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Paying for New Medical Technologies: What Options Might Medicare Consider?

*A study conducted by the Project HOPE
Center for Health Affairs for the
Medicare Payment Advisory Commission*

PAYING FOR NEW MEDICAL TECHNOLOGIES: WHAT OPTIONS MIGHT MEDICARE CONSIDER?

Summary of an Expert Panel Meeting Convened at the Medicare
Payment Advisory Commission Offices, Washington, DC, September 11,
2002

October 31, 2002

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Submitted to:
Medicare Payment Advisory Commission
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Objectives

There is continual tension between ensuring Medicare beneficiaries' access to the latest technology and providing an affordable public program that maintains the integrity of Medicare's trust funds. The design of a payment system critically affects incentives for the pace of adoption of new medical technology. For instance, there is broad agreement that cost-based reimbursement promoted a near maximum rate of growth and demand for new technology while bundled, prospective payment systems can provide incentives for more selective use of expensive treatment options.

In recent years, Medicare's system of paying for new medical technology in the outpatient setting was dramatically reformed through the introduction of a transitional pass-through payment mechanism. Under the pass-through mechanism, the Centers for Medicare and Medicaid Services (CMS) pays for many technologies using an adjusted charge-based methodology, much in the same way that it paid for services before the prospective payment system was implemented. Payment for pass-through drugs is based on their average wholesale prices. These rates are paid for a provisional period (2-3 years), until enough data are collected to allow them to be folded into a prospective payment category for medical visits or surgical procedures.

The initial pass-through program involved large numbers of existing technologies that had not previously been captured in the Medicare data. Going forward, only new technologies would be eligible for payment. In addition, CMS recently introduced stringent criteria to limit the number of new technologies that would qualify for this additional payment. A system for making additional payments for certain new technologies used in the inpatient setting has just been implemented. It also has stringent eligibility criteria and adopts a different payment mechanism. There is, however, continuing pressure from some stakeholders to expand the eligibility criteria and to increase payments in the inpatient setting.

The Medicare Payment Advisory Commission (MedPAC) has previously recommended that CMS maintain stringent criteria for a technology to qualify for pass-through payment and be given authority to use different payment mechanisms that are less subject to gaming and overpayment than those set out in statute. The Commission also seeks to increase its understanding of how best to pay for new medical technology within the constraints of a prospective payment system. To assist with this goal, the Project HOPE Center for Health Affairs convened a 14-member panel in September 2002. The purpose of this panel was to identify mechanisms Medicare might use to pay for new medical technology in the future, and to discuss the relative merits of each option.

In choosing panel members, the project team sought to recruit experts representing a broad range of perspectives from the health care system. Panel

members were chosen based on their professional backgrounds as well as their knowledge of Medicare payment policies and the assessment of new medical technologies. The expert panel included economists, reimbursement and outcomes research directors from device and pharmaceutical manufacturers, executives from large hospital systems, an executive from a Pharmaceutical Benefit Management (PBM) firm, representatives from the Centers for Medicare and Medicaid Services' (CMS) payment and coverage policy divisions, representatives from the private insurance industry, and a representative from the Veterans Health Administration (VHA). Prior to the meeting, all expert panel members were sent an agenda that included a list of relevant questions and background reading materials. This agenda and the list of reading materials are provided in Attachment 1.

The discussion focused around answering three basic questions:

- What principles should Medicare follow in paying for new medical technology?
- What constraints does Medicare face in paying for new medical technology?
- What options might Medicare consider for paying for new medical technologies?

Project HOPE began the meeting by presenting an overview of the way Medicare currently pays for new medical technology in the hospital inpatient and outpatient setting. Much of this information has been provided in previous MedPAC reports, and is not summarized here. Project HOPE also presented findings from a series of structured interviews conducted with large purchasers about methods they use to pay for new medical technology. Results from this survey were presented at an earlier MedPAC meeting and summarized in a separate final report (Mohr et al., 2002).

