MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

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9:40 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:
Use of market competition in fee-for-service Medicare
-- Anne Mutti, Sharon Cheng, Sarah Lowery

P R O C E E D I N G S

MR. HACKBARTH: This morning we have a series of presentations that will be followed by commission votes.

The first topic on the agenda is the use of market competition in fee-for-service Medicare. Let me welcome all of our guests. We appreciate your joining us.

Anne, Sharon, proceed whenever you're ready.

MS. MUTTI: At Tab B in your background material is a draft chapter entitled Use of Market Competition in Fee-for-service Medicare. It follows the online that we discussed at the last meeting, laying out the design issues that must be addressed and competitive pricing approaches for fee-for-service goods and services, and discussing the experience of two Medicare competitive pricing demonstrations.

In this presentation, though, we will focus on describing the results of the two demonstrations and presenting possible recommendations for you to discuss. I will briefly discuss the results from the participating heart bypass center demonstration and then turn it over to Sharon who will discuss the competitive bidding for DME demonstration.

Also, for the benefit of the audience, we have reordered the slides, so they will be a little different but they are all the same slides.

As we discussed at the last meeting, the Medicare participating heart bypass center demonstration was conducted between 1991 and 1996. The demo invited hospitals performing bypass surgery to offer a discounted price for all hospital and physician services bundled together -- that includes consulting physicians, as well -- surrounding two heart bypass DRGs.

CMS restarted the demonstrations to include more sights and more procedures, cardiac and orthopedic, back in 1998 and it was under a new name, the centers of excellence demonstration. Although there was considerable interest at the time among hospitals, Y2K and BBA priorities required postponement.

It was later relaunched again in 2000, focusing on three states. And while there was some interest in participation the discounts were not as great as they had been previously and ultimately, through the course of negotiations, interest waned on the part of the applicants.

They cited concerns about reductions in physician payment and some hospital reclassification issues. So it is now not in operation.

But just quickly to go over the results of that demonstration, it did produce Medicare savings of about $42.3 million and this is about 10 percent off the expected spending on bypass patients at those facilities. Participating sites were largely successful in reducing internal costs per episode. Three of the four original sites reduced costs between two and 22 percent between 1990 and 1993, depending on the DRG and the hospital.

Because the hospitals were able to bundle, they received the bundled payment and that aligned incentives between hospitals and physicians. And at the same time hospitals were adopting more information technologies that allowed them to track their costs to services. They were able to provide more incentives for physicians to change their practice patterns. And in so doing, they tended to reduce their ICU costs, their nursing, labs, and their pharmacy costs.

The three additional sites that were not subject to the same intense evaluation also appeared to have increased savings.

In terms of quality, the participating sites had lower mortality rates for these procedures than competitors, and that would be expected because that was the basis upon which they were selected. In addition, over the course of the demonstration their mortality rates declined, as did the overall mortality rates at competitor hospitals as well, during this time period.

Market share was one area where the demonstration did not perform up to expectations. Only two of the seven sites increased market share. Four sites increased volume, but two of those lost market share concurrently.

In considering the possible reasons for this outcome, the evaluators noted that some of the sites, or most of the sites, did not aggressively market the designation. Also, also local market conditions were changing at the same time. Competitor hospitals were beginning to do bypass surgery in some of these markets. Others were opening catheterization centers.

They also noted that there was a general reluctance among beneficiaries and physicians to change their behavior, even if they were aware. And not that many individuals, not that many beneficiaries, were aware of the information. More physicians were but neither seemed to change their behavior very much.

So that concludes the summary of that

demonstration and I'll turn it over to Sharon to talk about the DME.

MS. CHENG: The second demonstration that we'll talk about this morning is competitive bidding for durable medical equipment. This demonstration was mandated in the BBA in 1997, and in that legislation the Secretary was given the authority to test competitive bidding in up to five sites.

The legislation also gave the Secretary the authority, under the demonstration, to limit the number of winners of contracts to the number sufficient to meet demand.

The bidding began in this demonstration in 1999 and the demonstration was completed, according to the legislation, at the end of December, 2002. The demonstration was conducted in two sites, Polk County, Florida and San Antonio, Texas.

Between the two sites, there were three rounds of bidding for eight categories of durable medical equipment. The products ranged from those simple commodities that could be supplied through the mail, such as some medical and surgical supplies, to those that included a significant service component such as the training, follow-up, and repairs that could accompany the provision of oxygen.

To date, two of the three evaluations of this demonstration have been completed and they provide no evidence that competitive bidding has had an adverse impact on quality or access, but it has shown that competitive bidding does lower prices. The conclusions on Polk County to date are based on beneficiary surveys and comparisons with surveyed beneficiaries in neighboring Brevard County, which was chosen as a comparison county because it has a similar population. It also contains focus group meetings with referral agents, suppliers and beneficiaries in that county, and an analysis of both rounds of bids.

The final evaluation of Polk County will include additional site visits, interviews of suppliers, and referral agents to measure access and quality during the second round of bidding that occurred in that county.

