

Tackling Low-Value Care: Opportunities for Purchasers

Task Force on Low-Value Care

September 13, 2017

Outline

- 1 Background – why this matters
- 2 Measurement
- 3 Provider-facing levers
- 4 Patient-facing levers
- 5 Criteria for selecting actionable services

A Taxonomy of Waste

Administrative Waste

- Avoidable complexity
- Fraud
- Pricing failures

Operational Waste

- Inefficiencies in care delivery
- Unduly expensive inputs
- Errors
- Duplicative services

Clinical Waste

- Care that does not deliver net benefit (overtreatment)
- Care that offers no benefit over less costly alternatives
- Care that delivers benefit, but does not meet standards of cost-effectiveness

A Taxonomy of Waste

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Why Low-Value Care

Common

- 10-42% of Americans receive 1+ low-value services each year
- Physician survey: 21% of all care is unnecessary

Harm to Patients

- Direct physical harm and worry
- Cascading downstream harm
- Opportunity cost and time
- 17-33% of costs borne by patients

Expensive

- \$160-\$225 billion in annual all-payer spend (2011 dollars) due to over-treatment
- Commercial tools can ID 2-3% of all-payer spend as wasteful

Prostate-Specific Antigen (PSA) Testing



An initiative of the ABIM Foundation

American Academy of Family Physicians



Fifteen Things Physicians and Patients Should Question

11

Don't prescribe antibiotics for otitis media in children aged 2–12 years with non-severe symptoms where the observation option is reasonable.

The "observation option" refers to deferring antibacterial treatment of selected children for 48 to 72 hours and limiting management to symptomatic relief. The decision to observe or treat is based on the child's age, diagnostic certainty and illness severity. To observe a child without initial antibacterial therapy, it is important that the parent or caregiver has a ready means of communicating with the clinician. There also must be a system in place that permits reevaluation of the child.

12

Don't perform voiding cystourethrogram (VCUG) routinely in first febrile urinary tract infection (UTI) in children aged 2–24 months.

The risks associated with radiation (plus the discomfort and expense of the procedure) outweigh the risk of delaying the detection of the few children with correctable genitourinary abnormalities until their second UTI.

13

Don't routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam.

There is convincing evidence that PSA-based screening leads to substantial over-diagnosis of prostate tumors. Many tumors will not harm patients, while the risks of treatment are significant. Physicians should not offer or order PSA screening unless they are prepared to engage in shared decision making that enables an informed choice by patients.

Prostate-Specific Antigen (PSA) Testing

Common

- 18% of male Medicare FFS beneficiaries age 75+ received PSA test (2014)

