

Evidence-Based Medicine & Technology
Assessment in Washington State:
**The ABCDs to Improved Quality,
Reduced Variation and Lower Costs**

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Washington State Evidence-Based Purchasing Efforts

Goal – How to buy the most effective health care services for 1,300,000 citizens?

- ❖ By providing evidence-based benefits through statutes, sticks/carrots, data and building trust!

Why? We simply cannot talk about expanding access, unless we also talk about containing health care costs -- which means not only how care is paid for, but also how care is delivered.

The Journey Started in 2003: Just Getting our Feet Wet

- HB 1299 Collaborative legislative & executive branch effort started in 2003, with passage of relatively simple legislation
- Agencies providing state purchased health care will use evidence-based medicine principles to:
 - Develop common performance measures
 - Implement financial incentives for providers and facilities

WA Took a Plunge in Late 2003

- Senate Bill 6088 (2003) Prescription Drug Program
- Creates an Evidence-Based Rx Drug Program to develop a preferred drug list (PDL)
- Used by All State Purchased Health Care Programs
- Evidence-Based Practice Center in Oregon Reviews Drug Classes (Working with 13 other states in DURP)
- Independent P&T Committee selects the most or equally effective drug(s) in class
- Cost considered only when comparing equally effective drugs in developing preferred drug list.
- <http://www.rx.wa.gov/>

Getting to a Common Language:

Determining Medicaid “Medical Necessity”

- Administrative rule defines the process for determining “medical necessity” (2005)
- Negotiated with stakeholders over 18 month period
- Establishes a transparent, evidence-based process to determine medical necessity for services subject to prior authorization
- Treating provider has opportunity to submit evidence for review
- <http://apps.leg.wa.gov/WAC/default.aspx?cite=388-501-0165>

The ABCDs of Medical Necessity

Medicaid's Grading for Authorizations



A = Randomized controlled clinical trials

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



B = Consistent and well done observational studies

(cannot be based on Type IV evidence alone)

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

Washington State Gets Bold!

- House Bill 2575 (2006) Health Technology Assessment Program
- Fully transparent process to review effectiveness of selected technologies/procedures, with opportunity for public comment throughout the process
- Contract with evidence-based practice center for review of evidence related to selected technology
- Review by independent clinical committee in public meeting
- Committee's recommendation to cover, cover with conditions or not cover must be adopted by state purchased health care agencies
- <http://www.hta.hca.wa.gov/>

Good People Can Make Well Informed Tough Decisions!

Topic	Coverage	Utilization Impact
Upright MRI	No	-2,990,000
Pediatric Bariatric Surgery - <18yr	No	0
Pediatric Bariatric Surgery-18-21 yr	Yes / Conditions	-589,485
Lumbar Fusion	Yes, with limitations	-5,240,639
Discography	No	-324,000
Virtual Colonoscopy (CTC)	No	-11,100,000
Intrathecal Pumps	No	-691,326
Arthroscopic Surgery of the Knee	No	-400,000
Artificial Discs	Yes, with limitations	
Cardiac CT Angiography	ER only	
Cardiac Stent (Multiple Placement)		
		-21,335,450

The Tough Stuff: Liability and Evidence Don't Mix Well – Yet!

- SB 5930 (2007) Shared decision-making tool pilot
- Demonstration to evaluate the effectiveness of moving shared decision making (SDM) into routine clinical practice
- Focus on high variation, preference-sensitive areas
- Several large multispecialty practices are participating
- Include ongoing training and support of involved practitioners and practice teams
- Evaluation component included

Washington Adopts the Will Sutton's Rule of Health Care: Find the Money!

