The use of Comparative Effectiveness Research and Evidence Based Medicine in US Payor Decision Making

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Background

- The TPG-National Payor Roundtable (TPG-NPRT) focuses on market access programs within the United States and is a subsidiary of The Pharmacy Group.
- The JeSTARx Group provides evidence-based research and support to the Healthcare Industry.
- The TPG-NPRT maintains a proprietary database of Chief Medical Officers, Chief Pharmacy Officers and other key decision makers from health plans in the United States.
- Comparative Effectiveness Research (CER) is an evolving discipline:
  - The first edition of ISPOR's Lexicon defined "effectiveness" as:
    The degree to which a therapeutic outcome is achieved in a given patient population from a medical technology under actual or average conditions of use.[1]
  - ISPOR and the US Academy of Managed Care Pharmacy (AMCP), more recently defined "Comparative Effectiveness Research" (CER) as:
    The generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care. The purpose of CER is to assist consumers, clinicians, purchasers, and policymakers to make informed decisions that will improve health care at both the individual and population levels.[2]
  - ISPOR Task Forces have published two sets of Good Research Practices for Comparative Effectiveness Research.[3]
- Pharmacy & Therapeutic (P&T) Committees and technology assessment entities are tasked with making coverage decisions with limited information available.
- Based on recent programs with US Payors, Medical Directors, and Sponsors (pharmaceutical companies, medical device, and health technology companies), the authors and their organizations decided to conduct a survey of medical and pharmacy directors involved with P&T Committees on their policies regarding the use of Comparative Effectiveness Research (CER) and Evidence-based Decision Making.

Objective and Purpose

- This study sought to survey medical directors and pharmacy directors of US payors representing: Health plans, Insurers, Employer groups and Pharmacy Benefit Managers (PBMs).
- The survey focused on the:
  - The availability and use of Comparative Effectiveness Research (CER) for decision making.
  - Pharmacy & Therapeutics (P&T) committee process.
  - The use of Comparative Effectiveness Research to:
    - Control the growth of healthcare costs.
    - Ensure appropriate utilization of products.

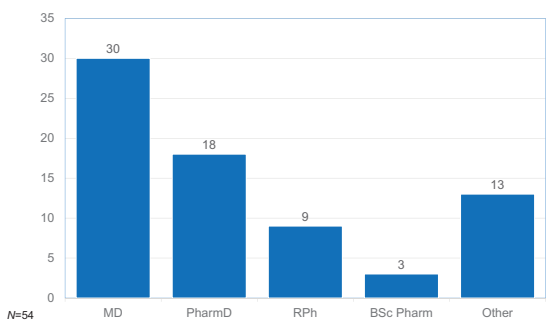
Methods

- An online, interactive survey was developed with 63 questions and included:
  - Yes / No questions
  - Lists for users to select single or multiple answers
  - Open-ended responses (ie, most desired change to their plan's/PBM's P&T process?)
- Invitations to participate were sent to 224 medical and pharmacy directors currently employed by US health plans and insurers from the TPG-NPRT database in December 2014.
- Material or financial incentives were not offered for completion of the survey.
- Topics included:
  - Plan coverage:
    - Geographical coverage
    - Types of lives
  - The area emerging Comparative Effectiveness Research is expected to affect most
  - About their agreement in progress in:
    - Obtaining usable information on Comparative Effectiveness Research of therapies today.
    - Using Comparative Effectiveness Research regularly in formulary decision making by 2015.
    - Managed care using Evidence-based Medicine (EBM) today in coverage decision making.

Results

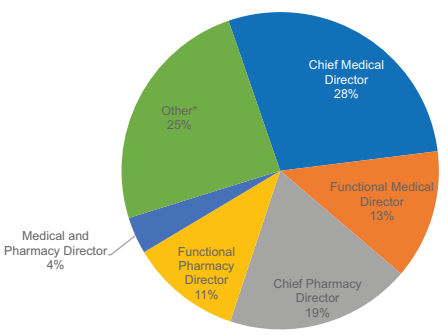
- A total of 54 persons responded to the survey invitation (**24.1% response rate**).
- Many advisors reported multiple degrees (Figure 1), and the most common degree was MD (55.6%).

