Low-Value Care 101:

February 28, 2019

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VIRGINIA CENTER FOR HEALTH INNOVATION

#lowvaluecare101

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Dr. Mark Fendrick

Director

Beth A. Bortz

President and CEO

Agenda

- Welcome
- Background on low-value care
- Creating ‘headroom’ through low-value care
- Virginia’s steps to improve health care value
- Q&A

What is low-value care?

- Some distinction between different definitions of “overuse” and “waste”
- Often used interchangeably
- “Waste” in general typically captures other inefficiencies
  - administrative (eg, system complexity)
  - operating waste (eg, duplicative services)
- Our focus: clinical waste

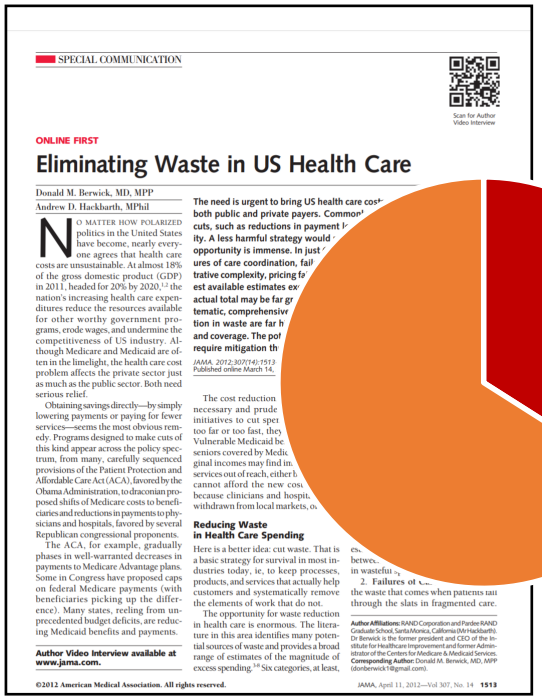
What is low-value care?

Clinical waste

- 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 waste?

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 cost-
both public and private payers. Common
cuts, such as reductions in payment l
ity. A less harmful strategy would
opportunity is immense. In just
ures of care coordination, fail
trative complexity, pricing fo
est available estimates ex
actual total may be far gr
tematic, comprehensiv
tion in waste are far h
and coverage. The pot
require mitigation th

JAMA. 2012;307(14):1513.
Published online March 14,

The cost reduction necessary and prude initiatives to cut spet too far or too fast, they Vulnerable Medicaid be seniors covered by Medic ginal incomes may find in services out of reach, either b cannot afford the new cos because clinicians and hospit withdrawn from local markets, o

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.[3-6] Six categories, at least,

2. Failures of c
the waste that comes when patients fall through the slats in fragmented care.

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

34% of spend wasted

2017 Physician Survey:

PLOS ONE

RESEARCH ARTICLE

Overtreatment in the United States

Heather Lyu[1]*, Tim Xu[2], Daniel Brotman[3], Brandan Mayer-Blackwell[2], Michol Cooper[2], Michael Daniel[2], Elizabeth C. Wick[2], Vikas Saini[3], Shannon Brownlee[3], Martin A. Makary[2,4]

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Check for updates

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Citation: Lyu H, Xu T, Brotman D, Mayer-Blackwell B, Cooper M, Daniel M, et al. (2017) Overtreatment in the United States. PLoS ONE 12(9): e0181970. https://doi.org/10.1371/journal.pone.018...

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Data Availability Statement: All of our data is owned by a third party. The authors had no special access privileges to the data. The third party is QuantiaMD and their contact information is info@quantiamd.com or +1.800.773.4162.

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Competing interests: The authors have declared that no competing interests exist.

Abstract

Backgr...nd

Overtrea... ...nt ... cause of ...reve...tab... about c...n per pe... ...n the ... prevalence, causes, and implications

Methods

... ...ysi... is fr... m... ...r in... ...r... ca... ...ssociation (AMA) masterfile par... extent of overutilization, as well as ca... outcome measures included: percent... cited reasons of overtreatment, potent... profit and overtreatment.

Findings

The response rate was 70.1%. Physicians re... overall medical care was unnecessary, includin... tests, and 11.1% of procedures. The most comm... of malpractice (84.7%), patient pressure/request (59... records (38.2%). Potential solutions identified were train... teria (55.2%), easy access to outside health records (52.0%)... (51.5%). Most respondents (70.8%) believed that physicians are n... essary procedures when they profit from them. Most respondents believe... ing fee-for-service physician compensation would reduce health care utilization and...