Harm to Patients

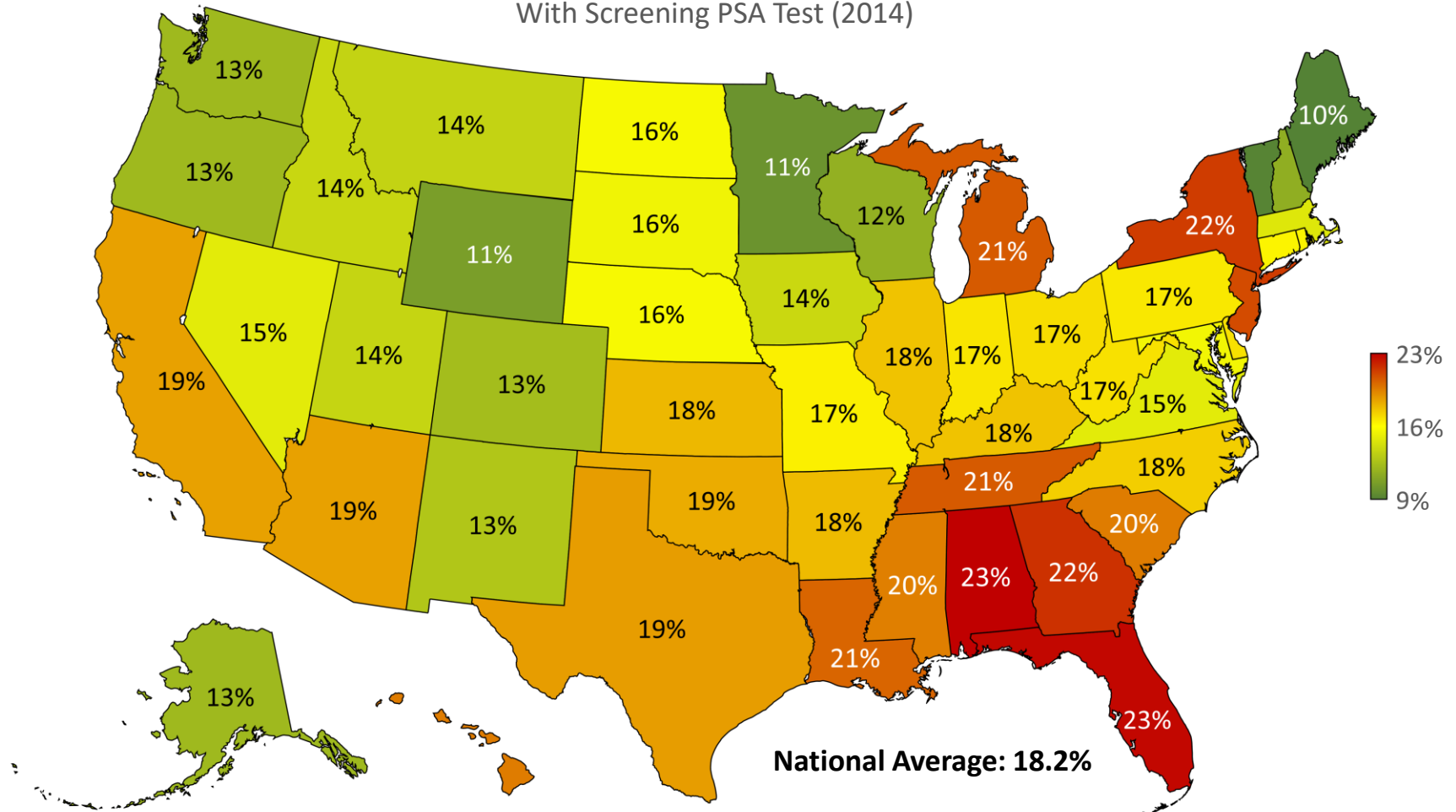
- Of men receiving a biopsy for an elevated PSA, 40% will have complications, 9% visit ED, 1% admitted
- Cascading harm from radiation, surgeries

Expensive

- \$79 million in spend in 2014 for lab tests for men 75+
- ~\$200 million in all screening/ diagnosis-related costs
- 5-year follow-up costs for treatment range from \$9,000-\$22,000/person

Prostate-Specific Antigen (PSA) Testing

Percent of Male Medicare FFS Beneficiaries Age 75+
With Screening PSA Test (2014)



