Smarter Health Care Coalition

April 19, 2021

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW Room 600E
Washington, DC 20201

Dear Secretary Becerra:

The Smarter Health Care Coalition (the Coalition) represents a broad-based, diverse group of health care stakeholders, including consumer groups, employers, health plans, life science companies, provider organizations, and academic centers.[1] Our goal is to better align health care spending with value, improve the patient experience, and lower health care costs by supporting innovative benefit design that encourages the use of high-value care, and discourages the use of low-value care.

Value-based insurance design (V-BID) is one method to better align health care spending with value. For over a decade, V-BID has successfully focused on reducing cost-sharing for high-value drugs and services. Section 2713 of the Affordable Care Act (ACA) is an example of V-BID, which requires certain high-value services to be covered by health plans without patient cost-sharing, such as vaccines, blood pressure screenings, tobacco use interventions, some types of cancer screenings, and more.[2] Eliminating or reducing financial barriers to high-value services and drugs is known to increase appropriate high-value care use, enhance equity and materially improve patient lives.[3] For example, annual lung cancer screenings for people aged 50 to 80 years old who are high risk because of smoking history must now be covered without cost-sharing, expanding access to underserved populations.[4]

Although important for population health, few if any of these high-value services will reduce health care *spending*. As you know, health care costs continue to rise, and the Medicare hospital insurance trust fund faces insolvency in the next six years.[5] Recent research also indicates little progress has been made in aligning health care spending with clinical value, despite years of increased awareness about waste in the health care system.[6,7] Because resources are finite, the

[1] https://www.smarterhc.org/
[2] https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
[3] https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1633
[4] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening
[5] https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf
[6] https://www.hcvalueassessment.org/application/files/5915/5853/6278/Research_Consortium_Research_Brief_No._1.pdf
[7] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776516

Coalition urges you to promote policies that both align spending with value, and also have the potential to reduce overall spending.

Health care stakeholders across the country are therefore increasingly interested in "low-value care" as an opportunity to reallocate health care resources, increase quality, and ultimately reduce overall spending.[8] Also known as clinical waste, low-value care broadly captures services for which the harms outweigh the benefits. In some cases, low-value care can result in physical harm to patients. Low-value care also comes with significant costs to the federal government and unnecessary out-of-pocket costs for patients. There is an estimated $101.2B in overtreatment or low-value care, one source of waste in the U.S. health care system.[9]

The COVID-19 pandemic has exacerbated long-standing health inequities across race and income. In general, studies have shown that minorities face a health care "double jeopardy": minorities are both less likely to receive effective care and appear to be more likely to receive low-value care.[10] Policies that address systemic bias in the health care system should be a priority for immediate action as we recover from the pandemic.

Accordingly, the Coalition believes the Secretary could use existing authority to reduce the provision of low-value care in the Medicare program.

We therefore recommend the Secretary of HHS exercise existing authority to:

1. Eliminate Medicare payment for services rated "D" by the US Preventive Services Task Force, per Section 4105 the Affordable Care Act

2. Add flexibility to the Center for Medicare and Medicaid Innovation (CMMI) V-BID Demonstration to allow Medicare Advantage organizations to reduce payments or increase cost-sharing for "D" rated, harmful preventive services, per Section 3021 of the Affordable Care Act

3. Further exercise CMMI authority to build a new, multi-state demonstration project to reduce low-value care in commercial, Medicare, and Medicaid populations.

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[8] https://www.modernhealthcare.com/transformation/industry-still-determining-what-services-are-worth-doing
[9] https://jamanetwork.com/journals/jama/article-abstract/2752664
[10] https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1416

1. Eliminate Medicare payment for services rated "D" by the US Preventive Services Task Force

Value-based preventive care is critical to a cost-effective, "smarter" health care system. Section 2713 of the ACA, which requires health plans to cover certain preventive services without patient cost sharing, has been a popular and bipartisan element of the health care system for a decade. Lesser known, however, is Section 4105 of the same law, which grants the Secretary of HHS the authority to eliminate payment in Medicare for preventive services that fail to achieve an A, B, C, or I designation from the US Preventive Services Task Force (USPSTF).

