



**The New England Comparative Effectiveness Public Advisory Council  
Public Meeting – October 29, 2014**

**Controversies in the Management of Patients with  
Type 2 Diabetes**

**Meeting Summary**

**Authored by:**



**CEPAC Voting and Policy Implications Summary  
Controversies in Type 2 Diabetes Management**

**October 29, 2014**

***About the CEPAC Process***

The New England Comparative Effectiveness Public Advisory Council (CEPAC) is an independent forum in which clinical and public policy experts publicly deliberate on evidence reviews of the clinical effectiveness and value of health care services. Through these deliberations, CEPAC provides guidance on how the existing evidence can best be applied to improve the quality and value of health care services across New England. CEPAC is composed of 17 members, a mix of clinicians, economists, and public representatives from each New England state that meet strict conflict of interest criteria (described in the Appendix). Representatives of state Medicaid programs and of regional private payers are included as ex-officio members of CEPAC. CEPAC members are recruited through an open public nomination process, and are selected on the basis of their experience and training in the interpretation and application of medical evidence in health care delivery.

Council members are intentionally elected to represent a range of expertise and diversity in perspective, and are therefore not pre-selected based on the topic being addressed to maintain the objectivity of the Council and ground the conversation in the interpretation of the published evidence rather than anecdotal experience or expert opinion. Acknowledging that any judgment of evidence is strengthened by real life clinical and patient perspective, subject matter experts are invited to participate in each meeting to serve as a resource to the Council during their deliberation, and to help form recommendations with CEPAC on ways the evidence can be applied to policy and practice. Clinical experts also provide input to Council members before the meeting to help clarify CEPAC's understanding of the different interventions being analyzed in the evidence review.

Led by the Institute for Clinical and Economic Review (ICER), CEPAC was originally funded by a federal grant from the Agency for Healthcare Research and Quality (AHRQ), but is now supported by a broad coalition of state Medicaid leaders, integrated provider groups, public and private payers and patient representatives. For more information on CEPAC, please visit [cepac.icer-review.org](http://cepac.icer-review.org).

At the October 29, 2014 meeting, CEPAC discussed issues regarding the comparative benefit of different management approaches for type 2 diabetes, as well as the benefit of devices to support insulin delivery and glucose monitoring in this patient population. CEPAC votes and discussion are intended to support the dialogue needed for successful action to improve the quality and value of health care services. The key questions are developed by the ICER research team for each appraisal, with input from the CEPAC Advisory Board to ensure that the questions are framed to address the issues that are most important in applying the evidence to support clinical practice and medical policy

decisions. This summary includes the results of the votes of CEPAC on these key evidence questions. In addition, we present policy considerations highlighted by CEPAC and by a Roundtable of regional clinical experts, patient advocates, and health insurance representatives that discussed the implications of CEPAC votes for clinical practice, and payer policies. The meeting agenda, including roundtable panelists, are shown in the Appendix.

## **Summary of the Votes and Considerations for Policy**

Following the evidence presentation and public comments, CEPAC voted on questions concerning the comparative clinical effectiveness and comparative value of second- and third-line treatment options for type 2 diabetes, as well as devices to support insulin delivery and the monitoring of blood glucose. We present below the voting results along with comments reflecting the most important considerations mentioned by CEPAC members during the voting process.

When voting on comparative value, CEPAC was asked to assume the perspective of a state Medicaid program that must make resource decisions within a relatively fixed budget for care. CEPAC is not given prescribed boundaries or thresholds for budget impact or incremental cost-effectiveness ratios to guide its judgment of low, reasonable, or high value. However, CEPAC did make use of a series of value categories designed by ICER to assist the Council in assigning an overall value rating (see Figure 1 below). CEPAC members who vote “no” on comparative clinical effectiveness are designated to a special “low” value vote category for lack of evidence to demonstrate comparative clinical effectiveness. Because all of the voting questions asked whether a particular drug or device was equivalent to or better than a comparator, CEPAC did not have the option to vote for two of the categories shown in the value matrix below, as these categories refer to a drug or device that has “worse outcomes”.

