Oregon's Drug Effectiveness Review Project

Country: USA
Partner Institute: Department of Behavioral Science and Health Education, Rollins School of Public Health, Emory University
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Health Policy Issues: Pharmaceutical Policy, Quality Improvement, Access

Current Process Stages

| Idea | Pilot | Policy Paper | Legislation | Implementation | Evaluation | Change |

1. Abstract

Among the health reforms undertaken by Oregon has been the adoption of a preferred drug list, the development of which has been informed by the state's Drug Effectiveness Review Project. DERP has grown beyond its initial mandate and is now a partnership of 11 state Medicaid agencies and a Canadian drug agency. The partnership's objective and in-depth reviews on drug effectiveness and safety have been used by state agencies to inform drug policy decisions and rein in Medicaid drug spending.

2. Purpose of health policy or idea

As a response to rapidly rising drug costs and a growing interest in evidence-based medicine, the Oregon legislature in 2000 created a preferred drug list (PDL) for Medicaid, to encourage the use of cost-effective drugs. In order to determine which drugs belonged on the PDL, the state partnered with the Center for Evidence-Based Policy at Oregon to review the existing evidence on the effectiveness of commercially available drugs. The resulting Drug Effectiveness Review Project conducts regular, systematic, evidence-based reviews of the comparative effectiveness and safety of popular drugs for seventy-five drug conditions (including drugs for Alzheimer's, anxiety, back pain, hypertension, eczema, hepatitis C, and ulcer).

What began as a state program has, in the intervening years, greatly expanded, as other states have sought to curb Medicaid costs, and particularly pharmaceutical purchasing costs. Eleven states (Arkansas, Colorado, Idaho, Oregon, Maryland, Missouri, Montana, New York, Washington, Wisconsin, and Wyoming) and the Canadian Agency for Drugs and Technologies in Health now participate in the program. Its members are, for the most part, state Medicaid programs. Each participant contributes equally to the financing of the project (paying US $75,000 a year to participate) and all participants collaboratively decide which drug classes will be studied, and when.

Evidence from the reviews is meant to guide state Medicaid offices in comparing the safety and effectiveness for drugs across a single indication. The project is thus intended to provide states with a means of ensuring that drugs are purchased efficiently - which in turn, it is hoped, will curb costs and help secure patient access to needed pharmaceuticals. DERP's directors have called it the largest effort in the country to "apply best practices and evidence-based analysis to pharmacy management issues."

The DERP review process is open for public comment, and the final reports produced by the project do not recommend or endorse any drugs, which enables the project to avoid charges of conflict of interest. Reports and
Main objectives
DERP’s main objective is to provide an objective source of information on comparative effectiveness and safety of drugs in different classes, in an effort to help alleviate the burden of prescription drug spending on state Medicaid programs.

Type of incentives
Though the DERP review results are publicly available, states have an incentive to become members of the project in order to access specialty reports, including executive summaries, and a network of Medicaid managers working to address the same set of cost-controlling concerns.

Groups affected
State Medicaid and other public insurance plans, Health care consumers, Pharmaceutical companies

3. Characteristics of this policy

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Degree of Innovation</th>
<th>Degree of Controversy</th>
<th>Structural or Systemic Impact</th>
<th>Public Visibility</th>
<th>Transferability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>traditional</td>
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</tr>
<tr>
<td></td>
<td>innovative</td>
<td>highly controversial</td>
<td>fundamental</td>
<td>very high</td>
<td>system-neutral</td>
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No program of DERP’s scale and scope currently exists, though there are other (mostly more limited) projects devoted to collecting and disseminating objective, evidence-based reviews of drug treatments, including Pennsylvania’s Independent Drug Information Service and the Vermont Academic Detailing Program. Because it strives for objectivity, the project has been largely non-controversial.

4. Political and economic background
Oregon has been pioneering the public provision of cost-effective care since 1989, when it obtained a federal waiver to restructure its state Medicaid program, creating the Oregon Health Program. The OHP greatly expanded health coverage in the state largely by cutting benefits down to a list of cost-effective, prioritized services.

