RESEARCH CONSORTIUM FOR HEALTH CARE VALUE ASSESSMENT (RC-HCVA)

PROSPECTS AND POTENTIAL TO PROPEL A HIGH VALUE U.S. HEALTH CARE SYSTEM – SYMPOSIUM NOTES

July 12, 2018 Symposium

August 20, 2018 Report

ALTARUM

SOLUTIONS THAT MATTER. HEALTH CARE THAT WORKS.

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Acknowledgments

The Research Consortium for Health Care Value Assessment is a partnership between Altarum and VBID Health, funded by the PhRMA Foundation's Value Assessment Initiative. George Miller leads the project from Altarum and Mark Fendrick leads from VBID Health. David Meltzer of the University of Chicago is Chair of the RC-HCVA Advisory Committee. This proceedings document was written by Beth Beaudin-Seiler with assistance from George Miller and several Altarum staff members who took notes during the discussions.

Inaugural RC-HCVA Symposium

On the afternoon of July 12, 2018 the Research Consortium for Health Care Value Assessment (RC-HCVA) sponsored its inaugural symposium (by invitation only). The RC-HCVA refers to its interested participants as "Colleagues in Value," and, from the over 200 potential individuals, approximately 140 invitations were rendered to attend the first symposium. These invitations were sent to clinicians, researchers, patient-advocates and policy decision makers, with the charge of participating in a highly-interactive event that would capture the challenges and opportunities that each of them had thought through, been exposed to, or discussed as part of their own work in the space of value in health care.

Beth Beaudin-Seiler (consortium administrator), David Meltzer, Joel Cohen, Sherry Glied, and George Miller (consortium co-director) at the opening session of the symposium

Sherry Glied, Joel Cohen, and David Meltzer kicked off the meeting with their thoughts on the opportunities and challenges in measuring low-value (LVC) and high value care (HVC) – and acting on these metrics.

Sherry Glied began her talk with two commonly-asserted propositions that she characterized as true with some modifications: (1) health care is too expensive, and (2) 30% of health care spending is waste. She argued (with examples) that these problems exists in most other sectors of the economy: people make poor purchasing decisions, many products do not work as intended, inappropriate production decisions are common, geographic variation in costs are ubiquitous, and administrative costs are high. She noted that the health care sector can learn from these other

industries. In any sector, achieving greater efficiencies requires investments and tradeoffs. At some point, the cost of reducing waste exceeds the cost of the waste being reduced. But this is no reason for complacency, and all sectors are constantly, and appropriately, looking for modest, incremental improvements in efficiency. However, we should be realistic about the savings and improvements resulting from such incremental changes: Health care is not an unusually wasteful and inefficient industry, and there is not a lot of low-hanging fruit. Finally, most of the work in improving efficiency will not be policy work, but rather management and organizational work within health care organizations. But there are policy problems, including problems associated with health care prices. But solving such problems means taking money out of people's pockets, which is why politicians tend to decry waste, fraud, and abuse. She views such a characterization as a distraction in addressing policy issues.

Joel Cohen described some of the issues related to establishing initiatives to help reduce low-value care. These include data issues such as quality and generalizability of data used to identify the occurrence and measure the extent of low-value care, and the difficulty in measuring marginal benefit and marginal cost of specific interventions. They also include the long-term issue of who bears the risk associated with inappropriate care. Finally, he noted the need for simplicity of the initiatives, including the need for them to be understood by providers, the need for them to fit into ongoing processes, and the requirement that they not be administratively complex.

David Meltzer issued a charge to the participants of the symposium. Participants were then divided into five panels corresponding to five separate content areas:

- clinical considerations;
- benefit/insurance design considerations;
- data measurement considerations;
- cost effectiveness analysis/methods considerations; and
- end-users/policy considerations

Each panel was tasked with considering and responding to the same two questions:

> *What are the research and implementation opportunities and challenges associated with reducing the use of non-value-added care and increasing the use of high-value care? What areas of research should be the focus of the Research Consortium for Health Care Value Assessment?*

The following summarizes the discussion by each group, including ideas for future work and focus of the RC-HCVA. The meeting agenda can be found in Appendix A. Appendix B contains speaker bios and Appendix C lists attendees.