Figure 1. Survey Respondent Degrees (multiple answers allowed)



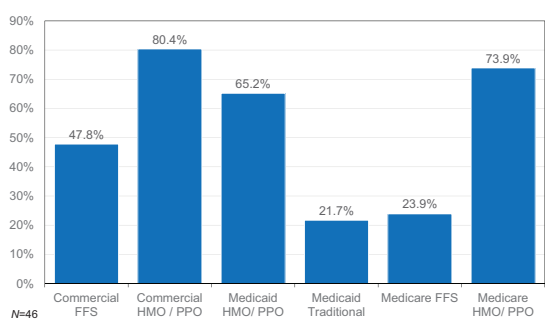
- 86% of the advisors were involved in formulary decisions.
- The respondents were mostly chief medical directors and chief pharmacy directors (Figure 2), the "Other" category included: VP (of Pharmacy, Medicine, or Medical Affairs); Chief Medical Officer, Senior Medical Director [3], and Consultant [3].

Figure 2. Respondent's Title within their Organization



- Most respondents worked for a health plan (83.6%) and 39.6% were local, 35.4% were national, and 25.0% were regional.
- The type of plans represented are shown in Figure 3.

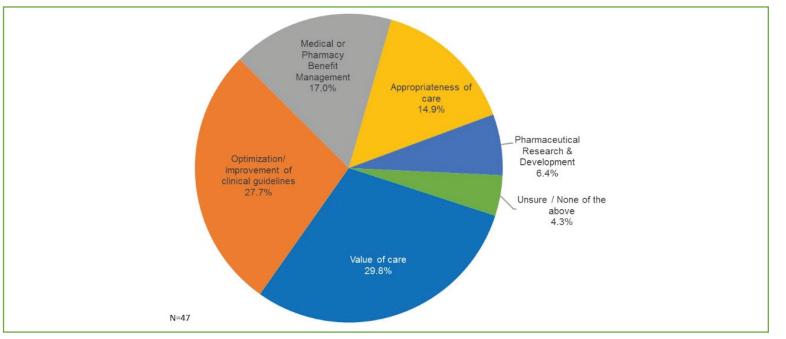
Figure 3. Type of Plans Represented by Respondents (Respondents can cover multiple types)



FFS=Fee For Service; HMO=Health Maintenance Organization; PPO=Preferred Provider Organization

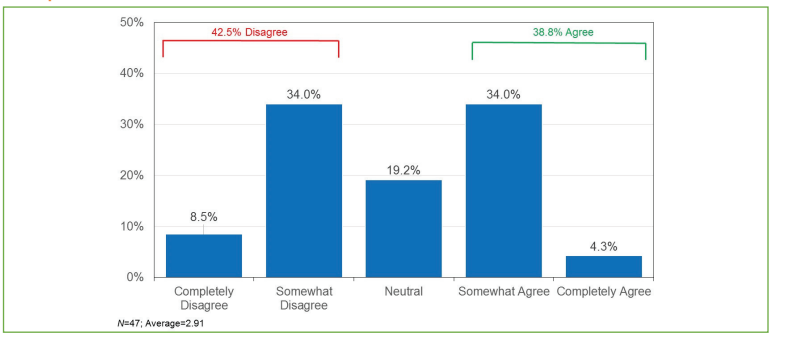
- From a list, advisors selected the area they expect emerging Comparative Effectiveness Research to affect most, with their responses shown in Figure 4:

Figure 4 The Area Emerging Comparative Effectiveness Research is Expected to Affect



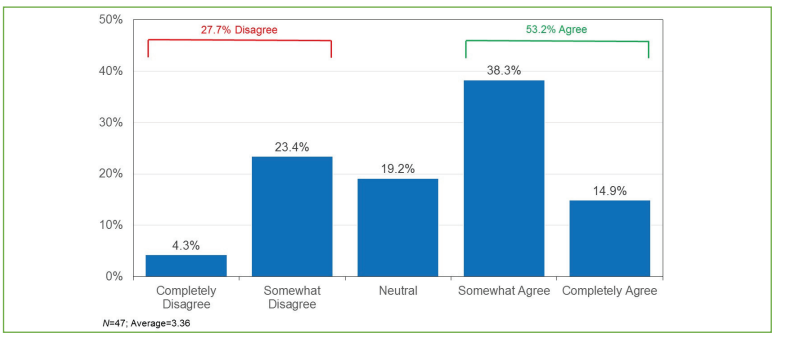
- While some advisors believe we are making progress in obtaining usable information on the Comparative Effectiveness Research of therapies, more advisors believe we are not:

