Low-Value Care Task Force:

VBIDHEALTH

LVC-TF #5, March 14, 2019

Visit the Task Force website

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:

SPECIAL COMMUNICATION

ONLINE FIRST

Eliminating Waste in US Health Care

Donald M. Berwick, MD, MPP

Andrew D. Hackbarth, MPhil

NO MATTER HOW POLARIZED politics in the United States have become, nearly everyone agrees that health care costs are unsustainable. At almost 18% of the gross domestic product (GDP) in 2011, headed for 20% by 2020,[1,2] the nation's increasing health care expenditures reduce the resources available for other worthy government programs, erode wages, and undermine the competitiveness of US industry. Although Medicare and Medicaid are often in the limelight, the health care cost problem affects the private sector just as much as the public sector. Both need serious relief.

Obtaining savings directly—by simply lowering payments or paying for fewer 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 Affordable Care Act (ACA), favored by the Obama Administration, to draconian proposed shifts of Medicare costs to beneficiaries and reductions in payments to physicians and hospitals, favored by several Republican congressional proponents.

The ACA, for example, gradually phases in well-warranted decreases in payments to Medicare Advantage plans. Some in Congress have proposed caps on federal Medicare payments (with beneficiaries picking up the difference). Many states, reeling from unprecedented budget deficits, are reducing Medicaid benefits and payments.

Author Video Interview available at www.jama.com.

The need is urgent to bring US health care costs into a sustainable range for both public and private payers. Commonly, programs to contain costs use cuts, such as reductions in payment levels, benefit structures, and eligi- ity. A less harmful strategy would reduce waste, not value-added c opportunity is immense. In just 6 categories of waste—overtre- ures of care coordination, failures in execution of care proc trative complexity, pricing failures, and fraud and abuse—' est available estimates exceeds 20% of total health c actual total may be far greater. The savings potential tematic, comprehensive, and cooperative pursuit o tion in waste are far higher than from more dire and coverage. The potential economic dislocatio require mitigation through careful transition st

JAMA. 2012;307(14):1513-1516
Published online March 14, 2012. doi:10.1001/jama.2012.362

The cost reductions in the ACA are necessary and prudent, but if other initiatives to cut spending are taken too far or too fast, they become risky. Vulnerable Medicaid beneficiaries and seniors covered by Medicare with marginal incomes may find important care services out of reach, either because they cannot afford the new cost-sharing, because clinicians and hospitals have withdrawn from local markets, or both.

Reducing Waste in Health Care Spending

Here is a better idea: cut waste. That is a basic strategy for survival in most industries today, ie, to keep processes, products, and services that actually help customers and systematically remove the elements of work that do not.

The opportunity for waste reduction in health care is enormous. The literature in this area identifies many potential sources of waste and provides a broad range of estimates of the magnitude of excess spending.[3-8] Six categories, at least, seem l exhau mates of thes and Me

1. Fa waste tha lack of wi best care p ample, patie ventive care p shown to be effec tient injuries and comes. Better care can estimate that this catego between $102 billion and $ in wasteful spending in 2011.[4,1]
2. **Failures of Care Coordination.** the waste that comes when patients fall through the slats in fragmented care.

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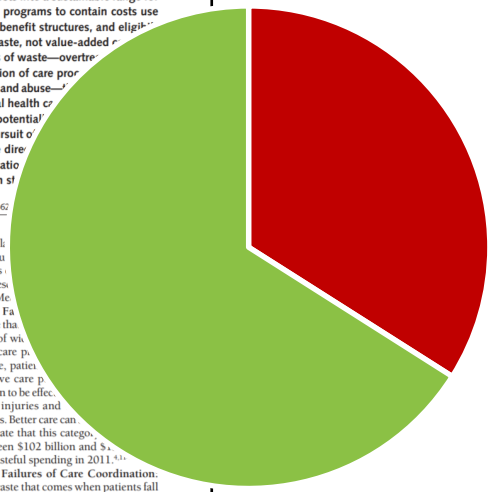