CLINICAL CONSIDERATIONS

The clinical considerations group discussed a number of existing initiatives around improving value in a clinical setting and the challenges that go with identifying and measuring low value care, for example:

- "Practice Wisely" - Takes Choosing Wisely recommendations and looks at distribution of "low value" care among providers. Look at outliers and call them out, letting them respond. Visible comparisons between providers may work under particular circumstances, especially where patients being treated are similar. However, in many settings where physicians are seeing different types of patients, comparisons won't have much impact.

- Practice Incentives - Currently, bonuses may be paid based on volume of care being provided, based on RVUs – incentives could instead involve bonuses for individual clinicians tied to LVC or HVC. Often pay for performance is too complicated and provides too little money to impact behavior.

When asked specifically what this group believed the research agenda for the RC-HCVA should be, they stated: 1) define low value care (to whom); and 2) don't only identify and measure services, do more to eliminate LVC and promote HVC.

From a clinical perspective, examining low-value care and high-value care requires defining the outcomes of value, which can be different between patient and physician. For example, a patient may care more about regaining mobility while a provider may be looking at clinical markers of "success".

The relationship between patient and provider is also important in making choices to forego low-value care. Patients need to sense the team is working toward their goal, even if it is not attained. Providers need to learn the best way to talk about low-value care (e.g. "this mammogram is not going to help you live longer" rather than "at your age, you don't need a mammogram").

BENEFIT/INSURANCE DESIGN CONSIDERATIONS

This group touched on a number of important points for deliberation. For example, there was thoughtful discussion on whether the consortium should focus on research areas such as:

- Should benefit design options differ for chronic vs episodic care? What is the research in this area?
- Reference pricing strategies – if providers responded by lowering prices in one area, do they raise prices in another?
- Tiered pricing strategies – should there be differences in copays for preferred providers?
- How are high-deductible health plans affecting reference pricing strategies?

Some of the same discussions regarding value to whom were also brought up in this group. They specifically described how insurance companies need to understand what is important to patients and how they define value, and whether that changes based on the demographics/ characteristics of the patient. It is important that they know how providers define value as well and whether they change based on demographics/characteristics of the provider.

In addition to needing to understand the definition of value of patients and providers, the group discussed other questions that fell into two categories: 1) patients or 2) providers/hospitals. For patients, the group suggested that, when designing benefits or insurance packages, it would be important to know:

- Can a benefit/insurance design be used to a) incentivize patients to travel to different hospitals/providers for care; b) incentivize adherence to medical instructions; c) impact social determinants of health; d) play a role in shared decision making; e) play a role in self-help groups/support groups to deter undesirable behaviors

For providers/hospitals, the group suggested it would be important to know:

- Can a benefit/insurance design be used to a) engage in shared decision making with patients; b) re-structure how hospitals think about pricing; c) re-think how administrative costs are viewed in medical loss ratios

Additionally this group discussed the need to understand if patients use the decision tools provided by insurers, and if they truly understand comparative effectiveness research.

DATA/MEASUREMENT CONSIDERATIONS

In the data and measurement considerations group, discussions revolved around the challenges of researching and measuring low value care. Per the other groups, this group discussed the need to understand the different perspectives of value in order to understand what needs to be done regarding value in health care. This group discussed challenges associated with reducing low value care and increasing high value care such as:

- Measuring Low-Value Care – Measurement can be done directly, such as with unnecessary imaging, but that is a clinical focus. Readmission is a form of low-value, as is administrative waste. We need to understand what is important to the system (individual based measures of low-value or population health). Do not forget prices when talking about value, yet we don't want patients to believe that price necessarily equals quality.
- Data issues – We do not have a consistent patient identifier to take people from birth to death through all of their health care events which can be tracked across systems. There are missing data in claims, no one organization has 100% of the data, (not even APCDs), and there are problems with coordination between systems that cause noise to appear in datasets. State Medicaid data can be noisy as well, but may offer opportunities to

understand value.