Figure 5 Progress in Obtaining Usable Information on Comparative Effectiveness Research of Therapies



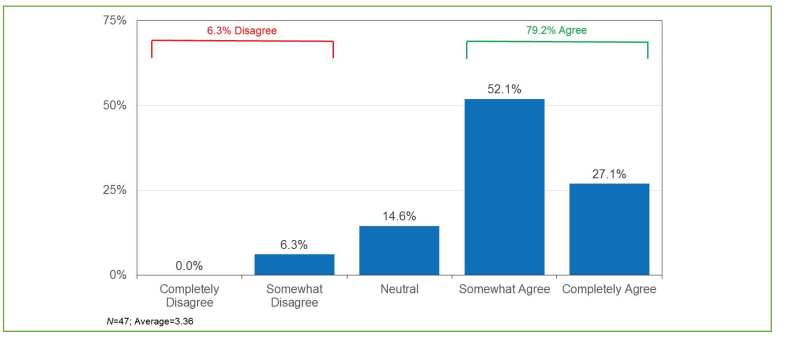
- Most advisors expect to regularly utilize Comparative-Effectiveness information in formulary decision making by 2015 (Average 3.36, Figure 6).

Figure 6 Respondents Expectations on their plan's use of Comparative Effectiveness Research in Formulary Decision Making by 2015



- Most advisors believed that managed care commonly uses Evidence-Based Medicine [EBM] today in coverage decision making (Figure 7).

Figure 7 Perceptions that Managed Care Commonly Uses Evidence-based Medicine today in Coverage Decision Making



- Open-ended responses of the most desired change to their plan's/PBM's P&T process included:
  - Increased use of Comparative Effectiveness Research (4);
  - Formulary changes, including: Close down our formulary; Limited formulary; Specialty tiers with closed formularies based on value; Restrict products like Express Scripps and CVS are doing; More control on the medical side drugs; More closed 4th and 5th tiers;
  - Utilization Management: Mandatory Pharmacist MTM/care management for specialty drugs; Efficient utilization management program; Better use of automated clinical management programs;
  - Step therapy: Greater step therapy; Increase the number of meds that require step therapy; More step therapy;
  - Co-pay: Change co-pays to percentages; Higher co-payment and co-insurance; modify co-pays based on adherence; Move into more cost share from co-pay;
  - Network changes: More restricted network;
  - Member changes: Develop member engagement benefits; Improve case management programs at the individual member level;
  - Provider changes: Increase provider risk for prescribing; Convince the network doctors to embrace cost-effective prescribing practices;
  - Better Integration: Better integration between Medical Management and Pharmacy; Total integration of care management: Silos are still prevalent;
  - Contract changes: Tougher contracting; Better pbm arrangement; Dollar caps; Shift financial risk;
  - Link costs to: Outcomes; Compliance; link costs to compliance with preventive care;
  - Do away with the move towards value-based healthcare. Most efforts are directed at coddling those with chronic illness secondary to a long period of neglect of health and failure to adopt healthy behaviors;
  - Add more pharmacists (2);
  - Consider other modalities of treatment like compound medications, and Complementary Medicine;
  - Figure out how to nullify the impact of coupons;
  - Aligned incentives;
  - Reference pricing;
  - Remove State requirements from the Medicaid programs.

Conclusions

- Formulary decision making in P&T committees is making progress in the use of comparative effectiveness research.
- The environment for P&T Committee decision making in managed care is undergoing a series of changes.
- Payor medical directors and pharmacy directors, who commonly serve as P&T Committee members, have a distinct understanding and opinions as to how to alter the process to adapt to these influences.
- Results suggest that the acceptance of evidence based medicine is valuable even if not comparative.

References

1. ISPOR Lexicon. Edited by Pashos CI, Klein EG, Wanke LA. ISPOR. Princeton, NJ. 1998.
2. Hines LE. Comparative Effectiveness Research [Glossary of Terms]", 2011 available at http://www.amcp.org/CERglossaryofterms/.
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Disclosures: None

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