In practice, this means that the Secretary could instruct the Centers for Medicare and Medicaid Services (CMS) to stop paying for "D" rated services that are harmful to Medicare beneficiaries, and waste hundreds of millions of taxpayer dollars.

The USPSTF was created in 1984 as an independent panel of volunteer clinical experts to establish evidence-based recommendations on preventive services.[11] The Task Force rates primary care, preventive services on a scale of "A" to "D", with A serving as the highest endorsement for a services' preventive ability, and D indicating "moderate or high certainty of no net benefit or that harms outweigh benefits."[12] The same service can be rated differently based on the population in question. Of the currently published recommendations by the USPTF, 19 published recommendations are D-rated (see Appendix A).[13] Services rated "A" and "B" by the Task Force are required to be covered without cost sharing per Section 2713.

The Task Force does not consider cost in recommendations. However, MedPAC has long documented millions of dollars in low-value care in traditional Medicare, from a sample of low-value services, some of which are D-rated preventive services.[14] These estimates show that between 34 and 72 percent of traditional Medicare beneficiaries received at least one of the tracked low-value services in 2018 (see Appendix B). For all these services, there is overwhelming and consistent evidence that the harms outweigh the benefits, but Medicare pays for them regardless. In total, MedPAC reported that Medicare spent between "$2.4 billion and $6.5 billion on [low-value care] services" in 2018.

Several low-value services measured by MedPAC overlap with D-rated services, such as PSA screening for men over the age of 70.[15] This screening for this population is known to be commonly unnecessary and can also result in immeasurable downstream harm and costs.[16] Medicare spent upwards of $79 million on PSA screenings for this population in 2018. Importantly, **these measurements underestimate the total cost of low-value care services**

[11] https://www.uspreventiveservicestaskforce.org/Page/Name/about-the-uspstf
[12] https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/methods-and-processes/grade-definitions
[13] https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P&grades%5B%5D=D&searchterm=
[14] http://medpac.gov/docs/default-source/data-book/jun18_databookentirereport_sec.pdf?sfvrsn=0
[15] Note: the USPSTF does not recommend PSA screenings for men over 70 but MedPAC tracked spending for men over 75 – the latter population would provide a more conservative estimate of "low-value" utilization, given that the likelihood of a valuable PSA test reduces as men age.
[16] https://www.ncbi.nlm.nih.gov/pubmed/29743049

because they do not capture the downstream costs associated with harmful care, such as treating infections related to biopsies from unnecessary PSA screenings.[17]

MedPAC spending analysis of low-value care in Medicare fee-for-service includes several USPSTF D-rated preventive screenings, and hundreds of millions in spending in 2014 alone:

- Carotid artery disease screening, asymptomatic adults (between $221 and $268 million)
- PSA screenings for men over 70 (between $44 and $79 million)
- Colon cancer screening in older adults (between $3 and $405 million)
- Cervical cancer screening over the age of 65 (between $39 and $44 million)

Most recently, one study showed that Medicare spending on ten D-rated services alone cost nearly $1 billion in Medicare spending annually, which again likely underestimates the total clinical and financial impact of these low-value services.[18]

Ongoing initiatives highlight the need to rethink the provision of low-value preventive services. For over a decade, the Choosing Wisely initiative has worked closely with specialty societies to develop lists of commonly overused clinical services, many of which are preventive.[19,20] Furthermore, private employers, state governments, and commercial health plan carriers have already taken steps to measure, report, and reduce low-value care beyond preventive services.[21] However, a recent JAMA study found that among individuals with fee-for-service Medicare receiving any of 32 measured services, low-value care use and spending decreased marginally from 2014 to 2018, despite a national education campaign to address low-value care and increased attention on reducing health care waste.[22]

The Section 4105 authority is an excellent opportunity to increase the value of Medicare benefits, reduce patient harm, and realize immediate savings for the Medicare program. Eliminating Medicare payments for D-rated preventive services would mitigate unnecessary patient out of pocket costs and, in some cases, the physical harm associated with these services. Furthermore, the savings associated with the reduction in payments for low-value services would create "headroom" in the Medicare program to focus more resources on evidence-based, high-value preventive screenings, services, medications, and more.