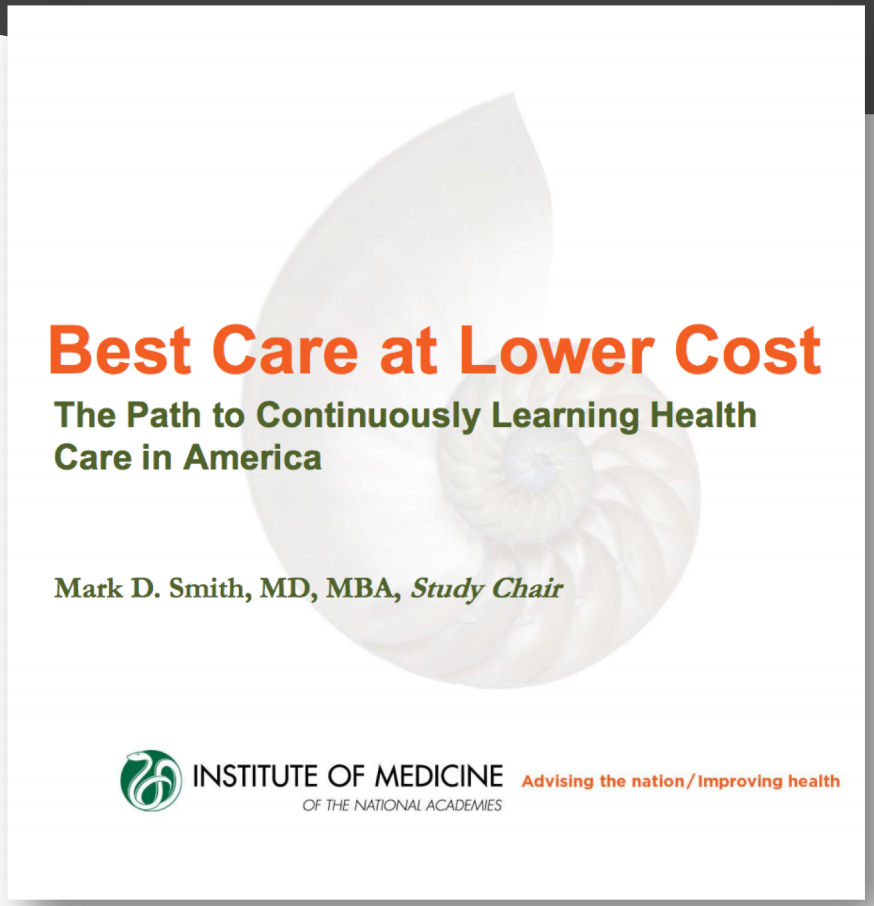
Conclusion

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

PLOS ONE | https://doi.org/10.1371/journal.pone.0181970 September 6, 2017 1 / 11 Save

21% of care unneeded

Why low-value care?



- National Academy of Medicine study found that low-value care costs the US system $765 billion in 2013.
- Bottom line: care that provides little to not benefit is pervasive and costly.
- And most estimates of spending are conservative: they do not track the cascading downstream 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)

Cascading downstream harm (and cost)

Opportunity cost, 'botheredness', health disparities

Direct physical harm and worry

Harm to patients

Out of of pocket costs

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

- 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.

What can be done?

We will discuss efforts to:

- **Identify** low-value care services most appropriate for systematic action
- **Measure** the utilization, spending, and waste-index
- **Reduce** spending and use of low-value care services through multi-stakeholder collaborations
- And **report** those findings to continue the momentum

Reducing Low Value Care to Create "Headroom" for Better Coverage of High Value Services

A. Mark Fendrick, MD

University of Michigan Center for Value-Based Insurance Design

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Health Care Spending:
Change the discussion from "How much" to "How well"

- Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality
- Irrespective of clinical advances, cutting spending is the main focus of health care reform discussions
- Underutilization of high-value care persists across the entire spectrum of clinical care
- There is more than enough money in the system; we just spend it on the wrong services
- Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation

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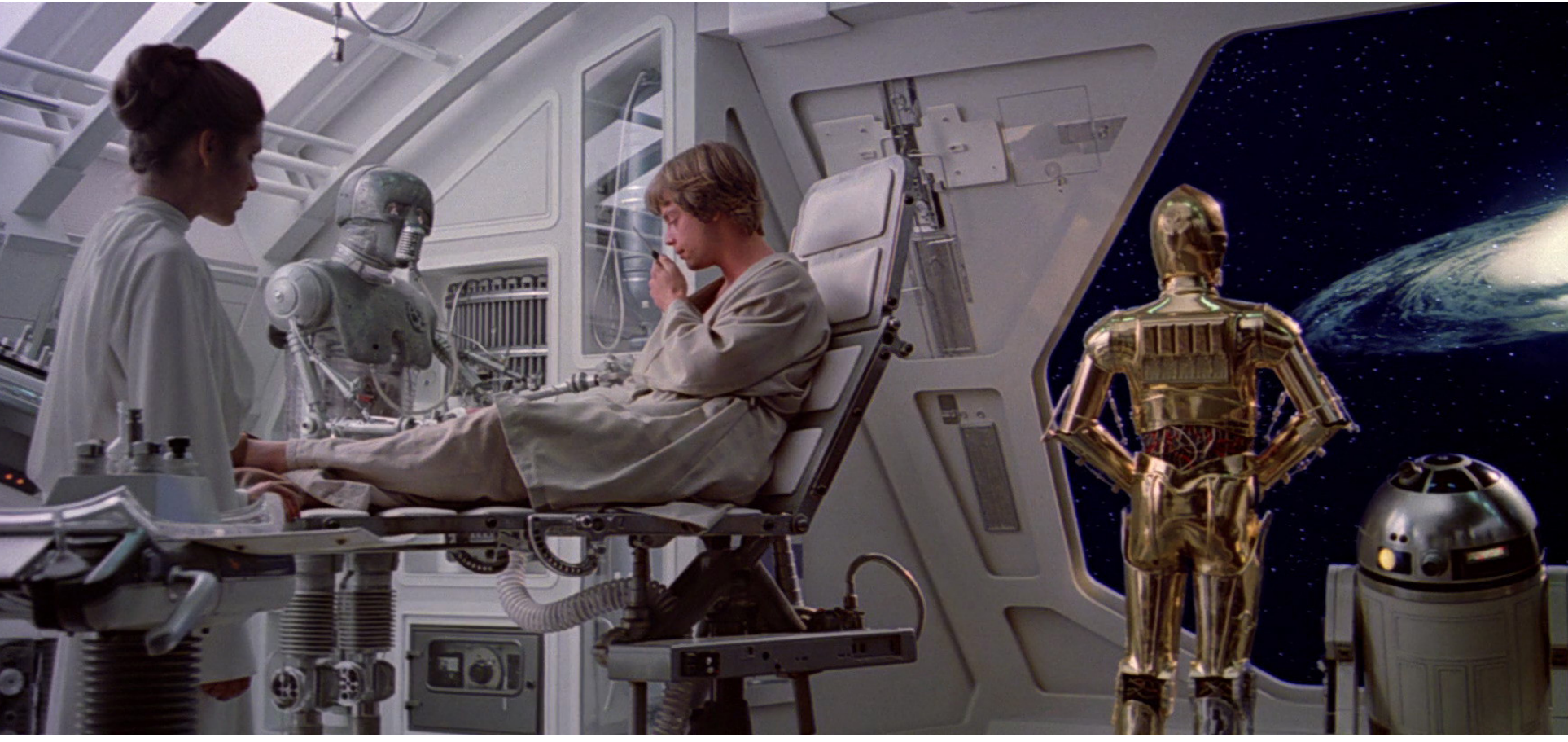
Star Wars Science



Flintstones Delivery

Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

Patient Worry About Out-of-Pocket Healthcare Costs at All-Time High

A report from the Commonwealth Fund noted that patients are not confident they can afford high out-of-pocket healthcare costs.

