

# Opportunity After Crisis: Enhancing Value in the COVID-19 Rebound

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The delivery of low-value care poses a major challenge for the US health care system, leading to patient harm, worsening disparities, wasteful spending, and the potential substitution for investments in high-value care.<sup>1</sup> The onset of the COVID-19 pandemic in early 2020 led to a significant reduction of both high-value and low-value care. This once-in-a-century disruption that nearly shut down all elective medical care provided an unprecedented opportunity to restructure and align provider- and consumer-facing incentives with the value of care delivered, reallocating more resources to high-value, underutilized services and decreasing utilization of low-value care.<sup>2</sup> In this issue of *The American Journal of Managed Care*<sup>®</sup>, Shahzad and colleagues report that this silver lining of the pandemic may have been partially achieved.<sup>3</sup> After the use of select high-value and low-value services declined to 53.2% and 56.2% of baseline, respectively, at their April 2020 nadir, by 2021 the high-value services rebounded faster and more completely than low-value services on average, suggesting that high-value services may have been prioritized in the recovery. However, only a small number of services were studied, and substantial heterogeneity in the recovery rates was reported, in that some low-value services rebounded quickly and some high-value services failed to reattain prepandemic levels.

The lack of a consistent relationship between value and decision-making by both patients and clinicians during the pandemic showed that there is substantial room for improvement in the attention given to health care spending efficiency. The authors noted that yet-to-be-implemented targeted interventions are needed to achieve a far-reaching and lasting reduction of low-value care. As a drastically different delivery system continues its transformation post pandemic, there is still time for policy makers, health plans, and providers to take advantage of this unprecedented opportunity.

Economic theory suggests that underconsumption of high-value care and overconsumption of low-value care are due to misperceptions of clinical benefit, which distort both demand and supply of these services.<sup>4</sup> Although benefit design can align patient cost sharing with value (eg, value-based insurance design [VBID]), provider-facing initiatives (eg, accountable care organizations, episode-based

payments) are the levers most likely to better align the delivery of services with clinical benefit. Additionally, payers can influence providers to promote an aggressive resumption of high-value care (to levels higher than prepandemic) balanced with prudent frugality that avoids resumption of wasteful low-value services.

To reach these goals, providers must be increasingly held accountable for reducing the use of low-value care, the same way they are currently rewarded for the delivery of high-value services. Tools such as clinical decision support, provider education, and performance feedback can be used in concert with alternative payment models to effectively contribute to reduced use of low-value care.<sup>5</sup>

One specific step forward would be to redesign employers' requests for proposals (RFPs) to include language that provides incentives for plans and clinicians to reduce low-value care. Although some RFPs currently request a description of activities designed to address low-value care, it is rare that these actions are directly tied to payment. One exception to this is a recent TRICARE RFP, in which capitation levels depend on achieving low-value care targets.<sup>6</sup> Similar arrangements, with an emphasis on shared savings between plans and providers when low-value care is reduced, should be expanded.

Another approach to address low-value care would be to build on the foundational work of the Choosing Wisely campaign, which drew upon medical professionalism to trigger conversations between patients and clinicians about potentially overused services. The publication and dissemination of more than 600 clinician-authored recommendations were the impetus behind hundreds of implementations to reduce low-value care, providing insight on how best to move the field forward.<sup>7</sup>

Moving forward, efforts to reduce low-value care should (1) focus on services for which the evidence showing a lack of clinical benefit is not controversial; (2) avoid services with high levels of patient-driven demand (eg, antibiotics for upper respiratory infection); and (3) emphasize services with low clinical nuance, meaning that they are typically provided in low-value clinical settings (eg, population-based screening for Vitamin D levels). A good place to start is the set of D-rated services from the US Preventive Services

Task Force. A recent study reported that 7 grade-D services were utilized more than 30 million times by Medicare beneficiaries each year, at an annual cost approaching \$500 million.<sup>8</sup>

As we reset post pandemic, providers and payers are in an excellent position to develop, implement, and evaluate policies that serve public interests first and foremost.<sup>9,10</sup> In addition to the aforementioned accountability programs for providers, plans should also experiment with more widespread rollout of VBID, as has been emphasized in guidelines from CMS.<sup>11</sup> This is also an excellent opportunity to test more nuanced designs of VBID, such as value-based high-deductible health plans<sup>12</sup> and personalized benefit design.

Value-driven policies should emphasize advances in equity and in generating and using patient-centered outcomes data to determine which clinical services should be encouraged (and discouraged) based on specific clinical scenarios. As most agree that there is more than enough money in the US health care system, the postpandemic period is an ideal time to prioritize a reallocation of health care expenditures driven primarily by individual and population health gains. ■

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