Creating 'Headroom" to Pay for High-Value Services: Using Value-Based Insurance Design to Reduce No-Value Care

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Creating ‘Headroom” to Pay for High-Value Care
Identifying /Removing Unnecessary Services

- **Clinical services to prevent and treat disease have led to impressive reductions in morbidity and mortality**

- **Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation**

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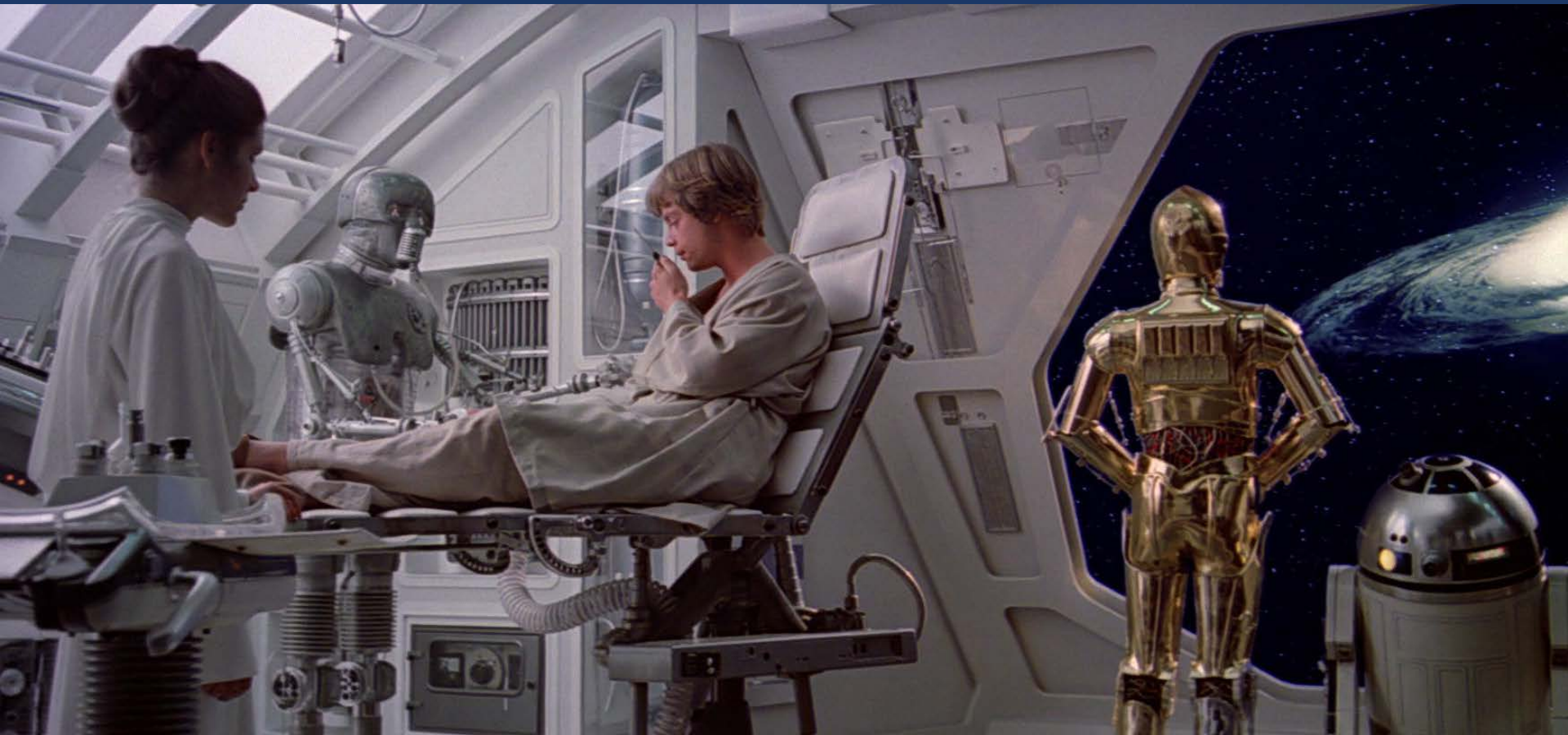
Star Wars Science