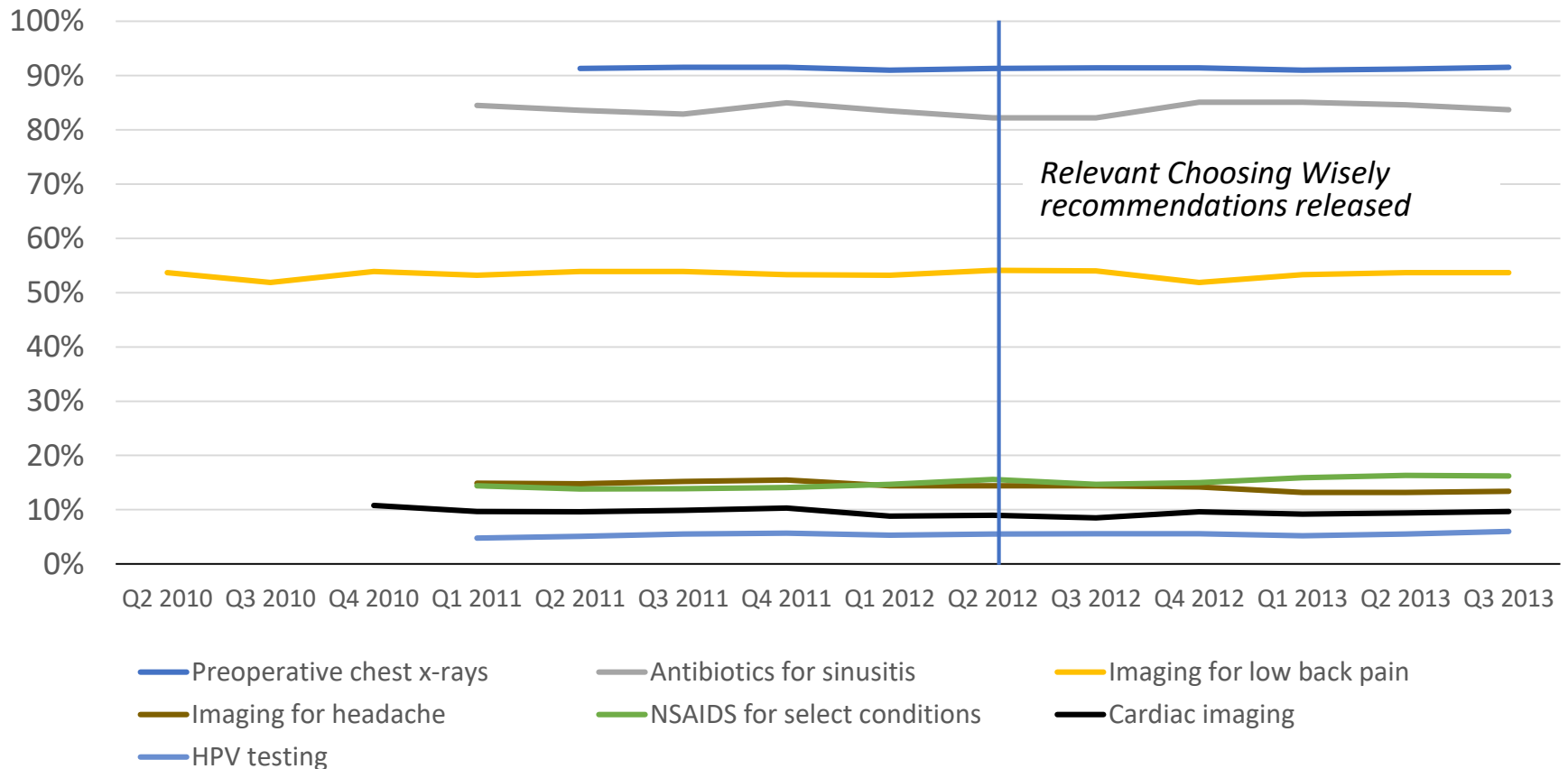
Health Waste Calculator

Share of Instances In Which Commonly Overused Service is *NOT* Appropriate

Waste Category	Total Services Measured	Wasteful Services	Wasteful Services/1000	% of Wasteful Dollars	% of Total Dollars	Quality Index	Waste Index
Screening Tests							
Annual EKGs "Don't order annual EKGs or any other cardiac screening for low-risk patients without symptoms."	191,123	38,001	95.3	21.50%	0.60%	80%	20%
Diagnostic Testing							
Low Back Pain Imaging "Don't do imaging for low back pain within the first six weeks, unless red flags are present."	3,810	3,601	8.5	9.80%	0.45%	5%	95%
Cardiac Imaging "Don't perform stress cardiac imaging or advanced non-invasive imaging in initial patient evaluation without cardiac symptoms unless high-risk markers are present."	21,012	9,022	21.2	21.20%	0.39%	57%	43%
Total (all measures)	333,326	129,997	278.3	100%	2.50%	61%	39%

Information Only – Not Enough

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



Levers

Provider-Facing Levers (Supply)

Coverage policies

Payment rates

Payment models

Profiling data

Clinical decision support



Patient-Facing Levers (Demand)

Value-Based Insurance Design

Network design

Prior authorization



Supply: Coverage Policies (Yes/No)

Description and Advantages

- Vigorous enforcement of medical necessity standard
- New edits to reject claims for clearly unindicated services
- Merit recognized in the ACA
 - Section 4105: Evidence-Based Coverage of Preventive Services in Medicare