34% of spend wasted

2017 Physician Survey:

PLOS ONE

Overtreatment in the United States

Abstract

Background

Methods

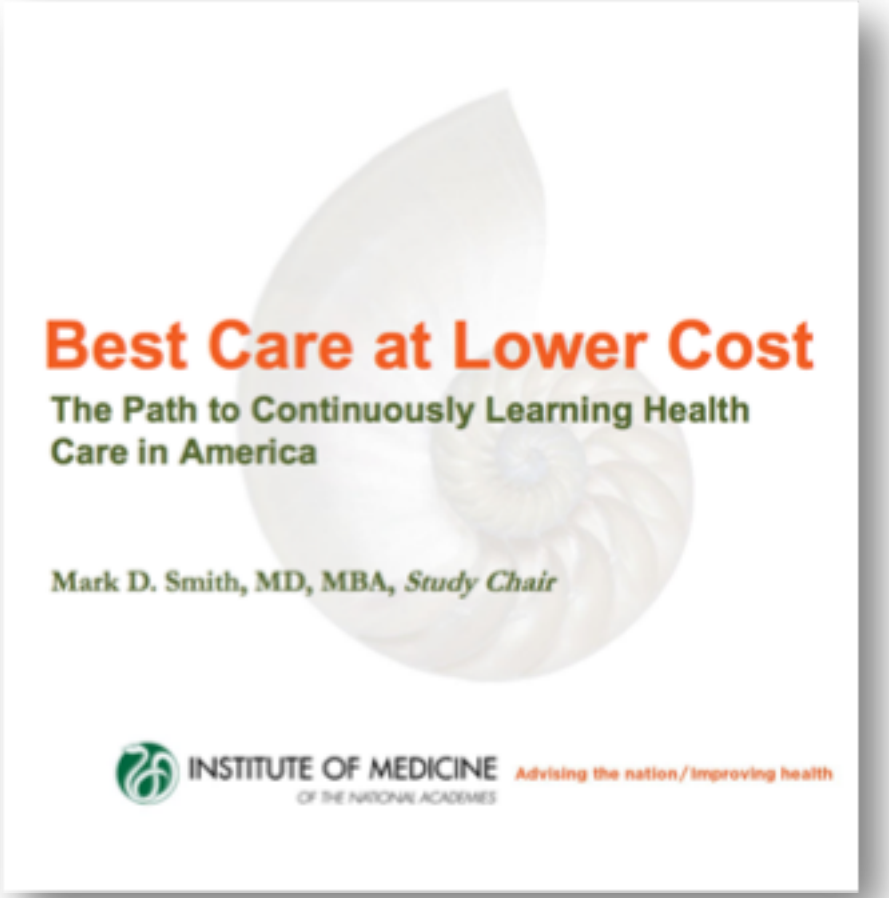
Findings

Conclusion

21% of care unneeded

Background: Why low-value care?

Why address low-value care?



- 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 high-value care
  - The savings are immediate + substantial
- And an ethical imperative
  - Patient harm

Why low-value care?

