Provider-Plan Partnership Models Enable High-Value Care

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KEY HIGHLIGHTS

- Low-value care—unnecessary and potentially harmful services—puts patients at risk and contributes $76 to $226 billion in wasteful spending annually.
- Reducing the use of low-value care has been challenging despite efforts such as new value-based payment models and consensus-driven initiatives designed to increase awareness of low-value services.
- Partnerships between health plans and care providers are a promising solution; Elevance Health's Prior Auth Pass program, a partnership to advance high-value care, has shown positive results.

Overview

Growth in U.S. healthcare spending continues on an unsustainable trajectory. In 2018, healthcare expenditures accounted for nearly 18 percent of gross domestic product (GDP)—translating to more than $11,100 in spending per person, and over $25,000 per household.[1]

And national health spending is estimated to continue to grow, reaching 19.7 percent of GDP by 2028, rising from $3.6 trillion to $6.2 trillion.[2] While some degree of growth is to be expected due to economic and demographic factors—including increases in prices for medical services and products, and the aging of the population—wasteful spending is a significant driver.[3]

Research shows that **low-value care costs between $76 to $226 billion** annually.

Studies estimate that between 25 and 30 percent of annual healthcare expenditures are wasteful.[4,5] A growing body of evidence suggests that a large portion of this waste—10 to 25 percent—is made up of low-value care, or "care that, according to sound science and the patients' own preferences, cannot possibly help."[6,7] Research also shows that low-value care costs between $76 to $226 billion annually.[8,9] What's more, studies have found that exposure to low-value diagnostics and treatments can put patients at risk of physical harm not to mention anxiety and other effects from clinically insignificant findings.[10]

Low-value care is persistent and pervasive. Polling of healthcare providers, employers, and individuals reveals broad awareness that many healthcare services are unnecessary.[11-13] Historically, there has been little consensus on what actually constitutes low-value care—as well as few opportunities to measure it and design interventions to address the problem. But recently, researchers and the medical community have made important strides in defining low-value care and developing recommendations for specific services that should be reduced or eliminated.

So far, most interventions have focused on consensus recommendations from healthcare providers or value-based reimbursement models, with limited results. More recently, promising solutions involve partnerships between payers and providers. These partnerships have the potential to address waste, decrease spending and administrative burden, and, most importantly, improve outcomes for patients.

Defining and Identifying Low-Value Care

Stakeholders across the healthcare system recognize that delivery of unnecessary services is common but they have varying views on a definition for low-value care.

Physicians surveyed in 2017 indicated that **21 percent of overall medical care was unnecessary.**

Physicians surveyed in 2017 indicated that 21 percent of overall medical care was unnecessary.[14] Likewise, more than half of surveyed employers estimate that 10 to 25 percent of healthcare treatments provided to employees and their families is wasteful,[15] and even individuals recognize there may be benefits from reducing low-value care.[16]

Defining Low-Value Care

While reducing or eliminating the use of low-value care is often touted as a means for achieving a better healthcare system, precisely identifying low-value services is difficult because "the value of a specific clinical service is not always high or low but depends on who receives the service, who provides it, and where it is provided."[17] Nevertheless, defining low-value services is an essential step to identify, quantify, and address the problem.[18]

For instance, a prostate cancer screening (PSA test) is an effective tool to detect cancer, but in asymptomatic men above the age 70, experts have long agreed that the potential harm from a PSA test, such as unneeded biopsies and post-surgical complications, outweighs the benefit. A PSA test for this population is even rated as a "D" (discouraged from use) by the U.S. Preventive Services Task Force (USPSTF).[19] Despite the strong evidence, Medicare's authority to deny the service for men over age 70, and potential harm to patients, PSA tests are still covered by Medicare for men of all ages. In fact, fee-for-service (FFS) Medicare spent as much as $79 million for this service for men over age 75 in 2014.[20]

While there is no one definition for low-value care, it is generally defined as:

- Interventions that have no possible benefit to the patient, or
- Interventions where the potential harm outweighs the benefit.