Limitations and Complications

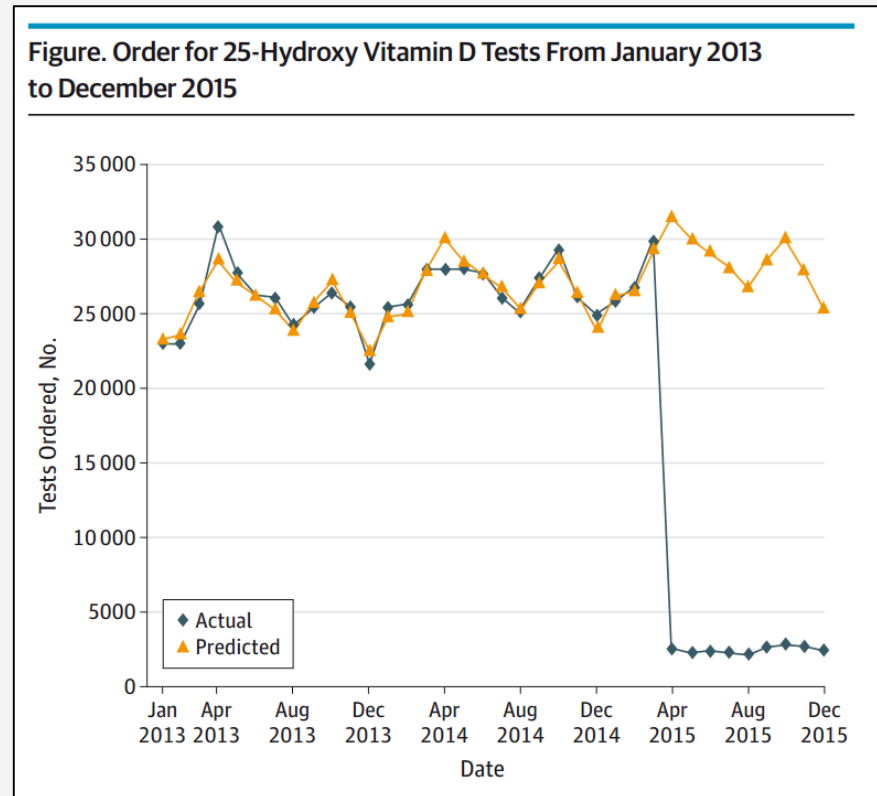
- Does available data allow clinically nuanced determinations?
- Is “juice worth the squeeze”? Risk of backlash
- Member liability
- Appeals
- Susceptibility to changes in coding



Supply: Coverage Policies (Yes/No)

Example: Alberta Health Changes Lab Requisition Form

- Vitamin D testing: prevalent, high waste index, revolt unlikely
- New requisition form required providers to select 1 of 5 evidence-based indications
- Tests reduced 92%
- \$3 million (USD) saved



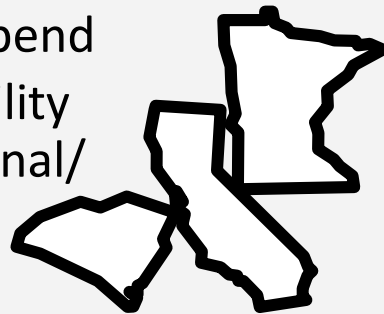
Supply: Payment Rates (How Much)

Description and Advantages

- Negotiate (or establish) rates that make commonly overused services less lucrative
- Avoid binary covered/not covered decisions

Examples

- Unneeded c-sections: harm, high unit price and aggregate spend
- Equalize facility fees for vaginal/cesarean deliveries



Limitations and Complications

- Reliance on fields available in claims
- Potentially punishing providers offering the many high-value c-sections
- Problems with small numbers

Supply: Payment Models (How)

Description and Advantages

- Range from:
 - Pay-for-performance (P4P)
 - Episodes (with or without downside risk)
 - Accountable care organizations (ACOs) (with or without downside risk)
 - Global payment (downside risk)
- Alternative payment models (APMs) may allow providers to reduce provision of low-value care without sacrificing revenue
- Service avoidance achieved through:
 - Incentives inherent in shared-risk arrangements and/or
 - Performance measures specific to low-value care

Supply: Payment Models (How)

Limitations and Complications

- Strength of incentives, and assumption of downside risk
- Reliance on retrospective reconciliation
- Critical mass of provider panel?
- Fear of stinting
- Historically, performance measures have not emphasized overuse
- Administrative complexity

Supply: Payment Models (How)