Panelists were asked to not only focus on incremental changes that Medicare might make to improve upon their system within existing constraints, but to also recommend options that may require statutory changes to implement. For example, Medicare currently is constrained by statute from entering into price negotiations with manufacturers. However, MedPAC staff was interested in hearing whether such negotiations, which are used extensively by the private sector, might be desirable or feasible for the Medicare program in order to achieve its goals of being a prudent purchaser of new medical technologies.

Many of the panel members had both public policy and private sector experience and were asked to leave their individual stakeholder agendas behind. They were requested to approach the issues from a more objective societal perspective, considering options that would be fair to Medicare beneficiaries, taxpayers, and providers. The overall intent was not to achieve consensus, but to obtain different perspectives about the options for paying for new technology that

Medicare might consider. As no roundtable voting was done, we could not discriminate between widespread agreement on an issue and views being expressed by a vocal minority. It also should be noted that this summary report reflects views expressed during the panel during the one-day meeting only. It may not necessarily reflect the views of the Medicare Payment Advisory Commission or Project HOPE.

What Principles Should Medicare Follow in Paying for New Medical Technology?

Panelists identified eight characteristics of a good payment system. Some of these characteristics are mutually-exclusive and there was not always agreement on whether these characteristics were desirable or how they should be defined.

Simple, Transparent, and Stable: Some panel members expressed that Medicare should be a good business partner for health care providers by having a payment system that is easy for providers and beneficiaries to understand and navigate. Transparency refers to the ability to easily see the effect that payment decisions have on the system. Stability means major changes in payment policies should occur relatively infrequently, as it becomes difficult to do long-range planning in an environment with frequent changes of direction.

Administratively Feasible: This characteristic, raised by panel members, refers not only to the ease of administration by CMS, but also the ease of administering the system by Medicare contractors and health care providers.

Adequately Funded: According to several panelists, a payment system needs to provide enough money for health care providers to make good treatment decisions and avoid the starvation of basic services to make room for high-cost, new medical technology.

Flexible: Many panel members agreed that a prospective payment system must be able to respond to technological change. This includes a need for an exceptions process, such as the pass-through mechanism, to allow beneficiary access to some cutting-edge, but expensive, technologies. It also applies to technologies that are not clinical, but have a significant impact on beneficiary outcomes, such as computerized physician order entry systems. One panel member suggested that flexibility also might be needed when a beneficiary has a serious, life-threatening illness with few options for treatment. In these cases, Medicare might want to pay for the use of investigational technology.

Encourages Value-based Decisions: When setting prices for new technology, a good system, according to many panel participants, would consider the effects of a technology's use on both quality of care and on costs. Implicit in this discussion was the idea that a good system encourages close ties between

coverage and payment policies. Both payment and coverage policies should incorporate evidence-based processes relying on credible, up-to-date evidence about the relative benefits of new technology – subject to external scientific review.

Value-based decision making for payment policies can help CMS assess whether they should reimburse more for the use of an innovative technology, or set the payment rate at the same level as a competing therapy. As many new technologies offer small advances over existing therapies for a substantially increased price, several panel members expressed that it is important for the system to be able to discriminate whether these incremental changes provide sufficient value relative to their impact on patient outcomes. Panelists acknowledged the difficulties CMS has faced in trying to incorporate cost-effectiveness into the coverage process, but many still felt movement in this direction is needed.

Some panelists felt that a payment system should incorporate stronger incentives for physicians to limit the use of technologies to specific subpopulations. Others felt the payment system should be more neutral, allowing physicians to make judgments about which patients might benefit most.

Builds on Timely Data at the “Appropriate” Level of Detail: While some panel members felt strongly that a good system would contain timely codes that enable the use of individual technologies to be tracked and their costs to be assessed early in the diffusion of a product, others felt broader disease-based payment systems may not require such detail. By adopting a payment mechanism that provides incentives for appropriate treatment of diseases, CMS would not need to monitor and pay for individual technologies.

Provides Consistent Incentives Across Providers: There was a lack of agreement about whether the system should provide consistent incentives for treatment decisions among different care providers (e.g., hospitals and physicians). One panelist was adamant that both physicians and hospitals should face the same financial risk for using new technologies. Another panelist noted that competing incentives in an inpatient setting often lead to decisions that provide for a high quality of care within budgetary constraints. For example, physicians would like to use the latest technology, but hospitals want to moderate cost. In practice, there is a process of joint decision making about when the use of an expensive new technology is most appropriate.

