VANDERBILT UNIVERSITY School of Medicine

Department of Health Policy

FIVE YEARS OF IMPROVING HEALTH THROUGH RESEARCH, EDUCATION, & SERVICE

Role of Evidence in Health Policy Decision-Making

October 21, 2018

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Thoughts in the Form of 3 examples

1. Congressional Budget Office (CBO) Use of Evidence
2. MACRA/MIPS and role of Medical Societies
3. America’s most famous surgeon & policy outside of DC

Hall, K. How CBO Promotes Integrity in Its Analyses. Presented September 6, 2017. https://www.cbo.gov/system/files/115th-congress-2017-2018/presentation/53068-presentation.pdf

I. CBO's Role

- **The House and Senate Budget Committees oversee the budget process, draft an annual budget plan, and monitor action on the budget.**
- **CBO provides the budget committees and Congress with objective, impartial information about budgetary and economic issues, including information and estimates required for the Congressional budget process.**

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CBO's Use of Models

- Use existing evidence to make future projections
- Facilitate consistency and replication of methods for estimates over time
- Enable timely responses to requests for estimates
- Incorporate behavioral responses (if feasible)
  - Households and businesses
  - Federal agencies
  - State, local, and foreign governments

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CBO's Considerations in Evaluating Evidence

- Generalizability of research findings to policy under consideration
- Potential biases in results
  - Determining the middle of the distribution of possible outcomes
  - Using weighted average of point estimates
  - Handling statistically insignificant estimates
- Characterization of uncertainty
  - Frequently qualitative due to insufficient evidence
  - Plausible ranges based on known sources of uncertainty
  - Indication of the sensitivity of results to variations in those sources

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https://www.cbo.gov/system/files/115th-congress-2017-2018/presentation/53068-presentation.pdf

MIPS
APMs
??

II. MACRA

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Key Provisions of MACRA

- Full and permanent repeal of the broken sustainable growth rate (SGR) formula used to calculate Medicare physician payments
- Annual positive updates of 0.5 percent from July 2015 to 2019
- Maintenance of fee-for-service as a payment option
- Elimination of current-law penalties from the existing quality programs, such as the Physician Quality Reporting System (PQRS), Electronic Health Record (EHR) Meaningful-Use Program and the Value-Based Modifier (VBM) Program in 2019, and combining these programs into a single Merit-Based Incentive Payment System (MIPS). The merit-based program would be based on physicians achieving a threshold, or benchmark. Such a system makes it possible for all providers who reach these quality benchmarks to achieve positive incentives or payment updates
- Incentives to move into advanced alternative-payment models (APMs), including 5 percent bonus payments from 2019 to 2024, and exemption from some other reporting requirements
- Inclusion of appropriate pathways for surgeons to develop, test, and participate in APMs, such as the Clinical Affinity Groups (CAGs) in ACS's Value-Based Update (VBU) proposal
- Prohibits CMS from implementing its plan to transition 10- and 90-day global payments to 0-day global payments
- Clarification that no standard or guideline created under federal health programs shall be construed as setting the standard of care for purposes of malpractice claims.

Frequently Asked Questions

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Medicare Physician Payment

ACS Testimony at House Energy and Commerce Health Subcommittee: An Update on the Merit-based Incentive Payment System

ACS Statement to House Ways and Means Health Subcommittee: The Implementation of MACRA's Physician Payment Policies

ACS Statement to House Energy and Commerce Health Subcommittee: MACRA and Alternative Payment Models: Developing Options for Value-Based Care

ACS Letter on 2018 Bipartisan Budget Act

ACS letter regarding February 6, 2018 continuing resolution

ACS response to CMS request for information related to the Medicare Access and CHIP Reauthorization Act (MACRA)

CMS Recognition of Provider Concerns

- Extend transition period through 2022
- More Advanced APMs added
- Gradually increase weight on cost category
- No MIPS payment adjustment for Part B drugs
- Add new eligible clinician types
- Remove MIPS quality measures that are identified as “low-value” or ”low-priority” by clinicians
- Allow clinicians to opt-in to MIPS if they meet/exceed low-volume threshold criteria

MEDPAC voted 14-2 to repeal MIPS, replace with voluntary value program

- Argues that:
  - MIPS is burdensome and complex
  - MIPS performance scores will not be easily interpreted/comparable across clinicians
  - MIPS scores will be very high for most clinicians, limiting CMS's ability to differentiate performance

- Suggests a program in FFS Medicare in which:
  - Clinicians can elect to be measured voluntarily
  - Clinicians can qualify for value payment based on group's performance on set of population-based measures

Report to the Congress: Medicare Payment Policy. *MedPAC.* March 2018.
http://medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0

III. Policy Outside of Washington…

Pulse Check: Atul Gawande goes to Washington (again)

'I hardly come to Washington,' the Harvard professor and best-selling author said. 'The reason why is because I don't think the story is in Washington.'

By **DAN DIAMOND** | 11/03/2017 10:00 AM EDT

Some Concluding Thoughts & Advice…

1. Understand systems & interests
    - Health systems (not just Boston!)
    - Payment systems (major levers for achieving policy goals)
    - Political process (consider an executive or legislative experience)
2. Values and goals matter
3. Use your super-power – your stories about patients
4. Aim for evidence-informed policy -- if not evidence-based -- wherever policy is made

”Target Population Health” Example

Illustrative Examples of Health Policies, Possible Goals, and Relevant Evidence Base.*

Specific Policy	Policy Goals	Stylized Assessment of Evidence
Free transportation to medical appointments	Reduce overall spending by promoting effective care	Theory suggests direction of effect is ambiguous (may increase use of cost-effective primary care that averts use of more expensive downstream care later, but must pay for transportation for many to avert potential downstream costs for some). Little evidence of savings.
	Improve health through better management of chronic conditions	Theory suggests improvement (patients more likely to use primary care when transportation costs reduced). Little evidence of improvement in health.
Allow hospital mergers in order to facilitate delivery of integrated care	Reduce prices through economies of scale	Theory suggests direction of effect is ambiguous (economies of scale could improve efficiency and decrease costs, but market power could increase prices). Evidence shows substantial increases in prices from mergers.
	Improve quality of care	Theory suggests direction of effect is ambiguous (economies of scale could improve quality because integration is easier, but larger market power reduces competitive pressure to improve quality). Evidence reveals mixed information on quality.

*Table is meant to illustrate the important characteristics of EBHP. It is not intended to be a comprehensive review of the evidence on any of these complex policies or the large literature that explores them.

Baiker, K. Chandra, A. Evidence-Based Health Policy. *NEJM*. 2018;377(35):2413-2415.