REPORT 7 OF THE REPORT OF THE COUNCIL ON MEDICAL SERVICE (A-08)
Value-Based Decision-Making in the Health Care System
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2007 Annual Meeting, the House of Delegates adopted the recommendations of Council on Medical Service Report 8, "Strategies to Address Rising Health Care Costs," which advocate four broad strategies to manage health care costs and improve value in the health care system: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute to patient care; and (d) promote "value-based decision-making" at all levels (Policy H-155.960[2], AMA Policy Database).

As part of its ongoing effort to further develop AMA policy related to costs and value, the Council on Medical Service has prepared this report on the fourth strategy, value-based decision-making. This report defines relevant terminology, examines decision-making processes over the life span and related to type 2 diabetes, highlights the role of physicians, and examines key obstacles to value-based decision-making.

Value-based decision-making can improve the processes by which health-related decisions are made, so that they take into consideration both costs and benefits – particularly clinical outcomes. Examples include physicians and patients choosing among drug therapies, insurers designing health plan cost-sharing features, and legislators determining public health budgets. Value-based decision-making should not be confused with value-based purchasing or value-based benefit design. The term "value-based purchasing" is often used interchangeably with pay-for-performance programs designed to contain costs and/or improve clinical quality by linking physician or hospital payment to specified performance measures. The AMA has established a comprehensive set of pay-for-performance principles and guidelines (Policy H-450.947). Value-based benefit design is a mechanism insurers use to manipulate out-of-pocket cost-sharing, typically to reward drug regimen compliance by patients with chronic conditions, thereby averting costly adverse outcomes.

The Council's analysis illustrates that increased support is needed for physicians to strengthen their role in the prevention of certain chronic conditions, such as type 2 diabetes, where several stakeholders, including individuals and their families, employers, schools and communities, already have prominent roles. Improving physician payment as it relates to chronic disease prevention can help augment the physician role in this regard. In addition, wider implementation of health information technology has the potential to greatly facilitate value-based decision-making. The implementation of a personalized health record and other health information technology initiatives will assist in improving the availability of information at the point of decision-making.

The AMA has established a considerable number of policies that address most of the obstacles to improving value. In this report, the Council's recommendations encourage physicians to consider value, the balance between benefits and costs, in their health care decision-making. The Council recommends principles intended to help physicians as they engage in value-based decision-making. In addition, the Council recommends addressing a critical error in the way preventive services are evaluated and funded by legislators.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7 - A-08

Subject: Value-Based Decision-making in the Health Care System

Presented by: Georgia A. Tuttle, MD, Chair

Referred to: Reference Committee G
(H. Christopher Alexander, III, MD, Chair)

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As part of its ongoing effort to further develop AMA policy related to costs and value, the Council on Medical Service has prepared this report on the fourth strategy, value-based decision-making. Value-based decision-making involves improving the processes by which health-related decisions are made, so that they take into consideration both cost and benefit – particularly clinical outcomes. This report defines relevant terminology, examines decision-making processes over the life span and related to diabetes, highlights the role of physicians, and presents policy recommendations.

BETTER VALUE FOR HEALTH CARE SPENDING

In January 2008, it was reported that health care expenditures exceeded $2.1 trillion in 2006. Policymakers and legislators increasingly look to physicians, whose decisions can have a profound impact on health care spending, to propose ways to address rising costs. As discussed in Council on Medical Service Report 8-A-07, the Council believes that AMA efforts to address rising health care costs should focus on achieving better value for health care spending. Achieving better value may involve strategies to reduce health care costs, but cannot be equated with cost-reduction *per se*. Value can be defined as the best balance between benefits and costs, and better value can be defined as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Clearly, opportunities to simultaneously improve outcomes and reduce costs should be pursued aggressively, as should opportunities to eliminate care that is both costly and harmful or minimally beneficial. However, opportunities to improve value may involve tradeoffs between cost and quality. For example, cost-cutting measures improve value when savings are significant and there is little compromise in quality or clinical outcome. Conversely, costly quality improvements and medical advances enhance value when the benefits of improved quality and outcomes outweigh the additional costs. Indeed, additional spending has yielded substantial clinical, economic and quality-of-life benefits, such as helping to dramatically reduce death rates for cardiovascular disease since the 1960s. Thus, the goal is not necessarily to reduce utilization but to find the most valuable use of services in accordance with their relative costs and benefits. The likely, but not

guaranteed, result of focusing on value would be lower per capita health care spending, with slower or negative cost growth over time.