Flintstones Delivery

Creating ‘Headroom” to Pay for High-Value Care
Identifying /Removing Unnecessary Services

- V-BID programs that reduce financial barriers “carrots” increase the use of high value services with little or no associated increase in total health care expenditures
- Lowering medical spending is the main focus of reform discussions
- Blunt cost sharing strategies lower expenditures, but reduce the use of high and low value services, and also worsen health care disparities
- To reduce spending and minimize harm, discouraging the use of specific no-value services “sticks” must be part of the strategy

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Creating ‘Headroom” to Pay for High-Value Care
Identifying /Removing Unnecessary Services

- Estimates of unnecessary care up to 30% of total spend
- Unlike delay for cost offsets from improved quality, savings from waste elimination are immediate and substantial
- Identification, measurement, and removal of unnecessary care has proven challenging

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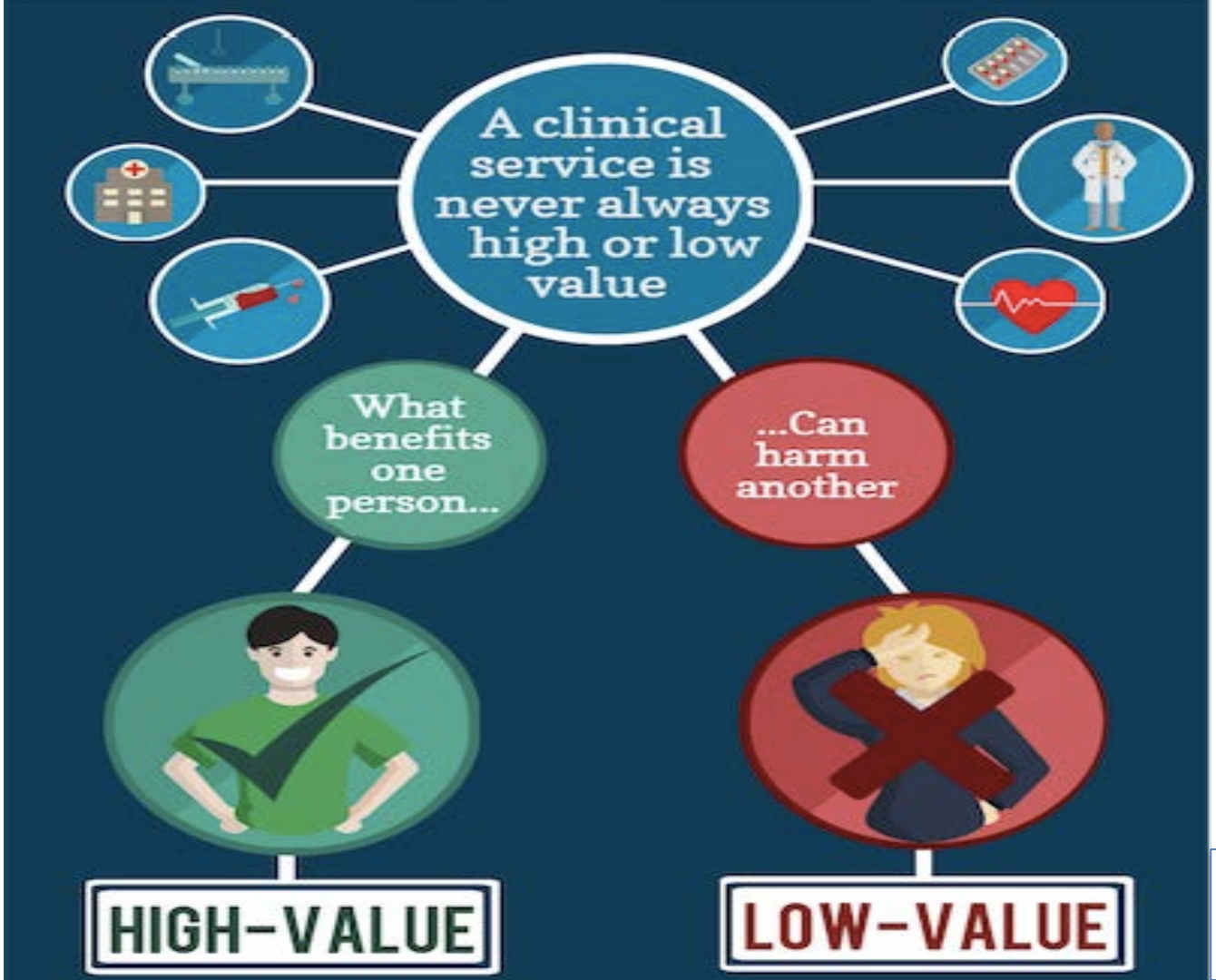
A clinical service is never always high or low value
What benefits one person...
...Can harm another
HIGH-VALUE
LOW-VALUE

