

Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?

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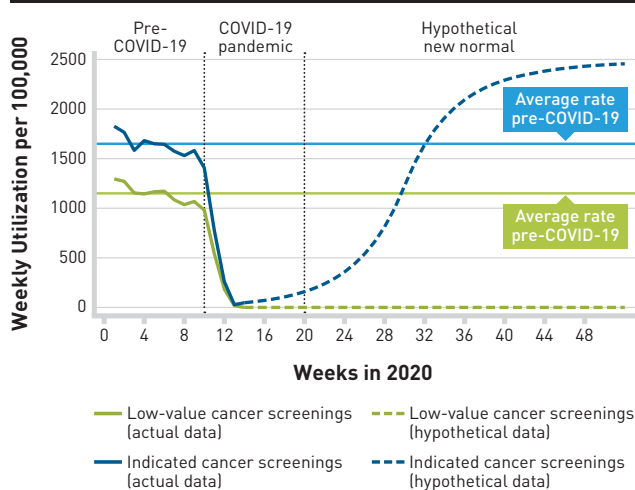
Even unprecedented crises can have silver linings. The coronavirus disease 2019 (COVID-19) pandemic is responsible for a dramatic reduction in clinician visits and medical procedures. This decline encompasses clinically indicated care but also includes services that deliver little or no clinical benefit. As we establish a “new normal” level of care post COVID-19, the medical community should leverage a rare opportunity to enhance the efficiency of the delivery system. Going forward, the key will be to invest in services that improve individual and population health while deterring a resurgence of low-value care (Figure).

A given clinical service is never by itself high or low value. Instead, its value depends on who receives it, when in the progression of a patient’s disease it is provided, and where the service is delivered. Consider cancer screening: Differentiating high- versus low-value care depends on various factors, including a patient’s age and risk profile, as well as screening frequency and site of care delivery. Among individuals at low risk or with a short life expectancy, cancer screening may often be deemed low value or even harmful because the risk of the procedure and follow-up care outweighs a small clinical benefit. Specific examples include prostate-specific antigen (PSA) screening for prostate cancer among men 70 years and older, cervical cancer screening among average-risk women younger than 21 years and older than 65 years, and colorectal cancer screening among nearly all adults younger than 40 years and older than 85 years.

Despite guideline recommendations, low-value care remains prevalent. For example, our analysis of commercial insurance claims from more than 750,000 Medicare Advantage enrollees shows that 4 in 10 men older than 70 years received at least 1 PSA screening test in 2019. Overall, researchers have estimated that the country spends \$100 billion annually on low-value care.¹

How the health care system will respond to the ongoing pandemic and its aftermath remains unclear. During March 2020, the frequency of all routine cancer screenings (and virtually all nonemergent care unrelated to COVID-19) nose-dived, regardless of clinical benefit.^{2,3} What is certain is that a large and rapid infusion of funds is necessary to support substantial unmet clinical demand and to restore the financial footing of clinicians and hospitals. A multipronged

FIGURE. Preventing the Resurgence of Low-Value Care in the Post-COVID-19 Era^a



COVID-19, coronavirus disease 2019.

^aAuthors’ analysis of commercial insurance claims data (the OptumLab Warehouse Data) among Medicare Advantage enrollees. Low-value cancer screenings (green lines) include prostate cancer screening among men 70 years and older, cervical cancer screening among non-high-risk women older than 65 years, and colorectal cancer screening among adults older than 85 years. Indicated cancer screenings (blue lines) include prostate cancer screening among men younger than 70 years, cervical cancer screening among non-high-risk women 65 years and younger, and colorectal cancer screening among adults younger than 75 years. The solid lines represent the actual utilization data prior to the COVID-19 pandemic, whereas the dotted lines represent hypothetical trends to highlight what should happen in the post-COVID-19 era.

strategy that aligns provider-facing incentives (eg, payment) and consumer-facing incentives (eg, benefit design) is warranted to ensure that a greater proportion of health care spending is dedicated to high-value care that improves health and a lower proportion to low-value care that produces no or little clinical benefit.^{4,5}

First, we need to build on alternative payment models that base reimbursement on patient-centered outcomes. The most impactful solution would increase reimbursement for high-value clinical services and reduce or cease payment for known low-value care. For example, a premium should be applied to payments that target

preventive services used in clinical scenarios with a US Preventive Services Task Force “A” or “B” grade (eg, colorectal cancer screening for those aged 50-75 years; *BRCA* risk assessment and genetic counseling/testing for those with a family history). Likewise, minimal/no reimbursement should be provided for services with a D grade (eg, colorectal cancer screening for those aged >85 years; *BRCA* risk assessment and genetic counseling/testing for those without a family history). Section 4105 of the Affordable Care Act provides the secretary of HHS authority to “provide no payment for a preventive service that has not received a Grade of A, B, C, or I by such Task Force.” Given the pent-up demand for high-value care, such clinically driven incentives would simultaneously motivate providers to optimize patient needs and address financial apprehensions.

Second, we should leverage the widespread adoption of electronic health records (EHRs) to make it easier to order high-value care with simplified processes and discourage the use of low-value care with alerts. A recent analysis of multiple EHR systems highlighted the lack of association between ease of ordering (ie, number of clicks per service) and the evidence-based value of clinical services.⁶

Third, health plans need to align patient cost sharing with the value of the underlying services. Current “blunt” instruments, such as plan deductibles, do not distinguish between high- and low-value care. A robust evidence base demonstrates that patient cost sharing indiscriminately decreases the use of both clinically indicated and unnecessary services. As alternative approaches, high-value medications that have demonstrated clinical benefit can be moved to “predeductible” status, in which patients face little or no cost sharing in a high-deductible health plan. Examples include insulin and other glucose-lowering medications for diabetes, inhaled corticosteroids for asthma, and tumor necrosis factor inhibitor therapy for autoimmune diseases. Similarly, for commonly overused low-value services (eg, the 3 low-value cancer screening scenarios mentioned previously), health plans can selectively increase the cost-sharing level as a lever to direct patient behavior. Also, a novel benefit design template—referred to as “VBID-X”—increases access to high-value care and targets low-value care without raising premiums or deductibles. In May 2020, the HHS 2021 Notice of Benefit and Payment Parameters final rule strongly recommended that federally qualified health plans adopt this approach.⁷

All stakeholders agree that there is more than enough money in the US health system, but misaligned incentives have driven spending for the wrong services in the wrong places on the wrong patients. The COVID-19 pandemic can become a catalyst to align incentives to invest more resources in high-value care and less in those that do not improve clinical outcomes. Without these changes, decreased revenues and furloughed employees will push providers for a rapid return to archaic volume-driven patterns to restore financial solvency. Some may aggressively increase the utilization of services, regardless of their value, to compensate for their financial loss.

Albert Einstein famously said, “In the midst of every crisis, lies great opportunity.” As we establish the new normal after COVID-19,

the medical community can propel a more efficient, patient-centered health system without increasing total expenditures. The resurgence should be clinically driven, but we also need to make providers “whole” for doing what is right from a patient-centered perspective. Specifically, incentives to encourage the delivery of evidence-based care, not services that produce the most revenue, must be implemented. As we reopen practices, ambulatory centers, and hospitals, providers should prioritize high-value services, and public and private payers must reimburse generously for these services while creating benefit designs that make them accessible and affordable. The added costs incurred from the increased use of high-value care can be paid for by reductions in the billions spent annually on the care that does not improve the health of Americans. ■

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