intended to avoid the delivery of commonly overused services. Many questions pertain to the "Top Five" services identified by the multi-stakeholder Task Force on Low-Value Care.

Use of Coverage Policies to Drive Low-Value Care Avoidance

Please describe general coverage policies and, where applicable, use of relevant edits and/or prior authorization requirements, for these five commonly overused services.

	General Coverage Policies	Relevant Edits	Relevant Prior-Authorization Programs
Diagnostic testing and imaging for low-risk patients prior to low-risk surgery			
Vitamin D screening			
Prostate-specific antigen (PSA) screening in men 75 and older			
Radiography, computed tomography (CT), and magnetic resonance imaging (MRI) for acute low-back pain for the first six weeks after onset, unless clinical warning signs are present ("red flags")			
Use of more expensive branded drugs when generics with identical active ingredients are available			

Use of Non-Financial, Provider-Facing Best Practices for Performance Improvement

- Does carrier distribute **profiling reports** on provider tendency to order specific commonly overused services relative to benchmarks or peers? If so, which specific services are currently included in these reports? How are services added and retired over time?

- Does carrier support **learning collaboratives** or continuous quality improvement (CQI) initiatives to engage providers on low-value care? Please describe programs and indicate proportion of network engaged over previous 12 months.

- Please describe policies, procedures, or incentives that encourage use of **clinical decision support tools** within provider electronic health records. If known, for what proportion of your network are these tools in common use?

Patient-Facing Initiatives

- Please describe **patient-facing outreach** related to low-value care. Please indicate the proportion of commercial enrollment engaged.

- Please describe how **value-based insurance design** is used to discourage use of low value services. Please indicate the proportion of commercial enrollment impacted.

Provider-Facing Financial Incentives, Performance Measures, and Network Design

- Please describe how carrier's **payment reform** efforts motivate reduced delivery of low-value care. Please indicate the proportion of the carrier's network included.

- Please describe how carrier uses **performance measures** specific to low-value services in payment reform efforts. Are any performance measures related to the "Top Five" currently in use? Please indicate the proportion of the carrier's network impacted.

- Please describe how carrier **sets fees or allowed amounts as to minimize incentives for the inappropriate provision** of commonly overused services (e.g., use of a single blended rate for vaginal and cesarean deliveries).

- Does carrier consider performance on measures of low-value care delivery in **network design**?

Other

- For multi-source drugs, does carrier ensure **patient assistance programs do not undermine incentives** for use of identical, lower-cost options? If so, how?

- Does carrier **discourage contracted providers from advertising services that are not evidence-based** (e.g., full body scans for disease screening in asymptomatic adults)? If so, how?

- Please describe any other relevant activities.