


FORUM



Reimbursement Policy Decision making process in the US: Private versus Public


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Reimbursement Policy Decision making process in the US: Private versus Public

Moderator





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Reimbursement Policy Decision making process in the US: Private versus Public

Speakers

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Elizabeth Adams, RRT, MPH
Research Analyst, OPCS VA Technology Assessment Program, VA Boston Healthcare System, Boston, MA, USA

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Determination of Health Care Coverage Decisions in VA


Presentation Overview

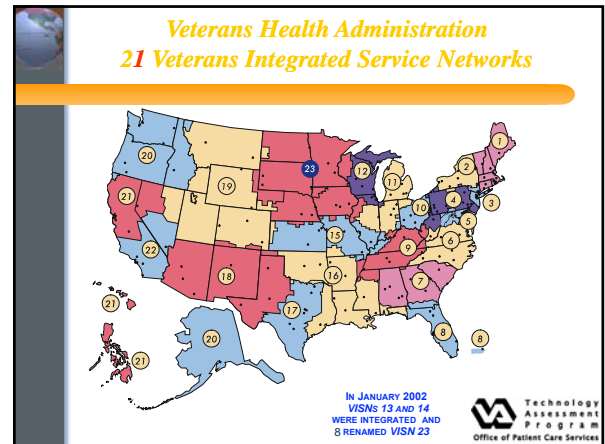
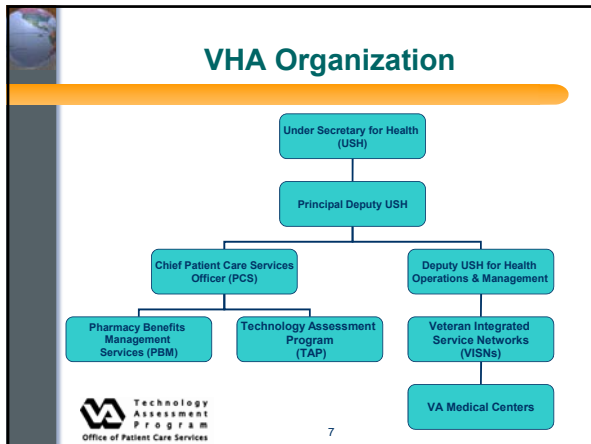
- Background on VA
 - Stats
 - Organization
- Level 1 processes:
 - VA National Formulary
 - National Leadership Board Health Systems Committee



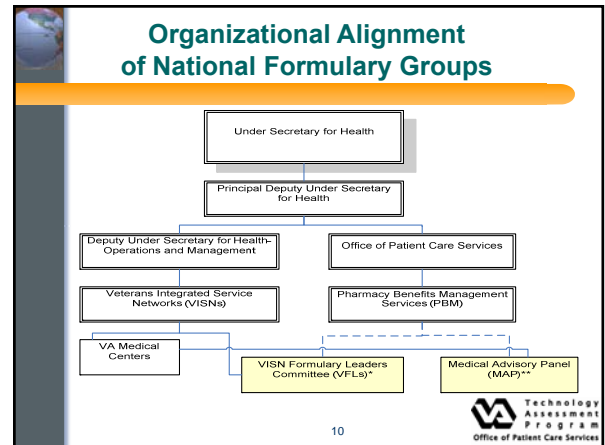
Background on VA

- 2nd largest federal agency in US
- Provides health care, financial assistance & burial benefits to Veterans & their families
- VHA
 - 153 medical centers + > 1,400 sites of care
 - FY08 budget = \$40 billion
 - 5.5 million Veterans



