Building A Better Health Care System Post-COVID-19: Steps for Reducing Low-Value and Wasteful Care

MARK MCCLELLAN

DIRECTOR
DUKE-MARGOLIS CENTER FOR HEALTH POLICY

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Corinna Sorenson PhD MHSA MPH, Mark Japinga MPA,

Hannah Crook, and Mark McClellan MD PhD

Robert J. Margolis, MD, Center for Health Policy

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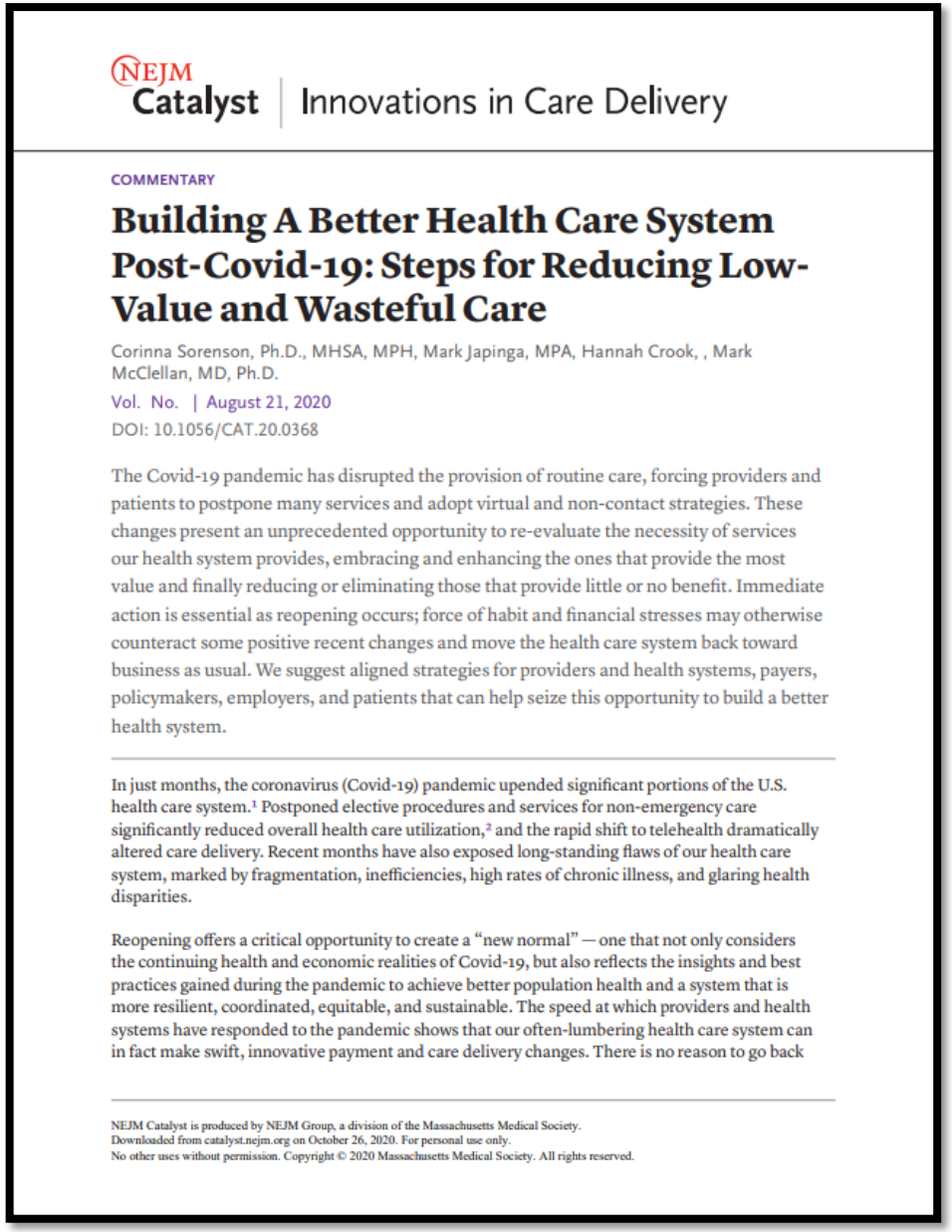

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COMMENTARY

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Corinna Sorenson, Ph.D., MHSA, MPH, Mark Japinga, MPA, Hannah Crook, , Mark McClellan, MD, Ph.D.