SCOPE OF THE REPORT

Value-based decision-making should not be confused with value-based purchasing or value-based benefit design. The term "value-based purchasing" is often used interchangeably with pay-for-performance programs designed to contain costs and/or improve clinical quality by linking physician or hospital payment to specified performance measures. The AMA already has established a comprehensive set of pay-for-performance principles and guidelines (Policy H-450.947). As noted, value-based decision-making refers to the process by which costs and benefits are weighed in health care decisions and does not address the issue of measuring physician performance.

VALUE-BASED DECISION-MAKING

Value-based decision-making can improve the processes by which health-related decisions are made, so that they take into consideration both costs and benefits – particularly clinical outcomes. Value-based decision-making can be thought of as an extension of evidence-based medicine, in which a host of private and public decisions are improved through greater availability of information and through incentives. Examples include physicians and patients choosing among drug therapies, insurers designing health plan cost-sharing features, and legislators determining public health budgets.

Council on Medical Service Report 8-A-07 identified a number of specific actions that can be used to promote value-based decision-making, including: promoting value-based or targeted benefit design by insurers; supporting comparative cost-effectiveness research for both clinical and non-clinical activities within the health system; continuing the development of health information technology; and using clinical performance and quality measurement to improve value. Among these specific actions, comparative cost-effectiveness research stands out as essential because it can provide information needed by patients and physicians to make value-based decisions. Useable, timely information can improve value by prompting patients to seek appropriate screening tests or encouraging physicians to adapt practice patterns. Information can also improve value by being used to design incentives for value-based decision-making, for example, through health plan benefit design, and disease management programs.

Value-based benefit design, also known as targeted benefit design, is one method of promoting value-based decision-making by patients. Insurers use value-based benefit design to manipulate out-of-pocket cost-sharing, typically to reward drug regimen compliance by patients with chronic conditions, thereby averting costly adverse outcomes. Several large self-insured employers have started experimenting with lowering co-payments for drugs identified as "clinically valuable," such as beta-blockers and ACE inhibitors.

In order to examine health-related decision-making processes systematically and in greater depth, the Council analyzed health care decision-making across the life span, and considered decision-making related to one costly chronic condition, diabetes. These examples are used to identify how health care decision-making processes can be improved to increasingly integrate value. Major elements of the decision-making process include who makes the decision; the range of available

choices and how they are determined; criteria for or objectives of decision-making; availability of relevant information; and incentives and constraints faced by decision-makers. The Council's analysis revealed a complex web of decision-making where the choices of each decision-maker can affect others, sometimes profoundly. In addition, people sometimes have little or no say in decisions that affect them.

HEALTH-RELATED DECISION-MAKING OVER THE LIFE CYCLE

Health care decision-making processes change and evolve over the course of the life span, with each phase of life involving new and different developmental and health concerns. At each stage of development, the goal of health care decision-making is to ensure and promote the short- and long-term health of the patient. In its review of health-related decision-making across the life span, the Council made the following observations:

The locus of decision-making evolves over the life cycle. The involvement of patients in their own health care decision-making processes is circular, with active involvement commencing in young adulthood and declining upon beginning the use of end-of-life health services, due to a loss of physical and mental faculties. The role of the physician in the health-care decision-making process is constant throughout the life cycle. Other stakeholders—parents, children, spouses and partners, schools, workplaces, the community, health plans and legislators—also impact health care decision-making processes at each stage.

Information is often not fully available at the point of decision-making. In order for a health care decision to truly be value-based, information relating to the relevant costs and benefits of each alternative intervention needs to be known at the point that the decision is made. However, throughout the process, necessary information is infrequently available in a form that can be acted upon. At the time of service, physicians and patients often lack a synthesis of relevant research, including clinical trial results. In addition, physicians may not have access to previous tests and services provided to their patients by others. More frequently, physicians and patients lack information related to the costs associated with each alternative intervention, including the patient's insurance coverage and expected out-of-pocket costs. This is mainly the result of third-party payers and purchasers generally not making useable cost data easily accessible to physicians.

