Medicare May Be Stifled in Effective Use of Data

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FROM HEALTH AFFAIRS

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

"We believe that the time is ripe for Medicare to use comparative effectiveness research to reach a new paradigm of paying equally for services that provide equivalent results," said Dr. Steven D. Pearson, president of the Institute for Clinical and Economic Review, Boston, and Dr. Peter B. Bach of Memorial Sloan-Kettering Cancer Center, New York (Health Affairs 2010;29:1796-804).

The Obama administration is helping create a larger comparative effectiveness enterprise through some $1.1 billion that was set aside as part of the American Recovery and Reinvestment Act of 2009, and 15 experts are to guide investments and coordinate research through the Federal Coordinating Council for Comparative Effectiveness Research.

However, the council's role is limited. It will not set clinical guidelines, or establish payment rates, or tell Medicare what to cover. The 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.

Dr. Pearson and Dr. Bach 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.

For instance, a superior rating would garner the highest payment. Such a product would have the fewest side effects or offer the most effective treatment when compared with similar treatments.

Next down would be the "comparable" product or service. Payment 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, for example.

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.

The new payment and coverage scheme might end up restricting 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. "Paying more for better results is the best way to spur the kind of innovation desired most by patients, clinicians, and payers," they wrote.

The new approach raises conundrums, they noted. It could be difficult to rate a service if 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 and Dr. Bach reported no conflicts. ■

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