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The Covid-19 pandemic has disrupted the provision of routine care, forcing providers and patients to postpone many services and adopt virtual and non-contact strategies. These changes present an unprecedented opportunity to re-evaluate the necessity of services our health system provides, embracing and enhancing the ones that provide the most value and finally reducing or eliminating those that provide little or no benefit. Immediate action is essential as reopening occurs; force of habit and financial stresses may otherwise counteract some positive recent changes and move the health care system back toward business as usual. We suggest aligned strategies for providers and health systems, payers, policymakers, employers, and patients that can help seize this opportunity to build a better health system.

In just months, the coronavirus (Covid-19) pandemic upended significant portions of the U.S. health care system.[1] Postponed elective procedures and services for non-emergency care significantly reduced overall health care utilization,[2] and the rapid shift to telehealth dramatically altered care delivery. Recent months have also exposed long-standing flaws of our health care system, marked by fragmentation, inefficiencies, high rates of chronic illness, and glaring health disparities.

Reopening offers a critical opportunity to create a "new normal" — one that not only considers the continuing health and economic realities of Covid-19, but also reflects the insights and best practices gained during the pandemic to achieve better population health and a system that is more resilient, coordinated, equitable, and sustainable. The speed at which providers and health systems have responded to the pandemic shows that our often-lumbering health care system can in fact make swift, innovative payment and care delivery changes. There is no reason to go back

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Some care shouldn't be restarted, because we can't afford to go "back to normal" in health care…

*This research is supported by a three-year partnership between the Duke-Margolis Center and West Health to accelerate value-based care

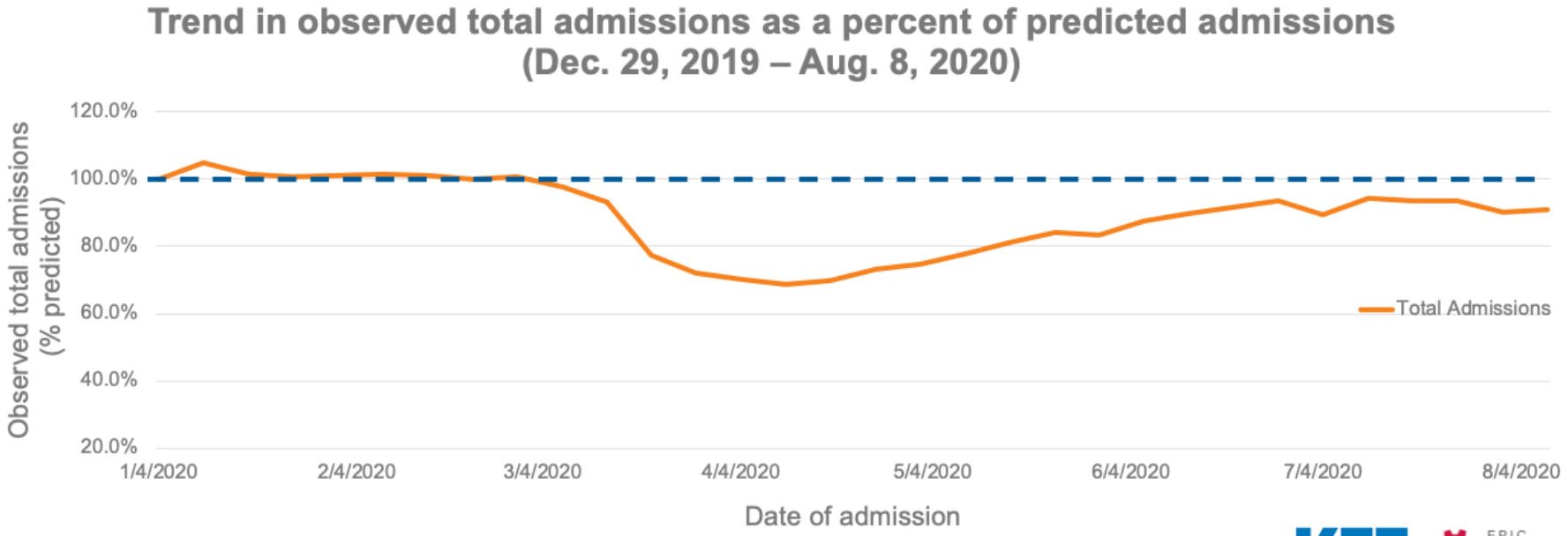
https://catalyst.nejm.org/doi/pdf/10.1056/CAT.20.0368