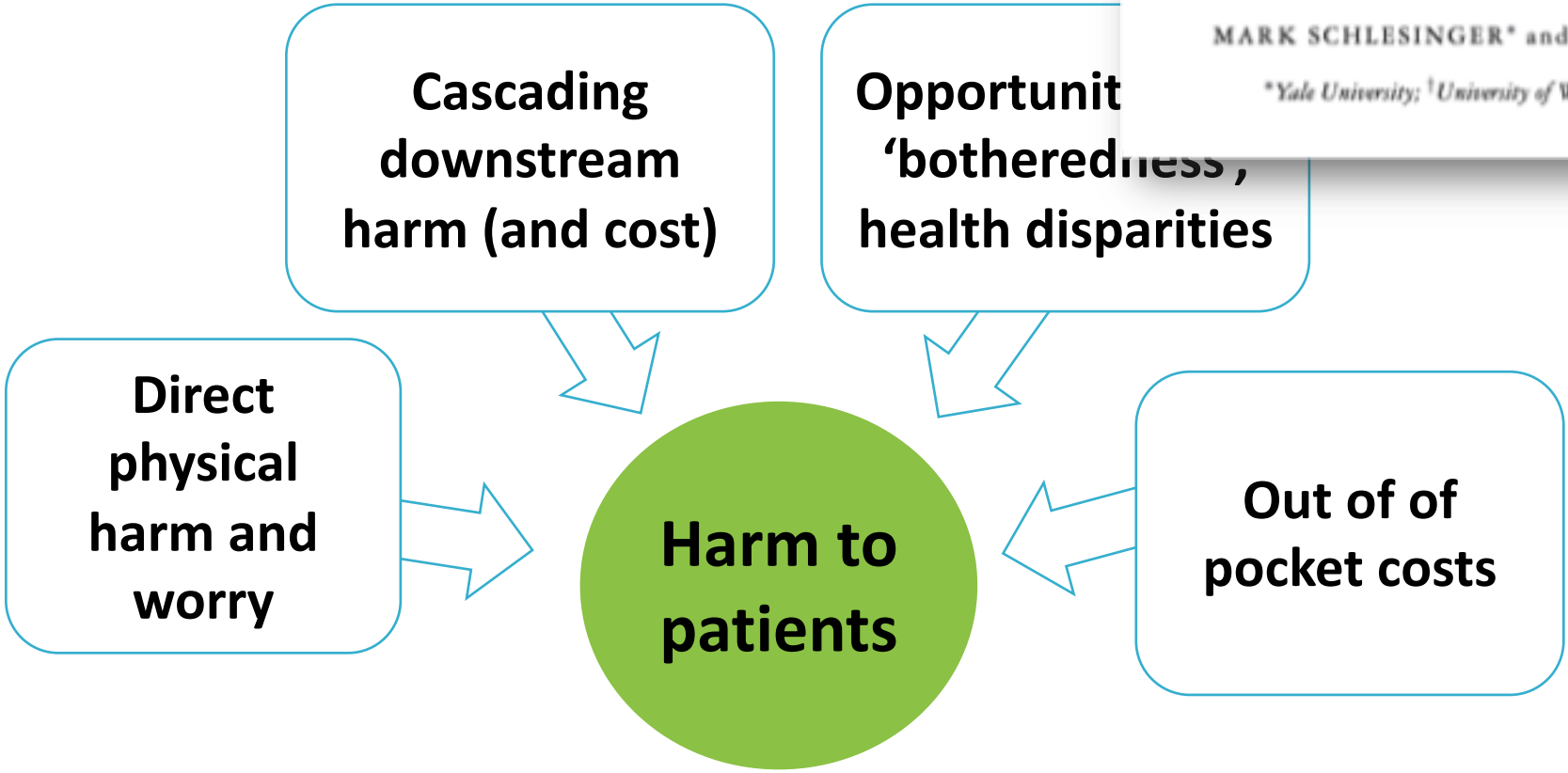

THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

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)



