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The Value of Low-Value Lists

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An international groundswell of activity is seeking to identify and reduce the use of health care services that provide little or no benefit—whether through overuse or misuse. There are strong imperatives for identifying such waste: (1) an ethical imperative to ensure patient safety and thus avoid tests and treatments that cause harm directly or indirectly without providing commensurate benefit; (2) a quality imperative to measure and reward best practices; and (3) an economic imperative to reduce spending and enhance the diffusion of cost-effective innovations.

England’s National Institute for Health and Clinical Excellence (NICE) commenced a formal agenda in this area in 2005. The most recent initiative garnering attention is Choosing Wisely, a US campaign led by the ABIM Foundation. Other countries are implementing similar approaches. A major challenge faced by these initiatives has been how to identify and prioritize candidate services for consideration in a reasoned and transparent manner. Today, several lists compiled by prominent organizations have identified numerous services as potentially low value in certain clinical circumstances (eTable, available at http://www.jama.com). The challenge facing payers and health care service providers such as physicians and hospitals is to develop and implement strategies to reduce the use of services that are identified in these lists, many of which are discretionary, if not potentially harmful.

The intent of the evidence-informed lists is to provide sets of specific services used in defined clinical scenarios that payers and health care professionals can target directly in rewarding value and limiting inappropriate care. As suggested by the lists, services that are ineffective, unsafe, or both for all patients and indications are rare. Typically, a service demonstrates safety and effectiveness profiles that depend on the characteristics of the population to whom it is provided. In essence, a service that is low value in some clinical circumstances might be high value in others. This clinical heterogeneity makes it difficult to develop simple approaches for identifying low-value services. For instance, although routine stress testing in asymptomatic patients is clearly of low value, stress tests can be very high value in those presenting with symptoms of ischemic heart disease. The main challenge is that interventions proven to be effective for specific clinical populations are often inappropriately applied to patients for whom benefit has never been demonstrated (indication or scope creep). In the United States in particular, extrapolation of evidence is encouraged by financial incentives embedded in physician payment systems and coverage designs with limited cost sharing for patients.

Just as the development of low-value lists is beset with clinical complexity, so too is their implementation. Although evidence-based assessments of individual health services often focus on use in specific populations and indications, the presumption of detailed clinical data is often at odds with the nature of existing data sources such as administrative claims. For instance, imaging for acute back pain usually is considered of low value, but this may not be the case in certain cases such as trauma or evidence of neurologic compromise. Although this information might be present in medical records, it typically is not captured well in claims. These data deficiencies present fundamental obstacles to translating comparative effectiveness research into effective policies because often the lack of detailed information on the clinical context (ie, indications) limits the usefulness of claims data for identifying and measuring the use of these low-value services.

One strategy to reduce waste is to deny coverage for wasteful services. Yet because of the aforementioned clinical heterogeneity that cannot always or easily be observed with current claims systems, the effectiveness of using coverage design to discourage use of low-value services is likely to be limited in scope. Similarly, value-based insurance design and related supply-side strategies (eg, not paying for never events) are fraught with measurement and data issues when applied to services of heterogeneous value. For example, developing benefit-based co-payments for automatic implantable cardiac defibrillators or for coronary revascularization procedures (higher co-payments for lower-value uses) would require the incorporation of complex and evolving guide-

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lines and clinical trial data into coverage designs, collection and processing of detailed patient data by payers, and sufficiently rapid co-payment determinations to allow cost sharing to have its intended effect on demand. Such strategies may indeed be suitable for services in which heterogeneity (eg, indications) is easily traceable in data systems or for services that are uniformly low value, such as vertebroplasty. 7 However, determining coverage or cost sharing for services of variable efficacy and for which claims data cannot elucidate high- from low-value applications could prove administratively complex and costly. Because it is not in the interest of anyone to construct blunt coverage rules that indiscriminately decrease both appropriate and inappropriate use, efforts by payers to discourage waste through coverage design alone ultimately may eliminate relatively few items from the lists.

When properly rewarded for delivering cost-effective care, health care organizations such as physician groups or integrated delivery systems are arguably better positioned to operationalize the full spectrum of low-value lists because strategies initiated closer to the point of care can be more clinically nuanced. The translational challenge is to develop tools that reliably and prospectively identify low value at the point of care. Comparative effectiveness research is now providing stronger, more nuanced evidence that can be used to support educational interventions and the development of formal clinical guidelines or decision support systems that encourage the use of treatments likely to work (eg, at what degrees of disease severity), while simultaneously discouraging use that is unlikely to be helpful, thus allowing clinicians to arrive at treatment indication criteria in an evidence-based way. For instance, Al-Khatib et al 6 provided an elegant example of this potential in their work determining characteristics and in-hospital outcomes of patients who receive a non–evidence-based automatic implantable cardiac defibrillator. They found that 22.5% of these procedures represented waste, ie, the inappropriate overuse of an otherwise effective intervention. Similarly the US Preventive Services Task Force (USPSTF) “D” list, with its blanket age-based recommendations, has gone the furthest in articulating the populations least likely to benefit and most likely to be harmed from services.

Conceptually, global payment arrangements that balance incentives to control spending with incentives to improve quality and outcomes could prompt health care organizations to develop tools to help member clinicians and managers to distinguish low- from high-value services, and low- from high-value applications of the same service. Payments that are sufficiently bundled and coupled with incentives to improve outcomes obviate the need for identifying and paying (or not paying) for specific services in specific settings, allowing health care organizations to incorporate lists of low-value services comprehensively using innovative and nuanced strategies. These might include clinical decision supports, shared decision-making tools, establishing preferred referral networks, reconfiguring capacity, physician profiling, and retraining. Success requires outcome measures sufficiently sensitive and broad to also identify underprovision of high-value services. Experimentation with global payment contracts is just under way, however, and much work remains to connect concept and practice and to align incentives for physicians within these organizations. 7 Programs sponsored through the Centers for Medicare & Medicaid Innovation and commercial programs such as the Blue Cross Blue Shield Alternative Quality Contract are recognizing the role of rigorous collection of evidence to inform the design of optimal managed care plans for beneficiaries in which payments are fully or partially capitiated. In addition, bundled payment models have brought with them incentives aligned with care optimization and value rather than promoting increased use of services, whether needed or not.

Despite the constraints imposed by Congress on considerations of cost and value in coverage and payment decisions, novel approaches are emerging by which attention to comparative benefit and comparative value can take root. 8 Although coverage design can be useful, it is not sufficient. Continued reform of payment and delivery systems will likely be needed to translate the growing evidence base into value.

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Online-Only Material: The eTable is available at http://www.jama.com.

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