Budgetary pressures forced the state to restructure the program again, in 2001; the new program increased cost-sharing, placed limits on benefits, and left many uninsured. The state Medicaid program’s budgetary challenges stemmed in part from skyrocketing prescription drug costs. In 2000 alone, the state’s Medicaid program’s prescription drug spending increased by 60 percent.

That year, state legislators approved a bill to establish a preferred drug list, which ranked drugs first in order of effectiveness, and then in order of cost. Because such comparative data was not widely available, the state began working with the Center for Evidence-Based Policy at Oregon Health and Science University to produce regular
reviews of classes of drugs. Shortly thereafter, Oregon partnered with neighboring states Washington and Idaho to sharing the costs-and results-of the reviews. Since then, the project has established partnerships with 8 other states and the Canadian Agency for Drugs and Technologies in Health, all of which have expressed interest in using the reviews to guide Medicaid drug purchasing policy and lend credence to the establishment of state PDLs.

5. Purpose and process analysis

Origins of health policy idea
The establishment of DERP is related to a series of steps that states across the nation have taken in recent years in attempts to control prescription drug spending in Medicaid programs, plans for state employees, and workers compensation programs. The establishment of PDLs has faced some opposition-particularly from pharmaceutical companies, who don't wish to see their own drugs removed from the lists, and at times from providers, who have expressed that it intrudes upon their ability to make autonomous decisions for their patients. DERP has positioned itself as an independent, transparent project with the sole aim of promoting evidence-based drug policy decisions.

The multistate nature of DERP parallels the multistate drug purchasing pools that arose during the same period. Massachusetts was the first state to implement a statewide bulk prescription drug purchasing plan, ten years ago. A few years later, Michigan and Vermont launched an effort to save Medicaid dollars by creating a joint bulk drug purchasing program. Michigan and Vermont's plan was approved by federal regulators in 2004, and in the years since, several more states, including Alaska, Hawaii, and Minnesota, joined their pool. Today, five multistate bulk buying pools exist, and at least 44 states have joined one of the five pools in order to realize cost savings on drugs provided through public health plans.

Initiators of idea/main actors
- Government
- Providers
- Patients, Consumers
- Private Sector or Industry

Approach of idea
The approach of the idea is described as: new:

Stakeholder positions
State Medicaid officials have said DERP is a high quality, thorough information source that has proven "indispensable" to their efforts to determine Medicaid drug policy on the basis of existing evidence. Member states say that they value their role in the decision making process, as well as the access DERP membership provides to a network of officials in other states with whom to discuss policy making and process decisions. While pharmaceutical companies have opposed PDLs in many states, they have been less stringently opposed to the DERP process, in part because they are given an opportunity to directly submit data for consideration in the reviews. Patient advocates have on occasion opposed the DERP review process, arguing that they do not take into account individual variations in response to medications (such as antidepressants). Physicians have largely adhered to PDLs, but state agency officials remark that DERP is hard pressed to challenge the influence of pharmaceutical companies on providers.
**Actors and positions**
Description of actors and their positions

**Government**
- State Medicaid agencies: very supportive strongly opposed
- Participating state legislatures: very supportive strongly opposed
- Oregon Health Plan: very supportive strongly opposed

**Providers**
- Physicians: very supportive strongly opposed

**Patients, Consumers**
- Patient advocates: very supportive strongly opposed

**Private Sector or Industry**
- Pharmaceutical companies: very supportive strongly opposed

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**Influences in policy making and legislation**
Former Oregon governor John Kitzhaber was influential in spearheading many of Oregon’s health reforms, including its adoption of a PDL, which was directly linked to the establishment of DERP.

**Legislative outcome**

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**Actors and influence**
Description of actors and their influence

**Government**
- State Medicaid agencies: very strong none
- Participating state legislatures: very strong none
- Oregon Health Plan: very strong none

**Providers**
- Physicians: very strong none

**Patients, Consumers**
- Patient advocates: very strong none

**Private Sector or Industry**
- Pharmaceutical companies: very strong none

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**Positions and Influences at a glance**

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**Adoption and implementation**
DERP began as a three-year project in 2003, and is currently in its third phase, which is contracted through 2012. Completed reviews currently cover well over half of drug utilization. Each drug class review takes approximately 18 months to complete; existing reviews are updated every 7 to 24 months. The reviews are conducted by Evidence-based Practice Centers (EPCs) that are contracted by the Center for Evidence Based Policy at OHSU.