ACA Sec 4105:
Selected No-Value Preventive Services Shall Not Be Paid For

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 not pay for USPSTF 'D' Rated Services

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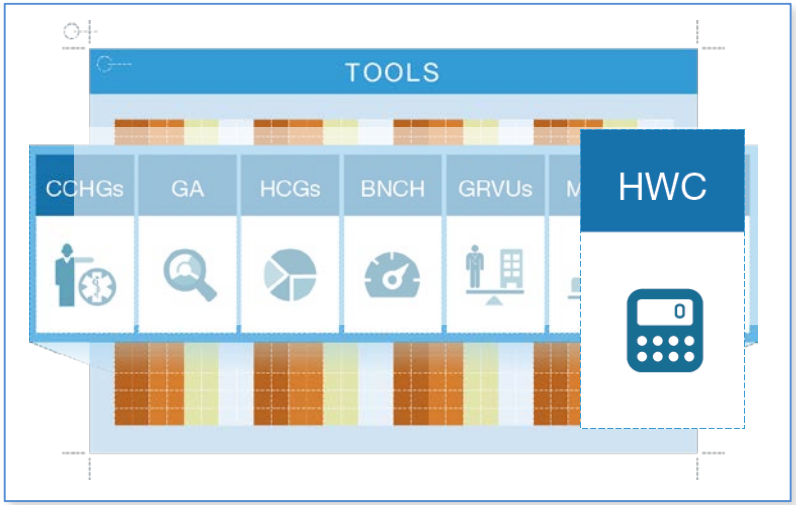
Identifying and Removing Unnecessary Care: Milliman Health Waste Calculator

- Collaboration between Milliman and V-BIDHealth
- Measures potentially unnecessary services
- Analyze cost savings potential
- Generate actionable reports and summaries