1 in 5 services provided to Medicare FFS beneficiaries are low-value.

Low-Value Care and *Choosing Wisely*

At the forefront of the effort to identify and reduce the use of low-value care is the *Choosing Wisely* campaign. Launched in 2012 by the American Board of Internal Medicine Foundation and nine medical specialty societies, *Choosing Wisely* set out to "advance a national dialogue around avoiding unnecessary medical tests and treatments."[21] Specifically, the mission of *Choosing Wisely* is to promote conversations between care providers and consumers to help them choose care that is: supported by evidence; not duplicative of other tests; free from harm; and truly necessary.[22]

Since the campaign's inception, specialty societies have tasked their members with identifying tests or procedures commonly used in their field that may be low-value. Based on their recommendations, materials were created in partnership with Consumer Reports to help individuals and their care providers talk about whether tests and procedures are appropriate. To date, over 80 specialty societies have joined the *Choosing Wisely* campaign, publishing more than 500 recommendations for clinicians and consumers.[23]

Identifying Areas of Waste

Material reductions in low-value care would reap substantial savings that could curb spending growth and free up resources for high-value services. As illustrated in this section, low-value services vary widely in volume and cost; even relatively low-cost procedures and tests can add up to significant waste due to the sheer volume of services rendered.

For instance, some of the most regularly cited areas of waste attributed to low-value care, and the associated annual price tag, include:[24]

$14.7 Billion
The use of branded drugs when generic equivalents are available.

$9.5 Billion
Diagnostic tests for low-risk surgery, such as metabolic screening or cardiac testing for cataract surgery.

$800 Million
Vitamin D tests, when results will not be used to inform clinical decision making.

Using the guidelines formulated under *Choosing Wisely*, researchers have begun to measure the magnitude of the problem of low-value care. One analysis of a sample of 1.4 million Medicare FFS beneficiaries found that over 20 percent of all services were low-value.[25] Research has also found that low-value care is prevalent among all payer types as well as geographies and that the prevalence of low-value care may have more to do with provider practice patterns.[26-28]

Recently, some stakeholders have moved to define low-value care as those services that receive a grade of "D" from the USPSTF. While this approach is straightforward to apply and measure, it does not capture the full breadth of possible low-value services and treatments, but instead focuses solely on the preventive areas that the USPSTF reviews.[29]

Low-value treatments and diagnostics can lead to **harmful follow-up care.**

Patient Harm and Care Cascade

Delivery of low-value treatments and diagnostics can, in turn, lead to unnecessary downstream spending, harmful follow-up care, and other adverse consequences sometimes known as the "care cascade." It is generally understood that patients who receive low-value services are at risk of complications and of incurring additional, unnecessary follow-up care. However, there is very little research that directly measures the frequency and cost of this care cascade.

For instance, building on the PSA test example used earlier, complications associated with biopsies following abnormal PSAs are associated with high rates of serious infections and hospitalizations.[30] Similarly, unnecessary imaging adds to lifetime radiation exposure; excessive radiation exposure increases the risk of certain cancers.[31]

Because existing estimates of the cost of low-value care do not include the care cascade, these estimates are likely very conservative. One of the few studies that specifically looks at the care cascade illustrates how estimates of the costs of low-value care fall short if we ignore the downstream impact. The study found that, after receiving a low-value EKG prior to cataract surgery, 16 percent of Medicare patients went on to experience a cascade event, costing $35 million, in addition to the $3.3 million spent for the initial low-value test.[32]

Beyond the medical services directly attributed to the care cascade, there are other harmful effects that have yet to be accounted for in the research into low-value care, such as anxiety and emotional distress and resources associated with accessing care like transportation costs and lost wages.