DERP members, who meet monthly by phone and twice yearly in person, decide what drugs to have reviewed, and how often the reviews will be updated. Drug classes are chosen for review based on several factors, including the amount of pharmaceutical budgets they account for, the number of drugs within the class, and the presence of new or
particularly expensive drugs within a class. Members also jointly determine the precise questions that each review will set out to address. A review of the evidence on statins, for example, may ask both how effective various statins are at reducing both cholesterol levels and cardiovascular events.

Previously, the reviews were limited to randomized controlled trials; they now regularly include other types of studies, such as observational studies, as well. The reviews consist of thorough, librarian-assisted searches, and input is also obtained from pharmaceutical companies. No fewer than two reviewers review each study considered for inclusion, and the results of each included study are synthesized independently by two separate reviewers. Before final reports are released, the reports are posted for public comment and then peer reviewed.

Some states use DERP alone to make drug policy decisions; others base purchasing policies on the evidence in DERP in combination with additional sources, including locally developed sources such as California’s Prescription Drug Information Project.

Monitoring and evaluation

Some states have directly attributed cost savings to DERP-directed purchasing decisions. In Washington, which became a DERP partner in 2004, a state level committee of physicians, pharmacists, a nurse and a physician assistant convenes on a monthly basis to review the reports provided by DERP and make recommendations on drugs based on effectiveness. A subsequent cost analysis on the recommended drugs conducted by the heads of the Health Care Authority, the Department of Social and Health Services, and the Department of Labor and Industries determines which drugs will be included on the state’s PDL. In 2006, providers were adhering to PDL recommendations roughly 80 percent of the time, and the state estimated that evidence-based drug purchasing, based on DERP data (and combined with the use of rebates from drug manufacturers), was saving the state about US $20 to US $23 million per year.
6. Expected outcome

DERP’s third phase began last fall (Fall 2009) and will continue through 2012. Some previous members, such as Alaska, Kansas and California, no longer participate. Others states, however, continue to join. In some cases, pressure from state medical and pharmaceutical organizations prompted state officials to either abandon sole reliance on DERP data or to exit the project completely. In California, for example, groups such as the Mental Health Association in California urged state Medi-Cal officials to not base purchasing decisions exclusively on DERP data. In 2010, DERP plans to produce updated reports on antihistamines, antipsychotics, MS drugs and NSAIDs. In 2011, the project will release final reports on diabetes drugs, antidepressants and asthma drugs.

No plans for changes in the financing, structure, or expansion or termination of DERP have been publicly announced. The project is affordable for member states and of value, and may indeed continue to add members (though member turnover may occur as some members decide that the publicly available reviews suit for their policy decision-making needs).

One analyst assessed DERP’s value within the current pharmaceutical purchasing climate: “Preferred drug lists and prior authorization are two of the tools available to states to manage the Medicaid pharmacy benefit. As states increase their reliance on these tools, a consensus appears to have developed among the states over the central role of evidence in making state decisions. DERP is an innovative approach to evidence-based reviews of prescription drugs that produces results that are useful to Medicaid policy makers and others.”

<table>
<thead>
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<th>Quality of Health Care Services</th>
<th>marginal</th>
<th>fundamental</th>
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<tr>
<td>Level of Equity</td>
<td>system less equitable</td>
<td>system more equitable</td>
</tr>
<tr>
<td>Cost Efficiency</td>
<td>very low</td>
<td>very high</td>
</tr>
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DERP is credited with significant cost savings in Oregon and Washington. In states where it is used in combination with other sources of information on drug safety and effectiveness, its impact is not as easily assessed.

7. References

Sources of Information


Author/s and/or contributors to this survey

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