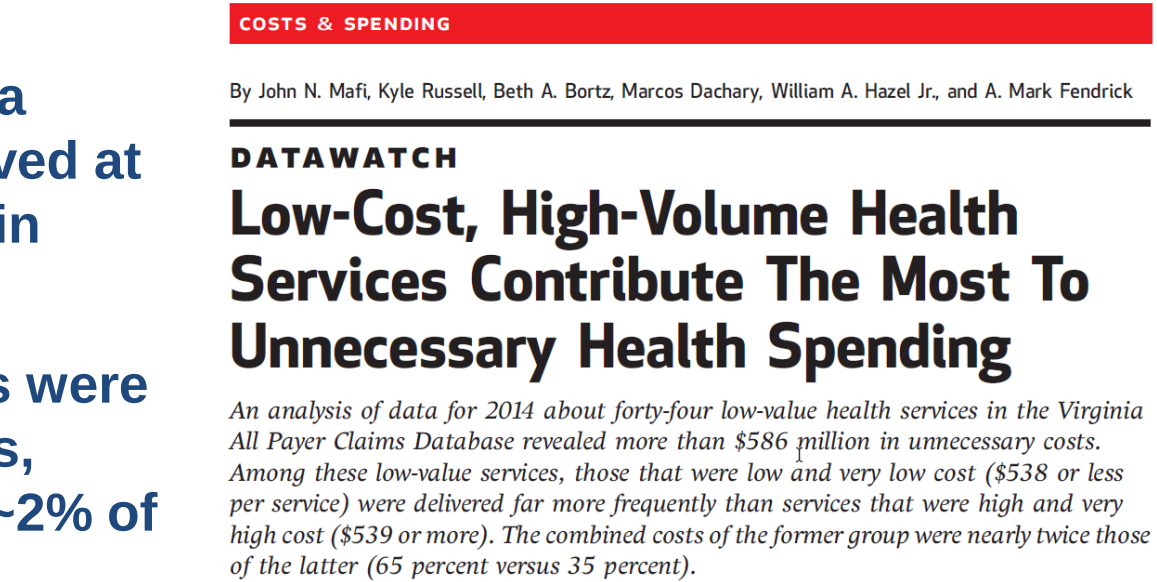


Milliman
MedInsight

VBIDHEALTH

Milliman Health Waste Calculator
Commonwealth of Virginia Unnecessary Care Initiative

- **Among 5.5 million Virginia beneficiaries, 1 in 5 received at least 1 low-value service in 2014**
- **The 44 low-value services were delivered 1.7 million times, which cost $586 million (~2% of healthcare spend)**



COSTS & SPENDING

By John N. Mafi, Kyle Russell, Beth A. Bortz, Marcos Dachary, William A. Hazel Jr., and A. Mark Fendrick

DATAWATCH

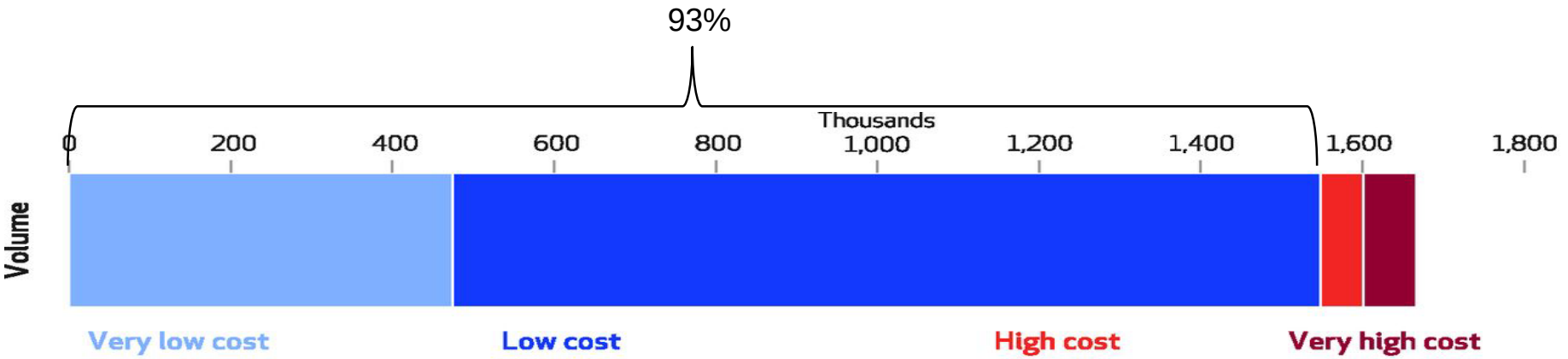
Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending

An analysis of data for 2014 about forty-four low-value health services in the Virginia All Payer Claims Database revealed more than $586 million in unnecessary costs. Among these low-value services, those that were low and very low cost ($538 or less per service) were delivered far more frequently than services that were high and very high cost ($539 or more). The combined costs of the former group were nearly twice those of the latter (65 percent versus 35 percent).

Milliman MedInsight

VBIDHEALTH

Over 90% of Low-value Services used in Virginia were “Little Ticket Items”