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Value-Based Insurance Design (V-BID): Sets consumer cost-sharing on clinical benefit – not price

- **Little or no out-of-pocket cost for high value care; high cost sharing for low value care**
- **Successfully implemented by hundreds of public and private payers**
- **Bipartisan political support**

The Upshot

Health Plans That Nudge Patients to Do the Right Thing

Austin Frakt
THE NEW HEALTH CARE JULY 10, 2017

RELATED COVERAGE

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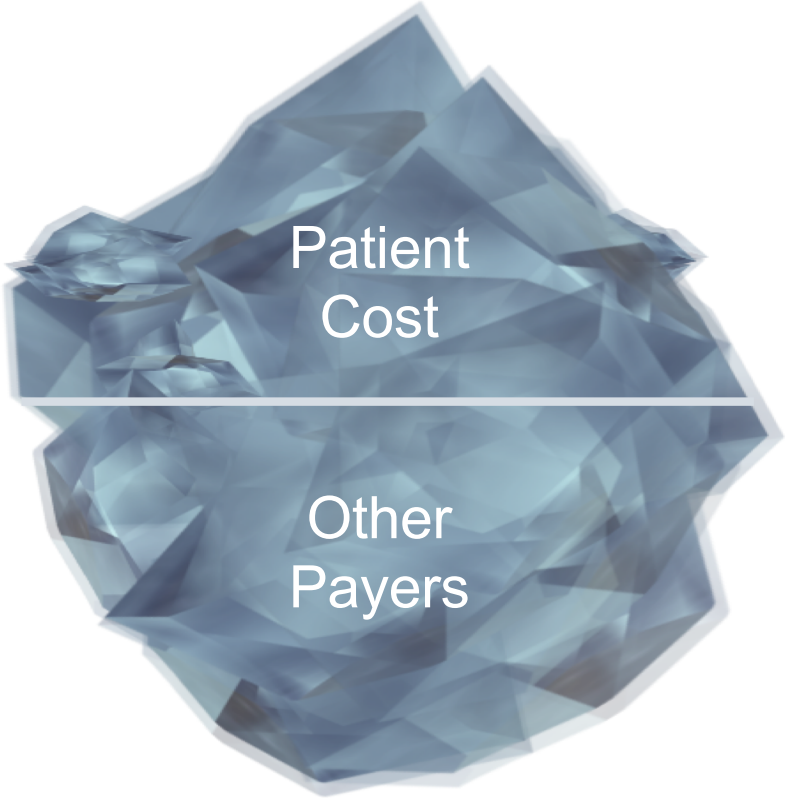
Motivation for Low Value Care Removal: The Health Care Iceberg

Health care is typically paid in two portions



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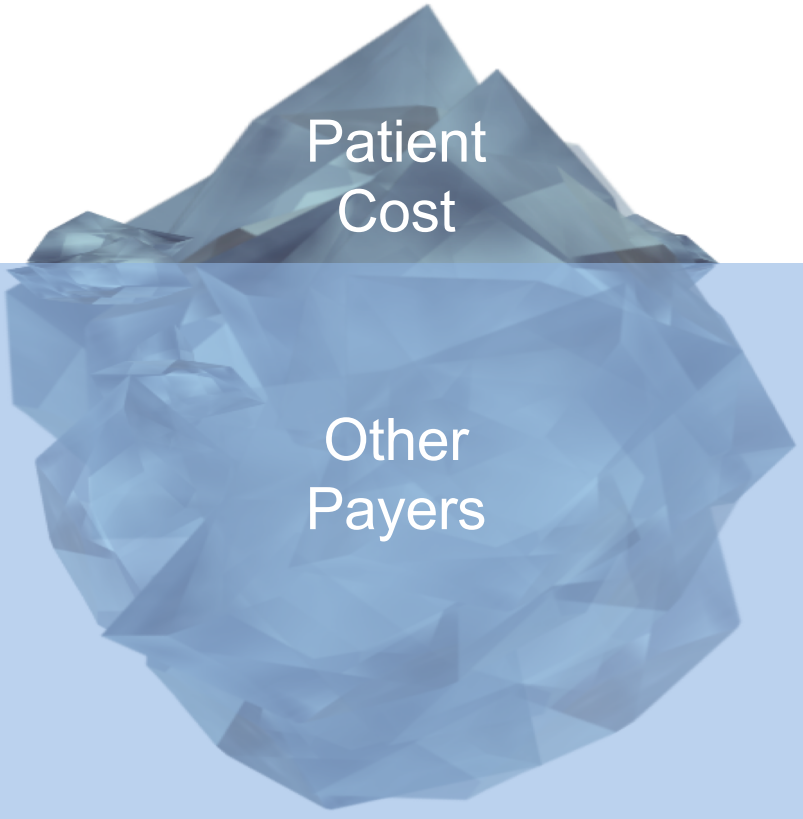
The amount a consumer pays for care is determined by their insurance coverage