**Figure 1. Evidence Categories for Ratings of Low, Reasonable/Comparative, and High Value**

<b>Low Value</b>	<b>Reasonable/Comparable Value</b>	<b>High Value</b>
1. <i>Worse outcomes; Higher or equivalent cost</i>	5. <i>Worse outcomes; Lower cost</i>	9. Comparable outcomes; Lower cost
2. Comparable outcomes; Higher costs	6. Comparable outcomes; Comparable cost	Promising but inconclusive evidence of better outcomes; Lower cost
3. Promising but inconclusive evidence of better outcomes; Higher cost	7. Promising but inconclusive evidence of better outcomes; Comparable cost	Better outcomes; Lower or comparable cost
4. Better outcomes; Too high a cost	8. Better outcomes; Reasonable higher cost	Better outcomes; Slightly higher cost

## Insulin choice for adjunctive therapy:

### ***Human insulin vs. insulin analogs***

1. Is the evidence adequate to demonstrate that ***NPH insulin*** (intermediate-acting human insulin) is functionally equivalent to ***long-acting insulin analogs*** for most patients with type 2 diabetes?

CEPAC Vote:

**9 yes (100%)**

2. If yes, from the perspective of a state Medicaid program, would you judge the value of ***NPH insulin*** compared to ***long-acting insulin analogs*** to be high, reasonable, or low?

CEPAC Vote:

**9 high (100%)**

**Comments:** A majority of CEPAC members voted that NPH insulin provides comparable outcomes at a lower cost, while some voted that there is promising but inconclusive evidence of better outcomes at a lower cost. CEPAC members emphasized that their high value votes do not mean that all patients are well-suited to treatment with NPH insulin. The decreased risk of hypoglycemia associated with long-acting insulin analogs may be of significant benefit to some patients. Choice of insulin should be guided in part by individual risk for hypoglycemia and cannot be based solely on comparative value.

## Second-line pharmacotherapy options for patients with inadequate glycemic control from metformin monotherapy:

### ***Combination therapy with Metformin plus DPP-4 inhibitor or sulfonylurea***

3. Is the evidence adequate to demonstrate that combination therapy with ***metformin + DPP-4 inhibitor*** is superior to ***metformin + sulfonylurea*** for most patients with type 2 diabetes for whom metformin monotherapy provides inadequate glycemic control?

CEPAC Vote:

**8 no (89%)**

*Note: CEPAC did not place a vote comparing the value of metformin plus a DPP-4 inhibitor versus metformin plus a sulfonylurea since a majority of the Council voted that there is insufficient evidence to demonstrate the superior effectiveness of DPP-4s relative to sulfonylureas.*

**Combination therapy with Metformin plus GLP-1 receptor agonist or sulfonylurea**

4. Is the evidence adequate to demonstrate that combination therapy with **metformin + GLP-1 receptor agonist** is superior to **metformin + sulfonylurea** for most patients with type 2 diabetes for whom metformin monotherapy provides inadequate glycemic control?

CEPAC Vote:

**6 yes (67%)** **3 no (33%)**

**Comments:** Members of CEPAC voting yes pointed to the reduced risks for hypoglycemia and benefits of weight loss for patients with type 2 diabetes as evidence of the clinical advantage of GLP-1 receptor agonists over sulfonylureas. Members voting no suggested that the specific sulfonylureas reviewed in the evidence were mostly older agents, and that more current versions may potentially perform better against GLP-1 receptor agonists.

5. If yes, from the perspective of a state Medicaid program, would you judge the value of **metformin + GLP-1 receptor agonist** compared to **metformin + sulfonylurea** to be high, reasonable, or low?

