Comparative Effectiveness a Tool for Medicare?

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The use of comparative effectiveness research would give Medicare a sophisticated tool for making coverage decisions on the basis of quality, but its ability to use such data is hamstrung by political interests and the health reform law, according to two researchers.

Dr. Steven D. Pearson, president of the Institute for Clinical and Economic Review in Boston, and Dr. Peter B. Bach, an attending physician at Memorial Sloan-Kettering Cancer Center in New York, say that Medicare can take advantage of the burgeoning comparative effectiveness movement to change its ways (Health Affairs 2010;29:1796-804).

Some $1.1 billion was set aside as part of the American Recovery and Reinvestment Act of 2009, and the Department of Health and Human Services announced that 15 experts would guide investments and coordinate research through the Federal Coordinating Council for Comparative Effectiveness Research. However, the council's role is limited in that it will not set clinical guidelines, or establish payment rates or tell Medicare what to cover. The Affordable Care Act further spelled out restrictions on how comparative effectiveness findings could be used by the federal government.

Currently, Medicare covers a drug, device, product, or service if the evidence supports its effectiveness. No comparisons are made to comparable technologies. Payment is set separately, based on arcane formulas that cover cost and maybe a small profit.

The authors propose that Medicare instead link coverage and payment decisions at the outset. The program could still use the "reasonable and necessary" threshold in deciding when to cover a product or service. But regulators could adopt a three-tiered effectiveness scale that would let them assign differing reimbursement to each level.

A "superior" rating for products with the fewest side effects, or those that offer the most effective treatment when compared with similar treatments, would garner the highest payment.

Payment for a "comparable" product or service would be slightly less than that for the superior product, as in the difference between what is paid for a brand name and a generic pharmaceutical.

The lowest rating would be "insufficient evidence." The service would be covered and reimbursed at the conventional cost plus a small profit, but the payment level would be reevaluated every 3 years.

The authors said that a 3-year time frame can act as both a carrot and a stick. Having coverage – at current Medicare rates – is better than not having coverage, so innovation will not be stifled. But limiting that rate to only 3 years gives manufacturers and clinicians greater incentives to conduct comparative effectiveness studies, they said.

This scheme might restrict access to new services, but the authors said they believe the "trade-off would be justifiable" because the services being reimbursed at the lower rate would have the least amount of evidence supporting their use.

They also said that using comparative effectiveness data, although threatening to manufacturers, might actually end up encouraging the development of superior products and services.

The new approach raises many conundrums, they acknowledge. It could be difficult to rate a service if comparative effectiveness differed across patient subgroups. And there is the question of whether previously covered services should be grandfathered in.

But overall, said Dr. Pearson and Dr. Bach, using comparative effectiveness data to guide payment would benefit both Medicare and physicians, who would no longer have "perverse incentives to invest in and deliver services that add to the cost but not the quality of care."

Dr. Pearson reported no conflicts. He is a member of the National Institutes of Health's Comparative Effectiveness Research Steering Committee. Dr. Bach made no disclosures. He serves on the Committee on Performance Management of the National Committee for Quality Assurance and the Institute of Medicine's National Cancer Policy Forum. ■