Can the Public Remedy Health Care?

After studying why health reform efforts have failed, a U.S. senator decides to look outside Washington.

BY JOYCE FRIEDEN
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WASHINGTON — Sen. Ron Wyden (D-Ore.) says that the answer to America’s health care problem does not lie with Congress—at least, not initially.

“I spent 2 years studying what went wrong in the Clinton debacle,” he said at a meeting sponsored by America’s Health Insurance Plans. Sen. Wyden was referring to President Bill Clinton’s unsuccessful effort to get Congress to pass health care reform in the 1990s. He also looked at a similar effort in the 1940s by President Harry S. Truman.

His conclusion: “There is a remarkable similarity between the two,” he said. “For 6 decades, the effort has involved trying to write a piece of federal legislation in Washington, D.C. (But) the special interests would attack the legislation and each other, and everything would fail.” Instead, he decided to go 180 degrees the other way, he said. “We’ll start it outside [Washington].”

In March, Sen. Wyden, along with Sen. Orrin Hatch (R-Utah) and Comptroller General David Walker, announced the formation of the Citizens’ Working Group on Health Care. The group is composed of 14 people from across the country, including physicians, health advocates, hospital administrators, academicians, nurses, and a union representative. Health and Human Services Secretary Mike Leavitt will serve as the 15th member.

CMS Eyeing Part D Performance Measures

BY JENNIFER SILVERMAN
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WASHINGTON — Medicare intends to use performance measures to monitor cost, quality, and access issues related to the new prescription drug benefit, a research analyst said during a meeting of the Medicare Payment Advisory Commission.

However, Medicare has not yet “determined what those measures will be and how they will be used,” said MedPAC analyst Cristina Boccuti. MedPAC makes recommendations to Congress on Medicare payment issues.

The Centers for Medicare and Medicaid Services will be collecting a large amount of data on the new drug benefit—or Medicare Part D—including drug utilization and plan benefit information, to construct these performance measures, Ms. Boccuti said. In addition to the agency’s need for the data, “congressional agencies will need Part D data to report to the Congress on the impact of the drug benefit on cost, quality, and access.”

MedPAC commissioners recommended that the Health and Human Services department establish a process for the timely delivery of this data to interested parties.

To identify how policy makers could use these measures to monitor the Part D program, MedPAC convened a panel of 11 experts representing health plans, pharmacy benefit managers (PBMs), employers, pharmacies, consumers, quality assurance organizations, and researchers. The panel agreed that CMS should collect and report on measures including:

- Outcomes measures such as control, access and quality assurance, benefit administration and management, and enrollee satisfaction.
- Cost data, measures such as inpatient and outpatient hospital charges, outpatient charges, imaging, lab, and pharmacy expenditures, and drug spending by plans and beneficiaries.
- Use of pharmacy networks, formularies (which include prior authorization and exceptions), appeals rates, and drug utilization.

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Some MedPAC members, however, were concerned that there is a pre-scriber code associated with each drug. The agency will be collecting data on actual drugs and the spending associated with those drugs, “so there will be the ability to track how much was paid at the point of sale,” Ms. Boccuti commented.

PPAC Members Scrutinize Part B Drug Proposal

BY JOYCE FRIEDEN
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WASHINGTON — Members of a Medicare physician advisory council debated questions about the Centers for Medicare and Medicaid Services’ proposed new program for paying for physician-administered outpatient drugs under Medicare Part B.

Medicare currently pays physicians the average sales price (ASP) of the drug—a number that is supposed to represent the total paid for the drug by all buyers divided by the number of units sold—plus an additional 6%. But under the proposed rule, beginning next year physicians would have a choice: they could either stick with the current system or obtain the drugs directly from a vendor that will be selected by Medicare via a competitive bidding process.

The system would require that physicians choose one system or the other for all the drugs commonly furnished to their specialty, according to Don Thompson, director of outpatient services at CMS’s Center for Medicare Management.

But Ronald Castellanos, M.D., a Cape Coral, Fla., urologist and chair of the Practicing Physicians Advisory Council, said at a council meeting that an all-or-nothing system would be unfair. “I think this is a good thing,” he said. “There are certain drugs that I use that I can’t buy for ASP plus 6%.”

Mr. Thompson said that while Dr. Castellanos couldn’t pick and choose what system he would use for which drug, he could try to influence which urology drugs would be included in the program. “The categories could be structured differently; your comment [on the proposed rule] could be, ‘I think this category should include these drugs and not these other drugs,’” Mr. Thompson said at the meeting.

Dr. Castellanos proposed that the council, which advises Medicare on matters of interest to physicians, urge CMS to revise the rule to allow physicians to pick and choose which system they would use “on a drug-by-drug basis.” That recommendation passed easily.

Dr. Castellanos wondered whether the drug vendors who are going to contract with Medicare would be required to provide drugs for beneficiaries who couldn’t afford the copays.

“The contractor would be required to supply drugs to you,” Mr. Thompson replied. “If you’re asking if a contractor would waive coverage for that particular beneficiary, there’s a separate requirement for vendors that would be any different from physicians, who can waive the copay on a case-by-case basis,” he said.

Dr. Castellanos pressed further. “These patients have ongoing treatments that can last for years. You’re telling me that even though a patient is unable to pay coverage, that the contractor will bill the patient, but still has to supply the drug?” he asked.

Mr. Thompson seemed to answer in the affirmative. “We did not propose any mechanism for a contractor to deny supplying drugs to a beneficiary,” he said.