HB 260

26-LS1128\R
Mischel
2/4/10

CS FOR HOUSE BILL NO. 260(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE KELLER

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to preventive care services for medical assistance recipients; and**
2 **providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 47.07 is amended by adding a new section to read:
5 **Sec. 47.07.047. Preventive care services.** (a) The department shall provide
6 services and opportunities to enable eligible medical assistance recipients to receive a
7 full range of preventive care services that are coordinated and that are provided in the
8 least restrictive and most home-like environment. The services must include
9 (1) coordination by a primary care provider;
10 (2) use of evidence-based practice guidelines;
11 (3) patient education;
12 (4) specialty referral and provider collaboration;
13 (5) routine health assessments;
14 (6) outcome assessment and measurement;

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1 (7) other preventive services identified by the department in regulation.
2 (b) To implement (a) of this section, the department may contract with
3 qualified entities or providers to provide preventive care services that include medical
4 home-based services and programs of alternative care for the elderly.
5 (c) The department may provide services required under (a) of this section
6 under a waiver, in accordance with 42 U.S.C. 1396 - 1396p (Title IX Social Security
7 Act), this chapter, and regulations adopted under this chapter, if the department
8 (1) finds that providing the services under a waiver is the most cost-
9 effective and cost-efficient method of providing the services;
10 (2) receives appropriations allocated for that purpose; and
11 (3) receives approval from the federal government for the waiver.
12 (d) The department shall evaluate the projected and actual savings resulting
13 from implementation of this section and provide an annual report to the legislature
14 describing the services provided, participant outcomes, and savings.
15 * **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to
16 read:
17 FEDERAL MEDICAL ASSISTANCE APPROVAL; NOTIFICATION. (a) The
18 Department of Health and Social Services may apply for a waiver from the United States
19 Department of Health and Human Services to provide preventive services to medical
20 assistance recipients under AS 47.07.047, enacted by sec. 1 of this Act.
21 (b) On or before July 1, 2011, the commissioner of health and social services shall
22 notify the revisor of statutes of the approval or denial of a waiver applied for under this
23 section.
24 * **Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to
25 read:
26 PREVENTIVE CARE SERVICES; REGULATIONS. The Department of Health and
27 Social Services may adopt regulations necessary to implement AS 47.07.047, enacted by sec.
28 1 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act) but
29 not before the effective date of sec. 1 of this Act.
30 * **Sec. 4.** Sections 2 and 3 of this Act take effect immediately under AS 01.10.070(c).

Adopted 3/23/2010. -liz

26-LS1128\R.2
Mischel
3/18/10

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: CSHB 260(HSS), Draft Version "R"

1 Page 2, line 14, following "outcomes,":

2 Insert "costs,"

L

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Adopted 3/23/2010. - liz

26-LS1128\R.1
Mischel
3/18/10

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: CSHB 260(HSS), Draft Version "R"

1 Page 2, following line 14:
2 Insert a new subsection to read:
3 "(e) The department shall establish measures that include medical, social, and
4 economic components for the services provided under this section. The measures shall
5 be used in evaluating outcomes and savings for purposes of reporting under (d) of this
6 section."

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ALASKA STATE LEGISLATURE

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REPRESENTATIVE WES KELLER
DISTRICT 14

Sponsor Statement
House Bill 260

"An Act relating to preventive care and disease management services for medical assistance recipients; and providing for an effective date."

"An ounce of prevention is worth a pound of cure." Those were words most of us heard from our mothers or fathers when we were young. Today, we have an opportunity to apply those words in a practical and economical sense. House Bill 260 will open the door for those receiving Medicaid to participate in preventative care and disease management programs.

Under the proposal, providers will be reimbursed for giving patients the option of learning and pursuing good health based on their personal history and risk factors. Often if a condition is dealt with early on, a cure can be as simple as a life style change. This could eliminate the need for extensive medical intervention later and will save money.

Preventative medicine is the basis for so much of our life style today from smoking cessation to reducing alcohol consumption. Currently, the Medicaid system does not permit, nor will it pay for preventative types of activity. House Bill 260 will give those using Medicaid the same opportunity to learn how to make changes in their lives that will help them live healthier.