Background: Identify

Why a Task Force

As of September 2018, there are over 550 Choosing Wisely Recommendations

Minimal progress from information-only

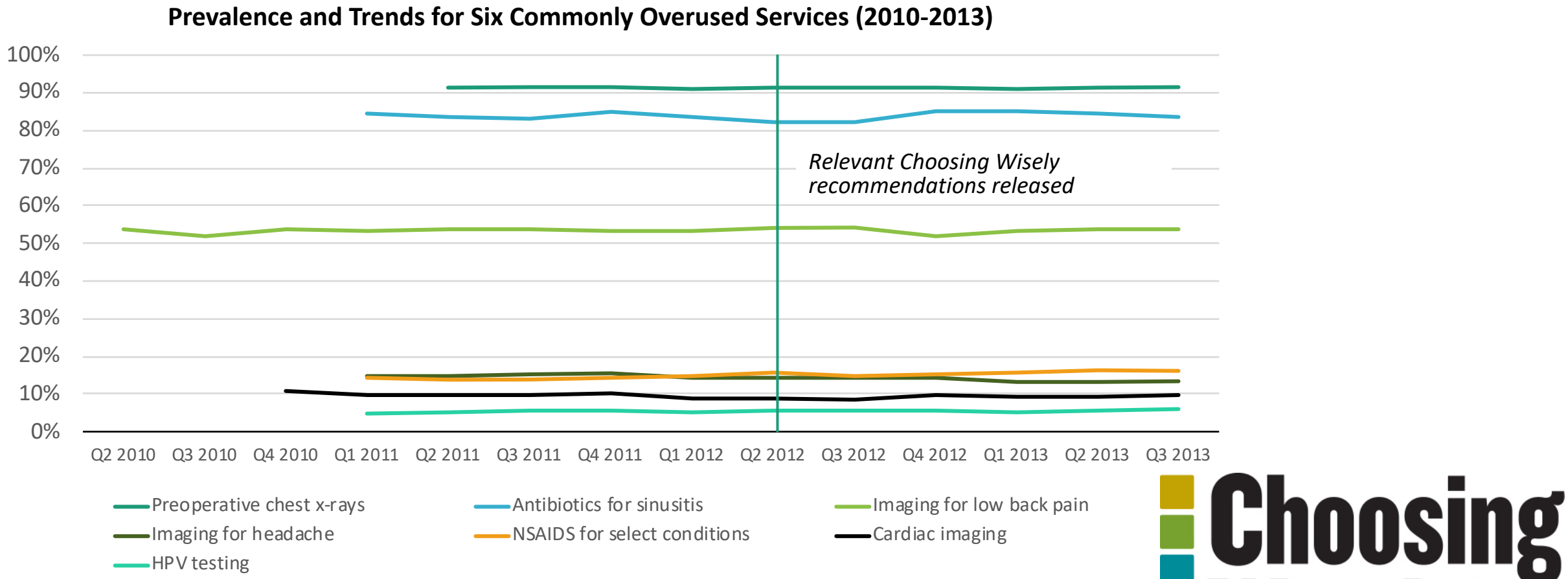


Figure derived from: Rosenberg A, Agiro A, Gottlieb M, et al. Early Trends Among Seven Recommendations from the Choosing Wisely Campaign. *JAMA Intern Med*. 2015;175(12):1913-1920.

Choosing Wisely®

An initiative of the ABIM Foundation

Building a Top Five List

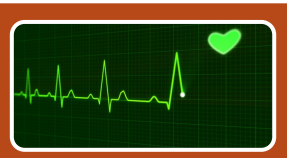
Key Criteria

Unit Price	Volume	Aggregate Cost
Harm	Political Sensitivity	High Waste Index

Fruit below the ground

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

Background: Identify

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.

BURDEN

Nationwide in 2014:

- 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

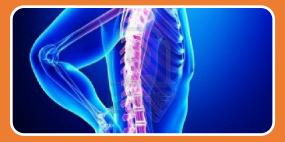
- Over-diagnosis associated with serious harm
- Harms of screening in men 75+ unambiguously outweigh benefit

BURDEN

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

BURDEN

Nationwide in 2014:

- 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 Health Waste Calculator
- Altarum PROMETHEUS Analytics
- 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 (July 2016 – June 2017)			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

Background: Measure

Low-value care levers

Background: Levers to reduce

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.

