

Comparative Effectiveness Assessments

What will their impact be?

How will CER assessments be used?

- “Too cold”
 - Dissemination of information to patients and clinicians
- “Too hot”
 - Direct mandates for “all-or-nothing” coverage decisions
- “Just right”
 - Providing “guidance” to patients, clinicians, and payers

What will patients and doctors do?

- Patients (Patients, patient advocates, or “the public”)
 - Participate in federal CER institute
 - Contribute to priority setting process
 - Contribute to dissemination
- Clinicians
 - Participate in federal CER institute
 - Develop their own (pre-emptive) guidelines
 - Co-brand products?

What will states do?

- Try to apply federal CER assessments to state policies
 - “Blunt” application to formularies
 - Complementary analyses of cost-effectiveness

States and CER assessments

- **Washington state Health Care Authority**
 - Participant in DERP and MED
 - Formal HTA program making coverage decisions based on safety, effectiveness, and cost-effectiveness
- **Proposed New England Comparative Effectiveness Council**
 - All six New England states
 - Adaptation of AHRQ reviews for regional implementation by public and private payers
 - Cost-effectiveness to be included

Washington Health Care Authority coverage decisions

ICER Integrated Evidence Rating

Comparative Clinical Effectiveness

Superior	A	Aa	Ab	Ac
Incremental	B	Ba	Bb	Bc
Comparable	C	Ca	Cb	Cc
Unproven	U/P	Ua	Ub	Uc
Insufficient	I	I	I	I

Comparative Value

a	b	c
High	Reasonable/ Comparable	Low

CTC (“virtual colonoscopy”)

CTC (“virtual colonoscopy”)

Comparative Clinical Effectiveness

Superior	A	Aa	Ab	Ac
Incremental	B	Ba	Bb	Bc
Comparable	C	CTC 1/3-price	Cb	Non-coverage
Unproven	U/P	Ua	Ub	Uc
Insufficient	I	I	I	I
Comparative Value		a High	b Reasonable/ Comparable	c Low

What will payers do?

- Medicare
 - Integration of CER assessments into National Coverage Determination (NCD) process
 - Future applications to reimbursement?
- Private payers
 - Initial coverage decisions
 - Payment and Benefit Design