COVID-19 Presents an Opportunity to Create a "New Normal"

- The system-wide disruption from COVID-19 provided an impetus for rethinking how to deliver care
- This is particularly true for low-value care, thanks to increased focus on patient safety, increased opportunities to engage patients digitally, and the implementation of alternative care models in some cases
- However, this window for change has been closing
  - Pre-COVID: Widespread low-value care, accounting for up to 10-20% of annual health spending
  - Beginning of COVID: Large decreases in outpatients and elective care – up to 58% lower than normal in March

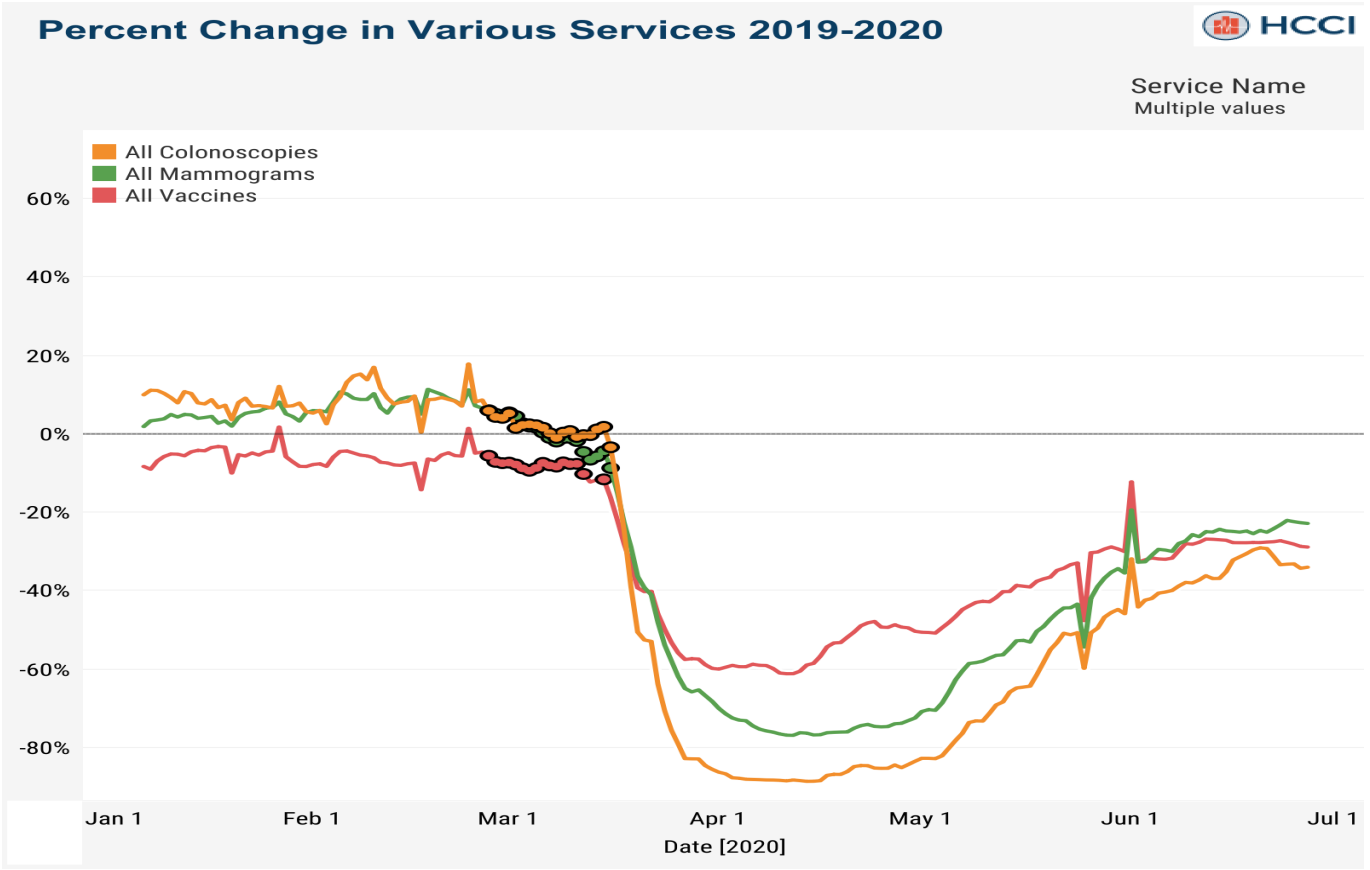
What's happened? Part 1…

Overall Admissions Decreased in March and April but Were Back at About 95% of Predicted Admissions by July 2020



SOURCE: Epic and KFF analysis of Epic Health Record System COVID-19 related data as of September 2020.