Blue colors signify low-cost (<$550) services

Mafi et al. Health Aff 2017;36:1701-1704

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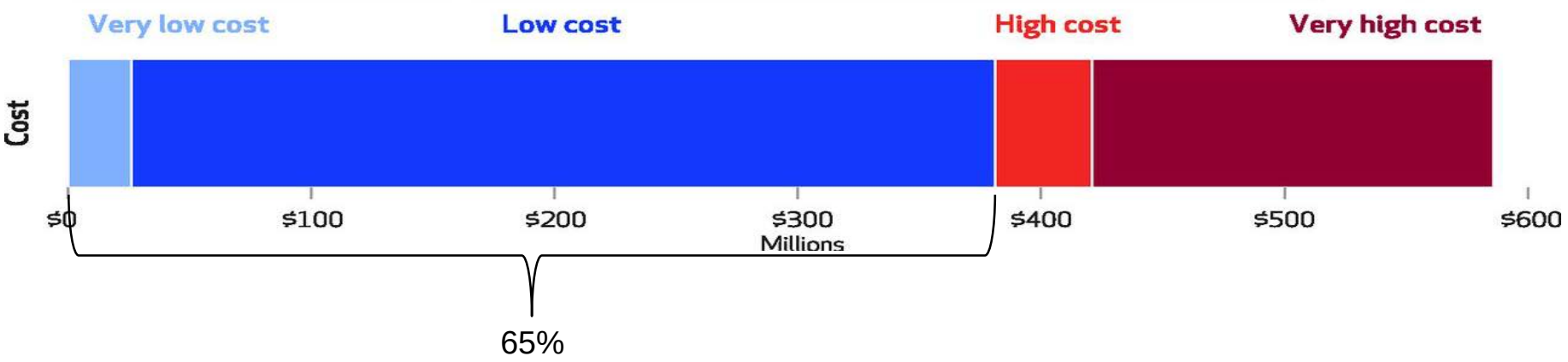
Nearly Two-Thirds of Expenditures on Low-Value Services in Virginia were on “Little Ticket Items”



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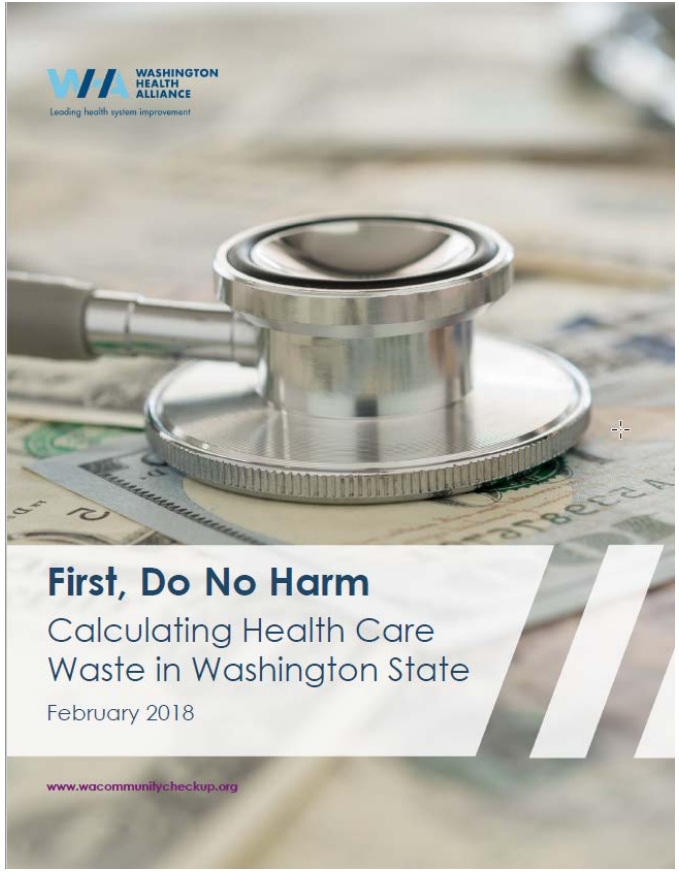
Community Coalition Reporting – State of Washington Health Alliance



- Approximately 1.3 MM individuals received one of the 47 services, and almost half (47.9%) of them received at least one wasteful service.
- An estimated $282 MM in wasteful spending
- This is surprising, given that Washington State leads the nation in providing integrated, high-value care in largely capitated payment systems

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Reducing Low Value Care: Where to Start?