**Comparative Effectiveness:
Demonstration kickoff meeting**
March 18, 2009

EACH members

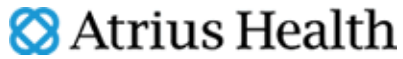


Providers

Health Plans

Employers

Other



ICER appraisals of localized prostate cancer treatment options

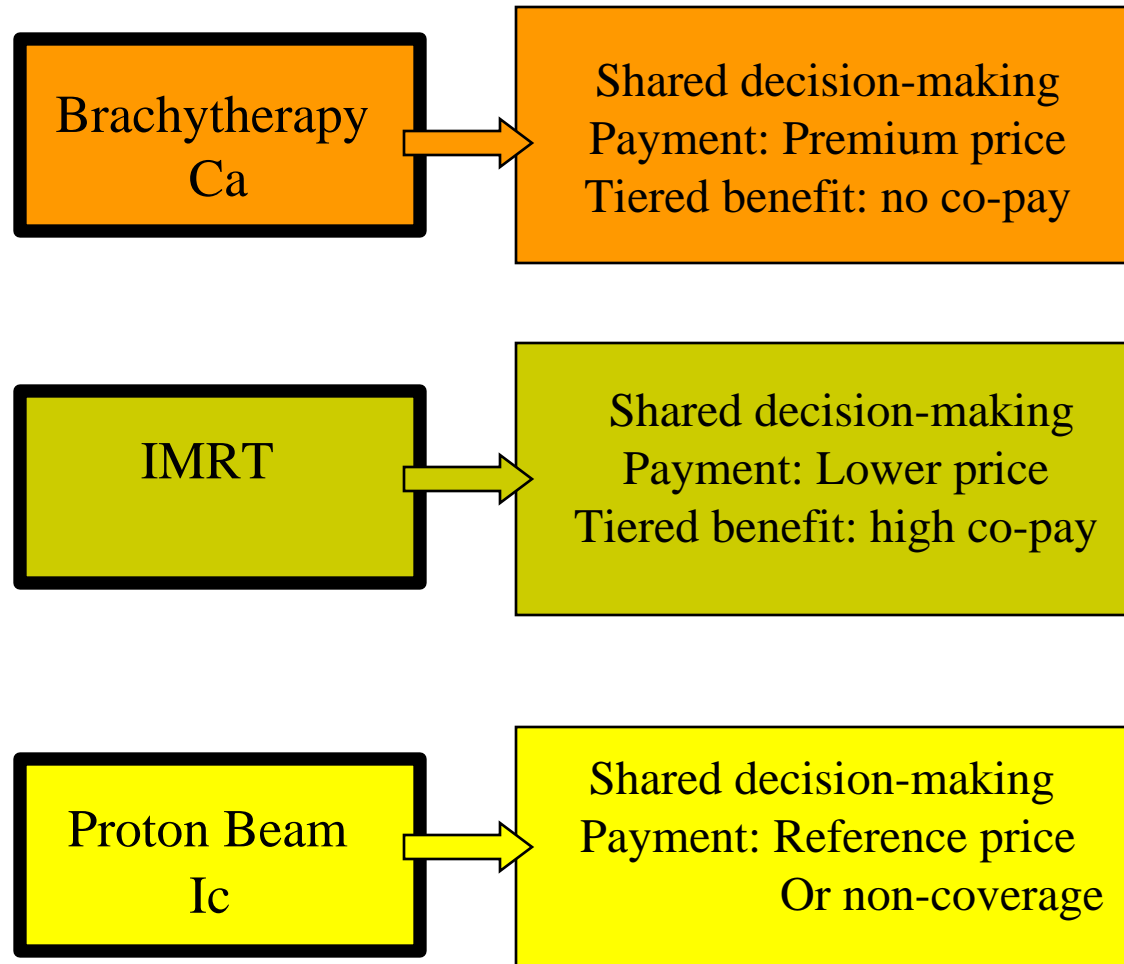
- Active surveillance
- Radical prostatectomy
- Brachytherapy
- IMRT
- Proton beam

Radiation for prostate cancer Compared to IMRT

Comparative Clinical Effectiveness

Superior	A	Aa	Ab	Ac
Incremental	B	Ba	Bb	Bc
Comparable	C	Brachytherapy Ca	Cb	Cc
Unproven	U/P	Ua	Ub	Uc
Insufficient	I	I	I	PBT = Ic
Comparative Value		a High	b Reasonable/ Comparable	c Low

From Comparative Effectiveness to Medical Policy



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PROSTATE CANCER

A diagnosis of prostate cancer can be overwhelming. Here, we present the results of a comprehensive review of the many management options available for men with low-risk prostate cancer. This patient decision aid is designed to give you an idea of the clinical effectiveness, side effects, and costs of the various options and to empower you to have the knowledge you need to make an informed decision with your health care providers. We also provide a list of key questions to ask your doctors about the different management options. The content of this website is based on a [comprehensive appraisal](#) of the different options for low-risk prostate cancer conducted by the [Institute for Clinical and Economic Review](#). The content was created in consultation with clinical experts from (list provider groups? List health insurers?). The Employers Action Coalition on Healthcare (EACH), an initiative of several employer groups, providers and health insurance companies, supported the development of this patient-decision aid.

This website is intended for patients who have a diagnosis of low-risk prostate cancer. It is important for you to confirm with your doctor that this information is right for you. If you have any questions or concerns about the use of this site, please contact your health care provider.



Payment and CER

- Principle
 - Equal pay for equal results as established by CER
- EACH Goal
 - Increase payment for brachytherapy
 - Decrease payment for IMRT
- Challenge
 - “Parsing” patients accurately
- Possible Approaches
 - Use diagnostic and therapy coding algorithms
 - Develop new codes (G-codes)
 - Manual review

Benefit Design and CER

- Oregon experiment
 - “Preference-sensitive” interventions trigger 50% co-insurance
 - All CT scans
 - All MRIs
 - All angioplasty and CABG
- California purchaser
 - Tiered benefit design for low back pain services
 - Are the coding systems precise enough to serve as EBM tools?

Looking Ahead

- Cost pressures are not going away, so cost and cost-effectiveness will be woven into the process, at first by states and payers
- Specialty pharma will be the first area of drug therapy to be a major focus of CER
- There will be assessments of delivery system interventions that may improve adherence
- A “make or break” moment for national CER will occur not within the first but within the first three years of a national CER program.





Thank you