What's happened? Part 2…



Source: https://healthcostinstitute.org/hcci-research/the-impact-of-covid-19-on-the-use-of-preventive-health-care

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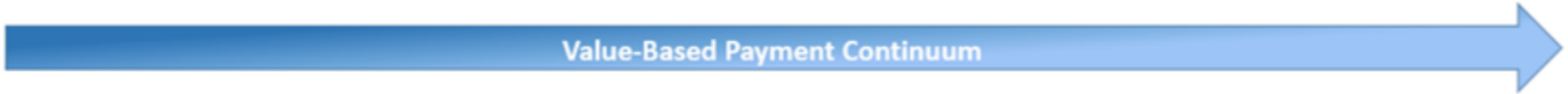
What could happen?

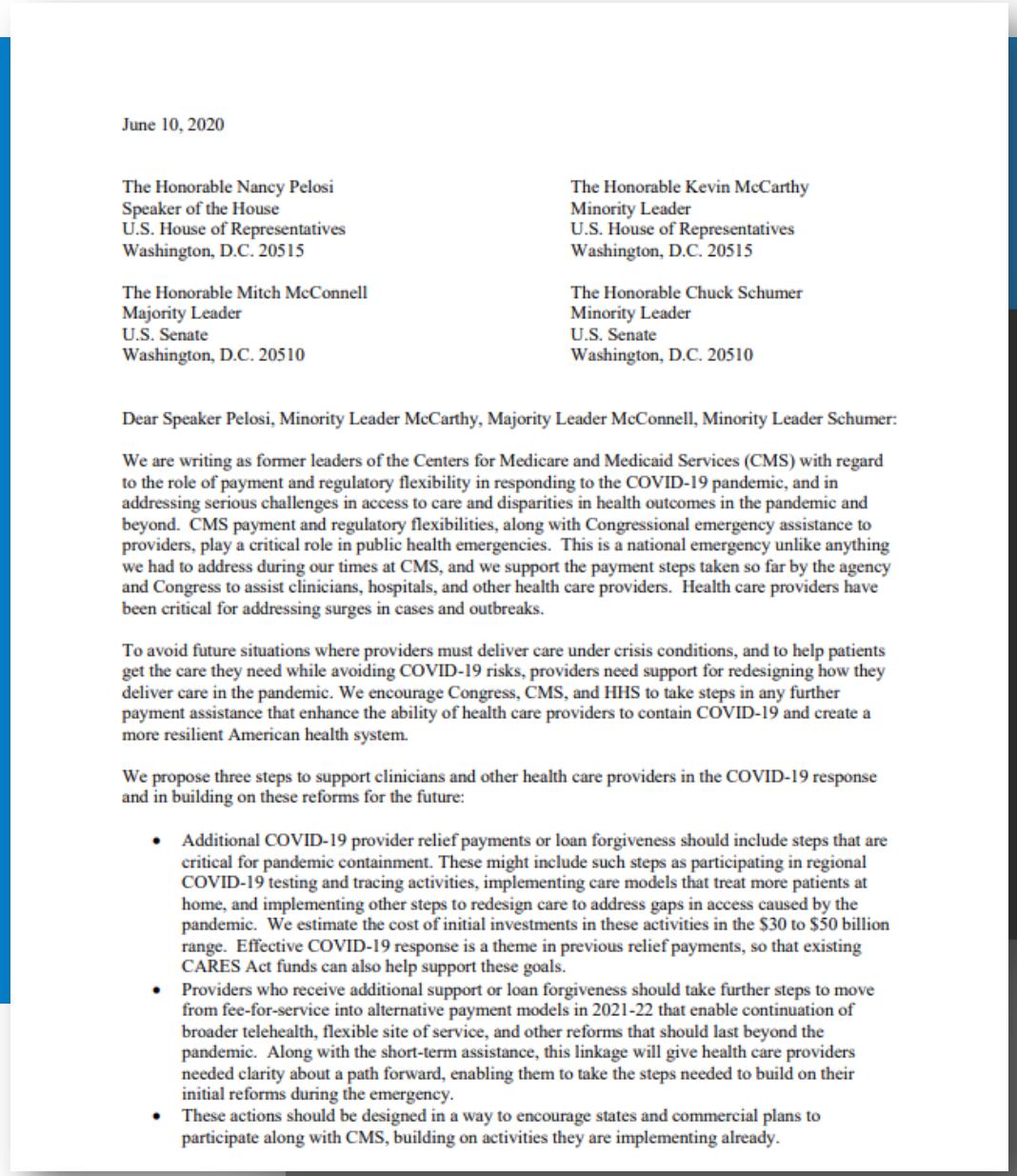
- Extensive research on the many barriers to reducing low-value care – overcoming them is difficult even in a pandemic
- Systematic care transformation efforts required – not than just focusing on 1-2 common services
- Pandemic still provides opportunities for health care providers, payers, and other stakeholders to take short- and long-term steps to reduce waste and build a system that prioritizes high-value care