CEPAC Vote:

**0 high (0%)** **0 reasonable (0%)** **6 low (100%)**

**Comments:** CEPAC members voted that the evidence demonstrates either better outcomes at too high of a cost, or promising but inconclusive evidence of better outcomes at a higher cost, making GLP-1 receptor agonists low value as compared to sulfonylureas for second line medication.

Third-line pharmacotherapy options for patients with inadequate glycemic control from metformin combination therapy with sulfonylurea:

**Combination therapy with Metformin plus sulfonylurea + either DPP-4 inhibitor or insulin**

6. Is the evidence adequate to demonstrate that combination therapy with **metformin + sulfonylurea + DPP-4 inhibitor** is superior to **metformin + sulfonylurea + NPH insulin** for most patients with type 2 diabetes with inadequate glycemic control?

CEPAC Vote:

0 yes (0%) 9 no (100%)

*Note: CEPAC did not place a vote comparing the value of metformin plus sulfonylurea and a DPP-4 inhibitor versus metformin plus sulfonylurea and insulin since a majority of the Council voted that there is insufficient evidence to demonstrate the superior effectiveness of DPP-4s relative to insulin as a third-line option.*

**Combination therapy with Metformin plus sulfonylurea + either GLP-1 receptor agonist or insulin**

7. Is the evidence adequate to demonstrate that combination therapy with **metformin + sulfonylurea + GLP-1 receptor agonist** is superior to **metformin + sulfonylurea + NPH insulin** for most patients with type 2 diabetes with inadequate glycemic control?

CEPAC Vote:

6 yes (67%) 3 no (33%)

8. If yes, from the perspective of a state Medicaid program, would you judge the value of **metformin + sulfonylurea + GLP-1 receptor agonist** compared to **metformin + sulfonylurea + NPH insulin** to be high, reasonable, or low?

CEPAC Vote:

0 high (0%) 0 reasonable (0%) 6 low (100%)

**Comments:** CEPAC members voted that GLP-1 receptor agonists have low comparative value, with some members voting that the evidence was promising but inconclusive of better outcomes at too high a cost, while others indicated that they felt the evidence suggested better outcomes at too high a cost.

## Insulin delivery:

### ***Insulin pumps vs. multiple daily injections***

9. Is the evidence adequate to demonstrate that any clinical subpopulation of patients with type 2 diabetes does better with ***insulin pumps*** compared to ***multiple daily injections***?

CEPAC Vote:

0 yes (0%) 9 no (100%)

**Comments:** CEPAC noted that this vote was based on an overarching lack of studies comparing insulin pump therapy to multiple daily injections in the type 2 population. While there may be some patients that could benefit from an insulin pump, more research is needed to produce evidence sufficient to support this claim.

## Glucose monitoring:

### ***Self-monitoring of blood glucose vs. Continuous glucose monitors***

10. Is the evidence adequate to demonstrate that any clinical subpopulation of patients with type 2 diabetes does better with ***continuous glucose monitors*** compared to ***self-monitoring of blood glucose***?

CEPAC Vote:

0 yes (0%) 9 no (100%)

**Comments:** CEPAC noted that some populations may be well-suited to continuous glucose monitoring and more research is needed to identify subpopulations that may perform better with CGMs, but there is not currently enough evidence to support their clinical utility for patients with type 2 diabetes.

### 7.3 Roundtable Discussion and Key Policy Conclusions

Following CEPAC’s deliberation on the evidence and subsequent voting, the Council engaged in a moderated discussion with a Roundtable composed of clinical experts, a patient advocate, and regional health insurers. The participants in the Roundtable discussion are shown on the following page.