- Patient preferences – do not necessarily equal what patients' value. Patients need to have discussions around cost, around trade-offs, around what high-value means.

This group also discussed some research opportunities:

- Noise in the datasets should not stop research regarding value in health care; the consortium should take the lead on bringing together the entities that have pieces of the data and the expertise in design and research to tackle the problem of identifying, measuring, and reducing low value care while increasing high value care.
- Understanding the definitions of value for different stakeholders throughout the health care system is important.
- We use claims data to measure overuse, but we need to reduce the burden on measurement, ask stakeholders what is important to them, and study what are the characteristics of a system that has high rates of both low-value care and high value care.

COST EFFECTIVNESS ANALYSIS/METHODS CONSIDERATIONS

The cost effectiveness analysis and methods considerations group discussed how the methods chosen to research low-value care impact the findings. This group also identified the need to operationally define value as well as identifying other challenges to using methods such as cost effectiveness analysis (CEA) when researching value. For example:

- Is there a better operational definition for a quality adjusted life year (QALY)?
- Does cost effectiveness analysis reflect the correct stakeholder? Often times it takes the provider perspective or a financial perspective, but can this be used by a variety of stakeholders, including patients?
- What are methods that payers would understand?
- How do social determinants of health play into cost effectiveness analysis?
- The public does not understand cost effectiveness analysis. "They think it is taking away care." What is the best way to explain the elements of CEA to the public?

The group discussed what needs to be done in this area to better understand value in health care, and what the consortium may be able to help with is 1) improving the methods and data used to do a cost effectiveness analysis, including defining value, re-defining QALY and adding layers of perspectives from multiple stakeholders; 2) improving communication to the public on what cost effectiveness analysis is, what the elements are and what it means; and 3) understanding better how to combine metrics in a CEA. We can currently report on $/QALY, but what other metrics should be included, such as quality overall and population health.

END USER/POLICY CONSIDERATIONS

The end user and policy considerations group discussed many aspects of measuring low-value care

and the impact on decision makers. The challenges for end users and policy decision makers included:

- The need for multi-component interventions into low-value care, not just financial interventions such as incentives for providers to adhere to guidelines.
- The need for awareness of how bundled services/payments/care may be contributing to low-value care (e.g. a lab bundle may include a test that is not really needed and low-value)
- The need to bring patients into the discussion of value and deciding on treatment, provide information that can easily be understood, make changes *with* patients not *to* patients.
- The need to bring insurers to the table so that standardized reports and measurements can be done.
- The importance of remembering research strategies for high value care.

This group offered several areas of discussion, including 1) challenges to identifying and defining low-value care; 2) identifying opportunities to reduce low-value care; and 3) challenges to research in high value care such as the fact that payers are not necessarily aligned with high-value care, what constitutes high-value care is not standardized, and there is a measurement gap in high-value care.

Summary

The discussions captured in the inaugural Research Consortium for Health Care Value Assessment symposium will help guide the efforts of the consortium, establish the focus of the research agenda of the consortium, and foster collaboration between researchers and data partners to provide guidance to decision-makers regarding value in health care. The main points of agreement include:

- VALUE TO WHOM – We must define value in a way that captures the perspectives of the key stakeholders (patients, providers, insurers, employers). If the consortium could collaborate with others and develop a matrix of value definitions that researchers or decision-makers could use as a lens through which to view value, it could be a major contribution to the field. Value to patients means X, value to providers means Y, and value to payers means Z, and there is a need to identify the trade-offs that occur when value to the patient does not mean value to the payer.
- DATA PARTNERSHIPS – Often times it is hard to access appropriate datasets for research on value in health care. If the consortium could collaborate with a data partner wherein other colleagues of the consortium could negotiate access to difficult datasets, it would further the research agenda on value in health care in a broad fashion.
- DO SOMETHING – do not let perfect be the enemy of good. Let's move forward in defining value for each stakeholder and acknowledging that value changes depending on who is asking the questions.