COVID-19 has impacted providers differently in value-based payment vs. fee-for-service



	Fee for Service (FFS)	FFS with Shared Savings	Limited Prospective Payment	Primarily Prospective Payment
Revenue Change	Significant drop in revenue triggers staff reductions, practice closures	Small shared savings backstop offers limited protection for staff reductions, fewer closures	Prospective payments guarantee small revenue stream, less drastic reductions	More stable revenue streams allowing for continued and expanded service delivery
Financial Stability	Direct financial assistance needed to maintain operations	Benefits from shared savings leads to smaller but still necessary need for financial assistance	Benefits from prospective payment leads to smaller but still necessary need for financial assistance	Most payments delinked from FFS means significantly higher stability
Flexibility for Care Reform	Requires financial assistance for COVID-19 response	Limited; Can support some investments in COVID-19 response, but more assistance required	Greater capacity than shared savings to support investments in COVID-19 response	Supports most key investments in COVID-19 response

Source:
https://healthpolicy.duke.edu/sites/default/files/atoms/files/best_practices_brief_final.pdf



June 10, 2020

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
Washington, D.C. 20510

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, D.C. 20510

Dear Speaker Pelosi, Minority Leader McCarthy, Majority Leader McConnell, Minority Leader Schumer:

We are writing as former leaders of the Centers for Medicare and Medicaid Services (CMS) with regard to the role of payment and regulatory flexibility in responding to the COVID-19 pandemic, and in addressing serious challenges in access to care and disparities in health outcomes in the pandemic and beyond. CMS payment and regulatory flexibilities, along with Congressional emergency assistance to providers, play a critical role in public health emergencies. This is a national emergency unlike anything we had to address during our times at CMS, and we support the payment steps taken so far by the agency and Congress to assist clinicians, hospitals, and other health care providers. Health care providers have been critical for addressing surges in cases and outbreaks.

To avoid future situations where providers must deliver care under crisis conditions, and to help patients get the care they need while avoiding COVID-19 risks, providers need support for redesigning how they deliver care in the pandemic. We encourage Congress, CMS, and HHS to take steps in any further payment assistance that enhance the ability of health care providers to contain COVID-19 and create a more resilient American health system.

We propose three steps to support clinicians and other health care providers in the COVID-19 response and in building on these reforms for the future:

- Additional COVID-19 provider relief payments or loan forgiveness should include steps that are critical for pandemic containment. These might include such steps as participating in regional COVID-19 testing and tracing activities, implementing care models that treat more patients at home, and implementing other steps to redesign care to address gaps in access caused by the pandemic. We estimate the cost of initial investments in these activities in the $30 to $50 billion range. Effective COVID-19 response is a theme in previous relief payments, so that existing CARES Act funds can also help support these goals.
- Providers who receive additional support or loan forgiveness should take further steps to move from fee-for-service into alternative payment models in 2021-22 that enable continuation of broader telehealth, flexible site of service, and other reforms that should last beyond the pandemic. Along with the short-term assistance, this linkage will give health care providers needed clarity about a path forward, enabling them to take the steps needed to build on their initial reforms during the emergency.
- These actions should be designed in a way to encourage states and commercial plans to participate along with CMS, building on activities they are implementing already.

Former Administrator Letter
June 10, 2020

"We encourage Congress, CMS, and HHS to take steps in any further payment assistance that enhance the ability of health care providers to contain COVID-19 and create a more resilient American health system."