Continuous Evaluation: A final characteristic discussed by the panelists is that evaluation is essential to ensure CMS is making the correct payment decisions. A good payment system would contain mechanisms to evaluate the effect of payment decisions on beneficiary use and outcomes. It would contain a systematic approach for understanding payment system impacts rather than patching problems as they arise.

What Constraints Does Medicare Face in Paying for New Technology?

CMS faces multiple constraints in trying to implement the best mechanisms for paying for new medical technologies. Some of these constraints are not unique to the Medicare program. Others are specific to a large, publicly-administered program that must be responsive to diverse stakeholders.

Constraints Faced by All Health Care Purchasers

Timeliness of Data: There is an inherent tension between the rapid pace of innovation and the availability of credible data that can be used for establishing good payment policies. Panelists noted delays with and the inflexibility of coding systems—used by public and private payers alike – constrain the ability to monitor the use and cost of new technologies. One panelist noted it takes one to two years for a new technology to be assigned a code. The annual cycle of assigning codes affects the timeliness of the system in establishing prices for new technology. It should be noted that CMS does issue its own codes for new technologies on a quarterly basis under the outpatient prospective payment system and that it made recent modifications to the meeting schedules for coding decisions to shorten the general process.

One panel member stated that data, by their nature, are retrospective. Payment decisions based on data available from two years ago offer different incentives for using medical technology than those that might be set on “real-time” information. While some panelists were adamant that CMS should be able to use privately-generated data to set payment policies, others noted there is a trade-off between timeliness and credibility of data.

Lack of Resources: Equally, all payers face budget constraints. However, effectiveness research, value-based purchasing and competitive bidding for new technologies, require a substantial amount of resources, and several panel members pointed out that other payers – including public payers like the VHA arguably invest more than Medicare in understanding which technologies to purchase, and the effect of their decisions on patient outcomes. One panelist stated that Medicare’s health services research budget was \$50 million per year, but much of this is devoted to broad policy issues and very little is spent on payment- or coverage-related research. By contrast, another panelist noted the VHA has a \$350 million budget for evaluating new technologies.

Constraints Unique to the Medicare Program

Programmatic Constraints: Medicare is responsible to diverse constituents. In devising its policies, CMS must work through a political process. Although one panelist suggested this was not necessarily bad, others felt there were legal restrictions that inhibited the flexibility of the program. Specifically, the Federal Advisory Committee Act (FACA) requires public notice for meetings and CMS must welcome all comers. As a result, CMS may not avail itself of closed expert panels to solicit freethinking about Medicare policies, such as the one that was convened for this project. The fundamental way in which transparency is imposed on the Medicare program is through FACA. CMS representatives, including those who formally worked at the agency, felt there is a tension between openness and timeliness.

This political process has also constrained Medicare's ability to adopt value-based purchasing tools, such as cost-effectiveness analyses, over the years. Although many panel members supported the adoption of value-based purchasing, some panel members posed the question, "Will the Medicare program be allowed to be discriminating?" That is, given the political environment in which Medicare operates, can it make a decision about not covering a specific technology based on relative cost-effectiveness and hold to it?

Several panel members noted political constraints have not been the sole barrier to the adoption of value-based purchasing principles, as discussions about the use of cost-effectiveness techniques for coverage decisions often unravel in methodological debates. Different stakeholders have differing views on how these principles should be implemented. For example, whose values should be used in these decisions? Should the program consider value to the Medicare program, or to society, in general? What is the most appropriate threshold (e.g., \$60,000 per quality-adjusted life year) for adopting new technologies?

Another programmatic constraint unique to Medicare is that its payment policy division is formally separate from its coverage policy division. This separation of functions occurred in 1997, and according to some panel members, there have been examples where coverage decisions were made and not communicated to staff in the payment division. For example, the payment division did not assign a Diagnosis-related Group (DRG) to pancreas transplants because they did not know a coverage decision had been made. While there is better communication now, according to CMS representatives, better policies might be made if there were a more formal connection between these two divisions.