- Although much of the low-value care discussion has focused on high-cost services, low-cost items are less likely to draw attention by particular clinicians or patient advocacy groups
- Choose services:
  - Easily identified in administrative systems
  - Mostly low value (little or no clinical nuance)
  - Reduction in their use would be barely noticed

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Multi-Stakeholder Task Force on Low Value Care: 5 Commonly Overused Services Ready for 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

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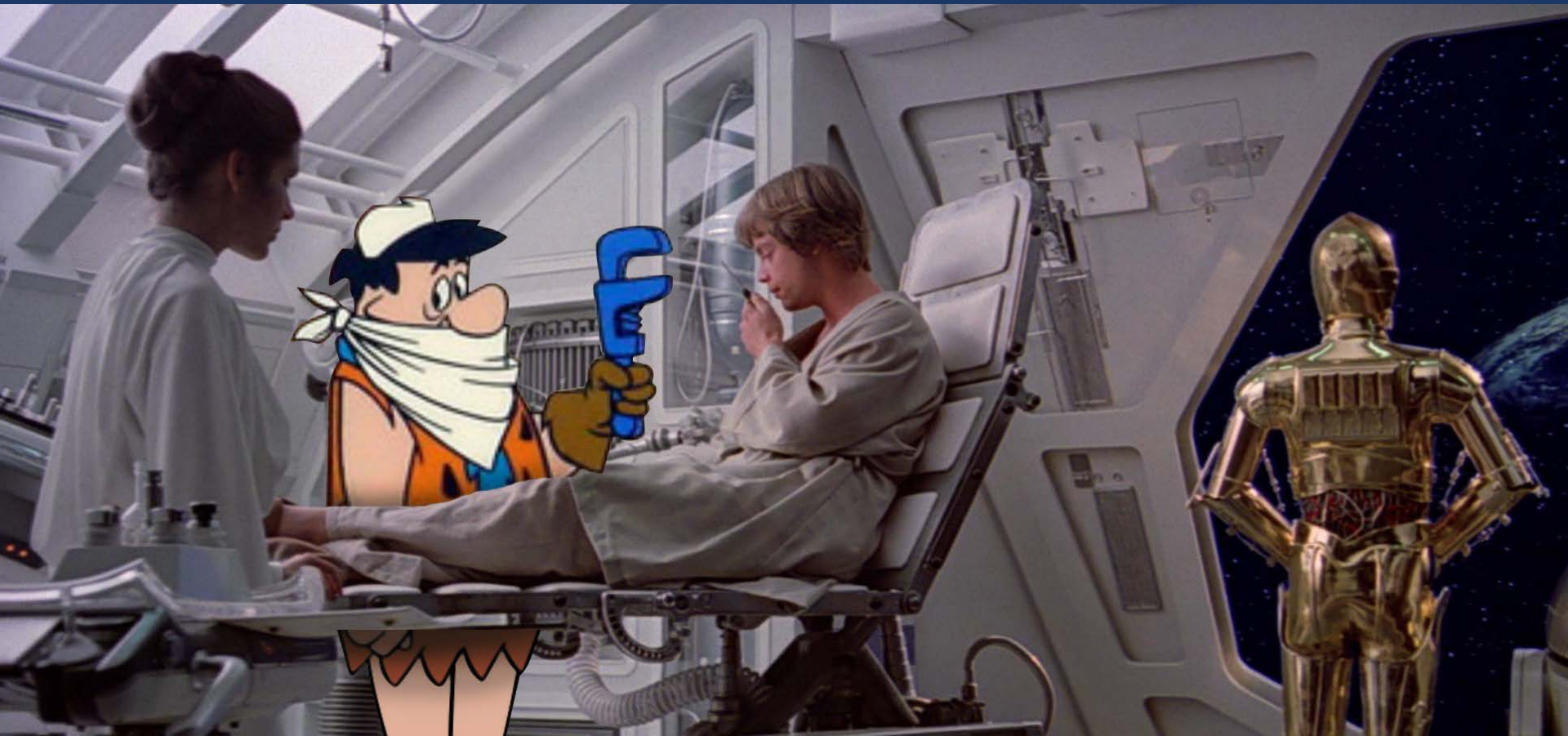
Moving from the Stone Age to the Space Age: Removing Unnecessary Services to Pay for High-Value Care



“If we don’t succeed then we will fail.”

Dan Quayle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Dan Quayle