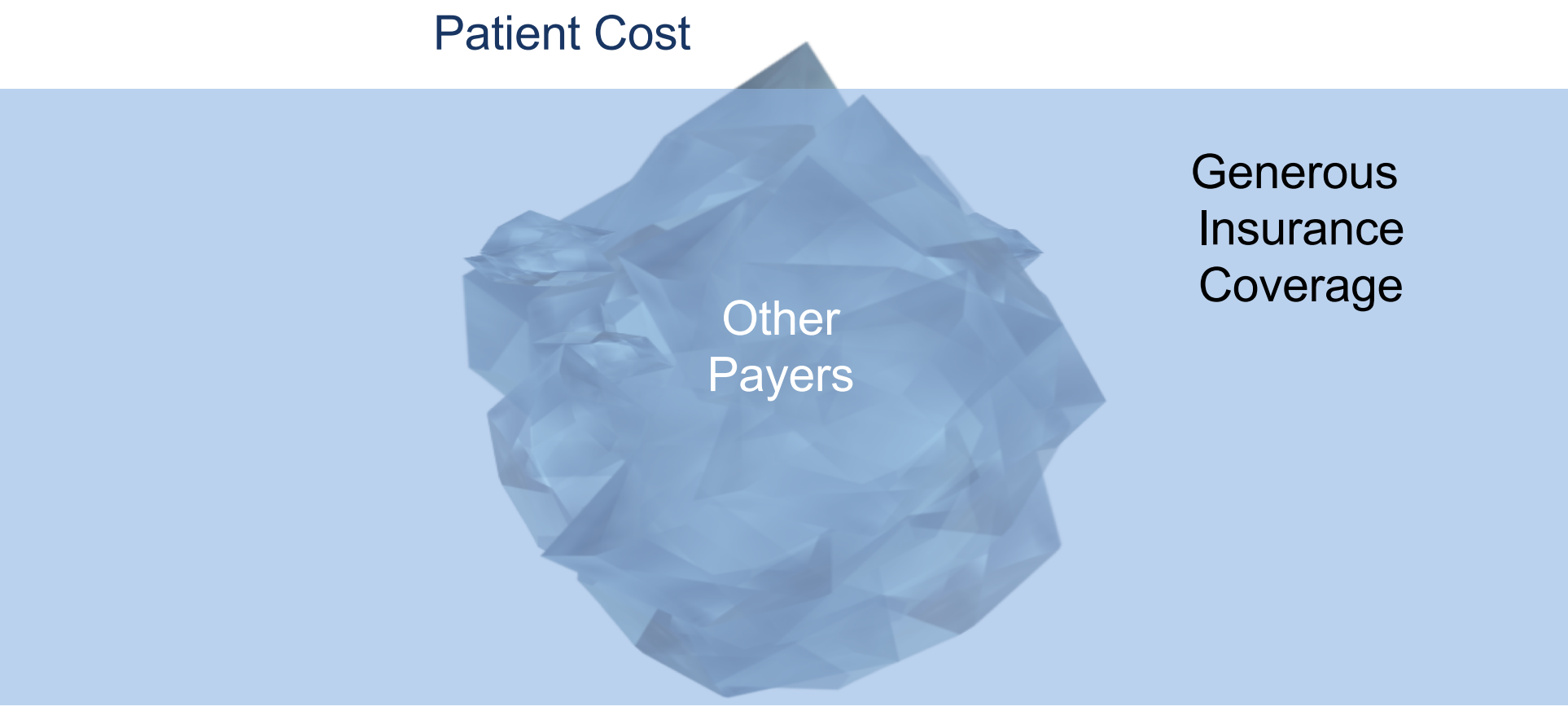
Insurance
Coverage

If coverage is not generous; patients pay the entire price

This scenario is typical for individuals who are enrolled in a health plan that includes a deductible

Skimpy Insurance Coverage

V-BID increases generosity of coverage for high value services



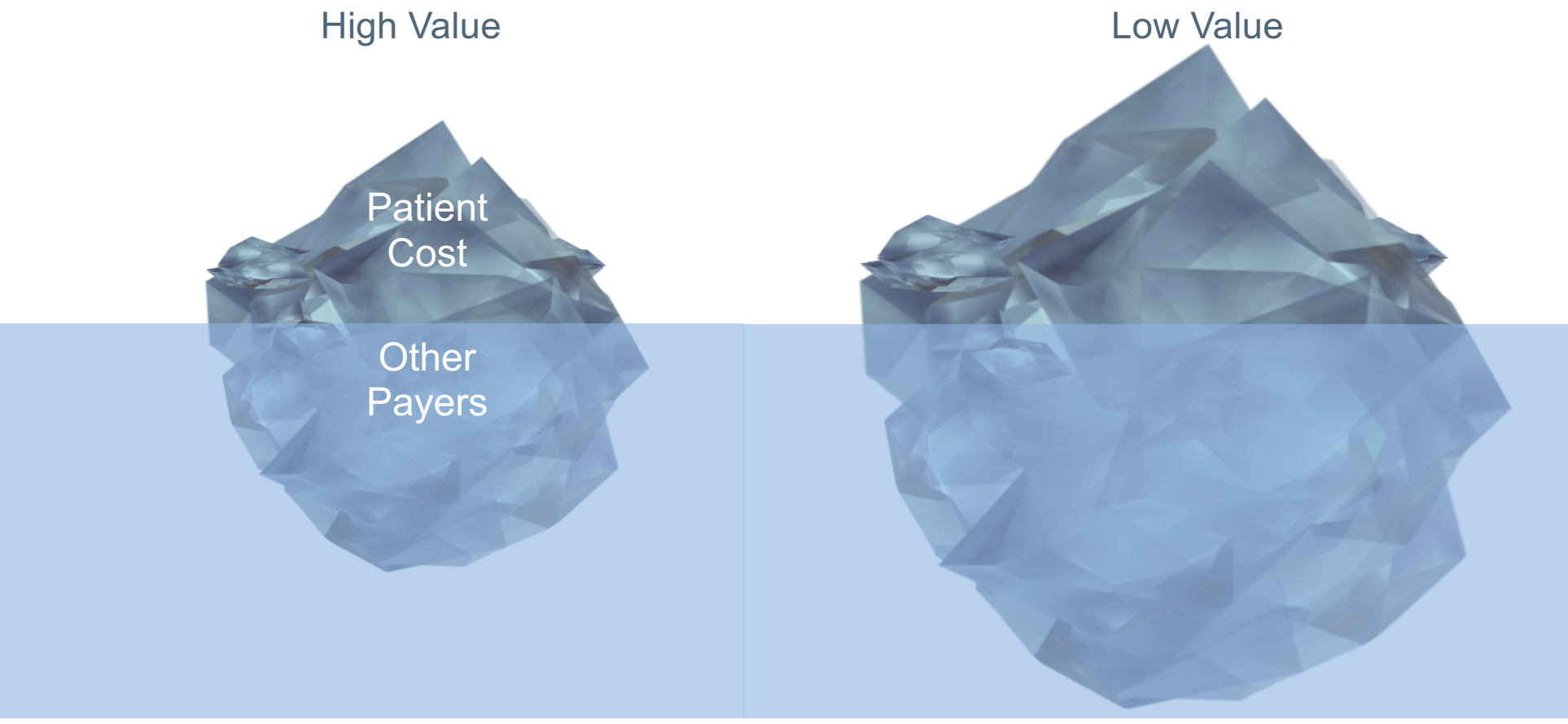
V-BID increases generosity of coverage for high value services

Patient Cost

Generous
Insurance
Coverage

How do we pay to provide better coverage for high value care?