- HB 2105 (2008) Advanced diagnostic imaging
- Identify highest cost/utilization advanced diagnostic imaging services for state purchased health care programs
- State programs to use common evidence-based guidelines and develop decision support or benefit management mechanisms for use with the guidelines.
- State programs in implementation phase
- Working with private purchasers and providers, by 2010, develop recommendations related to adoption by private purchasers as well

Evidence Meets Report Cards:

Improving Generic Performance in State Funded Drug Benefits

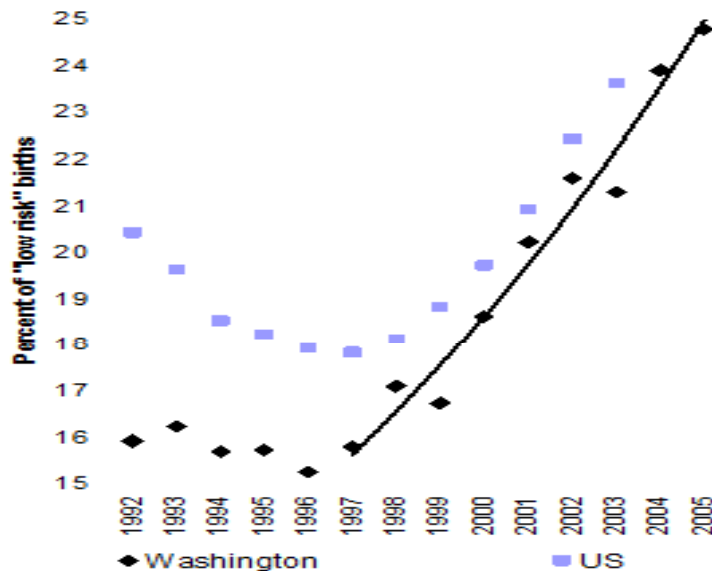
SB 5892 (2009) – Engaging the Community to Improve Generic Drug Use

- State Medicaid has 80% of the Rx spend in brand and 20% in generics
- But state's 63% generic utilization rate (rate of all generic options) is behind private plans (> 80%)
- 1,500 providers have generic fill rates under 80%
- State statute allows for feed back reports with sticks and carrots to improve generic use

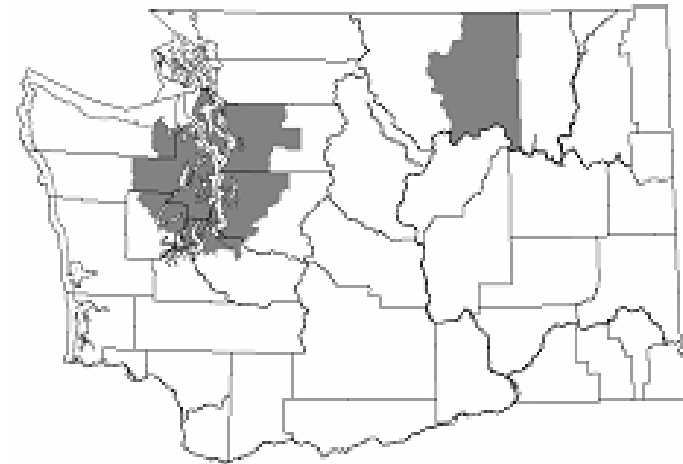
Evidence Meets Rates:

Why Pay for Elective C-Sections When There is Too Much Variations and Costs?

C-section rates for women with "low risk" births
Washington State & U.S. 1992-2005



Regions with higher than expected primary C-section rates
Excluding obesity, hypertension, diabetes, age>35, induced labor and malpresentation
2002-2005 combined