The symposium provided excellent insights into the opportunities and challenges of research in the space of low-value and high value care. It offered direction, focus and prospects for where the consortium should work, leverage partners, and foster collaborations to tackle some of the foundational questions regarding value in health care.

While it may not be within the purview of this consortium to develop a cross-cutting operational definition of "value" to multiple stakeholders, acknowledging that this gap in our understanding of value in health care is important, and this was continually emphasized in the small group discussions. It is critically important to acknowledge that research in low-value care is complicated. Retrospectively, it is easy to determine if a service was of low-value; however, it is much more difficult in real time, face-to-face with a patient, when decisions must be made quickly. These complications should not deter us or distract us from taking on the challenge of identifying, measuring, and reducing the use of low-value, non-value added, and no-value services in our health care system.

Appendix A - Agenda

With Funding from the PhRMA Foundation

Altarum Center for Value in Health Care & VBID HEALTH Present

Research Consortium for Health Care Value Assessment:

Prospects and Potential to Propel a High Value U.S. Health Care System

Thursday, July 12, 2018; 1:45 – 4:30

KAISER FAMILY FOUNDATION BARBARA JORDAN CONFERENCE CENTER, 1330 G ST. NW, WASHINGTON, DC

Contact: Paul Hughes-Cromwick, paul.hughes-cromwick@altarum.org; 734-717-9539

Précis: With funding from the PhRMA Foundation as part of its Value Assessment Initiative, Altarum and VBID Health have established the ***Research Consortium for Health Care Value Assessment***. The mission of the consortium is to promote the pursuit of value in health care delivery in the U.S. by identifying high- and low-value clinical services, tracking the use of such services, developing strategies that lead to better value, and helping to ensure that consumer preferences are incorporated into health care decisions. The consortium will achieve these goals by creating a learning community of researchers to facilitate collaboration, realize synergies and increase dissemination of this work critical to making patients' lives better. This invitation-only meeting seeks to glean *your ideas* about how to make the consortium work for you. Please join our moderated, *highly-interactive* discussion on the topics below. Altarum will capture the proceedings in a conference report.

Agenda

1:45 **Welcome, Introductions & Mission**

Eileen Cannon, President, PhRMA Foundation

George Miller, Altarum Fellow, Center for Value in Health Care: ***Consortium Co-Director***

2:05 **I. Health Care Value Topics: Refining the Consortium Framework**

Sherry Glied, Dean, New York Univ. Wagner Graduate School of Public Service – Opening Remarks

2:25 **II. The Value Agenda: Identifying the Research Gaps – Charge to the Roundtables**

David Meltzer, Professor, University of Chicago & ***Consortium Advisory Chair***

Joel Cohen, Dir., Center for Financing, Access & Cost Trends, Agency for Healthcare Res. and Quality

2:45 **III. Roundtable Breakout Session – Assigned Tables**

Beth Beaudin-Seiler, Sr. Analyst, Altarum & ***Consortium Administrator***: *Discussion on research gaps, on what areas consortium needs to focus research efforts, and how to maximize implementation of findings*