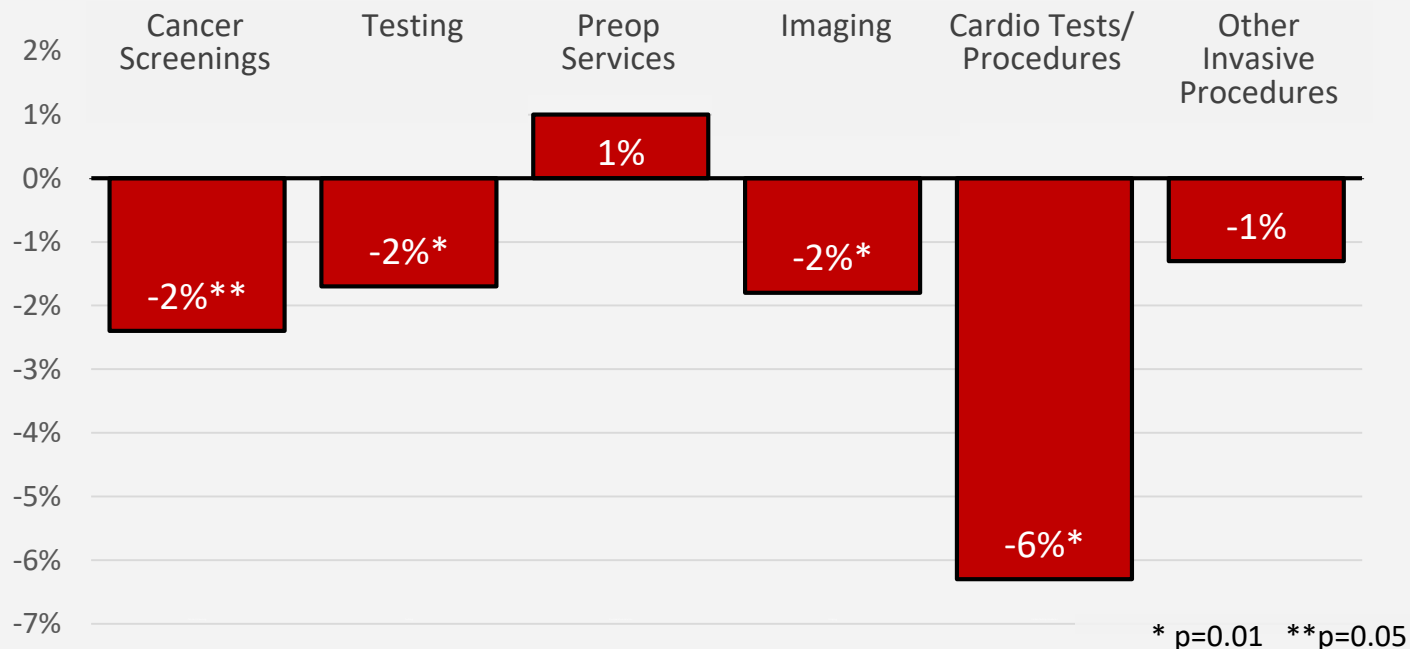
Examples: P4P, Episodes, and ACOs

- P4P: 2016 physician quality reporting system (PQRS) measures related to overuse of cardiac stress testing, advanced imaging, others
- P4P: 2017 MedPAC report discussed role for a low-value care composite in new Merit-based Incentive Payment System (MIPS)
- Episodes: CMS Bundled Payments for Care Improvement initiative
 - Savings of \$1,166/lower extremity joint replacement
 - Reduced use of post-acute care
- ACOs: Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC)
 - \$249 PMPY savings (not including bonus payments)
 - 25 percent of savings related to imaging
 - Included performance gate related to antibiotic overuse

Supply: Payment Models (How)

Example: Participation in Pioneer Model

Differential Change in Use of 31 Low-Value Services,
As Percent of Mean Service Use at Baseline



Supply: Clinical Decision Support

Description and Advantages

- Just-in-time “speed bumps” within electronic health record (EHR) when clinician orders commonly overused service
- Potential for integration with existing workflows
- Many bright spots to date (Cedars-Sinai, Christiana Care, others)