**Table. 1 Policy Roundtable Participants**

<b>Francis Basile, Jr., MD</b>	Chief of the Division of Primary Care, University Medicine, Inc. Clinical Associate Professor, Warren Alpert School of Medicine at Brown University
<b>Barbara Henry, RPh</b>	Senior Clinical Pharmacy Coordinator, Harvard Pilgrim Health Care
<b>Peter Hollmann, MD</b>	Medical Director, Blue Cross Blue Shield of Rhode Island
<b>Robert Smith, MD</b>	Professor of Medicine, Warren Alpert School of Medicine at Brown University Chair, U.S. FDA Endocrinologic and Metabolic Drugs Advisory Committee Former Director, Hallett Center for Diabetes at Rhode Island Hospital
<b>Rev. Albert Whitaker, MA</b>	Director, Mission Delivery, American Diabetes Association, New England Chapter
<b>Robert Zavoiski, MD, MPH</b>	Medical Director, Connecticut Department of Social Services

The Roundtable discussion explored the implications of CEPAC’s votes for clinical practice and medical policy, considered real life issues critical for developing best practice recommendations in this area, and identified potential avenues for applying the evidence to improve patient care. The main themes and recommended best practices from the conversation are summarized in the sections below. The Policy Expert Roundtable discussion reflected multiple perspectives and opinions and therefore none of the recommendations below should be taken as a consensus view held by all participants.

1. Clinicians should make treatment decisions with a consideration of the psycho-social context in which medications are being used. Health care teams that integrate nurse case managers, community health workers, behavioral health providers, pharmacists, and diabetes educators are ideal for providing comprehensive management of the condition and ensuring that different treatment approaches are feasible given each patient’s unique circumstances.

The Policy Roundtable discussion emphasized that diabetes is embedded in broader socioeconomic issues related to public health and health care access. Experts on the Roundtable noted that for many patients the disease will not be controlled nor treatment successful without first addressing



the underlying issues that affect an individual's ability to maintain a healthy lifestyle, access medication, and adhere to a complicated treatment regimen that can often be costly.

CEPAC members and Policy Roundtable participants stressed the importance of building health care teams that can more comprehensively manage a patient's condition. Nurse case managers, community health workers, pharmacists, and diabetes educators were all recognized as important potential members of health teams that help transition patients across different therapies, monitor glycemic control, and educate and provide support to patients as treatment strategies become more complicated and patients have more options to consider. By adopting a multiple-disciplinary care team approach, there are more opportunities to reach patients inside or outside of the practice setting to increase education and to better engage patients in their treatment choices. CEPAC members and Roundtable participants also emphasized how comprehensive health care teams are better equipped to intervene early when there are issues with treatment, thereby improving patient adherence. For example, some patients are unable to test blood sugar levels multiple times a day so are noncompliant to treatment regimens that require multiple daily injections and more frequent monitoring schedules. Nurse case managers and community health workers in particular can better account for the psycho-social context in which medications are being used and determine the feasibility of different management approaches given each patient's unique circumstances. As ACOs and global payment systems become more prominent, payers should ensure funding that adequately supports the provision of team-based services.

2. Consideration of pharmacotherapy for patients with type 2 diabetes should be only one component of a broader management plan that emphasizes lifestyle changes and behavioral support.

CEPAC members highlighted that the focus of the CEPAC meeting and this report only address a subset of the diabetes problem, and that for many patients, the disease has been managed through lifestyle changes and other public health approaches. CEPAC and Policy Roundtable members agreed that decisions of medication choice should be considered within a broader treatment strategy that prioritizes patient education, diet, and exercise. The patient representative on the Roundtable emphasized the essential role that education plays in helping patients understand their disease, the appropriate level of activity and carbohydrate intake, and consequences of diabetes if left uncontrolled.

3. To the extent possible, clinicians should determine appropriate HbA1c targets based on individual factors.

CEPAC and Roundtable panelists discussed at length the extent to which diabetes care can be personalized to achieve treatment goals. The philosophy of diabetes management heretofore has

been to bring patients to a specific HbA1c target of  $\leq 7\%$ . However, clinical experts on the Roundtable noted that the drive for blood glucose levels less than 7% will not be appropriate for many patients. Treatment aims should always reflect a balance between the goals of reducing long-term adverse clinical events and managing hypoglycemia and other side effects of treatment.

