

# **Value-Based Payment for Medical Technologies:**

## **Five Propositions**

**Donald W. Moran**

**October 2, 2007**

**THE MORAN COMPANY**

## **My assignment today is to:**

- address “practical considerations” of implementing value-based coverage and payment policies.
- outline the issues that seem to define how well – and how frequently – we could actually do this.
- identify the threshold conditions for making this work.

**I propose to do this by putting forward and examining five propositions that seem to me central in evaluating this space.**

## **Proposition One:**

There is a rebuttable presumption that every distinct medical technology will prove to be the most cost effective treatment alternative for at least some class of patients.

## **Implications of Proposition One:**

- “Clean kills” will be rare.
- “Value-based payment” will rarely be achieved through binary coverage determinations.
- While the presumption of cost-effectiveness is rebuttable, payers will have to carry this burden.
- It seems safe to proceed on the assumption that patient-specific facts and circumstances will be critical to making “value-based” determinations.

## **Proposition Two:**

No technology manufacturer can break even selling a product solely to the subset of patients for whom it is proven to be cost-effective.

## Implications of Proposition Two:

- “value-based payment” will be adversarial.
- Manufacturers will strive mightily – within the framework of whatever conditions of contest are established – to expand the reach of their products into ever-wider areas.
- Hence value-based determinations will not be “events,” but rather chronic processes.
- Rather than facing a dearth of comparative evidence, decision-makers will be buried in it.
- Sorting the wheat from the chaff will be a formidable task.

## **Proposition Three:**

The effectiveness of “value-based payment” will be constrained by the cost-effectiveness of the benefits management technologies selected to implement it.

## An illustration:

	Inpatient Pre-Certification	Prior Authorization of CT Scans
Cost of Target	\$6,000	\$ 600
Review Issue	Site of Service	Medical Necessity
Denial rate	10%	2%
Breakeven Cost	\$600	\$12



## **Proposition Four:**

Coverage review decisions that cannot be made via deterministic computer edits will rarely prove cost-effective unless the frequency of heuristic human intervention is very low.

## Implications:

- Calibration of medical review technology will be a critical determinant of the success of “value-based payment.”
- It may prove necessary to restrict coverage constraints to the subset of clinical distinctions that can be parsed via automated edits of claims data.
- In the hypothesized environment of endlessly shifting evidence, this is going to be tricky.

## **Proposition Five:**

The availability of clinical information from automated medical records is the most important real-world constraint on how far we can get with “value-based purchasing”.

## **Implications of Proposition Five:**

- If we want to be “evidence-based” in terms of coverage policy, we’re going to need to be “evidence-based” at the level of assessing individual patient characteristics.
- We are obviously fairly far from this capability at present.
- This discussion suggest that while we’re budgeting for all the randomized clinical trials it’s going to take to get the needed evidence at the top of the system, we ought to budget a few dollars to build out the technology base we’re going to need to apply it!

## **In the interim between now and health information *satori*:**

- Our ability to do value-based purchasing will depend on exactly what evidence we find.
- If epidemiological evidence supports patient subgroup segmentation, access to patient-specific clinical information may not be critical.
- It is, of course, possible to shift the burden of demonstrating the need for favorable coverage and payment to the manufacturer of the highest-cost alternatives.
- This would take somewhat more will than is typically observed at present!

## **Am I, therefore, pessimistic about “value-based” purchasing?**

- Not at all – we’re going to have to do this just to be able to afford whatever makes it through the screen.
- I’m simply trying to suggest that we need to think several moves ahead about the benefits management infrastructure that will be required to make use of “evidence” once we start getting it.
- Automated access to medical records information is as important to the operational implementation of this policy as it is to the research agenda that will define its content.