Health Care That Works:
Evidence-Based Medicaid

Discuss: Evidence-Based Benefits, Reference Pricing and Variable Cost Sharing with Examples from Washington Medicaid
What are some Standard Principles of Evidence-Based Coverage?

- Consistency of decisions
- Transparency of decisions
- Processes that highlight the evidence
- Lead with safety

Ensure Fairness and Consistency in Health Care Coverage and Medical Necessity Decisions

Evidence-Based Benefits are medically necessary benefits that offer access to affordable quality health care for the population served.

Evidence-Based Benefits use the best evidence of proven value to the population while respecting the appropriateness of services and the authority of the treating provider.

Washington State worked with providers and exchanged the “provider shall have substantial weight” for EBM and transparency.
How Does WA Medicaid Define Appropriateness? (WAC 388-501-0165)

**Evidence-Based Medicaid**

**A** = Randomized controlled clinical trials

**B** = Consistent and well done observational studies

DSHS generally approves above the line

Below the line, provider needs to show the evidence or DSHS will disapprove via Prior Authorization

**C** = Inconsistent studies

**D** = Studies show no evidence, raise safety issues, or no support by expert opinion

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IOM Essential Benefits
WHAT DOES SOLID EVIDENCE MEAN?
TECHNOLOGY HAS GOOD PROVEN VALUE

- cannot be based on Type III or Type IV evidence alone)

EXAMPLE: Cardiac rehabilitation

- Gets an “A” by helping patients recover faster than those who don't receive exercise programs.
- Helps avoid further surgery, hospitalization and another heart attack.
- Under ABCD evidence benefit design status has now changed to “Covered”
What does Reasonable Evidence mean?
Consistent direction of value!
- Cannot be based on Type IV evidence alone

EXAMPLE: Bariatric surgery in 2003 got a “D” but in 2004 got a “B”
- Cover for Diabetes and joint replacement
- Costs are down ($36,000 to $17,000 per case)
- Mortality and serious complications are reduced
- Require nutrition, medicine, psych, surgery and 5% weight loss per-op

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IOM Essential Benefits
What about EBM that is inconsistent or low level?

- PET Scans for oncology – allowed only with a non-diagnostic convention scan or will offset a surgery
- Bariatric Surgery – allowed only with BMI >35 and diabetes
- Botox requests for spasticity
- Chondroplasties without MRI evidence of injury
- High frequency oscillating VEST for non-CF
- Panniculectomies or other plastic surgery – only for functional improvement
  - Available if less cost, less risk and next step in reasonable care
  - There are multiple lists of ABCD for review and line drawing
What about things that will never have enough studies? Disabling idiopathic generalized dystonia

FDA and IRB Compassionate Use has not been a big deal in cost and complexity.
Can You Use Evidence for Reference Pricing, Benefit Design, and Payment?

- Generic Drugs
- Emergent ER
- Vaginal Deliveries vs. C-sections
- Older Codes (CPT/HCPCS with evidence)

Approve above the line and pay the rate for solid evidence treatments

Below the line the benefit is either non-covered or has a higher co-payment or is paid at above the line rates

- Brand Drugs with generic equivalents (SMAC)
- Non-emergent ER
- Elective C-sections
- New Codes
  - CPT & HCPCS require no evidence and cost is not considered (new codes get MSRP)
  - Placebo studies should no longer be good enough
Can You Use Evidence for a Reference Pricing, Benefit Design and Payment?

Payment/coverage for least costly/equally effective increases competition (i.e. less cost).

<table>
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<tr>
<th>PPI Class</th>
<th>Comparative Cost(NET)</th>
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<tbody>
<tr>
<td>PRILOSEC OTC</td>
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<tr>
<td>OMEPRAZOLE</td>
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<tr>
<td>ZEGGERID</td>
<td>3.4X</td>
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<tr>
<td>PROTONIX</td>
<td>3.7X</td>
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<tr>
<td>PREVACID SOLUTAB</td>
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<tr>
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<td>PRILOSEC</td>
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Average daily cost ratio = (net daily $ x daily utilization) / lowest daily cost drug
What if the Evidence says No Difference between Low and High Cost Health Care Services?

Zero co-payments
- Vaccines
- Least costly brand
- Generic Drugs
- Low cost technology with good evidence
- Emergent ER
- High level EBM

Higher co-payments
- Brand drugs with generics
- New technology without evidence
- Non-emergent ER
- Placebo studies

Increasing levels of evidence

Increasing Cost Sharing

Zero 25% 50% 75% 95%
**The Big Question: How do you spell effective?**

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
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<tbody>
<tr>
<td><strong>Quantity of literature</strong></td>
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<td></td>
<td>Few Studies/Small N</td>
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<tr>
<td>Many Consistent/Non-bias</td>
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<tr>
<td><strong>Quality of Evidence and Efficacy</strong></td>
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<td>Opinion</td>
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<td>RCT</td>
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<td><strong>Effectiveness</strong></td>
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<td>NNT 1/2</td>
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<td>NNT 1/100</td>
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<td>$150K</td>
<td>&gt;$500K</td>
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<td>More Expensive</td>
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<tr>
<td>More Expensive</td>
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<tr>
<td><strong>Benefit</strong></td>
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<tr>
<td>Large</td>
<td>Moderate</td>
<td>Unknown/Inferior</td>
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Can we agree on a line?
Putting It All Together

1) **Standardize Medical Necessity**
   Language and Processes should be evidence-based

2) **New Technology and "Off Label"**
   Use No Payment or No Coverage without Evidence

3) **Existing Technology**
   should only be covered with good evidence
   - Options should be based on evidence - determine when to non-cover, when to have higher co-pays, when to pay at older technology rates, and when there is compassionate use
   - Carefully measure access, quality outcomes and costs for any essential design because you must manage above and below any line to ensure it works
Questions?

The Current Principle in Health Care
“Facito aliquid operis …..”
Always do something

VERSUS

Our First Evidence-Based Principle
"Primum non nocere"
"Declare the past, diagnose the present, foretell the future; practice these acts. As to diseases, make a habit of two things — to help, or at least to do no harm."