Comparative Effectiveness Priorities Sought

BY JOYCE FRIEDEN

WASHINGTON — As with so many other things, when it comes to performing comparative effectiveness research, more is better, according to speakers at an Institute of Medicine meeting.

But more of what? That was the thorny question addressed at the meeting, convened in March by the institute's 23-member Committee on Comparative Effectiveness Research Priorities. The meeting was held to seek advice from various stakeholders on how the federal government should spend the $1.1 billion in stimulus money allocated for comparative effectiveness research (CER).

Committee chair Harold C. Sox emphasized that the committee's work was just beginning. "This is an information-gathering process," he told the audience. "It's a time for the committee to listen and take what we hear under advisement as we formulate our recommendations. We're early in our process."

He added that "it would be a mistake for anybody to infer any conclusions or drift in the direction of the committee's thinking by any questions the committee members may ask the speakers. We will be asking probing questions—just don't try to read something into it."

Once the committee finalizes its recommendations, it will write a report that will be scrutinized by a group of experts. The committee will be held accountable for responding to the criticisms of the reviewers, said Dr. Sox, editor of Annals of Internal Medicine and a past president of the American College of Physicians.

The committee's report on CER priorities is expected to be finished by July.

In a related effort, the Department of Health and Human Services recently named a 15-member Federal Coordinating Council for Comparative Effectiveness, which the department says will help the HHS, the Department of Veterans Affairs, the Department of Defense, and other federal agencies use the stimulus money "to coordinate comparative effectiveness and related health services research." In addition to various agency representatives, the council includes Dr. Ezekiel Emanuel, who is serving as a special adviser for health policy at the White House Office of Management and Budget.

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"We're early in our process," said Dr. Harold C. Sox, chair of a committee assessing comparative effectiveness research.

At the IOM meeting, the committee heard from dozens of speakers, each delivering a 3-minute talk advocating CER priorities. Ideas varied widely, from urologic diseases to the best way to use electronic health records. But one concept kept coming up over and over again: Focus on conditions that are widespread and cost a lot of money.

"The priority areas of CER should include high-volume, high-cost diagnostic and treatment modalities, and other kinds of health services for which there is significant variation in practice," said Dr. Nancy Nielsen, president of the American Medical Association. "Areas in need of further research include cardiovascular disease; disorders of endocrine and metabolic systems, including diabetes; and nutrition, including obesity."

She noted that CER findings are scarce in the area of nutrition and obesity. "It's an area of great national concern, and a wide range of interventions exist with little clarity about what is most effective."

Coronary heart disease was first on the list of Naomi Aronson, Ph.D., executive director of the Technology Evaluation Center at the BlueCross BlueShield Association. Dr. Aronson suggested looking at the management of chronic stable angina—"optimal medical management versus percutaneous coronary interventions, versus coronary artery bypass grafting. …Our concern is to understand what's optimal for specific populations."

Dorothy Jeffress, executive director of the Center for Advancing Health, did not name specific conditions but explained that "priorities for CER should be on high-volume and/or high-cost conditions for which there exist significant variation in practice and multiple treatment or diagnostic options."

Dr. Mohammad Akhter, executive director of the National Medical Association, asked the panel to consider many of the same issues other speakers mentioned, but also noted that his group has "trust issues" with government research funding. In an interview, Dr. Akhter said he wondered whether the ulterior motive behind CER was cost savings. Government efforts often purport to be about improving patient care, but then turn out to be something else entirely, he said. For example, peer review organizations started out being concerned about professionalism "and then they became punitive.… We should know what the aim of all this is. Is it just about saving money?"

That sentiment was repeated by other speakers. "The health of the public should trump business interests," said Dr. Ted Epperly, president of the American Academy of Family Physicians. "Cost-effectiveness is an important priority but comparative effectiveness research should be done in an impartial fashion," said Dr. Jack Lewin, CEO of the American College of Cardiology.