Panel members also pointed out that Medicare is constrained to implement budget-neutral payment policies. While this restriction is responsible to

taxpayers, it also leads to situations where new technologies compete with established services for resources.

Size of the Program: While the sheer size of the Medicare program offers some opportunities – for example, it has been able to adopt an administered pricing system – some panelists also remarked that its size can impose restrictions on what the program can do. For example, If Medicare used its monopsony power to restrict the use of technology to a few select products with better prices through a competitive bidding model, Medicare would, in effect, be deciding which suppliers survive and which do not. The panel was uncomfortable with CMS exercising this kind of power.

Also, the Medicare program has large ramifications on pricing in general. By establishing a fee schedule for new technology using prices other than those that are obtained in the marketplace (e.g., using fair return on equity or some other cost-based measure), CMS also runs the risk of driving out innovation. The difficulty lies in picking the right price outside of a market-based solution.

Also relevant to the size of the program, judgments about which technologies are appropriate may best be done at a local level where you can get physician buy-in. It is difficult to get buy-in from physicians at a national level.

Existing Complexity of Medicare's Payment Systems: Panel members pointed out that the ability to set fees with consistent incentives for the appropriate use of new technologies among providers and across settings of care is limited by the fact that Medicare has 15 different payment systems, each of which have different operating principles and procedures. Many of these systems, such as payments to physicians and even the new hospital outpatient prospective payment system pay on the basis of fees for service without taking the broad system of care for a disease or condition into account. As a result, it is difficult to adopt broader disease-based payment systems. However, CMS is currently experimenting with the case management of conditions rather than payments for individual services.

What Options Might Medicare Consider for Paying for New Medical Technologies?

Most of the afternoon was devoted to discussing which options Medicare might consider for improving the way it pays for new medical technology. Because of the wide-ranging nature of the discussion, it was difficult to thoroughly examine the relative merits of each of the options proposed. Nevertheless, as options were mentioned panelist raised some issues that may warrant further investigation as the Commission continues to explore mechanisms to improve the way in which Medicare pays for new medical technology.

Mechanisms to Establish Better Prices for New Technologies

Establish a Fee Schedule for Brand New Technologies on the Pass-through List: Last year, the Commission recommended that Medicare replace rates based on reported costs for pass-through technologies with a national rate. This recommendation was made because of concerns that cost or charge-based criteria provided incentives to inflate these measures. The Commission, however, did not have specific ideas about how Medicare might establish national rates for new technologies.

Many panelists underscored that Medicare does not have good information about what a technology costs early in its life cycle. As a result, it does not have the ability to say what is the right price. Because of its size, setting the price too low can have a big impact on the development of technology or alter decisions to invest in technologies for the over 65 market.

Panelists also noted that paying manufacturers' price at launch provides a strong incentive for innovation. Another panelist pointed out, however, that an earlier study completed by the Office of Technology Assessment showed the pharmaceutical industry obtains much larger profit margins than those obtained by other industries. This panelist questioned whether policy makers in the United States would agree that innovation should be preserved at its maximal rate at large public expense.

Many panelists felt that Medicare could pay rates more closely aligned to market value than those established through cost-to-charge ratios or the average wholesale price. Suggested approaches included:

- conducting a survey of hospitals or insurers to see what they are paying for technology;
- requiring that pharmaceutical and device companies provide CMS with their average manufacturer's price (which is net of all discounts), and is used by many Medicaid programs;
- pegging fees to the average hospital acquisition price, wholesale acquisition cost, or invoices; and
- looking to the VHA, which has established a Federal Supply Schedule price for pharmaceuticals and aggressively negotiates prices with manufacturers.

Many panelists opposed this last suggestion and raised concerns that it would drive innovation out of the system or substantially raise prices to the supply schedule. One of the difficulties with adopting prices negotiated by other payers is that Medicare cannot trade a guarantee of volume for reduced prices, as can be done by the VHA. Concerns were expressed that by putting "best prices" in the public domain, manufacturers will just increase their prices. Another concern was that governmental price schedules usually create major distortions in the private markets.