Missed opportunities can be costly. Missed opportunities to incorporate value with regard to prevention, early detection and treatment become evident in the relationship between child health and adult health. Health-related behavior and disease risk states during childhood affect the incidence and prevalence of chronic physical and mental conditions later in life. Rising health care costs attributable to certain diseases and conditions that are major cost drivers are the result of an increase in treated prevalence, not of an increase in treatment costs, and preventable diseases needlessly pose a large burden on the health care system. This observation indicates the need to promote more of a long-term approach to value-based decision-making to decrease the incidence and prevalence of conditions that are preventable.

Key obstacles interfere with value-base decision-making. Physicians and patients have obstacles to overcome in order to improve the physician-patient decision-making process. Both physicians and patients face time constraints, which for patients can lead to only accessing their physicians when they have a health condition that needs to be treated or managed—not for prevention. In addition, both face financial constraints. For patients, this is particularly evident when they have no

insurance, or have insurance with high levels of cost-sharing. For physicians, there frequently is little or no payment—particularly in the adult health context—for lifestyle counseling and other preventive services that are highly valuable. As outlined in Council on Medical Service Report 6-A-08, also before the House of Delegates at this meeting, the current structure of the Medicare Part A and Part B Trust Funds may serve as an obstacle to implementing value-based decision-making with regard to site of service. The Council notes that combining the trust funds may facilitate and improve value-based decision-making in this regard.

DECISION-MAKING RELATED TO CHRONIC DISEASE: DIABETES

The Council examined health care decision-making related to type 2 diabetes, the incidence and prevalence rates of which continue to increase in the US, because chronic diseases account for a large percentage of the increase in health spending. The following conclusions should be considered in improving health care decision-making processes related to type 2 diabetes to integrate value. These conclusions can also be applied to decision-making processes related to other lifestyle-induced chronic conditions, including overweight and obesity, heart disease (including its risk factors of hypertension, high blood pressure, high cholesterol, etc.) and those resulting from tobacco use.

Focus on prevention. Value-based decision-making related to type 2 diabetes and many other chronic diseases should focus on reducing incidence and prevalence rates. The increase in treated prevalence for several chronic conditions, including diabetes, cancer, hyperlipidemia and pulmonary disorders, was the most significant determinant of the growth in private insurance spending attributable to these conditions between 1987 and 2002. Therefore, the Council believes that value-based decision-making must emphasize prevention over the long-term.

Promote early screening and testing. Screening and testing individuals at risk for type 2 diabetes and other chronic diseases are of tremendous value and prompt early detection and intervention. There is a stage before type 2 diabetes develops—pre-diabetes—that presents an opportunity to incorporate value—both long- and short-term—into health-related decision-making processes. In order for value to be maximized, testing for diabetes should be targeted to patients with clear risk factors—including overweight and obesity, high blood pressure, low HDL cholesterol and high triglycerides and a family history.

Incentivize patient compliance. Patient compliance with diabetes care regimens is critical to maximize value in diabetes management and treatment. Considering that many interventions for diabetes have been determined to be effective in maintaining or improving one’s health status, in addition to being cost-effective, all diabetics should follow their treatment regimens. Value-based health insurance benefit design can serve as a vital tool to improve patient adherence to diabetes care regimens.

There is a broad coalition of stakeholders involved in the prevention of type 2 diabetes. As the prevention of type 2 diabetes is largely dependent on leading a healthy lifestyle, including following a healthy diet and active exercise regimen, several actors—including patients, parents, schools and workplaces—play primary and key roles in type 2 diabetes prevention. Although the role of physicians in decision-making related to type 2 diabetes is more prominent in the management and treatment of the condition, steps can be taken to strengthen their role in preventing lifestyle-induced chronic disease, including type 2 diabetes. In particular, coverage and

