

Medical Technology Adoption: The Payer Perspective

Interview with Dr. Victor G. Villagra

Dr. Victor G. Villagra is the past president of the Disease Management Association of America (DMAA), and former chairman of CIGNA's Technology Assessment Council.

Interviewer: Christian Renaudin, TMTG

CR: How does the adoption of new technology work?

VV: There are many pathways in the new technology awareness-to-reimbursement process. To build awareness, Managed Care Organizations (MCO) rely on an informal system of "field intelligence," which gauges provider demand for specific medical technologies. Information is gathered through medical directors and utilization management nurses engaged in authorizing requests for services at the local health plans. Other venues for awareness include coverage decisions by Medicare/Medicaid. Consumer demand represents a faint signal in the "awareness" radar screen and will certainly grow in importance. Other sources of awareness include press reports, web-based information services as well as trade publications. Finally, most MCOs use the services of technology assessment vendors such as ECRI, Blue Cross/Blue Shield TEC and Hayes.

The pathway to reimbursement has, at its core, the critical assessment of the peer-reviewed literature and proceedings from scientific meetings. Good science stands the greatest chance of influencing a positive coverage decision. I would add that scientific rigor in support of new technologies is absolutely necessary but not the only determining factor in new technology adoption.

CR: I overheard that most commercial health plans really start to reimburse new technology after HCFA/CMS decisions.

VV: This does occur some of the time. I believe CMS (formerly HCFA) follows a very rigorous peer-review process when considering reimbursement for new technologies. In my personal opinion CMS decisions have a great deal of integrity and credibility. Commercial health plans align themselves with CMS on issues that affect seniors. Now that so many MCOs have left the Medicare business, CMS coverage decisions may be less relevant unless the technology in question is also applicable to non-seniors.

CR: What are the criteria for the decisions?

VV: The first, most important criterion is demonstrating a positive health impact. A positive health impact should be proven in terms of clinical outcomes. It helps if the new technology is a unique or different solution to a clinical problem when compared to existing technologies (filling a gap).

The second criterion is the quality of the presented evidence. One looks at the data critically and approval comes quickly when supporting the data is compelling.

The third requirement is to compare the results with existing technologies. Critical factors may be: relative efficacy, side effects or the degree of invasiveness. If the new technology provides an advantage from any of these perspectives then the value to patients will be compelling.

Finally, availability is an important factor. Patient access to a new technology should be broad and not just through a few research-oriented medical centers. For example, multi-site employers want to see, whenever possible, the same services available to all their employees.

Cost considerations may come downstream from the initial scientific evaluation.

The full evaluation of emergent technologies takes place in institutional technology assessment committees (TAC). These committees are often outsourced.

CR: What role does the technology vendor have in order to facilitate the technology adoption process?

VV: This is highly variable among manufacturers and technology assessment committees. From the TAC perspective, you have two extremes: 1) the isolation approach; when the vendor wants to avoid “infomercials” and remains distant from the payer; 2) the open communication approach that involves direct contact with the payer. Many manufacturers are pro-active and aggressive in seeking reimbursement. This strategy may backfire when interacting with isolationist payers, and can outright irritate committees. A policy that allows for direct contact with vendors may be helpful because TACs can get a much better feel for the technology beyond the “dry” data. Interacting with the physicians who have experience with the technology but are not associated with the manufacturer (this may be difficult to find or impossible to verify) is another useful tool in the assessment process.

I strongly recommend that vendors critically evaluate how they present their products for scrutiny by adopting the perspective of decision makers in technology assessment committees. Packaging the contents is critically important. Anything that assists technology assessors to understand the value of the product or service as well as its risks will make their job easier and enhance the likelihood of a prompt resolution of coverage policy. Assembling the proper package also allows vendors to deal effectively with “isolationist” payers who may find that direct contact with manufacturers compromises their objectivity.

CR: What is the role of the payer when dealing with technology vendors?

VV: As I mentioned before, TACs will adopt a style and approach that gives them the greatest sense of control over the entire process. It is more common to be restrictive than open. There is an obvious need for both real and perceived objectivity on the part of coverage policy-making bodies. One wants science that speaks for itself without all of the fluff.