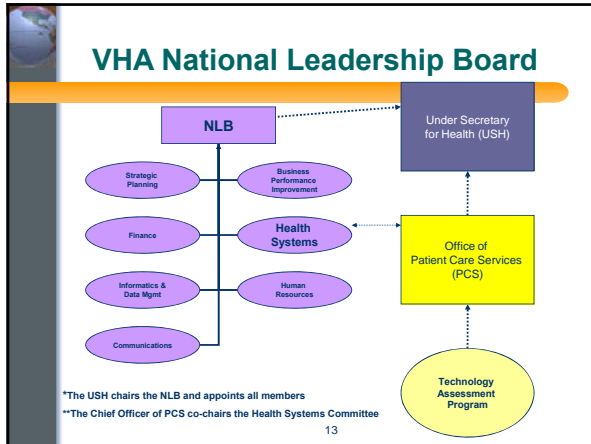



- ### VA National Formulary (VANF) Management
- Within PBM
 - Primary role = manage VANF
 - PBM staff produce literature reviews (not systematic) of safety, efficacy, effectiveness & cost-effectiveness
 - 2 parallel groups manage VANF:
 - Medical Advisory Panel (MAP)
 - VISN Formulary Leaders Committee (VFLs)
- 9



- ### VA National Formulary (VANF) Management
- | | |
|---|---|
| <p style="text-align: center;">MAP</p> <ul style="list-style-type: none"> • <u>Clinical</u> expertise • Field clinicians, VISN leader, DoD reps • MDs have majority vote • MAP recommendations prevail if no consensus with VFLs | <p style="text-align: center;">VFLs</p> <ul style="list-style-type: none"> • <u>Operational</u> expertise • 1 MAP MD, 21 VISN pharmacists, DoD and IHS reps, NCPS rep • Streamlines communication & add context |
|---|---|
- 11

- ### National Leadership Board (NLB)
- Advises USH on all VHA policy, planning, & performance
 - Disseminates information internally & externally
 - Members = all VISN directors, Chief Officers, other senior leaders appointed by USH
 - 7 committees w/ broad representation from field, Central Office & other stakeholders *ad hoc*
- 12



- ### Health Systems Committee
- Co-chaired by Chief PCS and VISN leader
 - Executive Decision Memo
 - Makes EB recommendations re patient care, research, education, & emergency preparedness
 - TAP support
- 14
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Reimbursement Policy Decision making process in the US: A Private Commercial Health Plan


Speaker





John Watkins RPh, MPH, BCPS
Pharmacy Manager, Formulary Development,
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- ### Premera Blue Cross
- 
- 1.5 million members
 - 1 million pharmacy lives
 - States covered:
 - Blue Cross (Washington)
 - Blue Cross Blue Shield (Alaska)
 - LifeWise Health Plan (Oregon)
 - Entirely Commercial PPO
 - Evidence-based formulary process using AMCP Format for submissions since 2001
- Our Mission: To provide peace of mind to our members about their health care.*
- 
- Premera Blue Cross is an independent licensee of the Blue Cross Blue Shield Association.

- ### Organizational History
- Speaker**
- Origin of the “Blues” in the U.S. (1930s)
 - Blue Cross: hospital insurance
 - Blue Shield: organized by physicians at the county level, to cover ambulatory care
 - Premera formed in 1998 by merger:
 - Blue Cross of Washington and Alaska
 - Medical Services Corporation (Eastern WA)
 - Premera Formulary program began 1996
 - Adopted AMCP Format-based process 2001
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- ### Resources We Currently Use
- Primary literature – we always search this first:
 - Clinical trials
 - Observational studies
 - Economic studies
 - Peer-reviewed formal evidence syntheses
 - Meta-analyses
 - Systematic reviews
 - Secondary Sources:
 - AMCP Format-compliant product dossier from manufacturer
 - Practice guidelines
 - Other organizations HTAs:
 - TEC (Blue Cross Blue Shield Association)
 - FDA reviews, NICE, CADTH, etc.
- 

Evidence Grades Look Neat

Best: Large, well-designed head-to head RCTs:
 Long-term studies, real clinical endpoints
 Well accepted intermediates
 Poorly accepted intermediates

Smaller RCTs, or separate, placebo-controlled trials
 Well-designed observational studies, e.g., cohort studies, case-control studies
 Safety data without efficacy studies
 Case series, anecdotes

Least: Expert opinion, expert reports, and other documents with no direct clinical evidence

But Reality Is A Continuum of Possibilities...

YES: Effective, safe, cost-effective, drug of choice for most patients

MAYBE: Inadequate, ambiguous or conflicting evidence:

- Questionable evidence/incremental benefit
- Marginal or no cost-effectiveness
- Few patients
- Likely to be over-promoted to inappropriate users,
- Concern about rumors, politics, etc.

