Priority strategy: waste_12_376_low value services

Priority strategy: Reducing low value services in MN

Strategy Catalogue unique identifier(s): 12, 376
Original submitting organization(s)/agency(ies): MDH, Bailit Health
Drafting organization/agency: MDH
Name(s) of priority strategy developer: Stefan Gildemeister
Email: Stefan.gildemeister@state.mn.us
Phone: 651-201-3554

1) This priority strategy addresses the following aspect of the Commission’s charge (select only the one that represents the best fit):

☐ Transform the health and human services system.
☒ Increase administrative efficiencies and improve program simplification within health and human services public programs.
☐ Identify evidence-based strategies for addressing the significant cost drivers of State spending on health and human services.
☐ Reduce waste in administrative and service spending in health and human service
☐ Advance health equity across geographies, racial and ethnic groups

2) Please describe the populations impacted by this strategy:

The provision of low value services has the potential to add significant costs to Minnesota’s health care system. These unnecessary costs lead to higher premiums and out of pocket costs for individuals and families, regardless of where they receive their care.

3) Problem statement

a) What is the primary problem the strategy is expected to mitigate or resolve relative to the focus area?

Recent research estimates that waste in health care accounts for about 25 percent of total health care spending. If those estimates hold in Minnesota, Minnesota would be wasting about $13 billion annually. A considerable portion of this amount is due to the provision of low value services, services that do not add value to patients in particular circumstances and can result in patient harm. Though providers and health insurance carriers are aware of low value care and many have worked to reduce the volume of it, national data suggest we have not made sufficient progress, let alone been successful in identifying the full scope of low value services.

b) What is the secondary problem(s) the strategy is expected to mitigate or resolve relative to the focus area and/or other focus areas?

Click or tap here to enter text.
4) Priority Strategy description
   a) What is the strategy?

The strategy involves quantifying how often low value services are delivered in MN, how much they cost, and who they impact. Also part of the strategy is to develop a statewide campaign to reduce low value services and an approach to holding payers and providers accountable for taking action to measurably reduce low value services.

b) What steps are required to implement the strategy?

The strategy includes four components: 1) estimating the volume of provider-driven low value services for which there is already broad consensus; 2) working with a group of stakeholders and experts to identify additional areas for low value care analysis and publicize results of measurement; 3) working with employers and providers in Minnesota to implement a statewide strategy to reduce the provision of a defined set of low value health care services; and 4) developing coordinated approach to accountability of payers and providers.

i. Who will need to take them?

MDH would lead the analytic effort to update existing estimates of the volume (# of procedures, cost) of low value services in MN, the selection of additional metrics of low value services, and analysis of that expanded set of metrics, in consultation with individuals and organizations with relevant expertise. MDH would use existing data available in the MN All Payer Claims Database (MN APCD) for this work.

A public/private collaborative that includes, as appropriate, MDH, DHS, MMB, employers, payers, and providers would implement a statewide initiative to reduce low value services. The collaborative would likely include a clinical learning community of providers who would develop best practices, protocols and reporting vehicles for reducing the incidence of low value services; an employer coalition that would explore opportunities to reduce low value services through benefit design, employee education, a commitment to submitting data into the MN APCD for analysis, and identify appropriate accountability mechanisms. MDH could convene this collaborative partnership to lead the effort, or make use of existing collaborative frameworks that have the expertise to take on that role.

The MN legislature would need to authorize the use of the MN APCD beyond 2023 for this effort.

ii. When will they need to be taken?

Assuming legislative authority and funding are received in 2021, work could begin in the latter half of that year.

iii. How long will implementation take?

This is likely to be a five year effort.

iv. What will be the associated systems impacts?

Click or tap here to enter text.

v. What will be the associated resource requirements?

Resources would be needed to fund analytic efforts, to support the work of advisory bodies selecting low-value services for analysis and improvement, and to support the efforts of the public/private collaborative in establishing statewide and/or provider-specific targets, developing communications and reporting frameworks or dashboards, and developing clinical best practices and protocols for reducing low value services.
vi. What will be the implementation challenges? Does the strategy create an administrative burden or additional costs for the State or for any external stakeholder(s)?

Some providers who have grown accustomed to providing certain services may be reluctant to move away from that approach, even in the face of clear evidence that the service is low-value and endorsement of the concept of low value services by professional organizations. Some patients have grown accustomed to receiving certain services and may be concerned when the service is not being offered / no longer available. Payers and providers may also be reluctant to have accountability mechanisms applied to them. Clinical champions will need to be engaged to help influence cultural elements that contribute to the provision of low-value services, and the State will need to lead efforts in accountability.

c) How will the strategy mitigate or resolve the primary problem it is addressing?

Click or tap here to enter text.

d) What are possible unintended consequences this strategy could have?

Click or tap here to enter text.

5) Expected results and supporting evidence

a) What are the expected results, and when will their impact be experienced?

In one state that has implemented a very similar initiative (VA), the collaborative set a target of reducing the incidence of a set of 7 provider-driven low-value services by 25 percent within three years. Depending on the services selected, a similar outcome for Minnesota, even if focused just on existing metrics of low value services, could result in savings of $15 million per year or greater. Savings potential could be substantially higher if additional identification of procedure-based low value services took place and methods for their systematic reduction were successfully implemented.

i. What is the anticipated fiscal impact to the State in the next biennium? (select one)

☒ New costs
☐ Budget neutral
☐ Cost savings

ii. If new costs or cost savings are anticipated, what is the scope? (select one)

☐ Small: $1 to $999,999
☒ Medium: $1 million to $9,999,999
☐ Large: Greater than $10 million

iii. Will any state investment be required?

Yes, resources will be needed to implement this strategy.

iv. What will be the programmatic and population impacts?

Click or tap here to enter text.

v. What are the key results of the equity review evaluation?

- What is the impact associated with most vulnerable populations?
- How will this strategy identify the full scope of low value services?
- How will this strategy consider cultural implications in its efforts to implement a statewide initiative to reduce low value services?
- What are the possible unintended consequences that this strategy could have?
- What are the programmatic and population impacts?
• Establish an equity analysis to determine the strategies potential impact.

Further Considerations
• Establish training tools to broaden cultural competency skills for patient advocates and community members.

b) What evidence supports the strategy’s effectiveness, if any?

Numerous studies have affirmed that a significant percentage of health care spending is associated with waste, including through the provision of low-value services. A study by RAND in 2016 (https://www.rand.org/pubs/external_publications/EP66620.html) found that spending on a group of 28 low value services totaled nearly $33M in 2013 among a group of approximately 1.5M people. In Minnesota, a study by the Minnesota Department of Health using the MN APCD found that, in 2014, there were approximately 92,000 encounters associated with low-value imaging, 69,000 instances of low-value screening, and 15,000 instances of low-value pre-operative testing. Total spending on these services was nearly $54M, with $9.3M paid by patients as out of pocket expenses.

6) Additional considerations for the Blue Ribbon Commission members to consider.
   a) Is there any additional information that the Blue Ribbon Commission should consider when reviewing this strategy?

      Click or tap here to enter text.

   b) Are there any perspectives/concepts/ideas the Blue Ribbon Commission members should discuss during the strategy presentation?

      Click or tap here to enter text.

   c) Other

      Click or tap here to enter text.