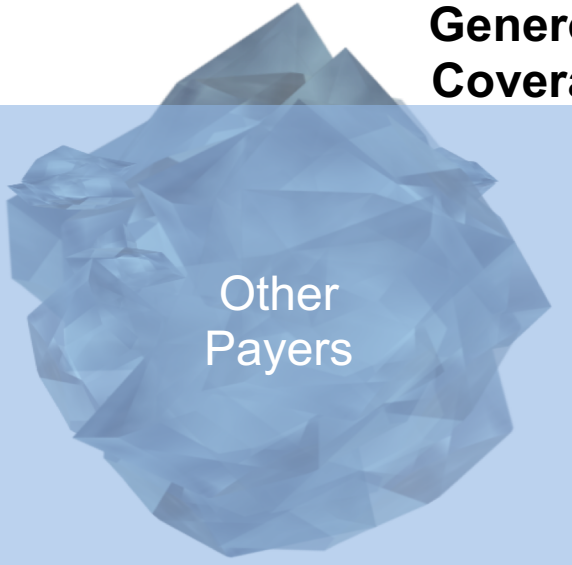
Creating ‘Headroom’ for Better Coverage of High Value Care Removing Billions Spent on Low Value Care



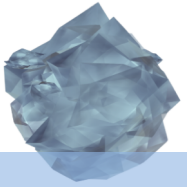
Paying for Better Coverage of High Value Care
Melt the Low Value Care Iceberg

High Value

Low Value



Generous Coverage



No Coverage

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Low-Value Care:
Identify

- **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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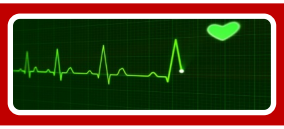
Multi-Stakeholder Task Force on Low-Value Care Identifies 5 Commonly Overused Services Ready for Action



1. Diagnostic Testing and Imaging Prior to Low Risk Surgery

2. Vitamin D Screening

3. PSA Screening in Men 70+

4. Imaging in First 6 Weeks of Acute Low Back Pain

5. Branded Drugs When Identical Generics Are Available

More information available on the VBIDHealth website.

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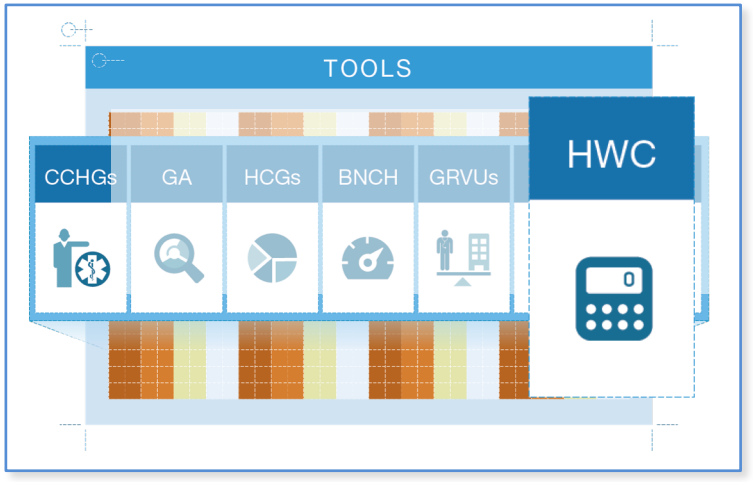
Low-Value Care:
Measure

Health Waste Calculator

- Collaboration between Milliman and V-BIDHealth
- Measures 47 potentially unnecessary services
- Analyzes cost savings potential
- Generates actionable reports and summaries



Milliman MedInsight

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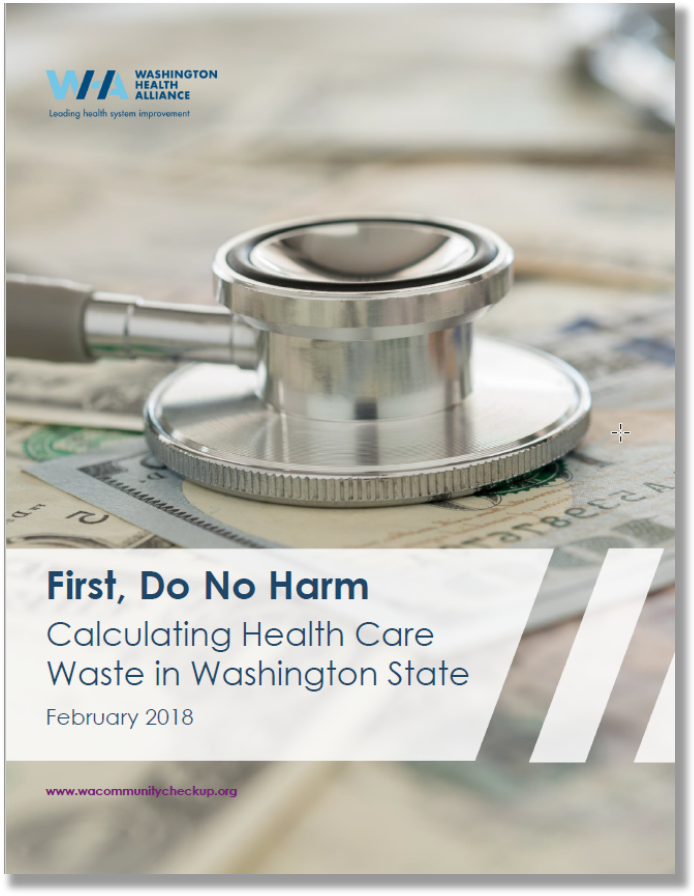
Measure:
State of Washington Health Alliance



- **Approximately 1.3 MM individuals received one of the 47 services, and almost half (47.9%) of them received at least one wasteful service.**
- **Result: an estimated $282 MM in wasteful spending.**

Low-Value Care:
Reduce

Provider-Facing Levers (Supply)	Patient-Facing Levers (Demand)
Coverage policies	*Value-Based Insurance Design*
Payment rates	*Network design*
Payment models	*Prior authorization*
Profiling data	
Clinical decision support	

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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

