Initiatives to Develop Evidence of Comparative Effectiveness and Put It into Practice

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Objectives

• Briefly Review Recent Initiatives for CER
• Place CER in the Broader Evidence Base for Health Care Reform
• Outline Options for Putting CER into Practice
High Hopes for Comparative Effectiveness research

- Rising health care costs are unsustainable
- Costs are driven by technology-related changes in medical practice
- When evidence is unclear geographic variations in care are high
- Some US communities achieve lower costs and high quality
- Therefore
  - production and use of better evidence MAY lower unnecessary costs
  - without reducing quality or access!
Stakeholders agree on need for more Comparative Effectiveness Research

- Advisors to Congress: CBO, MEDPAC, IOM
- Health Plans: AHIP; BCBSA
- Employers: eg NBGH
- Drug and Device Manufacturers: PHARMA, ADVAMED, BIO
- Consumer Groups: Consumer’s Union, Partnership to Improve Patient Care (PIPC)
- Professional Associations: Academy Health, AAMC, ACP, AAFP, ACS, AMA,
Why there isn’t enough privately funded CER

• Health Economists (eg CBO)
  – “…the private sector generally will not produce as much research on comparative effectiveness as society would value..”

• Drug/device Manufacturer CEO:
  – “Why did we do a comparative clinical trial that just handed the market to our competition?”

• Health plan CFO:
  – “This study you medical directors want costs $50 million; takes 5 years, and all our competitors can benefit from the information?”

• Consumer handbook publisher:
  – “I need to invest 100s of millions in research before I have a product to sell? And then do I sue patients using this “copyrighted” information without a subscription?”
Federal Support for CER has been Growing

- **2003-2008**: AHRQ Effective Health Care program (MMA authorized)
  - CERTs, DECIDE Network, EPCs, Eisenberg Center
  - Dedicated appropriation- $30 to 50M
- **2009**: ARRA 1.1 Billion
  - $400 M HHS; $300M AHRQ; 400 M NIH
Federal Coordinating Council Report on ARRA CER Investments

Strategic Framework

- Research
- Human & Scientific Capital for CER
- CER Data Infrastructure
- Dissemination and Translation of CER

Cross-Cutting Priority Themes
- Priority Populations
- Priority Conditions
- Types of Interventions

Specific investments can be within a single category and/or be cross-cutting in one of the priority themes

FCCCER Report July 2009
After the ARRA?
PPACA CER Investments

• Patient-Centered Outcomes Research Trust Fund
  – By FY 2013 the Trust Fund will provide an estimated $500 to 600 million a year for CER

• Patient-Centered Outcomes Research Institute (PCORI)
  – a private, nonprofit corporation ("neither an agency nor establishment of the US Government")
  – Identify national priorities for research
  – Establish research project agenda to address priorities
  – Carry out research project agenda ...in accordance with methodological standards adopted
Evidence-based, Affordable Health care
CBO “Score” for CER Savings

• $2.5 Billion spending on CER 2010-2019
• Federal Health Care savings $.3 Billion-
  – Federal investments in CER >=equal savings after 8 years
  – Assumes no changes in Medicare coverage rules
  – Anticipates evidence leads to changes in physician practice and patient choice
• Private Health Care Savings ($5 Billion in previous CBO estimate)
  – Anticipates private insurers would use CER

CBO, preliminary analysis of the Chairman’s mark for the America’s Healthy Future Act, Oct 2009; and Report on Comparative Effectiveness of Medical Treatments, Dec 2007
Policy Makers See a Central Role for CER in Health Care Reform

- Need for more comparative clinical effectiveness research
  - “relatively little rigorous evidence is available about which treatments work best for which patients…”*
- Need for more research on promoting use of CER in clinical practice
  - “…the financial incentives for both providers and patients tend to encourage the adoption of more expensive treatments...even if evidence of their relative effectiveness is limited.”*

*Orszag, NEJM, Nov 2007
How Policymakers would use CER to “Bend the Curve”

Negotiating with Manufacturers

• Coverage decisions- tightening the standard of evidence for wide coverage of new technology
• “Coverage with evidence development” - speeding collection of additional comparative effectiveness info thru mandated studies or registries tied to coverage
• Risk-sharing arrangements – e.g. manufacturers receive bonuses if projected outcomes are achieved
• “Comparative effectiveness research is vital,...
• but we must find ways to encourage providers to adhere to evidence-based guidelines and encourage purchasers to adopt evidence-based plan designs.”

