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July 2009

As pharmacists and health care professionals, we often find ourselves intrigued by the elegance of mathematical formulas. I recently attended a National Pharmaceutical Council symposium on evidence based medicine, "Entering a New Era of Evidence," and was struck by how managed care pharmacy fits into a formula for health care reform. While listening to a diverse group of experts and stakeholders give their presentations, I became increasingly excited about the role that managed care pharmacy leaders can play in furthering the goals of comparative effectiveness research, an important component of health care reform. Stated mathematically, MCP = CER, or "managed care pharmacy equals cost effectiveness research" when it comes to pharmaceuticals and perhaps even other health technology.

Comparative effectiveness is not a new concept to managed care. We've been championing the use of evidence in caring for patients through many efforts, the AMCP *Format for Formulary Submissions* being a gold standard tool to advance the collection of evidence for use in our formulary processes. (On a side note, the *Format* is currently undergoing a significant revision by the FMCP *Format Executive Committee*. The *Format* version 3.0 is expected to be released this fall.)

As your foundation, we strive to develop and share new knowledge to help you stay current in your profession, which in turn supports our efforts to improve the public health and help people receive appropriate medications to live happier, healthier lives. And as managed care pharmacy professionals, we must take a leadership role in

comparative effectiveness, and one way we do that is by being informed.

To assist us in our education, I asked my friends at Xcenda to share some of their knowledge regarding comparative effectiveness, especially their findings from querying your colleagues who participate in Xcenda's Managed Care Network (MCN). Xcenda is an integrated, world-class consulting organization focused on value, reimbursement and patient access and they are part of the AmerisourceBergen Specialty Group.

Thank you to **Peyton Howell** and **Tim Regan** who were willing to share this information and thank you to **Amanda S. Gilmore, PhD, MPH**, Associate Director at Xcenda, who authored the article on the right.

Dr. Gilmore concludes the article by stating, "Bringing the stakeholders to the table to come to consensus on transforming comparative effectiveness research will be a monumental task, but one that many are willing to consider, for the benefit of every party."

I hope you find this information useful in your efforts to advance comparative effectiveness within your organization, and I look forward to the opportunity that managed care pharmacy has to be a stakeholder and a leader in advancing comparative effectiveness as a component of health care reform. ■

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Comparative Effectiveness: Payers' Perspective

Amanda S. Gilmore, PhD, MPH
Associate Director, Xcenda

The passage of the American Recovery and Reinvestment Act (ARRA) of 2009 just months ago transformed comparative effectiveness from an idea to a solid concept — fully supported by creation of a federal coordinating council, national action plan and \$1.1 billion in funding. This centralized focus on comparative effectiveness research (CER) sets the stage for rational, value-based change and is likely to have far-reaching effects, impacting manufacturers, payers, and other stakeholders within the system.

In a recent market research survey of a panel of members from Xcenda's Managed Care Network (MCN), participants answered questions from the payers' perspective about comparative effectiveness. The panel was made up of 100 pharmacy and medical directors at health plans representing 195 million covered lives. More than 85% of the participants agreed that the additional federal funding and more coordinated efforts through the federal coordinating council will be a positive development related to research comparing treatment options. The panel was also asked about the

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Comparative Effectiveness: Payers' Perspective *continued*

influence the federal coordinating council would have on coverage decisions and cost sharing. More than half of the payers surveyed indicated they were conducting their own in-house CER, with 60% considering costs relevant or essential to the analysis.

As defined by the stimulus bill, CER is "research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions." While this definition includes head-to-head randomized controlled trials, it also includes non-randomized studies such as retrospective database analyses, decision models and systematic reviews that may compare drug therapies to other treatment modalities or procedures relative to a variety of clinical, functional, and economic outcomes.

Given that the ARRA also appropriated more than \$17 billion in financial incentives to promote the use of electronic medical records that will provide a richer data source for observational research, non-randomized studies are likely to account for a substantial proportion of the CER evidence base.

A wide variety of study designs and research methods will undoubtedly be used to address the higher-cost areas; however, the degree to which costs will be considered in the comparative equation is still largely unknown. Despite the wide acceptance that spiraling healthcare costs are the driver for most value-based reform initiatives including CER, the "cost line" has been toed very carefully — with ARRA's rules stating that the federal coordinating council may not "mandate coverage, reimbursement, or other policies for any public or private payer," the newly introduced Comparative Effectiveness Research Act of 2009 states that find-

ings may not be used to make coverage and reimbursement decisions. On the other hand, these rules do not explicitly preclude payers from adopting policies based on the resulting research. It is plausible, for example, that CER could generate the information needed to assess whether certain therapies are reasonable and necessary and to categorize drugs as interchangeable based on clinical criteria.

In addition to the role costs will play, much remains to be seen across many facets of CER as the healthcare reform landscape continues to be shaped. The certainties are that patients, providers, manufacturers, and payers will be affected in terms of out-of-pocket expenses, autonomy, evidence generation, and reimbursement structure at the very least.

Each entity has its own definition of how CER will be conducted and eventually considered. It is fairly certain that there will be a movement promoting informed choices, yet many questions need to be addressed by all stakeholders — manufacturers, payers, physicians and patients.

Nearly 90% of the participants in the recent Xcenda MCN survey panel agreed, by indicating that they believed the importance of CER will increase moderately or significantly with regard to decisions made in the healthcare system in the next two years. A similar majority also believed that the current availability and accessibility of credible data are very or somewhat inadequate for healthcare stakeholders.

Bringing the stakeholders to the table to come to consensus on transforming comparative effectiveness research will be a monumental task, but one that many are willing to consider, for the benefit of every party. ■