Many panel members voiced strong opposition to the adoption of a system used currently in the United Kingdom (UK) of setting payment rates based on a fair return on equity. In that country, pharmaceutical companies are required to submit UK accounting data at launch that allow authorities to limit the total amount paid to individual firms. The return on equity is calculated with respect to investment made in the UK. A fair rate of return is deemed to be 17- 21 percent. As one panel member adamantly exclaimed, “this is not on the table.” Some of the concerns panelists raised with this approach included:

- Should CMS pay for innovation throughout the world?
- What is the “right” level of innovation?
- How would failed products be incorporated into the calculation?
- If they do pay for failed products, how does that affect the incentives to produce successful products?

Use Competitive Bidding to Purchase New Technologies: One mechanism used by private payers to obtain good prices for medical technology is competitive bidding. The Medicare program is currently constrained from negotiating directly with manufacturers by statute, although a demonstration to evaluate the use of competitive bidding for purchasing durable medical equipment is currently underway. However, several panelists felt, as Medicare is currently constructed, it would be difficult to accommodate the use of competitive bidding. First, some panel members noted truly new technologies that might be listed on a pass-through mechanism often do not have competitors and little price negotiation can be done. Second, even for those products that may have competitors, some panel members noted the use of competitive bidding is resource-intensive and requires a completely different infrastructure than that currently used by CMS. Finally, several panel members noted that Medicare cannot trade guarantees of volume for price, unlike the VHA system, which is tightly closed with its own delivery system. Within the VHA, if a drug or device is listed on the formulary or payment schedule it is used, otherwise, it is not. This structure is very effective in gaining access to better prices. However, many panel members questioned whether Medicare would be allowed politically to restrict access to only selected products. Also, panel members noted Medicare is not currently in the business of directly purchasing from manufacturers and distributing to providers.

One panelist mentioned that Italy, France, and Spain have tried to implement competitive bidding for acquiring technology, but because of the complexity, Spain and Italy have abandoned this system at a national level and devolved responsibility to their regional systems. A few panelists noted there are pharmaceutical companies that sometimes will not release a particular product in France.

The potential to use PBMs or group purchasing organizations was briefly discussed. Proposals for a new Medicare outpatient drug benefit would all rely upon private PBMs to negotiate the best price. By allowing beneficiaries the choice of several PBMs, Medicare can bypass concerns about restricting access to a few products. However, the use of such entities to negotiate prices for the small number of drugs currently covered by Medicare or the limited number of devices that are expected to be on the transitional pass-through list in the future may not be warranted. Several panelists agreed that Medicare through its pricing system should put the burden for competitive bidding back into the hands of the providers who have the capability to negotiate.

Mechanisms to Improve Value-Based Purchasing or Treatment Decisions

Broaden Payment Bundles to Pay for Disease Treatment: In order to give providers the appropriate incentives to consider the value of their treatment options, a few panel members felt payment systems should be re-designed to pay for broader care bundles for disease treatment, such as case management payments for specific conditions. Perverse treatment incentives arise when Medicare micromanages prices for individual technologies. Medicare's inpatient PPS does better at this than its outpatient PPS.

Examine Cost-effectiveness Analyses for Coverage and Pricing Determinations: A wide range of panel members, from representatives of device manufacturers to public policy makers, agreed that cost-effectiveness analyses can be useful for making prudent pricing and coverage decisions. One panelist noted that outside of the United States, manufacturers are used to having to set prices cognizant of budget constraints because the purchasers are examining the cost per quality-adjusted life-year offered by a new technology relative to existing therapies. Other payers in the United States also make use of cost-effectiveness analysis. Some panel members felt that Medicare is lagging behind these other payers in this aspect.

Implement a Sliding Co-payment System: Sliding co-payments are used extensively by PBMs to channel patients to less expensive, therapeutically-interchangeable products within a formulary. This concept has also been suggested as a means of covering more costly new technologies for which there was still limited data about their superiority over existing therapies. Under this mechanism, prices would be set the same as existing therapies, but beneficiaries would be required to pay the additional cost until there was better data about the new technology's relative clinical efficacy. In this manner, decisions about value are pushed back to the individual. While this option was raised and several panelists liked the idea, there was little discussion about its relative merits. One panelist mentioned that a system of tiered co-payments had been discussed in the past and was likely to be politically infeasible.