1 physician payment for lifestyle counseling, as supported by Policy H-155.960[3], would help
2 augment the role of physicians in chronic disease prevention.
3
4 Accurate and timely information is needed. Patients tend to act only with immediate health
5 interests in mind, and typically do not have access to all necessary information when they make
6 health care decisions. Patients who possess clear risk factors may not have been adequately
7 educated about the importance of early intervention to reduce their chances of developing diabetes.
8 Often there are no incentives to encourage patients to seek testing or follow healthy lifestyles, even
9 if they have clear risk factors. Such incentives can come in the form of reduced health insurance
10 premiums, or workplace wellness programs that provide financial incentives for employees who
11 join a gym or show clear improvement in certain health indicators, including weight loss and blood
12 pressure.
13
14 KEY OBSTACLES TO VALUE-BASED DECISION-MAKING
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16 Efforts to integrate value into health care decision-making processes and reduce the burden of
17 preventable disease have been hampered by how legislators and insurers have defined value in their
18 respective decision-making processes. For these stakeholders, value has been defined as
19 prioritizing and maximizing short-term savings over long-term savings and the cost-effective use of
20 resources, even if long-term savings are substantial and cost-effectiveness ratios meet standard
21 definitions for cost-effectiveness. Insurers lack incentives to invest in prevention if they do not
22 anticipate covering the individual later in life when preventive services yield their greatest savings.
23
24 Due to prioritizing short-term savings over long-term cost savings and value, federal legislators and
25 government have underinvested in prevention and public health. One of the root causes of this
26 underinvestment is the process by which federal legislation is "scored"—the estimation of the
27 legislation's impact on government revenues and outlays. The scoring process has a significant
28 impact on what legislation is passed and how much is spent on health care and public health.
29 Every bill that is reported out of a congressional committee must be scored, and most health-related
30 legislation is scored by the Congressional Budget Office (CBO). Most CBO cost estimates show
31 how the relevant legislation would affect spending or revenues over the next five years or more. In
32 cases of intergovernmental mandates, cost estimates address appropriations needed for up to ten
33 years after the effective date of the mandate.
34
35 The CBO's scoring mechanism can undermine the success of legislation related to prevention and
36 public health because such legislation is likely to have immediate direct costs, but more long-term
37 savings and improvements in health outcomes. CBO's five-and ten-year projections often do not
38 allow for these long-term savings and improvements in health outcomes to be calculated in the
39 cost-benefit equations. For example, the CBO released a cost estimate in January 2008 on S. 625,
40 the Family Smoking Prevention and Tobacco Control Act. This legislation would authorize the
41 Food and Drug Administration (FDA) to regulate tobacco products, and would require FDA to
42 assess fees on manufacturers and importers of tobacco products. In its cost estimate, CBO
43 concluded that the legislation, if enacted into law, would cause a decline in smoking and reduce the
44 number of pregnant women covered by Medicaid who smoke during pregnancy, thereby improving
45 birth outcomes. However, the cost estimate only addresses the impact of the legislation on
46 Medicaid spending resulting from reduced smoking levels during pregnancies over the 2009-2018
47 period, not on other Medicaid spending (including longer-term), private health insurance
48 premiums, or Medicare spending, all of which would likely be affected by a decline in tobacco use.

AMA POLICY

AMA Policy H-155.960 advocates a series of specific actions to promote value-based decision-making. These actions, also supported by earlier policy, include: encouraging value-based or targeted benefit design by insurers (D-330.928[2], D-440.953[1b,c], H-110.990[1,2], H-165.882[1], H-290.972[2b], H-185.996); supporting comparative cost-effectiveness research for both clinical and non-clinical activities within the health system (H-335.964, D-110.991, H-525.993, D-460.986); continuing the development of health information technology (H-405.982, D-478.995, H-450.947, H-155.994); supporting third-party payment for lifestyle counseling by physicians (H-155.960[3], H-150.953[8], H-490.916, H-490.917); and using clinical performance and quality measurement to improve value (H-140.872[1a], H-450.947).