Interventions to Reduce Low-Value Care

In recent years, there have been two types of initiatives aimed at reducing low-value care: interventions that specifically targeted services defined as low-value, and broader cost containment initiatives that were expected to reduce low-value care, as well as mitigate other forms of waste and overutilization. Although results have been limited, there are several lessons to build upon for future interventions.

Choosing Wisely published more than **500 recommendations of low-value services to avoid.**

Physician-Led Initiatives: The *Choosing Wisely* Campaign

Since its launch, the *Choosing Wisely* campaign has brought together over 80 specialty societies, publishing more than 500 recommendations, and engaging over 1 million clinicians.[33] Yet, despite 40 percent[34] of surveyed physicians indicating awareness of the campaign, evaluations of *Choosing Wisely* find limited effectiveness.[35,36]

One of the first studies to evaluate its impact examined how the frequency of seven low-value services from the initial *Choosing Wisely* lists (published in 2012) fluctuated over a three-year span. Only two services (headache and cardiac imaging) experienced a small decrease in use.[37] Likewise, a study that examined changes in the use of low-value imaging for low-back pain—including x-rays, CT scans, and MRIs—among commercially insured individuals from 2010 through 2014 found just a four percent decline from pre- to post-implementation of *Choosing Wisely* recommendations.[38]

Given the broad awareness, and yet minimal impact of *Choosing Wisely*, it's important to take a closer look at why physicians use low-value treatments and diagnostics even when they may suspect it will have little-to-no benefit. Further, given that the recommendations borne out of the *Choosing Wisely* campaign were developed by clinicians using consensus-based processes, further investigation into barriers to their adoption is surely warranted.

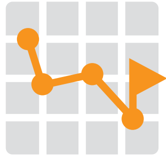
New Payment Models to Incent Cost Control and Reduce Low-Value Care

One of the desired outcomes of new payment models, such as accountable care organizations (ACOs) that shift more risk to providers, is that physicians will have greater incentive to stop delivering low-value care. Testing this theory, a 2015 study compared use of low-value services by two groups of beneficiaries—those attributed to Medicare Pioneer ACOs and those attributed to other FFS Medicare healthcare providers.

Using 31 measures, some of which were based on *Choosing Wisely* recommendations, researchers assessed changes in the use of low-value care across three categories—cancer screening, imaging, and cardiovascular testing and procedures—before and after the ACO contracts went into

effect. There was a statistically significant reduction in both volume (-1.9%) and spending (-4.5%) for low-value services in the ACO group relative to the FFS group.[39]

A separate study, designed to evaluate the impact of ACOs on specialists, found provider participation in a Medicare ACO had no impact on use of low- or high-value coronary revascularization, suggesting that the incentives of the current ACO program may be insufficient to influence specialist behavior.[40]



A prior authorization demonstration in Medicare FFS showed **a potential path toward reductions in low-value care.**

Medicare Demo to Reduce Unnecessary Care Using Prior Authorization

While not specifically focused on low-value care as defined by *Choosing Wisely*, a prior authorization (PA) demonstration in Medicare FFS showed a potential path toward significant reductions in unnecessary care. After PA was introduced for select services—power mobility devices, non-emergency ambulance services, home health, and non-emergency hyperbolic oxygen therapy—estimated savings to Medicare ranged from $1.1 to $1.9 billion across four demonstrations that spanned two to six years in duration.[41] Care providers interviewed for the evaluation noted that PA was effective at reducing unnecessary service use, although they also noted challenges with the PA process.[42] While PA is an effective tool, addressing provider challenges and reducing administrative complexity are key considerations for successful deployment.[43]

Insights Into Why Low-Value Care Persists

In 2017, a survey asked physicians to identify the top reasons associated with providing unnecessary services.[44] The survey found that physicians most frequently reported that fear of malpractice (85%) and patient pressure (59%) were responsible, but that difficulty accessing medical records (38%), lack of medical history (37%), and borderline indications (38%) were also top contributors.[45]