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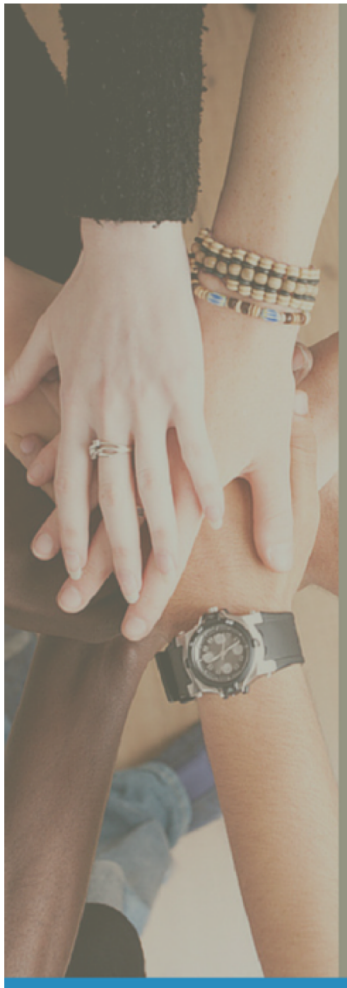
Virginia's Steps to Improve Health Care Value

Beth A. Bortz, President and CEO



ABOUT VCHI

Founded in 2012 as a 501(c)3 non-profit.

Mission: To accelerate the adoption of value-driven models of wellness and healthcare.

Governed by a diverse, multi-stakeholder board of directors.

vahealthinnovation.org

@VaHTHInnovation

Established as a Public-Private Partnership

- VCHI created in response to a recommendation of Governor Robert McDonnell's Virginia Health Reform Initiative
- Seven founding partners: Medical Society of Virginia, PhRMA, Virginia Association of Health Plans, Virginia Chamber of Commerce, Virginia Health Care Foundation, Virginia Hospital and Healthcare Association, and Virginians Improving Patient Care and Safety
- Founding chair was Virginia Secretary of Health and Human Services, Dr. William A. Hazel, Jr., MD; current Secretary Daniel Carey, MD serves on the Board of Directors
- Initially housed at the Virginia Chamber of Commerce
- Now housed with Virginia's association for federally qualified community health centers

VCHI Board and Leadership Council

AARP Virginia
Advocate Health
Aetna
Anthem
APC
Augusta Health
Aviant Health
Ballad Health
Biogen
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Bon Secours Virginia
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Inova Health System
Johnson & Johnson
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Maxim Healthcare Services
MSV Foundation
Merck
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Optima
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Patient First
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Privia Health
Riverside Health System
Sanofi
Sentara
UnitedHealthcare
UVA Health Care System
Va Academy of Family Physicians
Va Association of Health Plans
VCU Health
Virginia Health Care Foundation
Va Hospital and Healthcare Assn
Va Oral Health Coalition
Va Community Healthcare Association
Va Council of Nurse Practitioners
Virginia Nurses Association
Virginia Premier
Walgreens
Westrock
Workplan

Our work

Convening and educating stakeholders interested in accelerating the adoption of value-driven models of wellness and healthcare in an effort to improve patient outcomes and advance Virginia's well-being and economic competitiveness.

Overseeing and facilitating demonstration research to test and evaluate models of value-driven wellness and health care.

Leveraging data and analytical resources that inform and enable health care providers, public health professionals, government representatives, community organizations, employers and consumers to make better decisions.

Helping prepare the health care delivery system and the public for a high quality, value-driven health care marketplace which features engaged and satisfied clinicians and patients.

Our Plan of Attack

1. Identify: Build consensus around the Choosing Wisely® principles and the need to measure low value care

2. Measure: Leverage data from Virginia's All Payer Claims Database and apply the Milliman MedInsight Health Waste Calculator with the aim of prioritizing which medical tests and procedures should be reduced.

3. Report: Share early data with partners to test validity and acceptance. Build consensus around initial focus and develop an action plan.

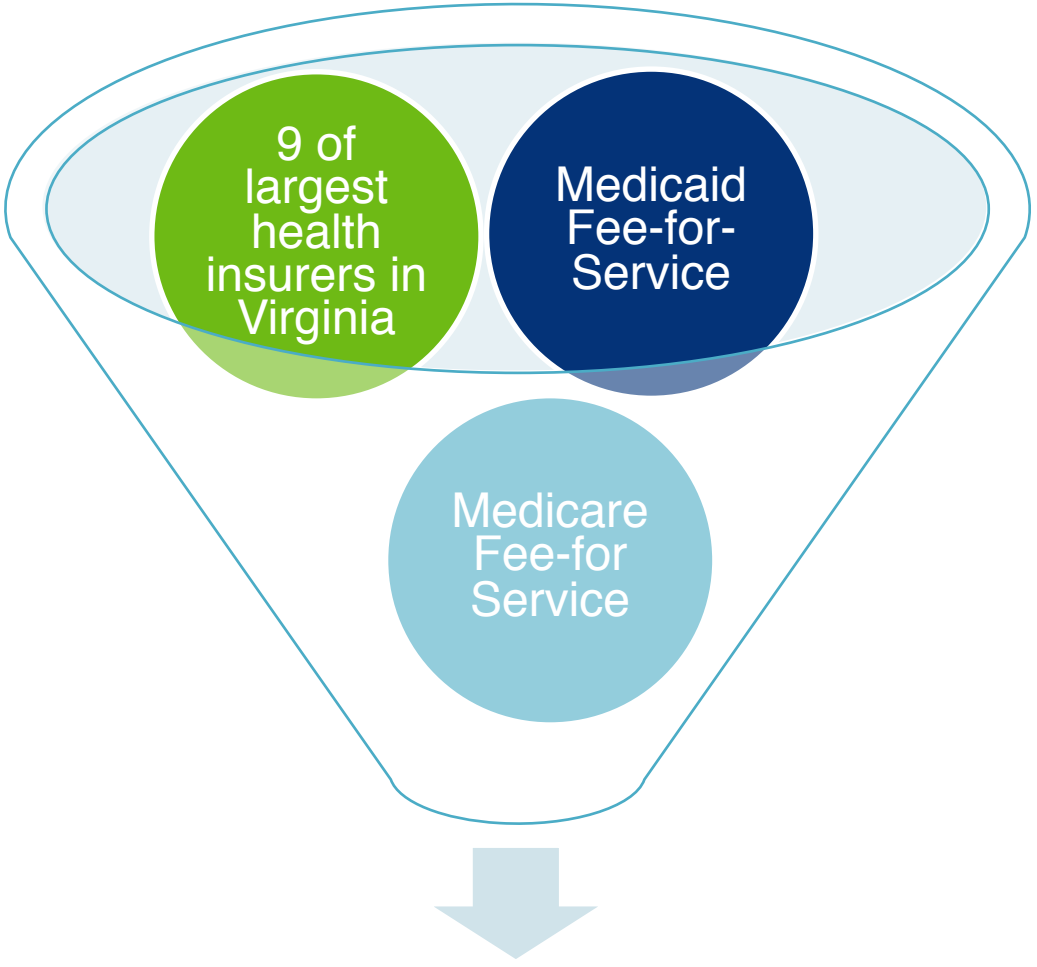
4. Reduce: Test multiple improvement strategies.