Limitations and Complications

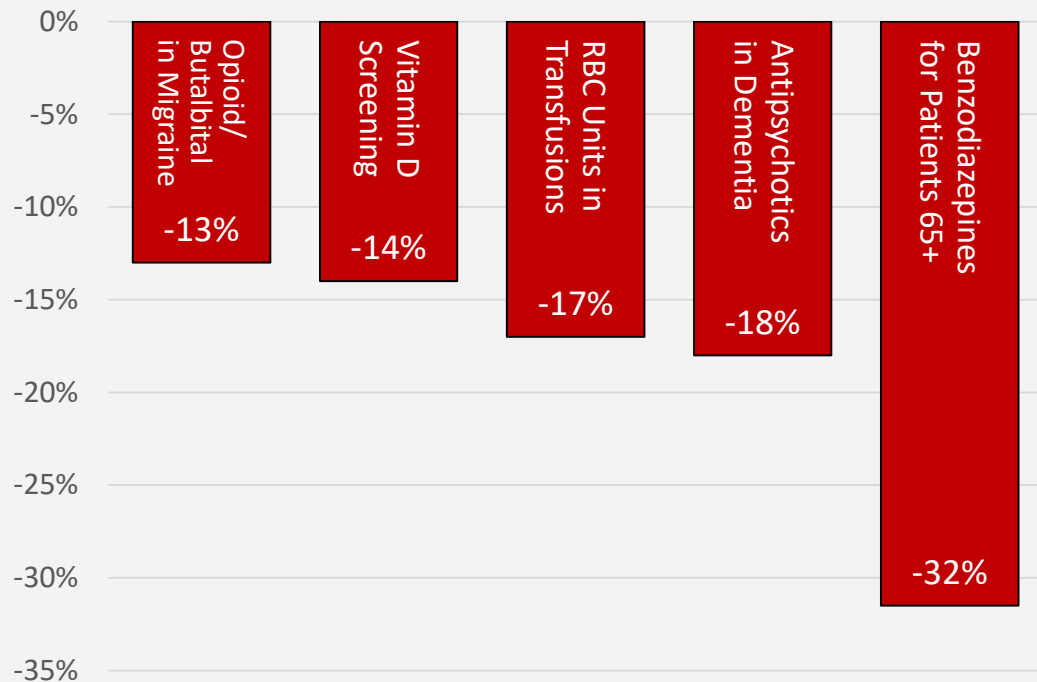
- Who accrues the savings? Providers or purchasers?
- Do providers have incentive to invest in CDS that will benefit payers?
- Relies on structured data and thoughtful programming to avoid alert fatigue

Supply: Clinical Decision Support

Example: Alerts in EHR at Cedars-Sinai

- 180 Choosing Wisely services targeted
- About 300 alerts displayed/day
- Acceptance ranges from 8%-27%
- \$3M+/year in averted spend
- Alignment with ACO efforts

Changes in Ordering Associated with Implementation of Decision Support



Supply: Clinical Decision Support

Example: Medicare Part B Requirements to Consult Appropriate Use Criteria for Advanced Imaging Services

- *Ordering* providers will be required to consult with service-specific appropriate use criteria (AUC)
- Applies to: MRI, CT, PET, nuclear medicine studies
- Consultation to be reported on *furnishing* provider's claim as condition of payment
- AUC defined by professional societies
- CMS intends for providers to interact through EHRs
- Priority conditions: headache, hip pain, low back pain, lung cancer, suspected PE, suspected CAD, others
- Threat of prior authorization for outliers
- Implementation date uncertain