E-Mail: Representative_Wes_Keller@legis.state.ak.us
Call Juneau Toll free: (800) 468-2186
Website: www.akrepublicans.org/keller/

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB260
() Publish Date:

Identifier (file name): HB260-DHSS-MAA-2-8-10
Title: Medicaid: Preventive Care/ Disease
Sponsor: Keller
Requester: House HSS

Dept. Affected: Health & Social Services
RDU: Health Care Services
Component: Medical Assistance Administration
Component Number: 242

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITU	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	94.2		94.2	94.2	94.2	94.2	94.2
Travel							
Contractual	9.6		9.6	9.6	9.6	9.6	9.6
Supplies	1.0		1.0	1.0	1.0	1.0	1.0
Equipment	7.6						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**112.4**		**104.8**	**104.8**	**104.8**	**104.8**	**104.8**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	56.2		52.4	52.4	52.4	52.4	52.4
1003 GF Match	56.2		52.4	52.4	52.4	52.4	52.4
1004 GF							
1005 GF/Program Receip							
1037 GF/Mental Health							
Other Interagency Receip							
TOTAL	**112.4**		**104.8**	**104.8**	**104.8**	**104.8**	**104.8**

Estimate of any current year (FY2010) c

POSITIONS

Full-time	1		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece:*

HB 260 would require DHSS to develop a program of preventive care and disease management for Medicaid recipients. The department anticipates complying with this requirement by establishing a Program of All-Inclusive Care for the Elderly (PACE) and/or medical home program. This bill would not affect the total number of Medicaid recipients served, but would alter the mix of services that some individuals receive and, in some instances, how they receive it.

DHSS anticipates that actual provision of the preventive care and disease management would occur through PACE and primary care providers. However, it would be necessary to hire one new staff to develop and oversee these programs.

(continued on Page 2)

Prepared by: William J. Streur, Deputy Commissioner
Division: Health Care Services
Phone: 269-7827
Date/Time: 2/5/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 2/8/2010

FISCAL NOTE

STATE OF ALASKA

2010 LEGISLATIVE SESSION

BILL NO. HB260

ANALYSIS CONTINUATION

Administrative Costs:

1 Medical Assistance Administrator III, $94, 207 (Range 20) ; . All personal services costs include benefits. Assumes $9.6 per FTE annually for office space, phones, and other contractual costs; $2.6 one time costs per FTE for computers and software; $5.0 one time costs per FTE for office equipment; $1.0 per FTE annually for supplies.

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FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB260
() Publish Date:

Identifier (file name): HB260-DHSS-MS-2-8-10
Dept. Affected: Health & Social Services
Title: Medicaid: Preventive Care/ Disease
RDU: Health Care Services
Component: Medicaid Services
Sponsor: Keller
Requester: House HSS
Component Number: 2077

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITU	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims	0.0		0.0	0.0	0.0	0.0	0.0
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match	0.0		0.0	0.0	0.0	0.0	0.0
1004 GF							
1005 GF/Program Receipt							
1037 GF/Mental Health							
Other Interagency Receipt							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) c

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece:*

HB 260 would require DHSS to develop a program of preventive care and disease management for Medicaid recipients. The department anticipates complying with this requirement by establishing a Program of All-Inclusive Care for the Elderly (PACE) and/or medical home program. This bill would not affect the total number of Medicaid recipients served, but would alter the mix of services that some individuals receive and, in some instances, how they receive it.

PACE is an optional benefit under both the Medicare and Medicaid programs. It serves people over 55 years who meet the State's standards for nursing home care. PACE providers receive capitated payments from Medicare and Medicaid and assume the risk for all Medicare and Medicaid services. For most patients, a comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized. A team of doctors, nurses and other health professionals assess participant needs, develop care plans, and deliver all services, which are integrated into a complete health care plan. (continued on page 2)

Prepared by: William J. Streur, Deputy Commissioner
Phone 269-7827
Division: Health Care Services
Date/Time 2/8/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date 2/8/2010

FISCAL NOTE

STATE OF ALASKA

2010 LEGISLATIVE SESSION

BILL NO. HB260

ANALYSIS CONTINUATION

Starting a PACE program requires an agreement between the State Medicaid and the federal Medicare programs. It may take as long as 2 years to initiate a program including the possible need to obtain a Medicaid waiver, negotiating an agreement with Medicare to participate in a regional program, and securing the interest of a PACE organization. Initially, capitated Medicaid payments to the PACE provider would probably equal what the Medicaid program is currently paying for services for these clients. Eventually, with enough actuarial experience, capitated payments might be adjusted downward if the program successfully bends the cost curve.