41 percent of physician respondents reported that **the reason for pursuing additional care was non-clinical.**

Further, the vast majority (over 70%) of respondents believed that overutilization was likely to occur when the physician profits from it.[46] In a survey conducted in 2019, which specifically asked physicians about their most recent care cascade event, 41 percent of respondents reported that the reason for pursuing additional care was non-clinical, and of those respondents, commonly cited reasons include: practice or community norms (50%), fear of a lawsuit (36%), and patient request (24%).[47]

Three important themes emerge from these surveys: physicians often feel pressure from patients for tests and treatments, lack of complete data can prevent a physician from ruling out unnecessary care, and reimbursement influences decisions around whether to pursue wasteful services. Furthermore, the medical community is broadly aware that both low-value care and care cascade occur frequently.

In addition to the pressures that physicians experience, there are also cases where providers and insurers agree that a service is of no value but the cost of an intervention, like implementing a PA requirement, is more expensive than the service itself. For instance, vitamin D tests are often ordered even though the outcome will not be used to inform treatment. Medicare Advantage plans must cover vitamin D tests for a variety of indications and because the test is both inexpensive and poses no risk to the patient, implementing a PA would be more expensive than simply allowing the test to occur, and, in effect, would just add waste.

Further, an estimated 12 million U.S. adults receive a misdiagnosis every year.[48] When a patient receives the wrong diagnosis, the resulting care that follows is unnecessary, and therefore low-value.

From the evidence currently available, it appears that provider consensus and awareness, as well as changes to reimbursement models, are not enough to drive significant and sustained reductions in the use of low-value services. PA programs show promise in reducing specific categories of unnecessary care, but physician burden is a potential barrier. Moreover, patient demand and gaps in medical history may be considerable drivers of persistent use of low-value services.

Reducing the Use of Low-Value Care

There is clear opportunity to do better at eliminating waste in our healthcare system. However, a variety of factors contribute to whether, where, and how low-value care is provided, underscoring the importance of developing solutions that are holistic and tailored to a patient's and provider's circumstances.

Health plans, in partnership with care providers, have a key role in **reducing low-value services.**

Since 2017, new work has emerged highlighting how health plans, in partnership with care providers and health systems, have a principal role in reducing low-value services.[49] These approaches include: stopping reimbursement for services that are clearly inappropriate, benchmarking high-value care providers compared to those that utilize low-value services, introducing incentives for reducing waste, creating networks of high-value care providers, implementing PA programs, and employing cost sharing strategies.[50,51] Two of these approaches—partnerships with networks of high-value care providers and PA programs—are explored in more depth below.

Prior Authorization to Address Unnecessary and Unsafe Care

PA requires a care provider to request approval for coverage before delivering a service. For example, obstructive sleep apnea is a common condition that is normally diagnosed using a sleep test. Physicians can choose to order a sleep test that occurs in a facility—such as a hospital or free-standing sleep lab—or allow a patient to use portable testing equipment in their home. Unless there is evidence of specific issues like congestive heart failure or severe chronic obstructive pulmonary disease, home sleep studies are more comfortable and convenient for the patient, less costly, and increase access in markets where demand for studies is high. For these reasons, a PA process is used to help ensure that the physician is aware that a patient without complications could benefit from an at-home study rather than a more expensive, and far less convenient, in-lab test.[52]

Care providers have highlighted that gaps in medical history make it difficult to determine whether a service is low-value.[53] Unlike most other healthcare stakeholders, health plans generally have access to a wide array of data representing most, if not all, of a member's interactions with the healthcare system. Plans' holistic view of how individuals access care and how providers deliver care enables them to design and implement PA programs that help reduce use of low-value care, help providers succeed in value-based care arrangements, and support providers in their efforts to meaningfully improve health outcomes.[54]