The Roundtable and Council members also agreed that patient preferences should inform decisions of treatment goals and pharmacotherapy choice. For many patients with type 2 diabetes, comorbid conditions are a major concern. Even a marginal increase in weight may require some patients to go back on blood pressure medication, complicating treatment regimens. Other patients may be unable to intervene independently to manage their risk of hypoglycemia, for example patients with disability. Council members and the patient representative on the Roundtable therefore underscored the importance of explaining the relative risks and benefits associated with different pharmacotherapy options in terms that are acceptable and understandable to patients, and developing HbA1c targets and other treatment aims with individual patient factors and the relative advantages and disadvantages of each treatment alternative in mind.

4. Based on the best available evidence, clinicians and payers should consider aligning patient education, practice standards, and payment policies to start patients who require insulin on human formulations first, unless there are contraindications or other factors suggesting that initiation on insulin analogs would be preferred.

The available evidence suggests that most patients with type 2 diabetes can achieve equal levels of glycemic control with regular human insulin (NPH) or long-acting analog formulations. The research demonstrates that NPH use does not result in higher levels of weight gain nor does it cause more adverse events, except for “nonsevere” hypoglycemia. Patients treated with NPH insulin may more often require twice daily injections than patients treated with long-acting insulin analogs. The possibility that this could adversely affect adherence to the insulin regimen and thus diabetes control has not been adequately evaluated. Accounting for both the evidence on clinical effectiveness and costs, CEPAC determined that human insulin offers high value compared to long-acting analog alternatives for many type 2 diabetes patients. CEPAC members and Roundtable panelists suggested that human insulin is potentially being underutilized and that more should be done by payers and provider organizations to promote its use in appropriate patients. Prior authorization and step-therapy requirements were offered as potential mechanisms to direct patients towards trying NPH first, with opt-out provisions for patients with co-morbid conditions, job conditions, or other factors that would elevate the risk that nonsevere hypoglycemia would produce significant effects on health or quality of life. CEPAC and Roundtable members cautioned, that any step therapy policies would have to be flexible in design and application to ensure the ability to rapidly switch patients to insulin analogs if needed.

Patient and clinical representatives suggested that additional patient education can help reduce the perceived concerns regarding hypoglycemia and adherence with NPH. Roundtable panelists advocated for more targeted education instructing patients on how to prevent and manage hypoglycemia, and pointed to existing guidelines from the [American Diabetes Association](#) that outline minimum standards for diabetes self-education and support. Roundtable panelists once again advocated for a team-based approach to managing diabetes that utilizes nurse case managers, community health care workers, and other health care professionals, particularly for patients on complicated medication regimens that include insulin.

5. Health plans and provider organizations should promote the use of high value drug treatment options while crafting approaches that are flexible enough to allow for personalized care that can meet individual patient needs. Specifically:

- *First-line therapy:* Nearly all patients requiring pharmaceutical treatment should be **started on metformin as first-line therapy**, and the use of metformin should be optimized before considering the addition of other options.
- *Second-line therapy:* For many patients who do not reach adequate blood sugar control with metformin monotherapy, **second-line therapy with sulfonylureas is a reasonable choice**. Although CEPAC voted that GLP-1 receptor agonists offer incremental clinical benefits related to reduced weight gain and incidence of hypoglycemia – benefits that will be of greater potential importance for some patients than others – CEPAC felt that the balance of the clinical benefits versus the high per-patient incremental cost made GLP-1 receptor agonists a “low value” second-line therapy compared to sulfonylureas. The evidence was not considered adequate to demonstrate clinical advantages of DPP-4 inhibitors over less-expensive sulfonylureas as second-line therapy.
- *Third-line therapy:* For patients who need additional therapy after metformin plus sulfonylureas, the evidence **suggests that adding NPH insulin is a reasonable choice**. As with second-line treatment, CEPAC voted that GLP-1 receptor agonists offer incremental clinical benefits versus NPH insulin related to reduced weight gain and incidence of hypoglycemia, benefits that will be of greater potential importance for some patients than others. Here too, CEPAC felt that the balance of the clinical benefits versus the high per-patient incremental cost made GLP-1 receptor agonists a “low value” third-line therapy compared to NPH insulin. The evidence was inadequate to demonstrate clinical advantages of DPP-4 inhibitors over less-expensive NPH insulin as a third-line therapy.

