COLORADO MEDICAL SOCIETY

Advocating Excellence In Medicine

COLORADO MEDICAL SOCIETY COMMENTS: COLORADO OPTION STANDARDIZED PLAN STAKEHOLDER MEETINGS

Required benefits and introduction to cost-sharing and benefit design
8/12/2021

- CMS supports decreased or no cost-sharing for defined high-value services (e.g., prevention, primary care, mental health, prenatal care, chronic disease management, immunizations, etc.) along with increased cost sharing for low-value services (expensive and overutilized). (See CMS' preliminary recommendations from the 7/26/2019 Keystone stakeholder presentation on HB19-1004)
- The University of Michigan Center for Value-Based Insurance Design is a helpful resource to look at when designing a standardized plan. In particular, the DOI should look at the V-BID X model plan.
- The V-BID X Summary highlights the following guiding principles when choosing high- and low-value services to target for decreased or increased cost-sharing:
    - Favor services with a stronger evidence-base and external validation.
    - Favor services with a high likelihood of being high- or low-value, independent of clinical context (services with less nuance are easier to implement).
    - Focus on areas with most need for improvement.
    - Consider equity, adverse selection, impact on special populations, and the risk pool.
- Table 1 in the V-BID X Summary identifies high-value services and drug classes. This is a helpful starting point.
- Table 2 in the V-BID X Summary identifies low-value services and categories. This is a helpful starting point, but we must be careful about overly broad categories (e.g., outpatient specialist services and outpatient surgical services are very broad and capture a significant amount of high-value care).
- Categories of services, as well as individual services and drugs, may be high-value in one context and low-value in another. Care must be taken to ensure patients for whom a service or drug would be high-value can access it even if that service or drug might be low-value for most patients.
- We anticipate the need to refine the lists of high- and low-value services over time.
- We must utilize the expertise of sub-specialty care providers and learn from our medical community about not only the medicine but also about what initiatives have been tried before.
- We should pay attention to lessons learned from the Center for Medicare and Medicaid Innovation (CMMI)—during the agency's first decade of operation, some of the value-based models saved money and improved quality but most did not. (See NEJM article)
- There will be difficult conversations around identifying low-value care. These additional resources should be consulted:

    - CIVHC: Low Value Care in Colorado
    - Choosing Wisely Lists of Recommendations
        - Recommendations regarding preventive care
        - Recommendations from the American College of Physicians
    - VBID Health Low-Value Care Task Force
    - U.S. Preventive Services Task Force
- In addition to differentiating high- and low-value care based on type of service, the *site* of service may be a useful differentiator. For example, a service may be high-value if provided in a setting without a facility fee, but the same service could be much more expensive and therefore low-value when provided in a setting with a facility fee.
- The differences between primary care and specialty care need to be evaluated and they may need to be approached in different ways.
    - The National Academy of Medicine's 2021 report Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care is a helpful resource.
- Attention must be paid to appropriate social supports (e.g., transportation and other social services).
- We should focus on the areas that drive premium dollars. According to the CDC, "90% of the nation's $3.8 trillion in annual health care expenditures are for people with chronic and mental health conditions."