Step 1 Identify: Build Consensus Around Choosing Wisely® and the Importance Of MEASURING Unnecessary Care

Series of Conversations:

- Medical Society of Virginia
- Virginia Hospital and Healthcare Association
- Virginia Chamber of Commerce
- Virginia General Assembly Joint Commission on Health Care
- Virginia Association of Health Plans
- Virginia Consortium of Health Philanthropy
- Virginia Council of Nurse Practitioners
- Virginia Community Health Care Association
- Virginia Academy of Family Physicians
- Virginia Population Health Summit

Step 2 Measure: Leverage APCD Data and the Milliman Health Waste Calculator



Medical and Pharmacy Claims for 5 million Virginians

The Milliman MedInsight Health Waste Calculator

- Version 6 has 42 measures, representing 60 Choosing Wisely recommendations.
- Sources for measures can include:
  - Choosing Wisely (from the ABIM Foundation)
  - US Preventive Services Task Force Grade D Recommendations
  - The American Medical Association's Physician Consortium for Performance Improvement
  - The United Kingdom's National Institute for Health and Care Excellence (NICE) Recommendations on High Quality Care
  - Medical Specialty Society Guidelines
  - High-quality, evidence-based research papers
- 400+ measures in the pipelines – initial measures were prioritized by:
  - Amenability to claims data analysis;
  - High prevalence;
  - High cost impact; and
  - Potential to cover a variety of subspecialties and patient populations.

Virginia Summary of Results – 2017 Data

	January 2019
Reporting Period	2017
Number of Measures	42
CMS Data Included?	Yes
Dollars Spent on Unnecessary Services	$747 million per year
Unnecessary Services Identified	2.07 million per year

Virginia Overall Results – 2017 Summary

39% of members exposed to 1+ low service

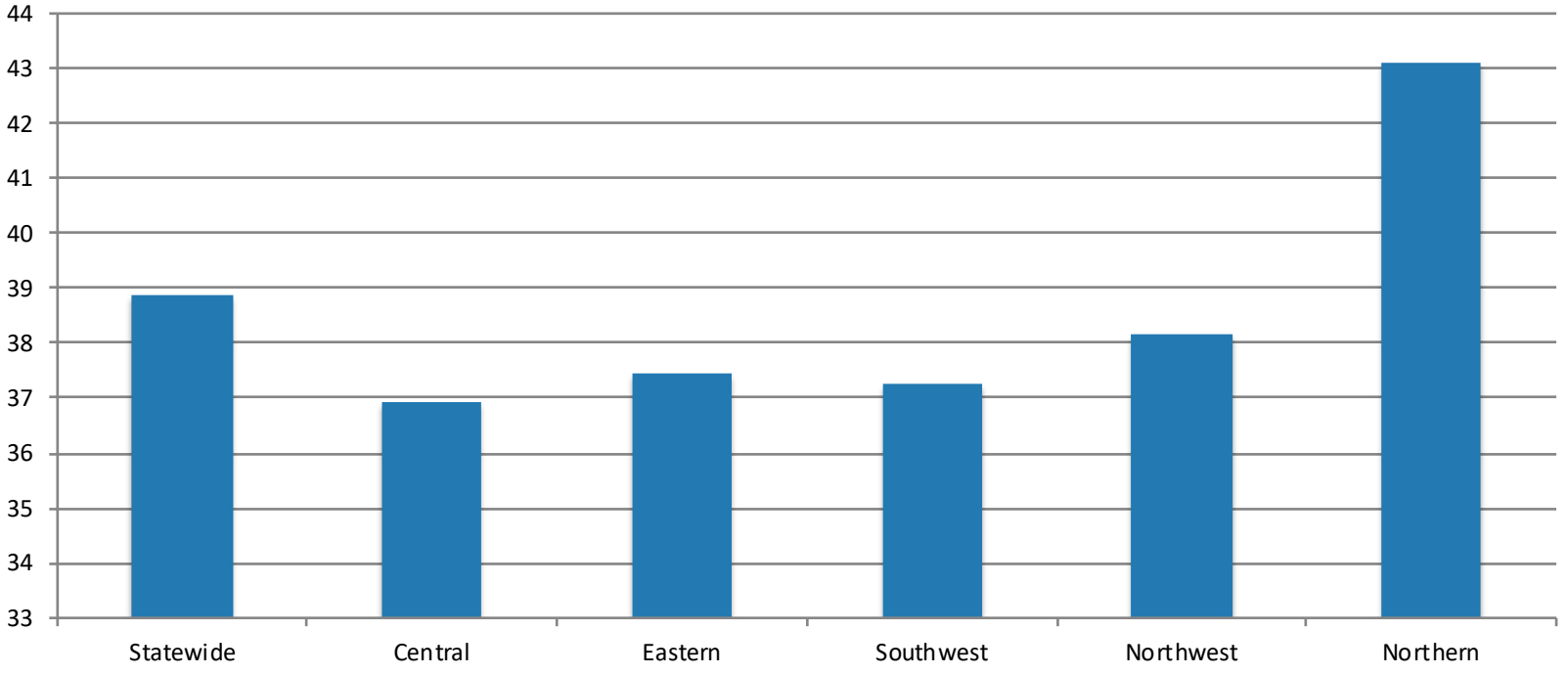
35% of services measured were low value

$11.48 PMPM in claims were unnecessary

Top 5 Measures by Percent of Low Value Dollars for Virginia - 2017

MEASURE	RISK OF HARM	% of Low Value Dollars	Average Proxy Cost Per Service	Low Value Index
Don't obtain baseline laboratory studies in patients without significant systemic disease undergoing low-risk surgery.	L	29%	478	82%
Don't routinely order imaging tests for patients without symptoms or signs of significant eye disease.	L	23%	386	54%
Don't place peripherally inserted central catheters (PICC) in stage III-V CKD patients without consulting nephrology	H	8%	18,154	77%
Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.	M	7%	329	8%
Don't do imaging for low back pain within the first six weeks, unless red flags are present	L	4%	1,673	67%