2. Add flexibility to the CMMI V-BID Demonstration to allow Medicare Advantage organizations to reduce payments or increase cost-sharing for "D" rated, harmful preventive services

The V-BID demonstration enjoys multi-stakeholder and bi-partisan support. The demonstration allows for a broad set of flexibilities to target supplemental benefits to enrollees based on

[17] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2735387
[18] https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13464
[19] https://www.choosingwisely.org/
[20] https://jamanetwork.com/journals/jama/article-abstract/2771511
[21] https://www.modernhealthcare.com/transformation/industry-still-determining-what-services-are-worth-doing
[22] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776516

chronic disease status or socio-economic status, or both. Plans have used this flexibility to reduce cost-sharing for high-value clinical services and drugs that will increase health outcomes and save costs long-term, as people with chronic conditions are better able to adhere to treatment regimens and avoid costlier short-term care (i.e., hospitalization). Although important for population health, few if any of these high-value services will reduce health care *spending*.

Reducing the use of low-value, harmful care can, however, reduce health care spending. There is overwhelming evidence that increasing cost-sharing on services can reduce their use – unfortunately, cost-sharing is often applied to services with no account for their clinical value. Blunt cost-sharing to contain health care use will reduce both high and low-value care indiscriminately, which can have negative effects on population health.[23]

To reduce harm and increase the efficiency of Medicare spending, Medicare Advantage organizations participating in the V-BID demonstration should be given the flexibility to increase cost-sharing on targeted services, such as USPSTF D-rated services.

The change would test two basic policy goals: 1) whether increased cost-sharing or reduced provider payments on a limited set of harmful, low-value services will reduce their use and 2) whether these changes will produce overall savings or create opportunities to decrease cost-sharing on high-value services.

Through the V-BID X project, the University of Michigan Center for Value-Based Insurance Design has demonstrated the possibility of reducing cost-sharing for a wide range of high-value drugs, services, and devices, with a net neutral impact on premiums.[24] The same principles could be applied to the demonstration: the savings associated with reductions in low-value care use should be passed on to the Medicare beneficiary in the form of either reduced cost-sharing or lower premiums.

3. Further exercise CMMI authority to build a new, multi-state demonstration project to reduce low-value care in commercial, Medicare, and Medicaid populations.

The Coalition also recommends using CMMI authority to establish a multi-state demonstration project to address low-value care through local partnerships and coalitions that identify, measure, and reduce targeted contributors of low-value care. With new funding in the 2020 omnibus for states to set up or improve All-Payer Claims Databases (APCDs), a powerful opportunity exists for states to build the analysis and partnerships with the health care industry necessary to breakdown the provision of unnecessary care.

There currently exist public-private partnerships within states along these lines. For example, in March 2019 the Virginia Center for Health Innovation (VCHI) launched a statewide pilot called

[23] https://www.rand.org/pubs/research_briefs/RB9174.html
[24] https://vbidcenter.org/initiatives/vbid-x/

"Smarter Care Virginia," to reduce the provision of low-value health care in the state, with support from Arnold Ventures.[25] To drive sustainability, VCHI built two complementary public-private task forces of government, health care system, and employer leaders to mobilize action around select consumer- and provider-drive measures of low-value care. The collaboration has been supported simultaneously by the Virginia APCD, providing analytical support and data to measure spending and use outcomes.[26] Smarter Care VA is specifically targeting unnecessary pre-operative testing as part this initiative, which started as a pilot project in Washington state as "Drop the Pre-Op".[27] Not only is unnecessary pre-operative testing a large source of unnecessary spending, but can also cause significant downstream harm.