3:45 **IV. Report Outs & General Discussion**

David Meltzer, Joel Cohen & **Roundtable Leaders**

4:30 **V. Wrap-Up & Next Steps**

George Miller

5:00 **Reception at *Ocean Prime*, 1341 G Street, NW**

Appendix B – Speaker Bios

David O. Meltzer is Chief of the Section of Hospital Medicine, Director of the Center for Health and the Social Sciences, and Chair of the Committee on Clinical and Translational Science at the University of Chicago, where he is Professor in the Department of Medicine, and affiliated faculty at the University of Chicago Harris School of Public Policy and the Department of Economics. Meltzer's research explores problems in health economics and public policy with a focus on the theoretical foundations of medical cost-effectiveness analysis and the cost and quality of hospital care. Meltzer has performed randomized trials comparing the use of doctors who specialize in inpatient care ("hospitalists"). He is currently leading a Centers for Medicaid and Medicare Innovation Challenge award to study the effects of improved continuity in the doctor patient relationship between the inpatient and outpatient setting on the costs and outcomes of care for frequently hospitalized Medicare patients. He led the formation of the Chicago Learning Effectiveness Advancement Research Network (Chicago LEARN) that helped pioneer collaboration of Chicago-Area academic medical centers in hospital-based comparative effectiveness research and the recent support of the Chicago Area Patient Centered Outcomes Research Network (CAPriCORN) by the Patient Centered Outcomes Research Institute (PCORI). Meltzer received his MD and PhD in economics from the University of Chicago and completed his residency in internal medicine at Brigham and Women's Hospital in Boston. Meltzer is the recipient of numerous awards, including the Lee Lusted Prize of the Society for Medical Decision Making, the Health Care Research Award of the National Institute for Health Care Management, and the Eugene Garfield Award from Research America. Meltzer is a research associate of the National Bureau of Economic Research, elected member of the American Society for Clinical Investigation, and past president of the Society for Medical Decision Making. He has served on several IOM panels, include one examining U.S. organ allocation policy and the recent panel on the Learning Health Care System that produced Best Care at Lower Cost. He also has served on the DHHS Secretary's Advisory Committee on Healthy People 2020, the Patient Centered Outcomes Research Institute (PCORI) Methodology Committee, as a Council Member of the National Institute for General Medical Studies, and as a health economics advisor for the Congressional Budget Office. Section of General and Internal Medicine, University of Chicago, 5841 S. Maryland Ave., MC 2007, Chicago, IL 60637, 773-702-0836, dmeltzer@medicine.bsd.uchicago.edu

In 2013, **Sherry Glied** was named Dean of New York University's Robert F. Wagner Graduate School of Public Service. From 1989-2013, she was Professor of Health Policy and Management at Columbia University's Mailman School of Public Health. She was Chair of the Department of Health Policy and Management from 1998-2009. On June 22, 2010, Glied was confirmed by the U.S. Senate as Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services, and served in that capacity from July 2010 through August 2012. She had previously served as Senior Economist for health care and labor market policy on the President's Council of Economic Advisers in 1992-1993, under Presidents Bush and Clinton, and participated in the Clinton Health Care Task Force. She has been

elected to the Institute of Medicine of the National Academy of Sciences, the National Academy of Social Insurance, and the Board of AcademyHealth, and has been a member of the Congressional Budget Office's Panel of Health Advisers.

Glied's principal areas of research are in health policy reform and mental health care policy. Her book on health care reform, *Chronic Condition*, was published by Harvard University Press in January 1998. Her book with Richard Frank, *Better But Not Well: Mental Health Policy in the U.S. since 1950*, was published by The Johns Hopkins University Press in 2006. She is co-editor, with Peter C. Smith, of *The Oxford Handbook of Health Economics*, which was published by the Oxford University Press in 2011.

Glied holds a B.A. in economics from Yale University, an M.A. in economics from the University of Toronto, and a Ph.D. in economics from Harvard University.

Joel E. Cohen, Ph.D., directs a staff of health economists, statisticians, social scientists, clinicians, and support staff conducting intramural and supporting extramural research on issues related to health care access, costs, and financing. He is also responsible for the design and fielding of the Medical Expenditure Panel Survey, which is a nationally representative survey of health care use, expenditures, and insurance coverage that is widely used by policymakers and researchers in analyses of the U.S. health care system.

Dr. Cohen has conducted research projects on a variety of health care issues, focusing particularly on analyses of financing and reimbursement methods and their effects on access to care, quality, and costs. His publications include studies of enrollment in Medicaid and the State Children's Health Insurance program, the impact of Medicaid reimbursement levels on utilization patterns for physician services and nursing home quality, methods of predicting which individuals are likely to be high cost, and the impact of obesity on health care expenditures.