HealthAffairs

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…

Provider-facing information, eg CDS

Patient-facing incentives, eg VBID

Provider-facing information alone

AJMC

Editorial: “Levers to Reduce Use of Unnecessary Services: Creating Needed Headroom to Enhance Spending on Evidence-Based Care”

Background: Levers to reduce

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

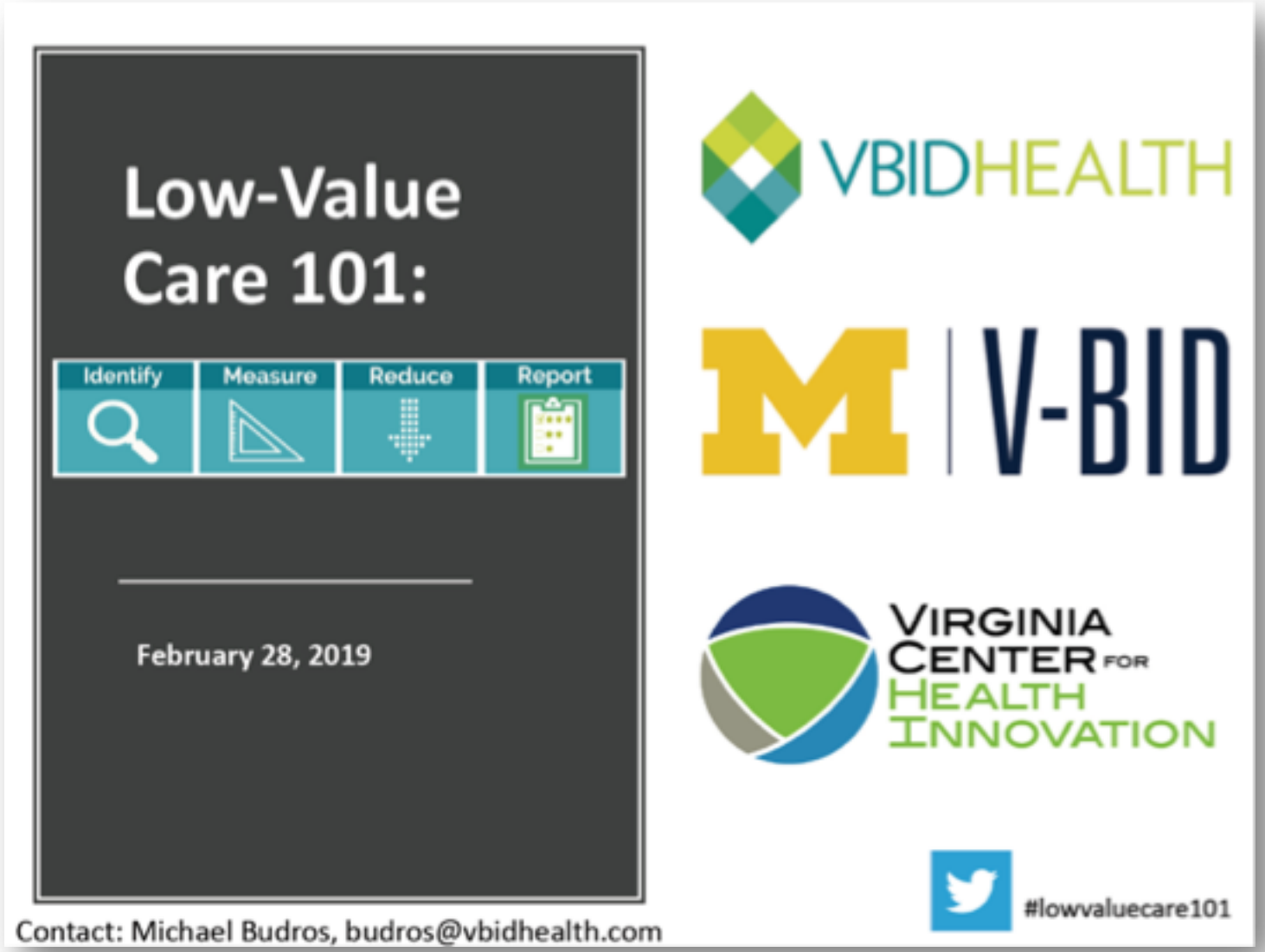
Other Low-Value Care Activities and Resources