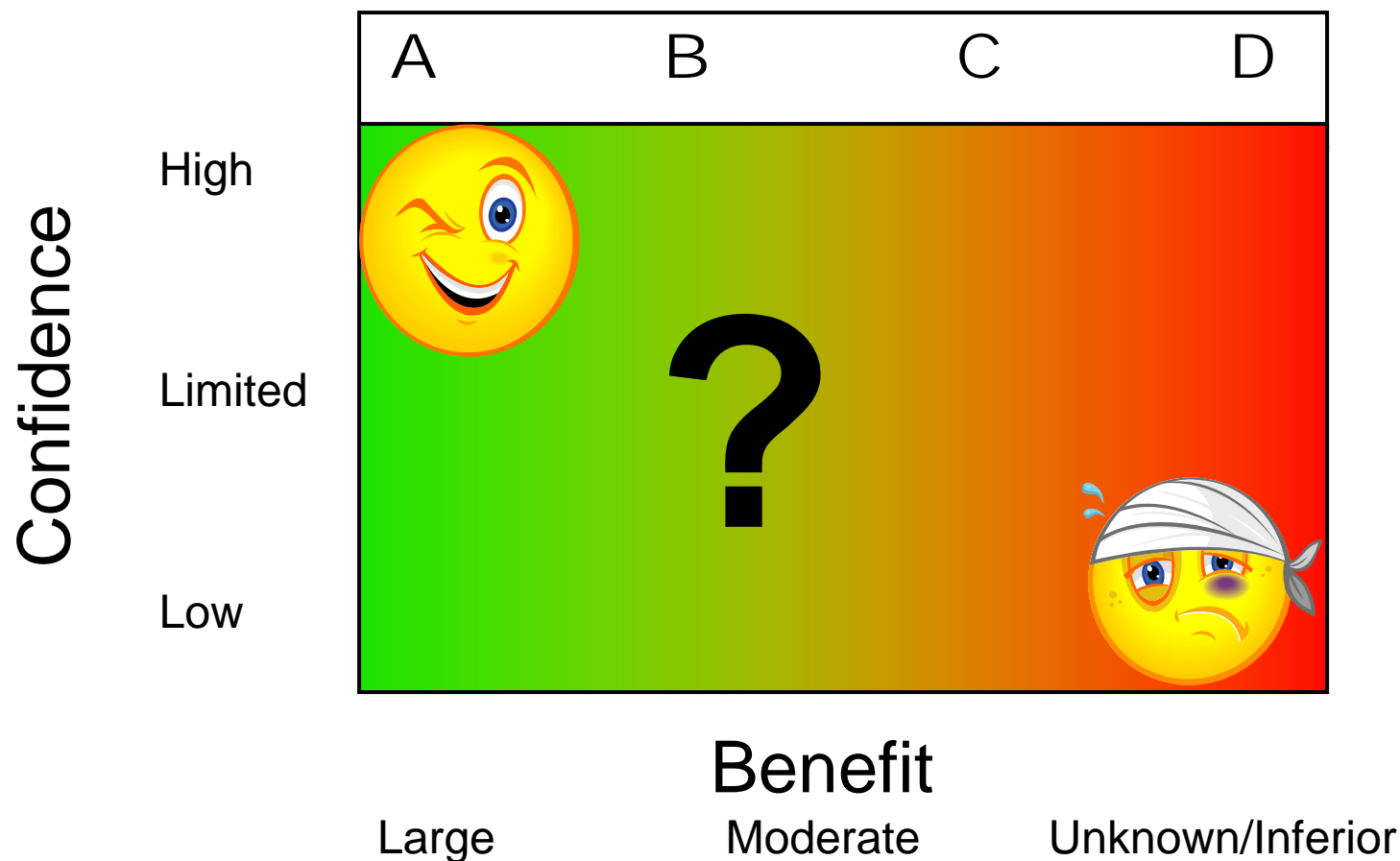
Washington State Medicaid will pay vaginal rates for

- DRG 371-CESAREAN SECTION W/O CC and
- DRG 373-VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES

What's the Real Problem?

- We want to pay for **Highly Effective Benefits!**
- We have to be careful not to pay for **Ineffective and Unsafe Benefits!**
- We need a process for **Everything** in between!

Grades the evidence



Evidence Base Benefits and Law has Been a Journey: Keys to the Path

- Be transparent
- Engage the provider community
- Find common values
- Make consistent coverage decisions
- Make bias free zones

Addenda

WA Quickly Found Out That Everyone Talks and Thinks Differently:

What is Medical Necessity and Reasonably Calculated?

“...describes requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, ‘course of treatment’ may include mere observation or, where appropriate, no treatment at all.”

-- WAC 388-500-0005, Medical definitions stemming from a 1983 consent decree

GRADE EXAMPLES: When to Pay and When to Question the Rationale?

GRADE A: Solid evidence that this technology has good value?