Dr. Cohen has been at the Agency and its predecessor organizations since 1989, and prior to that was a Research Associate at the Urban Institute. He received his M.A. and Ph.D. degrees in policy research from the University of Chicago.

Appendix C – Attendee List

First Name	Last Name	Affiliation	Panel	Leaders
Richard	Bankowitz	AHIP	Benefit/Insurance Design	Yes
Allan	Baumgarten	Michigan Health Plan Market Analysis	Benefit/Insurance Design	Yes
Beth	Beaudin-Seiler	Altarum		Float
Shelby	Berger	Cancer Support Community	Clinical	
Sabah	Bhatnagar	Altarum	CEA/Methods	
Diane	Bile	PCORI Science Division	Data/Measurement	
Beth	Bortz	Virginia Center for Health Innovation	End User/Policy	Yes
Randy	Burkholder	PhRMA	Benefit/Insurance Design	
Erin	Butto	Altarum	CEA/Methods	
Eileen	Cannon	PhRMA Foundation	Benefit/Insurance Design	
Gary	Claxton	Kaiser Family Foundation	End User/Policy	
Joel	Cohen	AHRQ	CEA/Methods	Yes
Carrie	Colla	Dartmouth University	End User/Policy	
Rebecca	Cooper	Altarum	Data/Measurement	Note-taker
Sabrina	Corlette	Georgetown University	Benefit/Insurance Design	
Gwen	Darien	Patient Advocate Foundation	CEA/Methods	
Susan	dosReis	University Maryland Baltimore	Data/Measurement	
Sammy	Dougherty	PhRMA	Data/Measurement	
Robert	Dressler	Christiana Care Health System	End User/Policy	
Emmy	Ganos	Robert Wood Johnson Foundation	Data/Measurement	

Robin	Gelburd	Fair Health	Data/Measurement	Yes
Sherry	Glied	NYU	Benefit/Insurance Design	
William	Johnson	HCCI	Data/Measurement	
Andrew	Hu	PCORI	Data/Measurement	
Paul	Hughes-Cromwick	Altarum		Float
Amanda	Hunt	Altarum	Benefit/Insurance Design	Note-taker
Christine	Juday	Sanofi	Clinical	
Ira	Klein	Janssen	End User/Policy	
Tad	Lee	Altarum	End User/Policy	Note-taker
Joanne	Lynn	Altarum	Clinical	
Greg	Matthews	Altarum	CEA/Methods	
David	Meltzer	University of Chicago		Float
George	Miller	Altarum		Float
David	Mirkin	Milliman	CEA/Methods	
Anne	Montgomery	Altarum	CEA/Methods	
Daniel	Mullins	University of Maryland Baltimore	CEA/Methods	
Lauren	Nevens	PhRMA	CEA/Methods	
Len	Nichols	George Mason University	CEA/Methods	Yes
Allison	Oakes	Johns Hopkins	Clinical	
Lucinda	Orsini	ISPOR	Data/Measurement	
Eleanor	Perfetto	National Health Council	End User/Policy	
Daniel	Polsky	Penn	Data/Measurement	Yes
Rosina	Pradhananga	Academy Health	CEA/Methods	
Lynn	Quincy	Altarum	End User/Policy	Yes
Shelby	Reed	Duke Clinical Research	Data/Measurement	
Corey	Rhyan	Altarum	CEA/Methods	Note-taker
John	Rother	National Coalition on Health Care	End User/Policy	

Jodi	Segal	Johns Hopkins	Clinical	Yes
Kirsten	Sloan	American Cancer Society	End User/Policy	
Jason	Spangler	Amgen Inc.	Clinical	
Dakota	Staren	Altarum	Data/Measurement	Note-taker
Ani	Turner	Altarum	Clinical	Note-taker
Autumn	Vonk	Altarum	Benefit/Insurance Design	
Joanne	Westphal	PhRMA Foundation	End User/Policy	
Lok	Wong-Sampson	ASPE	Benefit/Insurance Design	