Mark McClellan, Andy Slavitt, Don Berwick,
Tom Scully, Bruce Vladeck, and Gail Wilensky

https://healthpolicy.duke.edu/sites/default/files/2020-06/cms_resilience_letter_final.pdf

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COVID-19 Payment Reforms and Health Care Resilience

	Now: Non-FFS Resilience Payment	2021-2023: Implement Alternative Payment Model
Medical Practices	• COVID-19 testing, data sharing, and containment activities • Telehealth and remote monitoring to support home and community-based care	**Potential APM Options: Advanced Medical Home, Direct Contracting, Physician-led ACO** • Continued telehealth, site of service, and care team flexibilities to facilitate transition into an APM • Continued population health management activities
Hospital-Based Systems	• COVID-19 testing, data sharing, and containment activities • Resources to treat COVID patients • Resources to modify staffing and workflows to limit exposure risks	**Potential APM Options: Direct Contracting, Partial-Capitation Accountable Care Organization, Broader Bundled Payments, Global Budgets for Rural Hospitals** • Continued telehealth, site of service, and care team flexibilities to facilitate transition into an APM • Enhanced telehealth services to support delivering symptom management and other check-ins from home

https://healthpolicy.duke.edu/sites/default/files/2020-07/Resilience%20Proposal_073020FINALWeb.pdf

Steps for Providers and Health Systems to Reduce Low-Value Care

- **Providers and health systems** can sustain low-value care reductions by identifying, measuring, and reducing low-value services
- Providers and health systems should create a **"Do Not Restart" list** of low-value services, with alternative care pathways for affected patients
- Providers have a variety of resources at their disposal to help identify and measure low-value care
  - Choosing Wisely recommendations
  - U.S. Preventive Services Taskforce
  - Task Force on Low-Value Care
  - Milliman MedInsight Health Waste Calculator
  - Low Value Care Visualizer

Supporting Steps for “Do Not Restart” Lists

Provider and Health System Strategies to Support “Do Not Restart” Initiatives Post COVID-19

Target	Overarching Approach
Care planning	Work with high-risk patients to create “care blueprints” to avoid ED utilization and high-risk interventions
Point-of-care decisions	Build care guidelines into clinical decision support, such as EHR alerts
Shared decision making	Engage patients in conversation around risks and benefits of treatment
Alternative care pathways	Expand telehealth platforms and home- and community-based services

Steps for Payers to Reduce Low-Value Care

Payers can support reduction efforts by making eliminating low-value care the right financial decision. Examples of payer actions include:

- Supporting practice redesign and accelerate value-based payment models
- Reduce or cease payment for low-value services that create excess risk
- Adopting value-based insurance design principles that deter the use of low-value care and reduce barriers to necessary care

Steps for Employers to Reduce Low-Value Care

Employers are crucial to supporting these efforts, as the majority of Americans are commercially insured, and can support LVC reduction efforts by:

- "Centers of Excellence" programs
- Direct contracting
- Benefit designs that support the use of high-value care networks
- Securing payer commitments to engage in more value-based payments

Steps for Patients to Reduce Low-Value Care

Patients need to be engaged in low-value care reduction efforts as the health care system reopens, through strategies such as:

- Maximizing the use of telehealth services when appropriate
- Participating in shared-decision making conversations with providers about risks and benefits of care, and using conversations to avoid unnecessary care

This Can Be Done

- More research: Studies underway on organizations that have been successful in their efforts to reduce low-value care, affording opportunities for sharing learning
- More supports: Research results can provide a checklist, framework, or other tools that can use to guide low-value care reduction
- More reform: Further COVID-19 relief for health care providers is needed, but linked to “new normal” goals
- More implementation: Don’t wait

Next Steps: Case Study Project to Identify Best Practices and Tools to Reduce Low-Value Care

- Overview: Conducting case study interviews of organizations that have been successful in their efforts to reduce low-value care, including in the pandemic
  - Range of stakeholders, including providers, payers, and employers

- Goal: Analyze themes across organizations and use our findings to develop a checklist, framework, or other tool that organizations can use to guide low-value care reduction initiatives in the pandemic and beyond

Thank You!

Contact Us

100 Fuqua Drive, Box 90120, Durham, NC 27708

1201 Pennsylvania Avenue, NW, Suite 500
Washington, DC 20004

healthpolicy.duke.edu

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dukemargolis@duke.edu

Durham office: 919-419-2504
DC office: 202-621-2800

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