Other states are eager and well positioned to take on similar coalition-building around actionable measures of low-value care.[28] The states of Colorado, Delaware, Florida, Maine, Oregon, Tennessee, and Utah have all independently reached out to Virginia and Washington to seek assistance in getting started with the initial data analysis required to reduce low value care. For this reason, we see real benefit in supporting *a multi-state demonstration pilot through CMMI that would create additional resources and best practice support for states to build relevant partnerships, target specific services, and measure the associated change in spending*. The nature of the demonstration program would fit CMMI's mission to reduce spending without sacrificing quality: pilots to tackle low-value care would increase quality of care by removing harmful and or wasteful services, while also reducing health care spending.

In conclusion, the Coalition urges you to utilize existing legislative authority to help the Medicare program and the health care system as a whole transition to one that covers "smarter" care.

Sincerely,

Andrew MacPherson, Co-Director Katy Spangler, Co-Director Ray Quintero, Co-Director

[25] https://www.vahealthinnovation.org/scv/
[26] https://www.apcdcouncil.org/sites/default/files/media/vhi_slides_for_waste_calculator_presentation_5.16.19.pdf
[27] https://wahealthalliance.org/wp-content/uploads/2018/10/Drop-the-Pre-op-Info-Sheet-09.14.pdf
[28] https://www.healthaffairs.org/do/10.1377/hblog20171117.664355/full/

Appendix A

Table 1. Published USPSTF D-rated Services

Type	Year	Topic Name	Age Group	Category
Screening	2021	Screening for Asymptomatic Carotid Artery Stenosis	Adult, Senior	Cardiovascular Disorders (Heart and Vascular Diseases)
Screening	2020	Bacterial Vaginosis in Pregnant Persons to Prevent Preterm Delivery: Screening	Adolescent, Adult	Infectious Diseases, Obstetric and Gynecologic Conditions
Screening	2019	Abdominal Aortic Aneurysm: Screening	Adult, Senior	Cardiovascular Disorders (Heart and Vascular Diseases)
Screening	2019	Asymptomatic Bacteriuria in Adults: Screening	Adolescent, Adult, Senior	Infectious Diseases, Obstetric and Gynecologic Conditions
Preventive medication	2019	Breast Cancer: Medication Use to Reduce Risk	Adult, Senior	Cancer
Counseling, Screening	2019	BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing	Adult, Senior	Cancer
Screening	2019	Pancreatic Cancer: Screening	Adult, Senior	Cancer
Screening	2018	Cervical Cancer: Screening	Adolescent, Adult, Senior	Cancer

Screening	2018	Cardiovascular Disease Risk: Screening With Electrocardiography	Adult, Senior	Cardiovascular Disorders (Heart and Vascular Diseases)
Screening	2018	Prostate Cancer: Screening	Adult, Senior	Cancer
Preventive medication	2018	Vitamin D, Calcium, or Combined Supplementation for the Primary Prevention of Fractures in Community-Dwelling Adults: Preventive Medication	Adult, Senior	Metabolic, nutritional, and Endocrine Conditions
Counseling, Preventive medication	2018	Falls Prevention in Community-Dwelling Older Adults: Interventions	Senior	Injury Prevention, Musculoskeletal Disorders
Screening	2018	Ovarian Cancer: Screening	Adult, Senior	Cancer
Preventive medication	2017	Hormone Therapy in Postmenopausal Women: Primary Prevention of Chronic Conditions	Adult, Senior	Metabolic, nutritional, and Endocrine Conditions, Obstetric and Gynecologic Conditions
Screening	2017	Thyroid Cancer: Screening	Adult, Senior	Cancer
Screening	2016	Genital Herpes Infection: Serologic Screening	Adolescent, Adult	Infectious Diseases
Screening	2016	Chronic Obstructive Pulmonary Disease: Screening	Adult, Senior	Cardiovascular Disorders (Heart and Vascular Diseases)