Mechanisms to Ensure the System is Adequately Funded

Have an Update Factor That Allows More Money to Flow Into the System

For New Technologies: Payment rates under Medicare's inpatient prospective payment system are updated each year to reflect changes in hospital input prices, adjustments in patient case mix, and an allowance for scientific and technological advances and improvements in productivity. In practice, CMS has recommended that productivity gains offset cost increases associated with the adoption of new technologies, and the update factor has not allowed new money to flow into the system to cover high cost technologies.

Some panel members felt that rather than attempting to set payments for specific new technologies, a better solution would be to increase the amount paid to providers through a new technology component of the update factor. In this manner, CMS would not micromanaging technology use, but allow hospitals to make better decisions about delivering quality care. Other panel members expressed a concern that a general increase in DRG prices would not incent hospitals to make the best decisions about new technology use. More money becomes general money and may allow a hospital to continue to use inefficient technologies rather than adopt innovative, but costly, new techniques. Panelists also pointed out that such a mechanism does not reflect that there may be other savings in the system as a result of adopting a new technology.

Remove Budget Neutrality: There was much discussion about this point. Many panelists agreed Medicare must be responsive to its taxpayers, and a system with budgetary caps forces efficiencies to occur elsewhere to pay for new technology. However, budget neutrality may also force a decrease in payments for other services to pay for new technology. Some panelists felt the budget neutrality requirement could be removed in the few instances when Medicare is adopting truly valuable cost-increasing yet quality-enhancing technologies. Many panelists felt that the number of occasions that Medicare allows additional payments above the PPS amount (such as in the transitional pass-through mechanism) should be limited, so that even under a budget neutrality constraint Medicare could avoid starving basic services to pay for new technology.

Rebase the Payment System: Earlier in the day, a panelist mentioned that Medicare's system does not easily accommodate quality-enhancing, non-clinical system-wide improvements, such as computerized physician order entry systems. Another panelist suggested that it might be time to re-base the inpatient hospital payment system to reflect costs. The last time the system was rebased was in 1983. This discussion raised the question of how often should CMS take stock of the true costs of care.

Mechanisms to Improve the Flexibility and Administrative Ease of the System

Restrict Pass-through Payments Only to a Few Deserving Technologies:

The flexibility of a pass-through mechanism to pay for new medical technology seemed to be important to many panelists, but many felt that its use should be limited to relatively few major break-through technologies in a given year. One panelist suggested that CMS should be restrictive about indications for use of items that are on the pass-through list and use the transitional period to collect more data about its effects on outcomes. This idea of provisional coverage for pass-through items was introduced in legislation in the early 1980s.

CMS representatives noted the criteria to qualify for pass-through payments have become much more stringent in the past year. Questions were raised about whether CMS needs to further restrict the criteria over what is currently in law or broaden them. Some concerns were expressed that much of technological development in health care is incremental, and few technologies would qualify. Another panelist suggested that we could only determine if CMS' standards are too stringent by seeing what happens in the next few years.

CMS also asked for guidance about how the term "substantial clinical improvement" should be interpreted. Does one set of criteria fit all cases? Concerns about the cost thresholds were also discussed. By establishing these thresholds, CMS is inadvertently giving incentives to manufacturers to set their prices at a level that would allow them to qualify for pass-through payments.

Devise a Better Coding System for Devices: Another recommendation made by panelists for how Medicare could improve the way in which it pays for new medical technology would be to adopt a coding system for devices that was more specific, such as the National Drug Code system that is used for pharmaceuticals. A better coding system would enable hospitals to be paid for what they were using. Confusion arises among medical coders about whether a specific device qualifies for a transitional pass-through payment and results in hospitals under billing for these items. One panelist suggested the Food and Drug Administration (FDA) should issue the codes at time of approval, although if payment is associated with the codes it may raise concerns with FDA labeling issues. Another panelist thought the FDA might be in the process of standardizing labeling for devices, and CMS should stay apprised of this process.