Resources: Low-Value Care Toolkits

Low-Value Care Toolkits cover a wide scope of resources

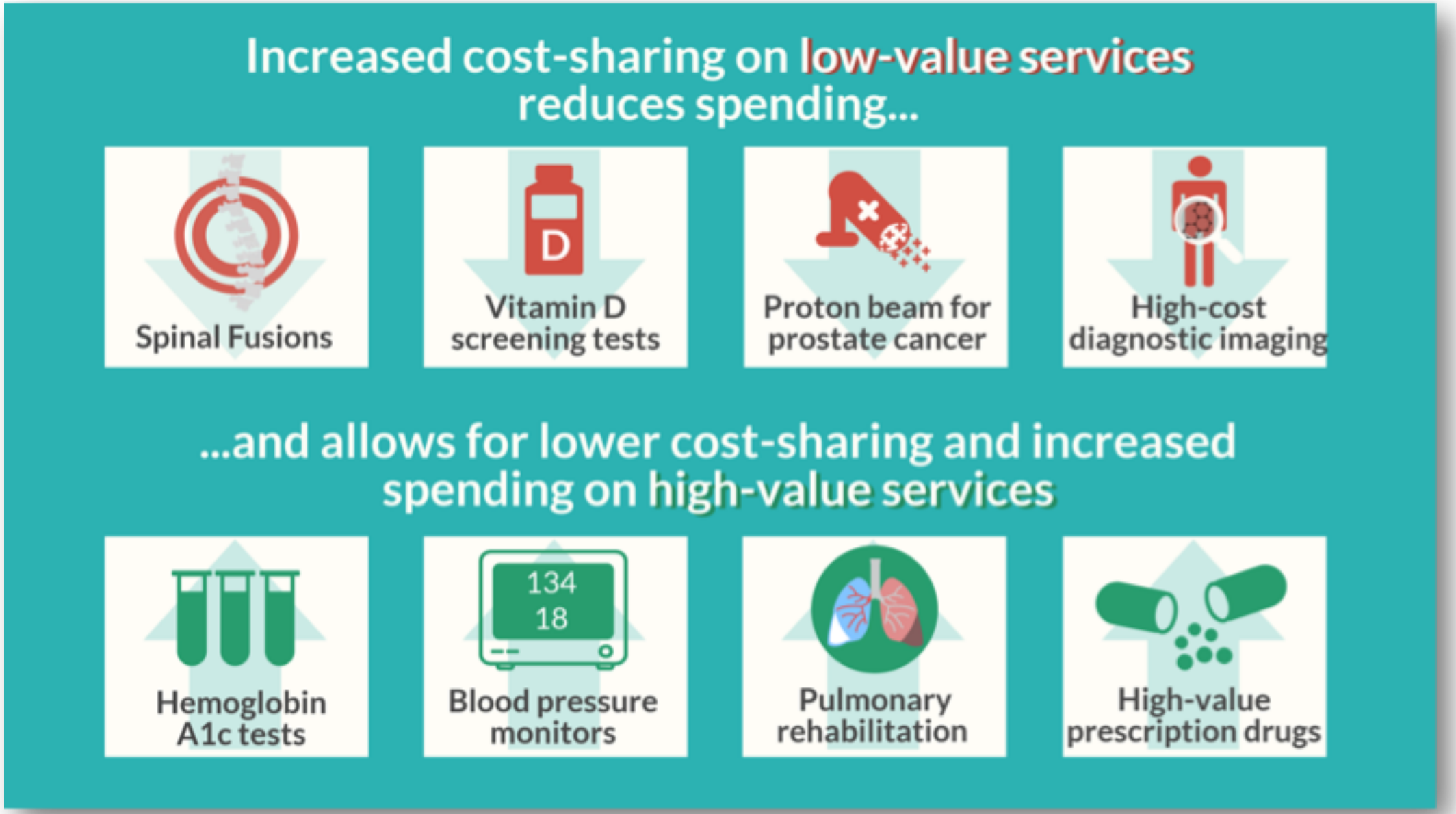
- **Organized background information and resources**
  - LVC white paper,
  - LVC infographic,
  - LVC one pager,
  - References to other resources (eg, IHA and WHA/drop the pre-op)
- **New business case templates**
  - Template with background and headers for any service
  - Template example with low 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