Medicaid Medical home is a model of health care delivery in which a Medicaid recipient chooses a primary care provider (PCP) who is responsible for coordinating the participant's care. These plans provide participants a medical home and a relationship with a primary care provider to increase primary care and reduce the need for specialty and emergency department care. PCPs are paid a monthly fee for coordinating the participant's care on top of the payment for providing medical services reimbursed on a fee-for-service basis.

Considerable efforts on the part of HCS would be necessary in order to recruit primary care providers to participate in a medical program. One potential opportunity would be to enlist the participation and partnership of the Primary Care Association and a contracting relationship with specific Community Health Centers to develop medical home programs. Potential cost savings from the program would be depending on the level of fees necessary to attract adequate PCPs. Because of the uncertainty about the necessary level of the fee, DHSS does not project spending reductions by FY 2016. However, DHSS does believe that Primary Care case management would result in improved quality of care for Medicaid recipients.

Preventive Health Care: An Ounce of Prevention

by Eve B. Scheffenacker

When people talk about the dire state of health care in this country, fingers point in every direction. At hospitals and HMOs (health maintenance organizations) that make treatment decisions based on cost-benefit analysis. At drug companies whose profit margins have been described as obscene. At insurance companies that won't insure people who've been treated for depression or acid reflux.

Clearly, there's plenty of blame to go around. So let's not overlook another influential group--patients like you and me, especially the ones who have insurance. While thousands of Americans do without medical care that they need but can't afford, an even larger number of insured people ignore health services that will cost them a little and could save everyone a lot.

What's the story?

A recent study found that, of the people who have preventive care benefits available through their medical plans, only 10% actually use them. The other 90% don't get routine exams like mammograms and prostate screenings, don't get lab work to check their cholesterol and blood sugar, and don't get their children vaccinated. They don't enroll in an exercise class or a disease management program. Not even when their plans cover all or most of the costs.

A new MRI available in some areas can diagnose heart disease 10 years before the person is at risk for heart attack.

Some of these people may not know the benefits exist and don't think to ask. A lot of them, though, are in denial, believing that "it"--heart disease, cancer, diabetes, or stroke--won't happen to them. Some of them may be right, but the odds don't favor them. The U.S. spends $240 billion a year treating diabetes, obesity, and tobacco-related diseases. That figure represents a lot of very sick people whose diseases could have been detected and managed by preventive care.

The pound of cure

These people may be making a risky and expensive mistake, because preventive care saves lives and money. So if you belong to the 90% majority that is choosing to go without preventive care, here are some reasons to consider joining the minority.

- *Preventive care is inexpensive long-term care* because it protects your future health. Medical and pharmaceutical advances have only a small effect on our overall health. In fact, 25 of the 30 years added to life expectancy in the past century are due to advances in preventive medicine and public health.

  Only 10% of the people who have preventive care benefits through their medical plans use them.

  Even when you're feeling well, the first signs of a critical disease may be present. Only blood tests, X-rays, and other procedures can detect those early signs. Doctors now are better educated about doing routine screening and knowing what to look for. In the meantime, advances in routine tests have made

them remarkably accurate. For example, a new type of MRI (magnetic resonance imaging; note that this test is not available everywhere) can diagnose heart disease as much as 10 years before the person is at risk for heart attack. Think how the death rate from heart attack might drop if more people took advantage of that one test.

Detecting a chronic or acute disease in its early stage puts you ahead of the curve. It also saves you a lot of money. Instead of working to combat an advanced disease and its complications, your doctor can focus on keeping a small symptom from becoming bigger. Usually, the earlier you start treating a condition, the better your chances of surviving. For example:

Detecting an acute disease in its early stages puts you ahead of the curve, medically and financially.

  - When doctors can diagnose heart disease before symptoms occur, they can treat and even reverse the progress of most conditions with outpatient care--and patient compliance.
  - Because colon polyps grow slowly, routine colonoscopies could prevent more than 90% of deaths from colon cancer.
  - Several studies show that routine mammograms after age 40 lower a woman's risk of dying from breast cancer.