Supply: Provider Profiling

Description and Advantages

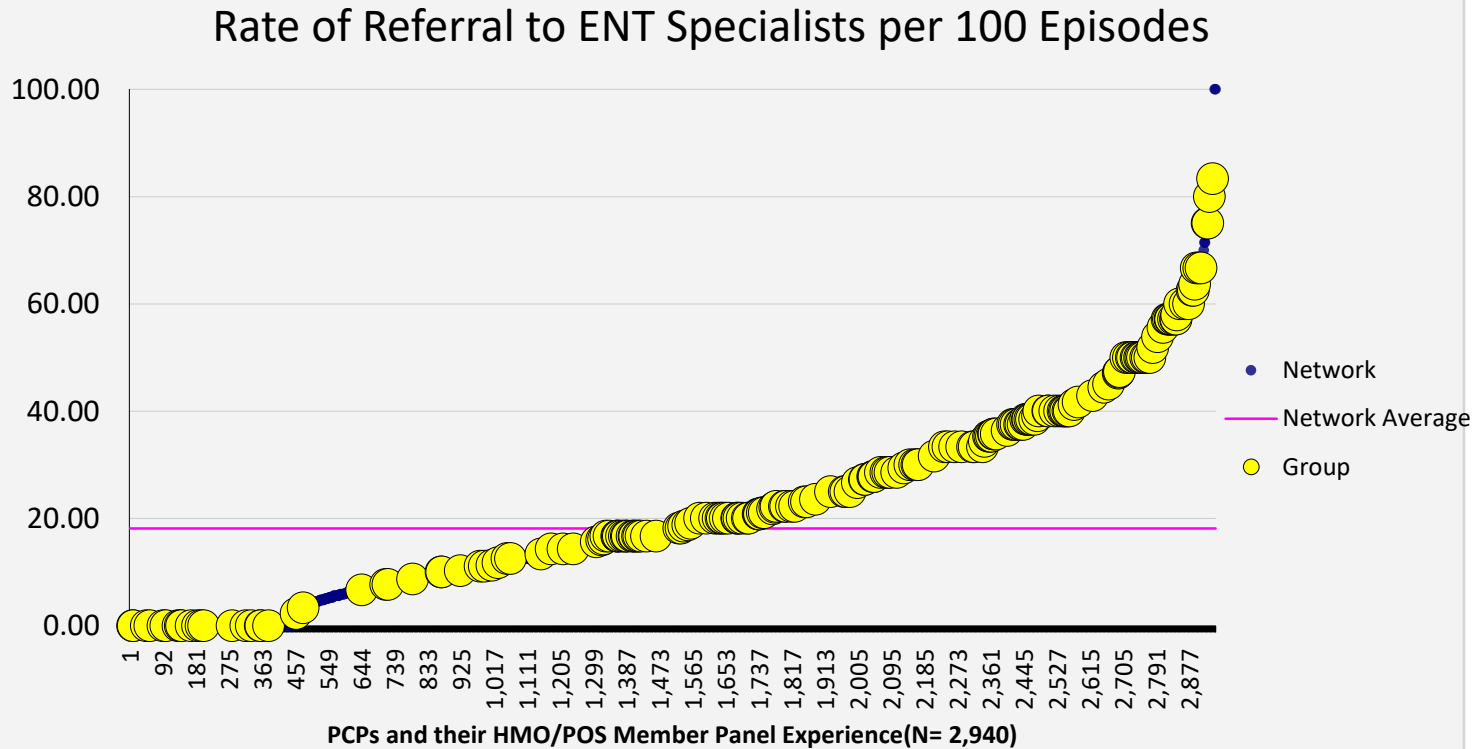
- Reports comparing patterns of practice against peers and/or national/regional standards
- May be prepared by payers or providers

Limitations and Complications

- Reports must be seen as timely and trustworthy
- Apples-to-apples? Potential need for risk adjustment
- Percent of panel covered
- Typically only applied to limited number of high-variation conditions

Supply: Provider Profiling

Example: Provider Profiling in BCBSMA Alternative Quality Contract



M. Carty. *Supporting Provider Organizations in the Alternative Quality Contracts (AQC)*.
Presentation to Spring Meeting of Task Force on Low-Value Care. (April 2017)

Demand: Value-Based Insurance Design

Description and Advantages

- Align patient-facing cost-sharing with value of underlying service
- Underused high-value service → low cost-share
- Overused low-value service → high cost-share
- Rich experience with V-BID for high-value care
- With V-BID for low-value care, potential for savings within plan year



Demand: Value-Based Insurance Design

Limitations and Complications

- Claims data often lacks key clinical details
- In some instances, the greater the nuance, the greater the administrative complexity
- Potential to punish patients for sins of the provider
- What services should be selected?
 - Varying risks of backlash



Demand: Value-Based Insurance Design

Example: Oregon Public Employees

- \$100 surcharge + 15% coinsurance for advanced imaging, sleep studies, endoscopies, foot surgeries, more
- \$500 surcharge + 15% for hip/knee replacements, bariatric surgery, spine surgery, more
- Cancer- and emergency-related surgeries exempt

Changes in Utilization of Services Subject to Additional Cost Tier (ACT)