NO: Does not work or unsafe, more expensive than equivalent alternatives, not first or second choice for most patients

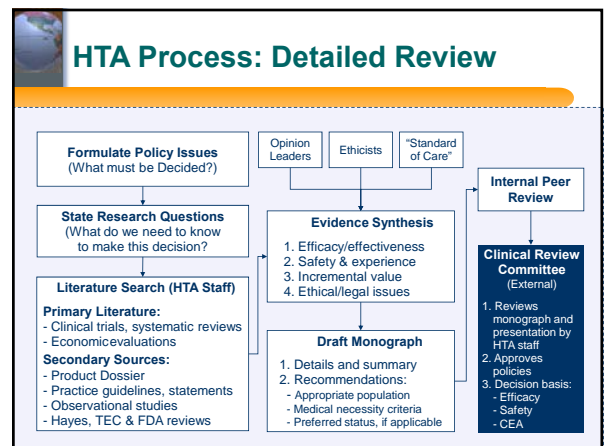
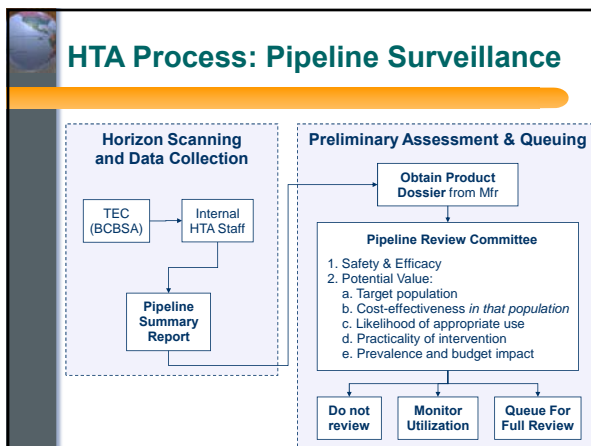
Can I buy a vowel?

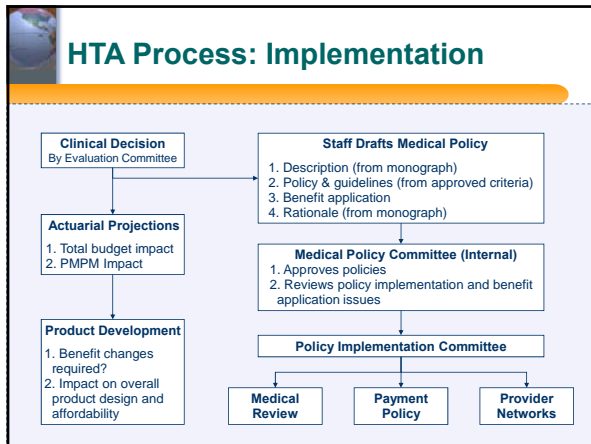
Pharmacist


WHEEL OF EVIDENCE

Case Example: Biologic DMARDs

- Data problems:
 - No Head-to-head trials, only placebo controls
 - Trials differ in
 - Definition of endpoints (Sharp scores)
 - Study populations
 - Monotherapy vs Biologic + Methotrexate
 - Possibility of dose escalation
 - Different models by 3 manufacturers
- How to make sense of this??
 - Default assumptions
 - Modeling





- ### Comparative Effectiveness
- Our “wish list” – types of studies
 - Large, head-to-head RCTs with real outcomes
 - Pragmatic trials
 - Retrospective database studies
 - Focus of studies
 - Evidence gaps
 - Biologics and other newer drug classes
 - High cost, high volume drugs
 - Special cases
- 

- ### Example: Comparison of Age-Related Macular Degeneration Treatments Trials (CATT)
- Federally Funded
 - National Eye Institutes of Health/NIH
 - Head-to-head
 - Intravitreal bevacizumab vs ranibizumab
 - The well-designed trial *we were waiting for*
 - 3 bevacizumab arms (different doses)
 - Adequate size: 1200 patients, 24 months
 - Started 1/2008, completing in 2011
 - Meaningful endpoint: mean change in VA
- Source: www.clinicaltrials.gov/ct2/show/NCT00593450?term=CATT&rank=2
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