Preventive medication	2014	Vitamin Supplementation to Prevent Cancer and CVD: Preventive Medication	Adult, Senior	Cancer, Cardiovascular Disorders (Heart and Vascular Diseases)
Screening	2011	Testicular Cancer: Screening	Adolescent, Adult, Senior	Cancer

Source: USPSTF website, published recommendations sorted by D rating, as of March 10, 2021

Appendix B

Table 2. MedPAC low-value services

Chart 5-6. Between 34 and 72 low-value services provided per 100 FFS beneficiaries in 2014; Medicare spent between $2.4 billion and $6.5 billion on these services

	Broader version of measure			Narrower version of measure		
Measure	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)
Imaging for nonspecific low back pain	12.0	8.9%	$232	3.4	3.1%	$66
PSA screening at age ≥75 years	9.0	6.2	79	5.1	4.2	44
Colon cancer screening for older adults	8.0	7.5	405	0.3	0.3	3
Spinal injection for low back pain	6.6	3.3	1,261	3.4	2.0	643
Carotid artery disease screening in asymptomatic adults	5.1	4.6	268	4.2	3.8	221
Preoperative chest radiography	4.6	4.1	67	1.1	1.1	17
PTH testing in early CKD	4.5	2.6	83	3.9	2.3	71
Stress testing for stable coronary disease	4.3	4.1	1,198	0.5	0.5	137
T3 level testing for patients with hypothyroidism	3.8	2.2	23	3.8	2.2	23
Head imaging for headache	3.6	3.3	242	2.4	2.2	160
Cervical cancer screening at age >65 years	2.2	2.2	44	1.9	1.9	39
Homocysteine testing in cardiovascular disease	1.5	1.2	12	0.4	0.3	3
Head imaging for syncope	1.2	1.1	78	0.8	0.7	51
Preoperative echocardiography	0.8	0.8	62	0.2	0.2	19
Preoperative stress testing	0.6	0.6	177	0.2	0.2	60
Screening for carotid artery disease for syncope	0.6	0.6	33	0.4	0.4	23
CT for rhinosinusitis	0.6	0.5	39	0.2	0.2	17
Vitamin D testing in absence of hypercalcemia or decreased kidney function	0.5	0.4	8	0.5	0.4	8
Imaging for plantar fasciitis	0.5	0.4	9	0.4	0.3	6
BMD testing at frequent intervals	0.4	0.4	9	0.3	0.3	6
Cancer screening for patients with CKD on dialysis	0.4	0.3	9	0.1	0.1	1
PCI/stenting for stable coronary disease	0.3	0.3	1,284	0.1	0.1	216
Arthroscopic surgery for knee osteoarthritis	0.2	0.2	204	0.1	0.1	108
Vertebroplasty	0.2	0.2	338	0.2	0.2	327
Preoperative PFT	0.2	0.2	2	0.1	0.1	1
Hypercoagulability testing after DVT	0.2	0.1	5	0.1	0.1	2
IVC filter placement	0.1	0.1	33	0.1	0.1	33
Carotid endarterectomy for asymptomatic patients	0.1	0.1	165	0.03	0.03	66
EEG for headache	0.1	0.1	4	0.04	0.04	2
Renal artery stenting	0.1	0.1	152	0.02	0.02	51
Pulmonary artery catheterization in ICU	0.01	0.01	0.2	0.01	0.01	0.2
Total	**72.2**	**37.4**	**6,526**	**34.2**	**22.5**	**2,425**

Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues, (Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. JAMA Internal Medicine 174: 1067–1076; Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. JAMA Internal Medicine 175: 1815–1825).