Health Care Reform: Creating a Sustainable Health Care Marketplace; Business Roundtable Report, Nov 2009
How Policymakers would use CER to “Bend the Curve”

Engaging Consumers

• Value-based insurance design- e.g. no “co-pays” for highly effective therapies

• Informed patient decision-making modules- helping patients understand evidence of risks and benefits for “preference sensitive” decisions
How Policymakers would use CER to “Bend the Curve”

Rewarding Providers?
The Medicare physician fee schedule
• Resource based Relative Value Scale – RBRVS
• Theoretically neutral relative to prescribing one service over another
• Why wouldn’t fee for service clinical practice naturally evolve to the more evidence-based service?
Rates of Four Orthopedic Procedures among Medicare Beneficiaries

Source: CBO
Problems with the implementation of RBRVS

• mis-estimates of work-some professional services overvalued relative to others
• overestimates (and overpayments) of practice expenses
• Physician entrepreneurism- various specialized practices invest in surgical or endoscopy facilities, radiation therapy equipment or scanners for advanced imaging
• some specialty physicians may have proprietary interest in the devices being implanted
Evolution of US medical practice

• Many highly specialized physicians focused on a limited number of services
  – skills and infrastructure to deliver these extremely efficiently
  – overvaluing of fees paid based on past or ‘typical’ effort and expense.

• Narrow scope of service
  – provision of services outside scope no longer financially rewarding or professionally comfortable
  – Maslow: “if all you have is a hammer, everything looks like a nail.”
Other flaws in Medicare FFS relevant to rewarding evidence-based care

• rewards services in the venue most cost-effective for the provider
• rewards duplicative services (eg readmissions, scans)
• rewards managing complex events and patients as multiples of discrete billable services (visits, admissions, tests; procedures).
• rewards differentiating in local market by offering ready access to high tech services.
FEE-FOR-SERVICE MEDICINE and MD INCOME

- Charges generate revenue
- Charges are a source of funds
- High charges = higher profit
Fee for Service incentives have been associated with which medical decisions?

1. Increased hospital admissions?
2. Increased office visits?
3. Increased tests/imagining?
4. Increased invasive procedures?
The Doctor’s (and Society’s) Dilemma

• That any sane nation,
• having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you,
• should go on and give a surgeon a pecuniary interest in cutting off your leg,
• is enough to make one despair of political humanity

*From The Doctor’s Dilemma by George Bernard Shaw*
Rewarding Providers – Payment Reform

• Value –based provider payments –
  – e.g. pay providers more for highly effective therapies
• Bundled payment-
  – use CER to guide what mix of services should be included in payment for an illness episode
Rewarding Providers – Payment Reform

• Pay for Performance (P4P)-
  – bonuses for compliance with CER-based guidelines or metrics

• Accountable care organizations-
  – aggregating medical practice into larger entities, simplifying bundled payments and P4P
Rewarding Providers- Other Incentives

- Provider feedback - on use of highly effective therapies
- Public report cards -
  - e.g. publish provider network rates of delivering highly effective treatments
Rewarding Providers- Other Incentives

• Information Technology-
  – building in CER-based computerized reminders, alerts, protocols
  – E.g. “meaningful use” under HITECH

• Malpractice reform-
  – e.g. protection from lawsuits for actions based on CER-based guidelines
  – Incentives to employ informed decision-making tools when obtaining patient consent
Commonwealth Report: savings from Federal investment in CER

- Center for Medical Effectiveness and Health Care Decision-Making.
  - Invest in the knowledge needed to improve decision-making
  - incorporate information about the relative clinical and **cost-effectiveness** of alternative treatment options into **insurance benefit design**.
  - **payment and cost-sharing incentives for providers and consumers** to use CER
  - Potential health system savings of **$480 billion over 10 years**, shared by all payers.

Commonwealth Fund report: Bending the Curve, June 2009
IOM 100 National CER Priorities

• Health Care Delivery Research questions
  – Primary research area- 22 questions
  – Primary or Secondary Research area- 50 questions

• Examples from the Top Quartile
  – Effectiveness of comprehensive care coordination programs
  – Effectiveness of approaches to disseminate the findings of CER
  – Effectiveness of delivery models to prevent dental caries in children

http://www.iom.edu/CMS/3809/63608/71025.aspx
The Evidence Base for Health Care Reform

Comparative Clinical Effectiveness Research

Research on Implementing CER

Patient and Community Engagement

Provider Incentives and Delivery System Transformation

Biomedical And Clinical Innovator Engagement

Evidence-based policy

Evidence-based, Affordable Health care
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