CR: Do you think there is a need for a broker who could mediate between vendors and the payers?

VV: In the short-term, I think all stakeholders need to master their role instead of introducing new players into the system. An in-depth dialogue between all stakeholders would help to create opportunities to make the entire system more efficient.

CR: In terms of the process, do you think that vendors could be more efficient by addressing both FDA approval and reimbursement at the same time, making their trials more cost effective?

VV: Manufacturers should concentrate on developing products that bring more than marginal value to the marketplace. If these products come with rigorous studies supporting their value, then the path to reimbursement will be short and relatively hassle-free.

There is a desperate need to enhance the approval-to-reimbursement cycle. Technological advances are proceeding too fast and delays to reimbursement can negate public access to life-saving technologies. I do not see the FDA & CMS holding hands to better integrate their processes anytime soon.

CR: Can you describe the issue of technology displacement?

VV: Unlike the orderly process that leads to approval of new technologies, retiring obsolete technologies or procedures does not follow a formal or active process. Consequently, obsolete technologies linger, produce less desirable results than alternatives and are costly to the system. I think that this is a major problem that needs to be addressed. Payers need better tools to “de-list” technologies, but I think they need the help in the form of a formal, active process to qualify “medical obsolescence”. Here I see a role for the government that should foster research in this area and develop a “rules of evidence” methodology applied to classifying medical obsolescence in its various stages. Armed with such a tool, payers can then stop reimbursing for obsolete practices. This is not happening anywhere in the world as far as I know and we absolutely need a parallel process to technology adoption,

CR: What are typical metrics that you use?

VV: If you are talking about performance metrics applied to approved and reimbursed technologies, it depends on the type of device, procedure or drug. There are, of course, phase IV surveillance studies, which are often required. Some manufacturers establish “registries” that have contributed to our collective understanding of the market performance of some technologies. This approach is subject to innumerable biases and is therefore not ideal. I would like to see the development of a more precise tracking system for things such as health impact, quality of life, functional status, cost burden, cost offsets and impact on productivity. With the availability of massive claims databases it is possible to quantify the real value of new technology entries. An ideal way to do this is through the ready-deployed infrastructure of Disease Management programs. Just imagine being able to answer the question, “What value am I getting for my healthcare dollars?” An answer will mitigate the frustration of many employers watching health care premiums climb into double-digit growth rates.

CR: Consumerism, direct marketing and university bias (research sponsoring) are growing issues that did not previously exist. They tend to bias the process of the technology adoption, especially those universities who are financed by vendors for their research.

VV: You got it. This is becoming a very important issue and sometimes a “catch-22” in our industry. These are new issues that can be considered a double-edged sword. The positive consequence of increased awareness is that it allows patients to benefit from technologies that they would not know of otherwise. But it can also lead to overuse, abuse and misuse and there is not a good control mechanism to assure the appropriate application of many of these new technologies. There is a terrible price to pay for misuse in the form of avoidable morbidity, mortality, side effects, and, for the device or pharmaceutical industry, events that may lead to market withdrawal of products with huge financial consequences.

CR: What do you see on the horizon for new technologies?

VV: Here is another “catch-22” between the increasing cost of technology development and the need to make technology affordable. Technologies that have a major positive effect on health outcome through better efficacy, fewer side effects or a major cost offset are more welcome than products that provide marginal benefits.

In terms of new technologies, I think the human genome project will bring extraordinary changes to healthcare. The impact will be a gradual transition and not a sudden paradigm change. This change will, however, be huge. The topics will be new biologicals, drugs and the coupling of diagnostics tests with highly targeted therapy.

An interesting area to follow will be the transition from IV chemotherapy to oral treatments for cancer. There is a lot at stake here.

In terms of device and imaging, I think there is great interest in coupling diagnostic imaging with therapy. Computer assisted molecular imaging is of great interest to me as well as imaging devices that serve as guidance to percutaneous treatment for the same condition.

Two other areas to watch are robotics and nanotechnology applications in healthcare. I think the interest will be strong if these new devices render surgical procedures more precise and less invasive.



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