But one person had a slightly different take: "Our industry believes comparative information on cost is equally important," said Carmella Bucchino of America's Health Insurance Plans. "If one intervention is marginally better, we still want to know how much more we're paying for that benefit." ■

Medicaid Is a Better Payer Than Medicare for Health IT

BY JOYCE FRIEDEN

While Medicare is almost always a better payer than Medicaid, one notable exception is the health information technology funding contained in the Recovery Act.

For physicians applying for incentive money to purchase electronic health record (EHR) systems, "Medicaid is a little better than Medicare because there's more upfront money," Dr. William Jessee, president and CEO of the Medical Group Management Association (MGMA), said during a teleconference on the stimulus bill.

The Recovery Act—formally known as the American Recovery and Reinvestment Act of 2009—includes about $19 billion for spending on health IT, said Dr. Jessee. Physicians can apply for money through either Medicare or through Medicaid, but not both. Other clinicians eligible for the Medicare incentive include dentists, podiatrists, optometrists, and chiropractors.

To qualify for the incentive, physicians must be "meaningful electronic health records users" and use electronic prescribing. In addition, the EHR must have the capability of exchanging information with other users, and physicians must report clinical quality measures to the Health and Human Services department, presumably through the Physician Quality Reporting Initiative, Dr. Jessee said.

To be eligible for the Medicaid incentive, at least 30% of a provider's practice base must be Medicaid recipients. Pediatricians have a lower threshold—just 20%, he said.

The states administering the Medicaid portion of the incentive can make payments to Medicaid providers for up to 85% of net average allowable costs, to a maximum of $63,750 over 6 years for a certified EHR. The maximum incentive starts at $25,000 in the first year and then gradually decreases each year.

Under the Medicare incentive, physicians who are using an EHR in 2011 or 2012 can receive an incentive equal to as much as 75% of their Medicare allowable charges per year for the cost of their hardware and software, up to a maximum of $44,000 over a 5-year period. (The maximum allowable benefit per provider is $15,000 in the first year and gradually decreases over the next 4 years.) Physicians practicing in health professional shortage areas can receive a 10% additional payment, he noted.

Many provisions—such as who is a "meaningful" user—haven't yet been made clear. "What's [also] still fuzzy is, do you report in 2010 and get your first payment in 2011, or report in 2011 for a first payment in 2012?" Dr. Jessee said. The incentive also comes with a "stick" attached: Physicians who are not using an EHR by 2015 will see a decrease in their Medicare payments.

Also still to be determined is what constitutes a certified EHR. Still, Dr. Jessee said, "you need to be very careful to make sure that the product you use or are contemplating investing in will be a certified product that qualifies for an incentive. We suggest putting a [clause] in your contract saying that the vendor will make sure the product you're using will qualify for the incentive."

In addition to the federal EHR incentives, Congress allocated another $2 billion for indirect grants to support HIT, primarily at state and regional levels, he said. "It's an HIT extension service modeled on the agricultural extension service, with the idea that people will need assistance implementing HIT. No one knows who's going to be performing that function, or whether it will be national, state, or local, but a substantial sum of money has been devoted to supporting that extension service."

Although there has been speculation about whether the government was going to come out with a free EHR for providers, "my guess is, don't hold your breath," he said. "Remember when HHS said it was going to create a 'freeware' version of [the EHR used by the Veterans Affairs department]? They found that it wasn't exactly free, and it didn't lend itself to being transferred from a large mainframe environment to a disseminated environment."

The interim regulation spelling out all the EHR requirements is due to be published no later than July of this year. Practices that already have EHRs will have until Jan. 1, 2014, to comply with the new rules; those who buy EHRs from now on will have to comply either by the day they purchase the system or by Jan. 1, 2011, whichever is later, he said.

The teleconference was sponsored by MGMA, MedFusion, Athena health, and MicroMD. ■

Pages 24a—24b