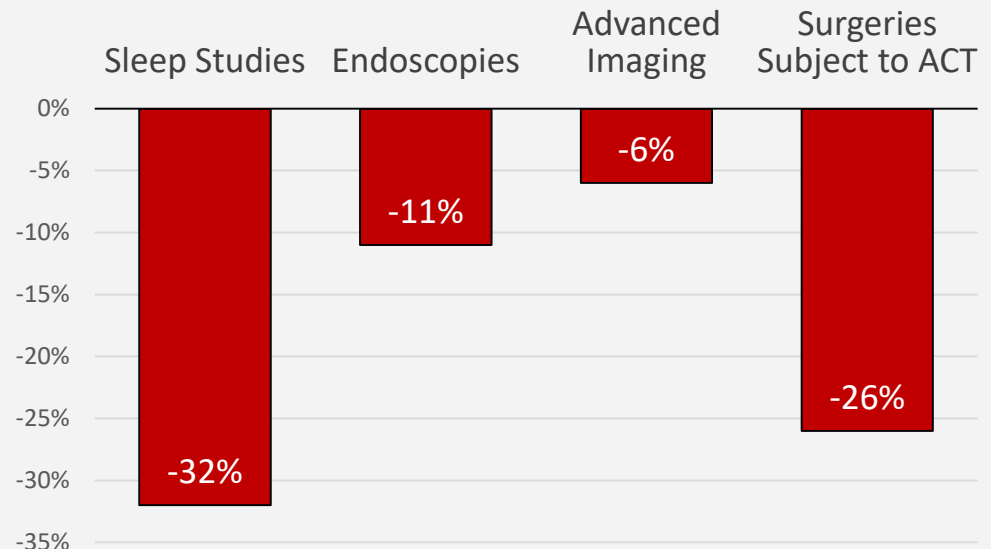


Figure derived from: Gruber J, Maclean JC, Wright BJ, Wilkinson ES, Volpp K. The Impact of Increased Cost-Sharing on Utilization of Low Value Services: Evidence from the State of Oregon. National Bureau of Economic Research; 2016.

Demand: Value-Based Insurance Design

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Demand: Network Design

Description and Advantages

- Narrow and tiered networks can steer members to high-value providers
- Historically, unit price or PMPY spend has been preeminent consideration
- Could favor providers who:
 - Perform well on composite measures of low-value care
 - Use clinical decision support tools
 - Use shared-decision making tools
 - Participate in learning collaboratives

Limitations and Complications

- High performers may still deliver substantial amount of low-value care
- Most effective in impacting **initial** care-seeking decisions
- Regulatory barriers

Demand: Network Design

Example: Covered California Standards for Maternity Care

Covered California expects Contractor [i.e., health plan] to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. Beginning with the application for certification for 2019, as detailed in Article 1.02(3), Contractors must either exclude hospitals from networks serving Enrollees that are unable to achieve an NTSV C-section rate below 23.9 percent from Provider networks or to document each year in its application for certification the rationale for continued contracting with each hospital that has an NTSV C-Section rate above 23.9 percent and efforts the hospital is undertaking to improve its performance.

Demand: Prior Authorization

Description and Advantages

- Require justification for medical necessity of service or medication
- Carriers typically assess requests against written medical policies
- Approval may hinge on patient- and disease-specific characteristics
 - Severity of patient's condition
 - Response to previous treatments tried
- Payment may be denied if authorization not obtained
- Common for advanced imaging, cardiac interventions, lab tests, specialty medications, much more
- Sentinel effect

Demand: Prior Authorization

Limitations and Complications

- Administrative expense and contributor to burnout in practices
 - Ill-will
- Administrative expense for purchasers
 - Not practical for low-cost services
- Varying medical policies across carriers
- Not suitable for emergencies
- Electronic prior authorization still often aspirational

Demand: Prior Authorization

Example: Prior Authorization for Advanced Imaging

- Advanced imaging: harm (CT), high unit cost, high aggregate cost
- Lee and Levy (2012) reported on experience of 47 employer-sponsored plans with prior auth for advanced imaging
- Prior authorization implemented in 2006
- No comparison group, many other changes in environment

	Annual Average Growth in Use	
	2002-2006	2006-2009
CT	20.4%	3.1%
MRI	16.6%	1.1%

Levers

Provider-Facing Levers (Supply)

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