% of Distinct Members Receiving 1 or More Low Value Services in 2017 by Health Planning Region



Step 3 Report: Share data to test validity and acceptance

Early lessons learned

- Word Choice Matters- "Waste" will strike a nerve with certain audiences
- May want to focus on reducing harmful measures first – and not focus solely on potential cost savings
- May want to prioritize reducing those measures with a high waste index, even if the likely cost savings is lower. Easier to message and change behavior.
- Need to be prepared to address provider medical liability concerns
- Consumer education needs to be conducted concurrent with provider education

Statewide Data Starts to Create a National Stir

COSTS & SPENDING

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

DOI: 10.1377/hlthaff.2017.0385
HEALTH AFFAIRS 36,
NO. 10 (2017): 1701–1704

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).

Health Affairs article, ***"Low-Cost, High Volume Services Contribute The Most To Unnecessary Health Spending"***, was the 3rd most read Health Article in 2017.

Report: Establishing a Virginia Health Value Dashboard

- The purpose of the Health Value Dashboard is to prompt action for improving the value of health care services.
- Our measurement approach is to identify and report on the delivery of both low value and high value clinical services across Virginia and its regions.
- Our action aims are to engage key stakeholders in systematically reducing low value services, increasing high value services, and improving the infrastructure for value-based care. We invite all organizations that provide, purchase, or fund health care to engage in this effort.

2019 Virginia Health Value Dashboard

An initiative of the

VIRGINIA CENTER FOR HEALTH INNOVATION

Overview of Aims

Aim I: Reducing Low-Value Care

A. Utilization and cost of potentially avoidable emergency room visits
B. Low Value Services as captured by the MedInsight Health Waste Calculator
C. Inappropriate Preventable Hospital Stays

Aim II: Increasing High-Value Care

A. Virginians who are current with appropriate vaccination schedules
B. Comprehensive Diabetes Care
C. Clinically Appropriate Cancer Screening Rates

Aim III: Improving the Infrastructure for Value-Based Care

A. Commercial in-Network Payments That Are Value Oriented
B. Claims in Virginia's All-Payer Claims Database
C. Value-Oriented Payments that Place Doctors and Hospitals at Financial Risk for Their Performance

Aim I: Reducing Low Value Care

A. Utilization and cost of potentially avoidable emergency room visits

- Potentially avoidable ED visits - As a percentage of total ED visits
- Potentially avoidable ED visits - Per 1,000 member months
- Potentially avoidable ED visits - Per member per year

B. Low Value Services as captured by the MedInsight Health Waste Calculator

- Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery
- Don't obtain EKG, chest X-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery
- Don't perform population based screening for 25-OH-Vitamin D deficiency
- Don't perform PSA-based screening for prostate cancer in all men regardless of age
- Don't do imaging for low back pain within the first six weeks, unless red flags are present

C. Inappropriate Preventable Hospital Stays

- Prevention Quality Indicator #90: Prevention Quality Overall Composite Rate (per 100,000 population)

Aim II: Increasing High-Value Care

A. Virginians who are current with appropriate vaccination schedules

DATA SOURCE: APCD; VIIS; C4P

- Childhood and Adolescent Immunization Status

B. Comprehensive Diabetes Care

DATA SOURCE: APCD; C4P

- Hemoglobin A1c (HbA1c) Testing
- Medical Attention for Nephropathy

C. Clinically Appropriate Cancer Screening Rates

DATA SOURCE: APCD

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening

Aim III: Improving the Infrastructure for Value-based Care

A. Commercial in-Network Payments That Are Value Oriented

DATA SOURCE: C4PR

- Catalyst for Payment Reform Composite Score: Increasing the Percent of Commercial In-Network Payments that Are Value Oriented

B. Claims in Virginia's All-Payer Claims Database

DATA SOURCE: APCD

- Percent of Virginia Total Covered Lives with Claims Included in the Virginia All Payer Claims Database
- Percent of Virginia Commercially Insured Lives with Claims Included in the Virginia All Payer Claims Database

C. Value-Oriented Payments that Place Doctors and Hospitals at Financial Risk for Their Performance

DATA SOURCE: C4PR

- Catalyst for Payment Reform Composite Score: Increase the Percent of Value-Oriented Payments that Place Doctors and Hospitals at Financial Risk for Their Performance

Measures for Future Consideration

A. Utilization of High Cost Service Siteswhen Lower Cost Sites are Available

B. Medication Adherence for Patients with Chronic Illnesses, Including Mental Health

C. Access to Primary Care for the Medically Underserved

D. Smokers in Smoking Cessation Counseling Programs

E. Utilization of Appropriate Hospice Care and Palliative Services for Patients with Advanced Illness

F. Adults with Serious Mental Illness Receiving Appropriate Treatment

G. Share of Total Dollars Paid to Primary Care Physicians vs. Specialists

H. Providers that Score Well on the Merit-based Incentive Payment System

I. Virginians with documented Advanced Directives

Step 4 Reduce: Begin Pilot Projects with Interested Partners

- FQHCs
- Medicaid and State Employee Health Plan
- Health System Collaborative
- Employer Task Force

Low-Value Care 101: Identify, Measure, Reduce, Report

February 28, 2019

Questions?

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Contact: budros@vbidhealth.com

Thank you for joining us!

For Health Waste Calculator questions, contact: Katy@Spanglerstrategies.com or visit VBID Health website.

More resources, news, and tools available on our websites:

- http://vbidcenter.org/
- http://vbidhealth.com/
- http://vahealthinnovation.org/

A recording of this webinar will be made available on the VBID Center and VBID Health low-value care webpages soon.