CEPAC and Roundtable panelists discussed at length the options available for incentivizing the use of high value treatment options that may be underutilized in some settings. Council members

highlighted the need for measures that ensure that patients are not unnecessarily receiving more expensive agents first, and pointed to the experience of MassHealth (Massachusetts Medicaid) which implements tight preauthorization controls over costly new drug therapies. In the case of second-line treatment options, the Council acknowledged that there are some patients for whom sulfonylureas may not be appropriate, but that it is a minority of patients. Clinical protocols and medical policy should therefore encourage consideration of initial second-line therapy with a sulfonylurea. CEPAC members agreed with payers on the Roundtable, however, that policies should not prevent the possibility of individualized treatment, and that exceptions must be made to allow patients that may benefit more from specific agents access to these therapies. For instance, some patients will benefit more from GLP-1 receptor agonists as initial second-line therapy due to the drugs' positive effect on body weight. When developing policy, health plans and provider organizations must balance the mutual goals of maximizing health system value while creating an environment in which clinicians can provide individualized treatment as necessary without undue difficulty.

6. The policy and clinical community should support the development of evidence and future research in the following areas:

- Further study of insulin pumps and continuous glucose monitors is needed to understand if certain patient subpopulations with type 2 diabetes may benefit from these technologies. For future research to be relevant, additional regulation may be required from the FDA since at present, devices change and are upgraded so frequently that conducting meaningful long-term studies is impossible. CEPAC members recognized the challenge to developing a robust evidence base for devices as it is more difficult to perform a blinded study and there may be issues regarding confounding.
- Further research is needed to understand the heterogeneity of treatment effects, specifically for identifying patient subpopulations whose risk of significant hypoglycemia should lead to initial treatment with insulin analogs, GLP-1 receptor agonists, or DPP-4 inhibitors. Many important patient subpopulations are excluded from clinical trials, so little is known at present about treatment effects in patient groups that are not well studied.
- The research community should develop study designs that reflect patient preferences and analyze treatment regimens that are feasible for patients to maintain. Further studies should also be framed around more patient-centered questions, like the percentage of patients that achieve reductions in HbA1c levels without experiencing an adverse event. Conceptualized this way, research will more helpfully inform treatment decisions by addressing the questions that matter most to patients.

- Additional long-term studies are also needed that analyze primary rather than intermediate outcomes. Patient and clinical communities want to know the effect new medications have on mortality, myocardial infarction, stroke, and other long term complications of diabetes (e.g. retinopathy, neuropathy). Evidence on long-term outcomes exist for sulfonylureas, but are still lacking for newer medications.