- *Regular preventive care means better overall care from your primary doctor.* When you receive regular preventive care, your doctor can track your health over a period of years. He or she then is more likely to notice small but telling changes in your weight or blood pressure, sleep patterns, or appetite. Your doctor also can help you manage behaviors that contribute to heart disease, diabetes, and cancer. Walking 20 minutes a day, cutting back on fat in your diet, or stopping smoking are manageable changes that literally can save your life.
- *Routine immunizations give you and your children immediate protection.* Pediatric vaccinations protect children from serious infections including polio, chicken pox, and meningitis. And among older Americans, the annual flu shot can prevent the flu and other, more serious complications including heart attack, pneumonia, and stroke.

Take care of yourself now and protect the health you hope to enjoy 10 years from now.

Bottom line--preventive care could lead the way to health-care reform

Everyone, including you, saves money when more people make an effort to stay well. And we could be talking about a lot of money. According to the National Congress on Pre-Symptom Medicine, regular use of preventive care by Americans could cut projected health-care costs by 50% over the next 10 years.

Think about what that means. If there's any truth in that statistic, a large part of the solution to the health-care crisis is in our control. The financial impact of the preventive care that you and your family members receive in the coming years can reach far beyond your paycheck. It can have a strong and salutary effect on the health-care industry and even the economy. With rising health-care costs undermining the profitability of businesses and the health of millions of people, that possibility is worth exploring and acting on.

A large part of the solution to the health-care crisis is in our control.

So find out what coverage your medical plan has for wellness and preventive care. Make an appointment now for a routine physical or a bone density test. Take your children in for their vaccinations, or get a flu shot at a health fair. Grit your teeth and schedule a mammogram, colonoscopy, or prostate exam. Take care of yourself now and protect the health you hope to enjoy 10 years from now. You'll save money that you can spend on more pleasant pastimes. You'll also be doing your part to resolve the health-care crisis.

It can only do you good!

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

FEBRUARY 14, 2008

Does Preventive Care Save Money? Health Economics and the Presidential Candidates

Joshua T. Cohen, Ph.D., Peter J. Neumann, Sc.D., and Milton C. Weinstein, Ph.D.

With health care once again a leading issue in a presidential race, candidates have offered plans for controlling spiraling costs while enhancing the quality of care. A popular component of such plans involves greater promotion of preventive health measures. The first element in Hillary Clinton's plan is to "focus on prevention: wellness not sickness." John Edwards has stated that "study after study shows that primary and preventive care greatly reduces future health care costs, as well as increasing patients' health." Mike Huckabee has said that a focus on prevention "would save countless lives, pain and suffering by the victims of chronic conditions, and billions of dollars." Barack Obama has argued that "too little is spent on prevention and public health."

Indeed, some evidence does suggest that there are opportunities to save money and improve health through prevention. Preventable causes of death, such as tobacco smoking, poor diet and physical inactivity, and misuse of alcohol have been estimated to be responsible for 900,000 deaths annually — nearly 40% of total yearly mortality in the United States.[1] Moreover, some of the measures identified by the U.S. Preventive Services Task Force, such as counseling adults to quit smoking, screening for colorectal cancer, and providing influenza vaccination, reduce mortality either at low cost or at a cost savings.[2]

Sweeping statements about the cost-saving potential of prevention, however, are overreaching. Studies have concluded that preventing illness can in some cases save money but in other cases can add to health care costs.[3] For example, screening costs will exceed the savings from avoided treatment in cases in which only a very small fraction of the population would have become ill in the absence of preventive measures. Preventive measures that do not save money may or may not represent cost-effective care (i.e., good value for the resources expended). Whether any preventive measure saves money or is a reasonable investment despite adding to costs depends entirely on the particular intervention and the specific population in question. For example, drugs used to treat high cholesterol yield much greater value for the money if the targeted population is at high risk for coronary heart disease, and the efficiency of cancer screening can depend heavily on both the frequency of the screening and the level of cancer risk in the screened population.[4]

The focus on prevention as a key source of cost savings in health care also sidesteps the question of whether such measures are generally more promising and efficient

