The New England Comparative Effectiveness Public Advisory Council (CEPAC)

Adapting federal CER reviews to support payer policy decisions

ICER
INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW

The Rationale

- State and regional private payers are important customers of medical evidence reviews
- Important barriers exist that impede optimal use of evidence in payer policy decisions

Barriers to effective use of AHRQ reviews

- Lack of cost information
- Not timed to decision-making
- Content
  - Too long and diffuse, too much focus on uncertainty, no straightforward guidance

AHRQ: Catheter ablation for afib

- Key Question 1.
  - What is the effect of RFA on short-term (6 to 12 months) and long-term (>12 months) rhythm control, rates of congestive heart failure, left atrial and ventricular size changes, rates of stroke, quality of life, avoiding anticoagulation, and readmissions for persistent, paroxysmal, and long-standing persistent (chronic) atrial fibrillation?
- Key Question 2.
  - What are the patient-level and intervention-level characteristics associated with RFA effect on short- and long-term rhythm control?
- Key Question 3.
  - How does the effect of RFA on short- and long-term rhythm control differ among the various techniques or approaches used?
- Key Question 4.
  - What are the short- and long-term complications and harms associated with RFA?

Context: Barriers to effective use of AHRQ EPC reviews

- Lack of cost information
- Not timed to decision-making
- Content
  - Too long and diffuse, too much focus on uncertainty, no straightforward guidance
- Not persuasive with local clinical experts
  - Need to integrate evidence review with local views
- Lack of public legitimacy
  - Difficult to make negative judgments on evidence given perceived conflict of interest

CEPAC: Governance, Content, and Structure

- The Goal
  - To "adapt" AHRQ evidence reviews to meet the needs of state and regional payers, thereby enhancing the application of evidence in policy and practice
- Governance
  - Advisory Board of state Medicaid directors, medical society representatives, regional private insurers, and patient advocates
- Supplementary Content
  - Recently published studies
  - State-specific prevalence, utilization patterns
  - Comparative value analysis: costs, budget impact scenarios, and cost-effectiveness analysis
- Structure
  - CEPAC

New England CEPAC

- Independent from state and other payers
- 19 members (minimum two per state)
  - 2:1 ratio of practicing clinicians with evidence review experience and public health policy experts
  - Ex-officio representation of public and private payers
- Process
  - Receive adapted AHRQ review
  - Discussion with regional clinical experts
  - Public deliberation, voting
  - Policy roundtable to discuss applications of CEPAC findings

CEPAC Report

- Voting
  - Is the evidence adequate to demonstrate that intervention A is equivalent or superior to intervention B for patients with this condition?
  - Based on reimbursement levels provided with this report, would you judge the value of intervention A to be of 1) high value; 2) equivalent/reasonable value; or 3) low value compared to intervention B?

CEPAC Report

- Policy recommendations
  - Actions that can be taken to improve outcomes and/or value by payers, providers, patients
  - Comments on coverage options, e.g. CED
  - Future research recommendations

Key Votes: Catheter ablation

- 15 to 1 that evidence was adequate to demonstrate *superior* clinical effectiveness for catheter ablation after poor response to medical management
  - Comparative value: 13 “reasonable” value; 3 “low value”

- 16 to 0 that evidence was inadequate to demonstrate that first-line catheter ablation was equivalent or superior to medical management

- 16 to 0 that evidence was inadequate to demonstrate that minimally invasive surgical ablation was equivalent or superior to catheter ablation or continued medical management

Applications

- Broad dissemination efforts
- Payers: no direct action taken

Lessons from the ablation CEPAC

- The “not my problem” problem
  - Payers view “no” votes as actionable primarily by hospital and clinical communities
- The “all or nothing” problem
  - Payers may be unable to use their data infrastructure to target coverage or payment policies to different uses of procedures
- The “too small to care, too big to fail” problem
  - Small-ticket items not worth the effort; but once a big-ticket service it may be too late to restrict coverage without pushback from clinical community and patients (viz. vertebroplasty).
- The “better ways to get there” problem
  - More palatable tools for cost control include tiered networks favoring high-value clinicians

Treatment-resistant depression (TRD) December 2011

- Treatments
  - Transcranial Magnetic Stimulation (TMS)
    - Not covered by any insurers
  - Electroconvulsive Shock Therapy (ECT)
    - Covered by all insurers
  - Vagus Nerve Stimulation (VNS)
    - Not covered by any insurers

Key Votes

- 10 to 5 that evidence was adequate to demonstrate *equivalent or superior* clinical effectiveness for TMS compared to usual care
  - 5 voted “superior”; 5 voted “equivalent”
  - Comparative value: 6 “reasonable” value; 4 “low” value

- 9 to 6 that evidence was adequate to demonstrate *equivalent or superior* clinical effectiveness of TMS compared to ECT
  - All 9 voted “equivalent”

Applications

- Payer coverage
  - Regional Medicare contractor for New England changed draft non-coverage policy for TMS to positive coverage (3/12)
  - BCBS Rhode Island also began covering TMS (3/12)
  - Anthem BCBS began covering (8/12)
  - Medicaid in RI and VT are working with medical advisory committees to introduce coverage for TMS
  - Medicare regional contractor for mid-Atlantic states has asked ICER to run a teleconference with other payers and clinical experts in that region to review evidence on TMS
- Providers/Researchers
  - Based on CEPAC recommendation, New England's leading TMS researcher offers to perform voluntary coverage with evidence development

ADHD

- 13-0 vote that the evidence is adequate to demonstrate that parent behavior training is superior than usual care for most preschoolers with ADHD
  - Comparative value: 6 “high” and 7 “reasonable”
- Outcomes
  - Medicaid program of Rhode Island is using the CEPAC report to develop systems of referrals for parent behavior training and setting up a certification program for providers who use an evidence-based model
  - “Action Guide” version of the report incorporated into major national patient information websites
  - Plans underway in Maine to develop a meeting between AAP and APA to discuss care coordination for children with ADHD.

Lessons from TRD and ADHD

- Timing matters
  - Picking topics that fit with payer timetables
  - Preparing the ground in advance for receipt of CEPAC reports
- Payers need very specific guides to help translate evidence into coverage decisions
  - Codes, benchmark language
- “Action Guide” for multiple stakeholders helps
- Still easier to introduce or facilitate coverage than to say “no.”

Conclusion

- Payers are very interested in improving the use of evidence in medical policies
- Payers view the role of evidence broadly, not just as a guide for coverage decisions, but as a tool for other medical policies and for use by all providers and patients
- Key facilitators:
  - Timing
  - Inclusion of cost/cost-effectiveness information
  - Clear interpretation of “what the evidence means”
  - Transparent, explicit, rigorous, trustworthy process