EXAMPLE: Cardiac rehabilitation

GRADE B: Reasonable evidence of value

EXAMPLE: Bariatric surgery in 2003 got a “D” but in 2004 it gets a “B”

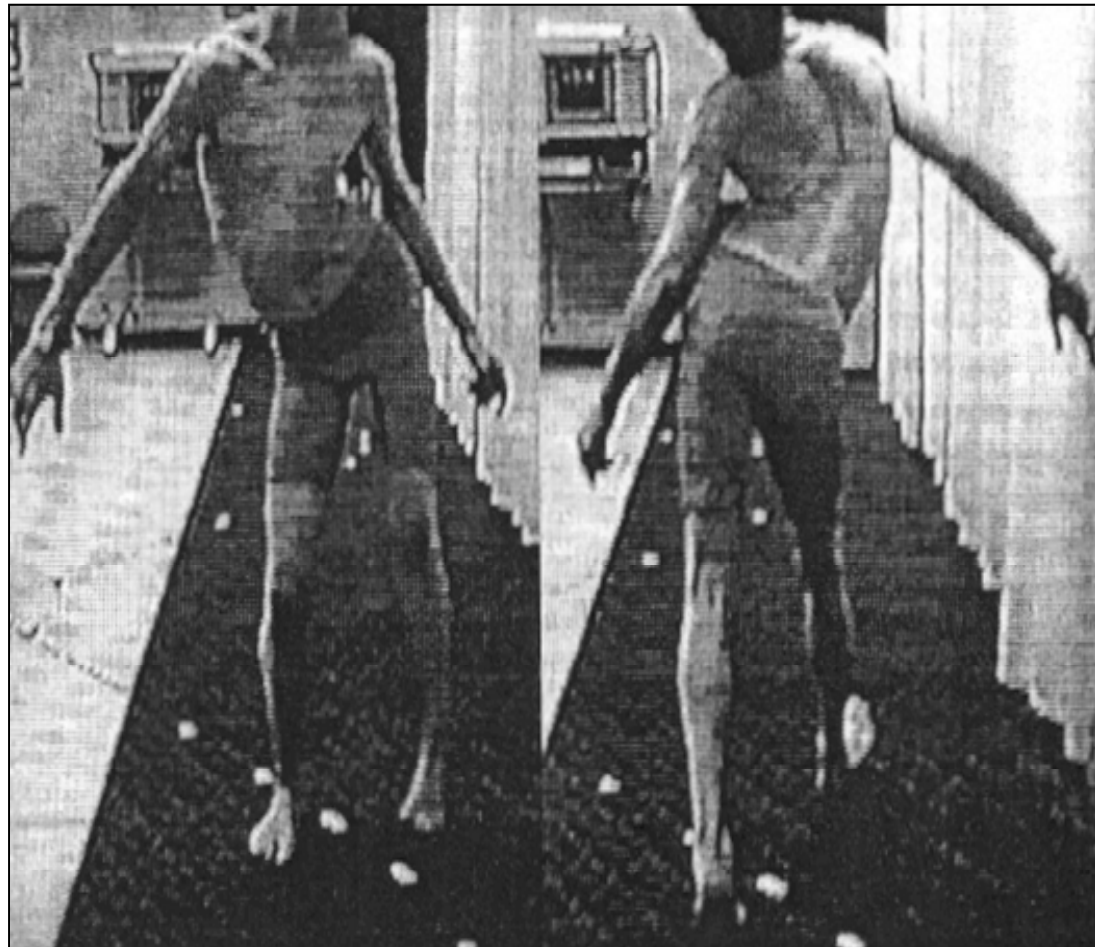
GRADE C: Inconsistent and value?

- Less risk to the client
- Less cost the state
- Next step in reasonable care

GRADE D EXAMPLE: When to Pay for Experimental Care?

Must demonstrate improved outcomes by:

- FDA humanitarian device exemption
- Institutional Review Board approval
- Dossier workbook to show the value



The Big Question: How Do You Spell Effective?

		A	B	C	D
		Confidence	High	Quantity of literature	
Many Consistent / Non-bias				Few Studies / Small N	
Limited	Quality of Evidence and Efficacy				
	RCT		Observational		Opinion
Low	Effectiveness				
	NNT 1/2		NNT 1/25		NNT 1/100
	Safety				
	NNH 1/100	NNH 1/25		NNH 1/2	
	Quality of Life				
	< \$50K	\$150K		>\$500K	
	Cost Effective Comparison				
	Less Expensive			More Expensive	
	Benefit				
	Large	Moderate		Unknown/Inferior	