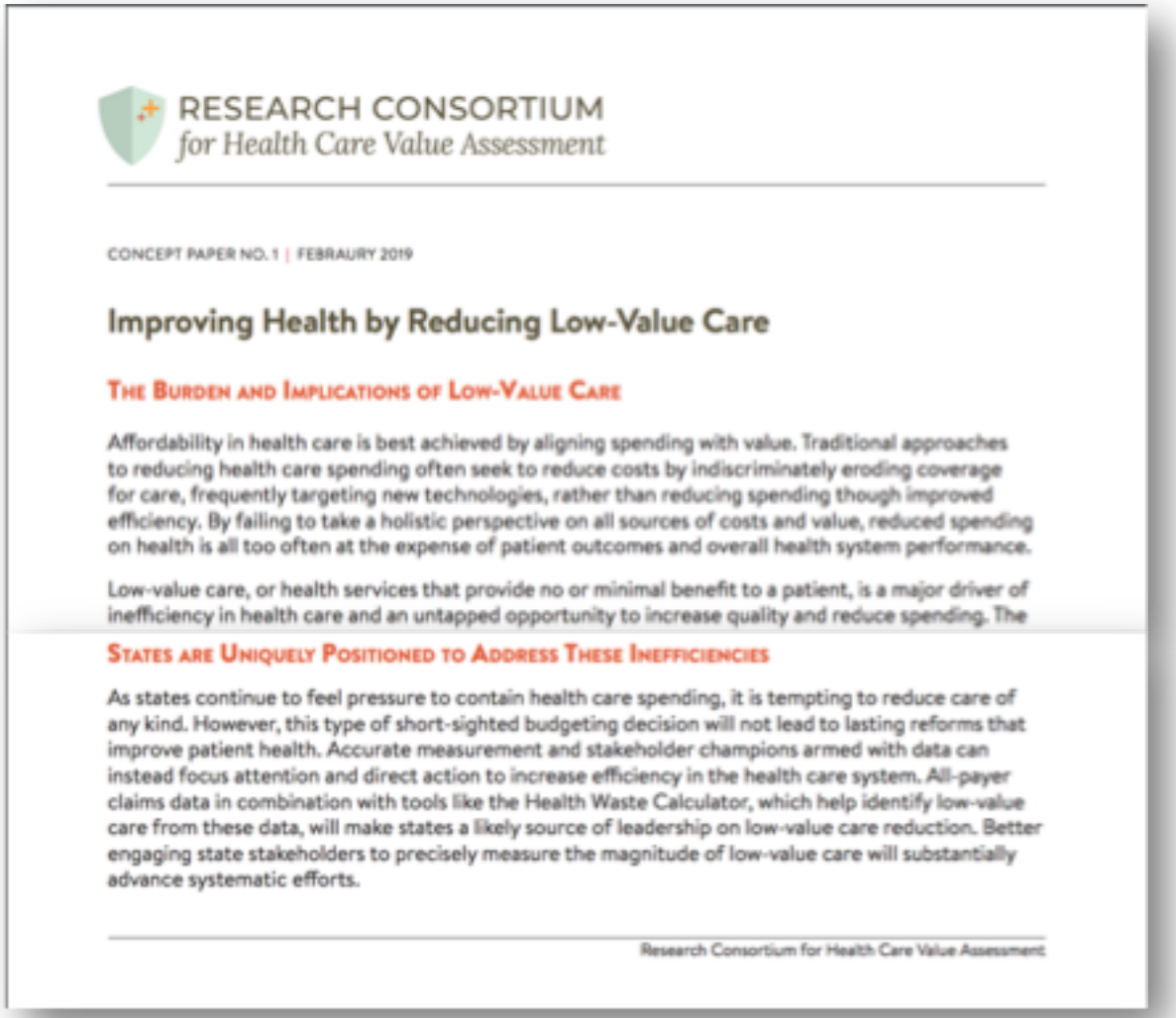


- Mark Fendrick + Beth Bortz
- What is LVC and IMRR
- Opportunity for state engagement in LVC specifically
- 378 registrants, 203 unique visitors
- http://vbidcenter.org/lvc-101-webinar/