# Appendix

## Controversies in Type 2 Diabetes Management

Wednesday • October 29, 2014 • 10:00AM – 4:00PM

### Agenda

Brown University

Petteruti Lounge • Stephen Robert '62 Campus Center

75 Waterman Street • Providence, RI 02912

Time	Activity
9:30AM – 10:00AM	Registration
10:00AM – 10:15AM	<ul style="list-style-type: none"><li>Meeting convened and opening remarks: <i>Steve Pearson, MD, MSc, President, Institute for Clinical and Economic Review</i></li></ul>
10:15AM – 11:30AM	<ul style="list-style-type: none"><li>Presentation of the Evidence: <i>Daniel Ollendorf, PhD, Chief Review Officer, Institute for Clinical and Economic Review</i></li><li>CEPAC Q&amp;A</li></ul>
11:30AM – 12:00PM	<ul style="list-style-type: none"><li>Public Comments and Discussion: <i>Members of the public pre-registered to deliver oral remarks</i></li></ul>
12:00PM – 12:30PM	<ul style="list-style-type: none"><li>Break for Lunch</li></ul>
12:30PM – 2:00PM	<ul style="list-style-type: none"><li>CEPAC Deliberation and Votes: <i>ICER staff, clinical experts, and a patient representative will be available for questions from the Council during deliberation.</i></li></ul>
2:00PM – 3:50PM	<ul style="list-style-type: none"><li>Policy Roundtable: <i>Consideration by CEPAC and Roundtable of Best Practice Recommendations (Panelists listed on back)</i></li></ul>
3:50PM – 4:00PM	<ul style="list-style-type: none"><li>Meeting Adjourned</li></ul>

<b>CEPAC Members</b>	<b>Policy Roundtable Participants</b>
<b>Robert H. Aseltine, Jr., PhD</b> Professor, Division of Behavioral Sciences and Community Health, University of Connecticut Health Center Deputy Director, Center for Public Health and Health Policy Director, Institute for Public Health Research, University of Connecticut	<b>Francis Basile, Jr., MD*</b> Chief of the Division of Primary Care, University Medicine, Inc. Clinical Associate Professor, Warren Alpert School of Medicine at Brown University
<b>R. William Corwin, MD</b> Physician Champion, Co-Lead, Epic Acute Care Implementation Lifespan	<b>Barbara Henry, RPh</b> Senior Clinical Pharmacy Coordinator, Harvard Pilgrim Health Care
<b>Austin Frakt, PhD</b> Health Economist, VA Boston Healthcare System Associate Professor, Boston University School of Public Health Associate Professor, Boston University School of Medicine	<b>Peter Hollmann, MD</b> Medical Director, Blue Cross Blue Shield of Rhode Island
<b>Claudia B. Gruss, MD, FACP, FACG, CNSC (Chair)</b> Physician, ProHealth Physicians	<b>Robert Smith, MD</b> Professor of Medicine, Warren Alpert School of Medicine at Brown University Chair, U.S. FDA Endocrinologic and Metabolic Drugs Advisory Committee Former Director, Hallett Center for Diabetes at Rhode Island Hospital
<b>Claudio Gualtieri, JD</b> Associate State Director of Advocacy Connecticut AARP	<b>Albert Whitaker, MA*</b> Director, Mission Delivery, American Diabetes Association, New England Chapter
<b>Christopher Jones, PhD</b> Assistant Professor, Department of Surgery Director, Global Health Economics Unit, Center for Clinical and Translational Science, University of Vermont College of Medicine	<b>Rob Zavoiski, MD, MPH</b> Medical Director, Connecticut Department of Social Services
<b>Stephen Kogut, PhD, MBA, RPh</b> Professor, University of Rhode Island College of Pharmacy	
<b>Julie Rothstein Rosenbaum, MD**</b> Associate Professor, Yale School of Medicine	
<b>Cynthia N. Rosenberg, MD (ex-officio)</b> Senior Medical Director, Harvard Pilgrim Health Care	
<b>Jeanne Ryer, MS</b> Director, New Hampshire Citizens Health Initiative	
<b>Tom Simpatico, MD (ex-officio)</b> Chief Medical Officer, Vermont Department of Health Access	
<b>Keith A. Stahl, MD</b> Physician and Medical Director, Catholic Medical Center	
<b>Mitchell Stein, MBA (Vice-Chair)</b> Independent Health Care Consultant	

***\*No conflict of interest to report \*\* Will be recused from voting during this meeting***

***All voting members of CEPAC meet the following COI criteria:***

- A specific financial association, such as individual health care stock ownership (including those held by spouse or minor child) in excess of \$25,000 during the previous year from any one health care manufacturer or insurer
- Financial association, such as individual health care stock ownership (including those held by spouse or minor child) in excess of \$50,000 in aggregate during the previous year from health care manufacturers or insurers