Mechanisms to Enable the Agency to Learn from Past Pricing and Coverage Decisions

Expand the Resources Available for Evaluating the Effect of Payment and Coverage Decisions: As noted previously, CMS has a limited capacity to conduct clinical effectiveness research or to evaluate the impact of its payment and coverage policies on use and outcomes. While many panelists agreed that expanding CMS' evaluative capacity may be desirable, some suggested studies could be focused on those 6-10 technologies that have a large cost and outcomes impact. Several panel members acknowledged Medicare has a powerful database for research, and should have the ability to use it to establish better pricing policies. While some panelists suggested that this might be more economically achieved by expanding the number of joint research initiatives between CMS, the National Institutes of Health, and the Agency for Health Care Research and Quality, others noted that CMS is concerned about a very specific population of Medicare beneficiaries, and its concerns about establishing appropriate payment policies are not shared by these other agencies.

**Attachment 1. Agenda and List of Reading
Materials**

Medicare Payment Advisory Commission

Expert Panel Meeting

*Paying for New Medical Technologies:
What Options Might Medicare Consider?*

Wednesday, September 11, 2002

Medicare Payment Advisory Commission
601 New Jersey Avenue, NW
Suite 900
Washington, DC 20001

Agenda

- 9:30 – 10:00** Arrival and continental breakfast
- 10:00 – 10:15** **Welcome**
Lu Zawistowich, Acting Director
Medicare Payment Advisory Commission
- 10:15-10:30** **Goals and structure of the meeting**
John Iglehart, Health Affairs
- Why do we care about revising the way Medicare pays for new medical technology?**
Penny Mohr, Project HOPE Center for Health Affairs
- 10:30 – 11:00** **Introductions**
Panel members will be asked to share (in one or two sentences) the facets of Medicare's payment systems they have dealt with previously and their current vantage point.

11:00 – 11:45

What principles should Medicare follow in paying for new medical technology?

- What are the characteristics of a good payment system?
- Which characteristics are most important from a societal perspective?
- Does this vary by setting of care?
- Are some of these principles mutually exclusive?

11:45-12:00 PM

Break

12:00- 12:45 PM

What constraints does Medicare face in paying for new medical technologies?

- Does Medicare face constraints that the private sector does not?
- Do constraints vary by setting of care?
- Are there particular types of technologies for which it is more difficult to design a good payment policy?
- In what ways might some of these constraints be minimized or resolved?

12:45 – 1:30 PM

Lunch

1:30 – 1:45 PM

What do other large purchasers of health care do?

Penny Mohr, Project HOPE Center for Health Affairs

This session will present the findings from Project HOPE's survey of purchasers of health care services. Representatives from large health insurers, group purchasing organizations, pharmacy benefit management firms, the military and Veteran's health systems, and two national health systems were interviewed to understand the methods they use to establish or negotiate payments for new medical technologies. Case studies were used to illustrate commonalities or differences in their approaches. These case studies include: drug-eluting stents; biologically-manufactured skin; implantable cardiac defibrillators; and a monoclonal antibody for treating breast cancer.

1:45-3:15 PM

What options might Medicare consider for paying for new medical technologies?

- What is the array of options available?
- What ties (if any) should there be between the pricing and coverage determination process for Medicare?
- What are the relative strengths and weaknesses of each option?
- What are the trade-offs for each option?

3:15 – 3:30

Break

3:30 – 4:00

Meeting Summary

Penny Mohr, Project HOPE Center for Health Affairs, Panel Chair

List of Reading Materials

Federal Register. Excerpt from: Medicare program; payments for new medical services and technologies under the acute care hospital inpatient prospective payment system; final rule. 2001;66(1741):46901-46925.

Federal Register. Excerpt from: Medicare program; changes to the hospital inpatient prospective payment systems and Fiscal Year 2002 rates; proposed rule. 2001;66(87):207-344.

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Medicare Payment Advisory Commission (MedPAC). Chapter 3. Paying for new technology in the outpatient prospective payment system. In *Report to Congress: Medicare Payment Policy*. Washington, DC. March 2002:111-120.

MedPAC. Chapter 3. Accounting for new technology in hospital prospective payment systems. In *Report to Congress: Medicare Payment Policy*. Washington, DC. March 2001:35-45.

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