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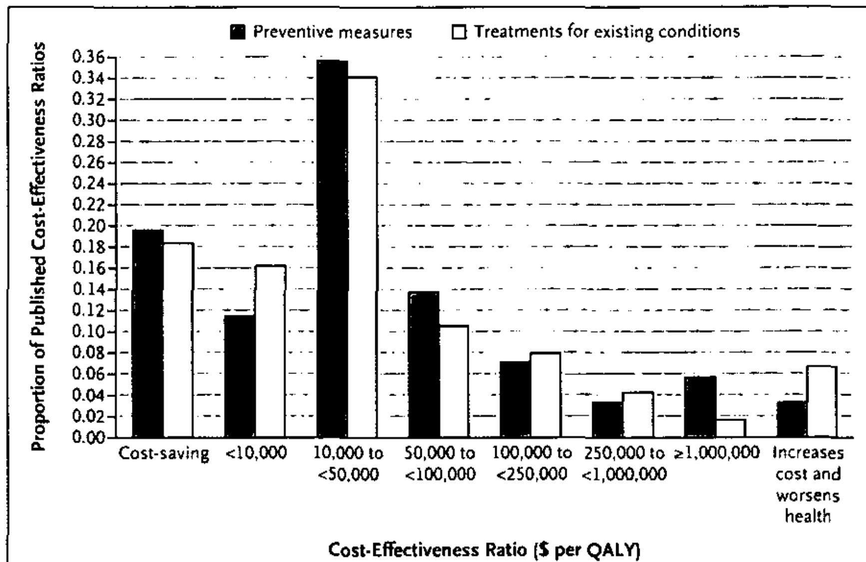

Distribution of Cost-Effectiveness Ratios for Preventive Measures and Treatments for Existing Conditions.

Data are from the Tufts–New England Medical Center Cost-Effectiveness Registry. QALY denotes quality-adjusted life-year.

than the treatment of existing conditions. Researchers have found that although high-technology treatments for existing conditions can be expensive, such measures may, in certain circumstances, also represent an efficient use of resources.[5] It is important to analyze the costs and benefits of specific interventions.

A systematic review of the cost-effectiveness literature sheds light on these issues. We analyzed the contents of the Tufts–New England Medical Center Cost-Effectiveness Analysis Registry (www.tufts-nemc.org/cearegistry), which consists of detailed abstracted information on published cost-effectiveness studies through 2005. Each registry article estimates the cost-effectiveness of one or more interventions as the incremental costs (converted here to 2006 U.S. dollars) divided by the incremental health benefits quantified in terms of quality-adjusted life-years (QALYs). Low cost-effectiveness ratios are "favorable" because they indicate that incremental QALYs can be accrued inexpensively. An intervention is "cost-saving" if it reduces costs while improving health. Poorly performing interventions can both increase costs and worsen health.

Our analysis was restricted to the 599 articles (and 1500 ratios) published between 2000 and 2005 that properly discounted future costs and benefits. We classified 279 ratios as preventive because they refer to interventions designed to avert disease or injury; all 1221 other ratios pertain to treatments, a category that includes both "tertiary" measures (designed to ameliorate the effects of a disease or condition) and "secondary prevention" measures (designed to reverse or retard progression of an existing condition), such as the use of implantable cardioverter–defibrillators in patients with myocardial disease.

The bar graph shows that the distributions of cost-effectiveness ratios for preventive measures and treatments are very similar — in other words, opportunities for efficient investment in health care programs are roughly equal for prevention and treatment, at least as reflected in the literature we reviewed. Moreover, both distributions span the full range of cost-effectiveness. The table shows the cost-effectiveness ratios for selected interventions of various types.

These results are consistent with earlier reviews but cover a larger sample of studies and quantify benefits in terms of QALYs. Some preventive measures save money, while others do not, although they may still be worthwhile because they confer substantial health benefits relative to their cost. In contrast, some preventive measures are expensive given the health benefits they confer. In general, whether a particular preventive measure represents good value or poor value depends on factors such as the population targeted, with measures targeting higher-risk populations typically being the most efficient. In the case of screening, efficiency also depends on frequency (more frequent screening confers greater benefits but is less efficient). Third, as is the case for preventive measures, treatments can be relatively efficient or inefficient.

Of course, our review reflects a selected sample of studies in the peer-reviewed literature and does not cover all possible opportunities to spend resources to improve health. In addition, there may be inconsistency among the studies in terms of the methods used. Still, our analysis is based on a large and diverse set of studies that used recommended metrics for cost-effectiveness analysis, and we believe that it offers important lessons.