Numerous other AMA policies indirectly support value-based decision-making by advocating: the use of market forces, patient choice, price and quality transparency, and consumer decision-making support (H-373.998, H-110.990[3], H-400.960[3], H-165.845[2,5], H-165.845, H-165.985, H-330.898[5,6], H-155.961, H-180.957, H-165.854, H-290.972[2h], H-185.953); reward-based healthy lifestyle incentive programs (H-170.963, H-290.972[2c]); appropriate physician reimbursement (H-385.951, D-285.972[2,3], H-450.947); physician autonomy in medical decision-making (H-285.954, H-320.995, H-410.970, H-320.953, H-335.996, H-410.997); and preservation of the patient-physician relationship (H-525.993, H-140.920, H-450.947[(1)2], H-140.989, H-140.966, H-450.944[2], H-140.919, H-450.941). Finally, Policy H-450.944 opposes Medicare pay-for-performance initiatives such as value-based purchasing programs that do not meet AMA Pay-for-Performance Principles and Guidelines (H-450.947).

DISCUSSION

The Council's analysis illustrates that increased support is needed for physicians to strengthen their role in the prevention of certain chronic conditions, such as type 2 diabetes, where several stakeholders, including individuals and their families, employers, schools and communities, already have prominent roles. The examination of health care decision-making related to type 2 diabetes showed that most of the opportunity to improve value lies in the prevention of type 2 diabetes, not in the management and treatment of the condition. This reality holds true for many conditions and diseases that contribute significant costs to the health care system. The limited physician role results from the fact that as patients age into adulthood, the focus of physician visits are to treat or maintain certain health conditions or diagnoses. There are fewer visits during which preventive interventions and value-based decision-making can be integrated. The Council notes that AMA policy advocates coverage for lifestyle counseling (H-155.960[3]).

Although useable, timely information is often not fully available and easily accessible to physicians at the point of decision-making, improved physician access to cost and clinical outcome data is forthcoming. Wider implementation of health information technology has the potential to greatly facilitate value-based decision-making. The implementation of a personalized health record and other health information technology initiatives will assist in improving the availability of information at the point of decision-making. For example, if links from an electronic medical record were directed toward a synthesis of research on a particular intervention or treatment, as well as the patient's insurance coverage and expected out-of-pocket costs associated with each intervention, the physician would have complete information available at the time of the decision.

Also, electronic information resources, including UpToDate, are emerging that provide evidence-based, peer-reviewed clinical information to physicians through the Internet, desktop or PDA. Ultimately, physicians have a vital role in guiding health care decisions made with their patients. Although the health care decisions of patients are sometimes influenced by school entry requirements or community health educators, the large majority of health care decisions are decided jointly by physicians and patients. Physicians have a larger role in the prevention of infectious disease than chronic disease, as the incidence of many chronic diseases is affected by individual choices and healthy lifestyles. The current structure of physician payment as it relates to chronic disease prevention contributes to this reality. In determining interventions and treatments throughout the life cycle, physicians constitute primary decision-makers. The partnership between patient and physicians in decision-making provides the foundation for a strong patient-physician relationship. The Council believes that fostering value-based decisions between physicians and patients will require a concerted effort on behalf of all stakeholders.

Finally, by examining health care decision-making over the lifespan and for the chronic condition of diabetes, "value" is defined differently by key decision-makers, including but not limited to patients and their families, insurers, legislators, and society. The Council notes that the AMA has established a considerable number of policies that address most of the obstacles to improving value. In this report, the Council recommends addressing a critical error in the way preventive services are evaluated and funded by legislators. Primarily, the Council encourages physicians to consider value, the balance between benefits and costs, in their health care decision-making. Doing so may be difficult for physicians, who may have no idea how much most services and procedures cost. The Council is hopeful that its recommendations will help physicians as they engage in value-based decision-making.

POLICY RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of this report be filed:

1. That our American Medical Association reaffirm Policy H-155.960[3], which supports adequate third-party payment for lifestyle counseling provided by physicians. (Reaffirm HOD Policy)

2. That our AMA adopt the following principles to guide physician value-based decision-making:

   a) Physicians should encourage their patients to participate in making value-based health care decisions.

   b) Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.

   c) Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each

alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.

d) Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.

e) Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.

f) Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (New HOD Policy)

3. That our AMA advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient. (Directive to Take Action)

4. That our AMA encourage efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress. (Directive to Take Action)

Fiscal Note: Staff cost estimated to be less than $500 to implement.

References for this report are available from the AMA Division of Socioeconomic Policy Development.