Policies and Politics of Comparative Effectiveness

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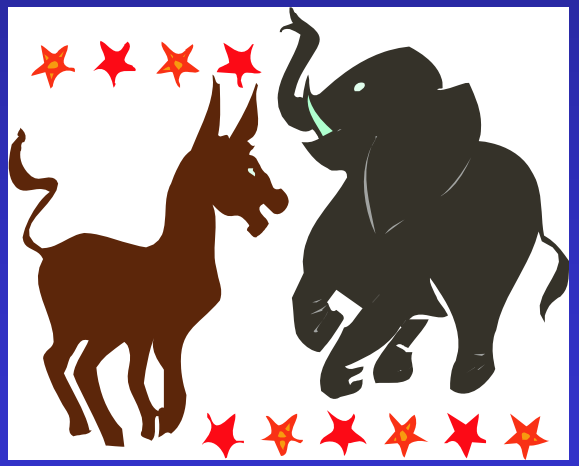
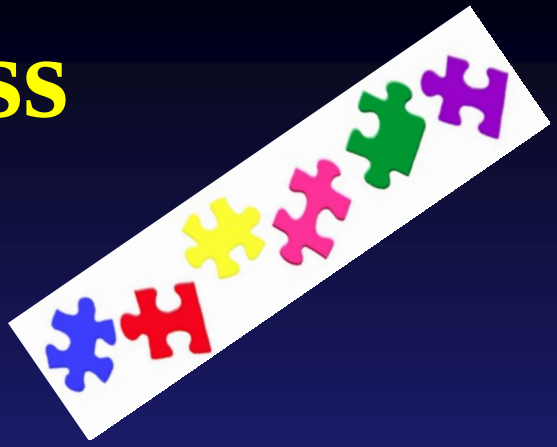


Comparative Effectiveness Research



- Convergence of Interests: --

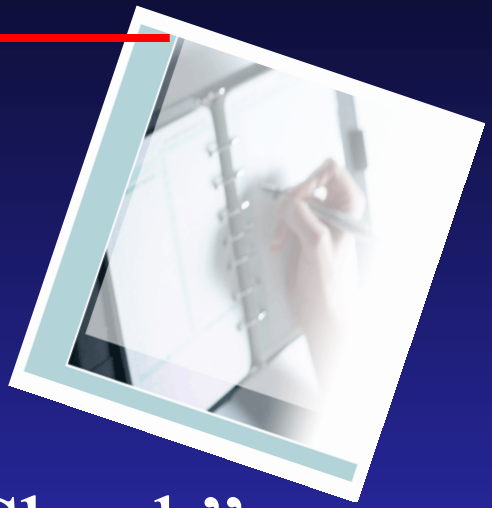
  Major focus on ↓ ing uninsured

  Need to ↑ value, slow spending

- To change from where we are, need

Better Information; Better Incentives

Better Data Starting to be Available…



- "Hospital Compare"
- Joint Commission's "Quality Check"
- PQRI

But ***more*** and more ***comparative*** data is needed!

CER Extends this Effort

Strategy:

conduct, support, synthesize research

Focus:

outcomes, effectiveness, appropriateness of alternative medical interventions for different subgroups

Broad spectrum of ***treatments*** and ***methods***

Pre-ARRA Legislative Attempts

- HR 2184, “Allen/Emerson”
  -- Introduced 5/07
- HR 3162, “CHAMP” Bill
  -- Passed House 8/07
- S. 3408, “Baucus/Conrad”
  Introduced 8/08

Stimulus Bill "Surprise"

- $1.1 billion for comparative effectiveness research
  - -- $300 million for AHRQ
  - -- $400 million for NIH
  - -- $400 million for HHS Secretary

- CER, ***not*** CCE, is the language used

But ….

Only supports research/ dissemination of information

Not mandating coverage or reimbursement

Many Questions Left Unanswered

- Governance issues; participation by stakeholders
- Priority setting
  - -- IOM reported to Sec'y late June
  - -- Unclear what happens next
- Role/authority of Federal Coordinating Council?
- Future legislation; future funding?

IOM Recommendations

- Balance portfolio of research topics
  - -- 29 research areas; 4 quartiles of priority
  - -- 49 of 100 require RCTs; implies other methods are important too
- Many topics are not just drug-on-drug comparisons
  - -- For example, effective treatment strategies for atrial fibrillation

Critical Issues Still Needing to Be Defined

- Role: Information gathering – not decision-making
- Function: Fund research; disseminate data
- Scope: Comparative data analysis; population variations
- Funding: TBD

CER in HCR Legislation

- Major bills under consideration all contain CER language
  - -- House Tri-Committee Bill
  - -- Senate HELP Committee Bill
  - -- Baucus/Conrad (June 2009 version)
  - -- SFC ??

Many areas of similarity; A few important differences

Similarities:

-- Broad array of treatments/methodologies

-- Broad representation of stakeholders as advisors

-- Broad dissemination of findings

-- Seriously underfunded (need $bil – not $mil)

Difference:

-- New center in AHRQ v. non-profit corp.

Explosive Politics Around CER

CER has become a "lightening rod" for criticism by some conservatives; some in industry

"gov't run health care"; "socialized medicine"; "gov't monitoring your doctor"; "code words for denying care by birth date"

More to come in conference?

Controversies Reflected in Legislation as well

Mostly center on ***cost-effectiveness*** concepts and the ***use*** of CER

-- Baucus/Conrad prohibit Institute from issuing practice or coverage guidelines

-- HELP prohibits recommendations from being used at mandates for payments, coverage or treatment

-- House is silent and therefore potentially permissive

How Should Costs be Considered?

- Cost/effectiveness measures are important
  - -- especially when alternative treatments are possible
  - -- ***easier*** if not life threatening

- Politically safer/wiser to keep clinical effectiveness research separate from cost-effectiveness analyses

  CCE – more complex, expensive, time-consuming
  Must remain "***untainted***"

CER is only a First Step, Yes - Need Better Incentives

- Realign financial incentives/accountability
- Reward institutions/clinicians who provide high quality/efficiently produced care
- Use “value-based” insurance and “value based” purchasing
- Reward healthy lifestyles by consumers

Will Better Information, Better Information Systems and Better Incentives --

- Improve Values?
  Yes, should improve values
- "Bend the curve"?
  Should – and better than the Alternatives!