Our findings suggest that the broad generalizations made by many presidential candidates can be misleading. These statements convey the message that substantial resources can be saved through prevention. Although some preventive measures do save money, the vast majority reviewed in the health

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Cost-Effectiveness of Selected Preventive Measures and Treatments for Existing Conditions (2006 Dollars).*

Intervention	Cost-Effectiveness Ratio
Preventive measures	
Haemophilus influenzae type b vaccination of toddlers	Cost-saving
One-time colonoscopy screening for colorectal cancer in men 60–64 years old	Cost-saving
Newborn screening for medium-chain acyl-coenzyme A dehydrogenase deficiency	$160/QALY
High-intensity smoking-relapse prevention program, as compared with a low-intensity program	$190/QALY
Intensive tobacco-use prevention program for seventh- and eighth-graders	$23,000/QALY
Screening all 65-year-olds for diabetes as compared with screening 65-year-olds with hypertension for diabetes	$590,000/QALY
Antibiotic prophylaxis (amoxicillin) for children with moderate cardiac lesions who are undergoing urinary catheterization	Increases cost and worsens health
Treatments for existing conditions	
Cognitive-behavioral family intervention for patients with Alzheimer's disease	Cost-saving
Cochlear implants in profoundly deaf children	Cost-saving
Combination antiretroviral therapy for HIV-infected patients	$29,000/QALY
Liver transplantation in patients with primary sclerosing cholangitis	$41,000/QALY
Implantation of cardioverter–defibrillators in appropriate populations, as compared with medical management alone	$52,000/QALY
Left ventricular assist device, as compared with optimal medical management, in patients with heart failure who are not candidates for transplantation	$900,000/QALY
Surgery in 70-year-old men with a new diagnosis of prostate cancer, as compared with watchful waiting	Increases cost and worsens health

* The cost-effectiveness ratio is the incremental costs divided by the incremental benefits, relative to a comparator. The comparator is omitted from the intervention's description if it was no treatment or current treatment or if the intervention was added to, rather than substituted for, another treatment. The cost-effectiveness estimates listed are point-estimate values from the original articles (a more detailed table appears in the Supplementary Appendix, available with the full text of this article at www.nejm.org). Preventive measures are those designed to avert the development of a condition. Treatments for existing conditions include both those designed to prevent the progression of a condition and those designed to ameliorate the effects of a disease or condition. QALY denotes quality-adjusted life-year. For more information see www.tufts-nemc.org/cearegistry.

economics literature do not. Careful analysis of the costs and benefits of specific interventions, rather than broad generalizations, is critical. Such analysis could identify not only cost-saving preventive measures but also preventive measures that deliver substantial health benefits relative to their net costs; this analysis could also identify treatments that are cost-saving or highly efficient (i.e., cost-effective).

In addition to determining which preventive measures and treatments are most efficient, it will be necessary to identify those that are not yet fully deployed and those that could serve a large population and bring about substantial aggregate improvements in health at an acceptable cost. Findings that some cost-saving or highly efficient measures are underused would indicate that current practice is inconsistent with the efficient delivery of health care. Other services might be identified as overused, and such findings would underscore the importance of fashioning policies that provide incentives to shift practice toward more cost-effective delivery of health care. In the face of increasingly constrained resources, there is a realistic way of achieving better health results: conduct careful analysis to identify evidence-based opportunities for more efficient delivery of health care — whether prevention or treatment — and then restructure the system to create incentives that encourage the appropriate delivery of efficient interventions.

No potential conflict of interest relevant to this article was reported.

Dr. Cohen is a research associate professor of medicine and Dr. Neumann a professor of medicine and the director at the Center for the Evaluation of Value and Risk in Health, Institute for Clinical Research and Health Policy Studies, Tufts–New England Medical Center, Boston; Dr. Weinstein is a professor of health policy and management at the Harvard School of Public Health, Boston.

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3. Russell LB. Prevention's potential for slowing the growth of medical spending. Washington, DC: National Coalition on Health Care, October 2007. (Accessed January 24, 2008, at http://www.nchc.org/nchc_report.pdf.)
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5. Weinstein MC. High-priced technology can be good value for money. Ann Intern Med 1999;130:857-8.

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