

Incorporating Cost into Comparative Effectiveness?

AcademyHealth

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Why not include costs in comparative effectiveness?

- Job #1 – reducing uncertainty in providing care to patients
- Argument about a national entity not cost effectiveness for individual patients
- Diverse payer environment – not the UK
- Cost effectiveness analysis is used by countries to limit coverage of treatments (e.g., NICE) – and is a poison pill
- “Incremental cost effectiveness” favors already covered treatments, if used in coverage decisions
- Cost effectiveness is an assessment based on averages and can underestimate value for individual patients
- Methods are imperfect (cost/QALY)
- Childhood leukemia example – presumption against less well proven innovation, especially incremental innovation

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Will CE address cost drivers?

- Not as currently framed – drug to drug, device to device
- Geographic variations – driven by processes of care around episodes
- CBO’s “technological change and growth in spending” misinterpreted
- Fee-for-service rewards doing more, not getting better results

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What Would Medicare Do?

- Likely not to deny coverage if any beneficiaries could benefit
- Might consider in setting reimbursement rates
- What is cost effectiveness if Medicare doesn't have cost information except hospital proxy costs (expenditures)
- Could allow conditional or facility/physician specific coverage but don't need cost data to do
- Could use comparative effectiveness information to reward use of best practices, through P4P
- Could use power of Medicare to disseminate (e.g., lung volume reduction surgery)
- Need to focus on drivers of Medicare costs – chronic disease, fee-for-service (“pay for doing”)

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What to do?

- Support and fund significant comparative clinical effectiveness research
- The information will drive use, cost sharing, practice guidelines
- Address concerns about systems costs – NQF focus on episodes, CE can inform processes of care
- Drive investment by companies/innovators in innovation that can change the standard of care – rewarding outcomes and greater efficiency
- Focus on the drivers of costs – improving chronic care management, variations in processes of care, fee-for-service payment that pays for doing

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