In addition, PA can reduce unnecessary services. A common example is diagnostic imaging for uncomplicated headaches. One study estimated that the frequency and cost of headache-related imaging that goes against clinical guidance and best practice is between 544,000 and 817,000 cases at a cost of $146 to $211 million annually for Medicare FFS alone.[55]

The same study also found that physicians frequently report that patient pressure is a large reason as to why they order the imaging and that PA policies are often helpful in mitigating that pressure.[56]

The importance of creating PA processes and systems that do not add administrative complexity cannot be overstated. AIM Specialty Health (AIM), a wholly owned subsidiary of Elevance Health, manages PA programs across several clinical areas to ensure patients receive drugs, procedures, and treatments that are safe, effective, and consistent with medical evidence. AIM works closely with physicians from a broad array of specialties and other external experts to ensure PA programs reflect the most up-to-date medical evidence and clinical consensus. In addition, over 80 percent of PA requests received by AIM are through an automated online platform.

Prior Auth Pass waives PA requirements for 400 outpatient services for **providers committed to value-based care.**

Prior Auth Pass Program

Collaboration between care providers and payers is essential to achieving greater efficiency and value. Elevance Health's affiliated health plans are partnering with providers who have demonstrated their commitment to value-based care and accountability through risk-based arrangements—to streamline the PA process for many common medical procedures performed in an outpatient setting. The goal is to reduce administrative burden for both providers and plans, while ensuring more high-value, affordable care for consumers.

The Prior Auth Pass program waives PA requirements for over 400 outpatient services across a wide range of clinical areas, such as radiology, rehabilitation, minor surgery, and general medical services. The participating care providers were selected due to their demonstrated track record of PA approvals at or above 90 percent and strong investment in value-based care arrangements (e.g., by taking on downside risk).

A collaborative, retrospective monitoring process helps guard against over-utilization of select services. Additionally, when cases arise in retrospective reviews where it is unclear why a procedure was approved, it is addressed collaboratively in a monthly meeting between care providers and health plan representatives.

Elevance Health's affiliated plans worked with the South Bend Clinic in Indiana and the Cleveland Clinic in Ohio to co-design and pilot the Prior Auth Pass program. The results from the Prior Auth Pass pilot are promising. From July 2018, when the program started, to March 2019, utilization of services remained steady, demonstrating that removing PA did not increase utilization. Moreover, participating care providers experienced substantial decreases in administrative burden. On average, the pilot participants experienced a 58 percent reduction in PA requests per provider per year for commercial members. Similarly, for Medicare Advantage members, the reduction was 64 percent per provider per year.

Based on the findings of the pilot, Elevance Health's affiliated plans have expanded the program to additional care providers that meet similar criteria to the high-value care providers included in the pilot.

Conclusion

The use of low-value care has a significant, negative impact on individuals and our healthcare system. Persistent and pervasive use of products and services that have little or no clinical benefit, or for which the risk of harm outweighs the potential benefit, is driving wasteful spending and increasing costs for consumers. It is also detracting from efforts to improve outcomes and quality, and potentially exposing individuals to harm.

Collaborations between plans and providers can **reduce use of low-value services** while ensuring consumers' access to needed care.

Collaborative efforts between health plans and care providers have the potential to reduce the use of low-value services, while protecting, or even improving, consumers' access to the care they need. Innovative initiatives like the Prior Auth Pass program are leveraging value-based arrangements and reducing administrative burden. In addition, where PA is necessary, it is important to help ensure that PA processes are efficient for providers. Increasingly, partnerships between care providers and health plans are enabling better processes that help reduce low-value care and boost the provision of high-value products and services—all with the goal of better outcomes and lower costs.

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ABOUT US

Elevance Health Public Policy Institute

The Public Policy Institute (PPI) was established to share data and insights that inform public policy and shape the healthcare programs of the future. PPI strives to be an objective and credible contributor to healthcare transformation through the publication of policy-relevant data analysis, timely research, and insights from Elevance Health's innovative programs.

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