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



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



RESEARCH CONSORTIUM
for Health Care Value Assessment

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.

Find the paper on the Value Consortium website.

Low-value Care in the News

MEASURE.

Health services research
Research

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

Kelsey Chalmers[1,2], Sallie-Anne Pearson[3], Tim Badgery-Parker[1,2], Jonathan Brett[3], Ian A Scott[4,5], Adam G Elshaug[1]

Author affiliations +

BMJ Open

Low-value Care in the News

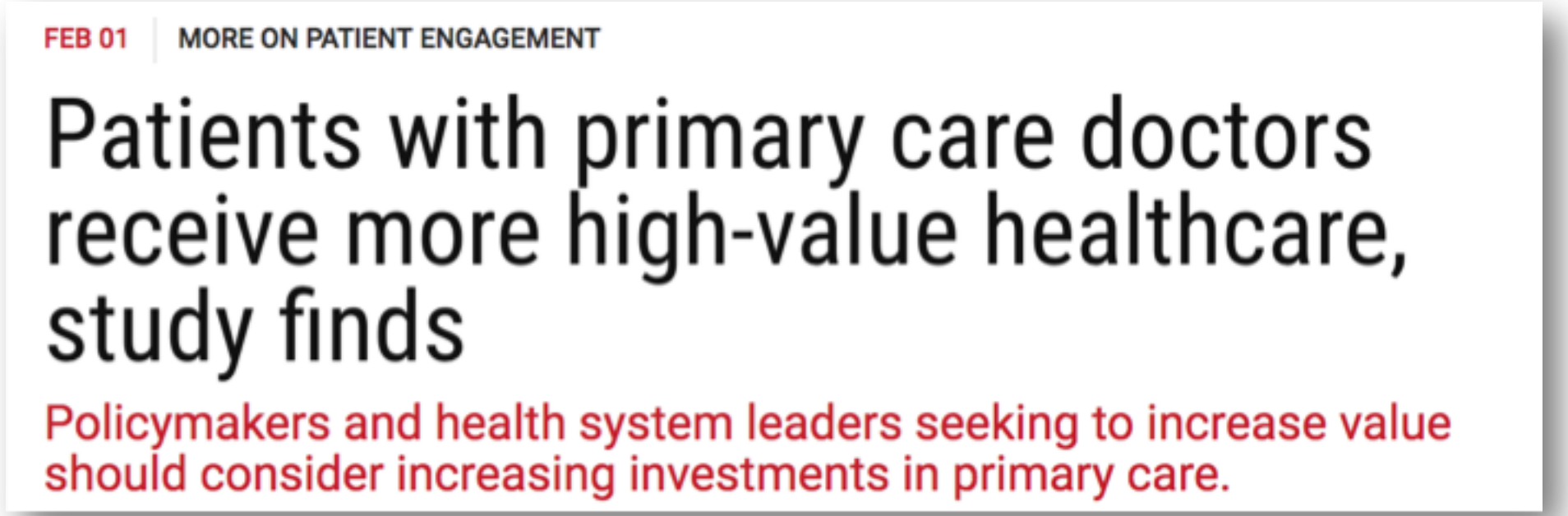
REDUCE.

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

KRIS B. MAMULA
Pittsburgh Post-Gazette
kmamula@post-gazette.com

APR 13, 2018 | 9:27 AM

Low-value Care in the News




REPORT.