With respect to the San Antonio site, there has been a baseline beneficiary survey, focus groups with stakeholders and an analysis of the bids that were submitted. The final evaluation for San Antonio will have a follow-up survey for information from beneficiaries and suppliers to assess access and quality during the San Antonio phase.

The spending information that we have has been based on the prices that were bid. The final evaluation

will have a claims analysis that will determine what impact, if any, competitive bidding had on the volume of DME that was supplied under the demonstration.

Based upon the first and second evaluations, the market functioned largely as was hoped. There were 73 bids from 30 suppliers in Polk County and 180 bids from 80 suppliers in San Antonio. This suggested a large number of suppliers are willing to participant, though not all, in competitive bidding.

Of the 16 winners in Polk County's second round, half were winners in the last round and half were new. This suggests that the competitors weren't eliminated in the first round, but instead returned to challenge winners in the subsequent round. And this suggests that competitive bidding can be sustained over a series of rounds.

We also found that Medicare spending could be reduced by $8.5 million or about 20 percent off the fee schedule prices assuming no change in volume. Savings generally increased in the second round of bidding. The agency's administrative costs for operating this demonstration were $4.8 million, $1.2 million for startup costs. The second evaluation estimates that adding a new site with this competitive bidding system would cost between $300,000 and $500,000 per year.

Surveys and focus groups to date found largely positive results in terms of access and quality. For example, Polk County beneficiaries reported an increase in the quality of training after one year of the demonstration, no difference in the frequency of maintenance visits before and after the demonstration, and little or no wait for deliveries of oxygen. Overall satisfaction ratings from users of DME were high before the demo and remained at high levels one year later in Polk County.

Referral agents in San Antonio and Polk noted that problems that they had with winning suppliers were often transitional in nature and could often be solved by switching to another winning supplier.

However, some beneficiaries and referral agents raised concerns about the quality of DME under competitive bidding. In Polk County, there was a decrease in the provision of portable oxygen as opposed to a stationary concentrate or other forms of oxygen. Portable oxygen may be important to the quality of life that may have health benefits conferred by the additional mobility it gives a beneficiary. Evaluators note that the decline in portable oxygen could be due to a coverage policy change that occurred during the demonstration. However, in Brevard, the comparison county, there was no decrease in the amount of

portable oxygen over the same period of time.

Also, in Polk County beneficiaries and referral agents complained about the substitution of less satisfactory urologic suppliers. And in San Antonio, improper equipment for wheelchairs was sometimes delivered and the repairs were sometimes not satisfactory.

The evaluators concluded that the problems warrant monitoring and follow-up. And while characterizing all their observations as preliminary, the evaluators conclude that the results, on the whole, have been positive.

Based on the Commission's comments from the last meeting, there was an indicated interest in building upon the results to date of the DME demonstrations, so we've brought you this draft recommendation for your possible consideration. This draft recommendation would allow Congress to give the Secretary authority to implement competitive pricing for DME as demonstrated, unless a third evaluation presents significantly different evidence than the first two evaluations. Congress would have a fixed period of time to review and approve any implementation plan.

This second recommendation is intended to encourage the Secretary to pursue additional competitive pricing demonstrations by removing the need to seek legislative approval for additional demonstrations of this sort. Thus, the Congress should give the Secretary demonstration authority to initiate competitive pricing demonstrations.

In our third draft recommendation, because it seems important to balance regulatory flexibility and congressional oversight, we have drafted recommendation number three. By this recommendation, for demonstration that prove successful, the Secretary should have the authority to implement competitive pricing. The Congress would have a fixed period of time to review and approve any implementation plan.

On this next slide, to develop an idea of the potential for new markets if competitive bidding were to be expanded beyond the two markets or eight categories of items for which it's been tested, staff has made some measurements of existing DME markets. We used a 5 percent sample of claims for DME in 2001, which captured over 50,000 DME suppliers.

Preliminary results suggest that 75 metropolitan statistical areas are at least as large as Polk County, which was the smaller of the two sites. Those MSAs include about 20 million Medicare beneficiaries.

We also made a preliminary estimate of the

competitiveness of markets based on the type of DME. The measurement of competitiveness was the Herfendahl index score for an MSA or for a state-wide rural area. The Herfendahl index reflects a concentration of the market. Thus, a market with four competitors that each had 25 percent share of the market would be more competitive than a similar market with four competitors but in which one competitor had a dominant 70 percent share and the other competitors had 10 percent share each.

Using this measurement of market concentration, the markets for oxygen and hospital beds and medical/surgical suppliers across the country are relatively unconcentrated, and by this measurement would be deemed to be relatively competitive. By contrast, the markets for DME drugs and nutrition suppliers are relatively concentrated and would be characterized as less competitive.

However, as an important caveat on that research, the demonstration of competitive building yielded lower prices for DME, drugs, and nutrition as well as oxygen, hospital beds, and medical/surgical supplies. This would suggest that perhaps the Herfendahl index is not the best indicator of the potential effectiveness of competitive bidding, especially because it fails to account for the behavior of new entrants in a reconstituted market.

Research of this nature could be expanded. We could explore different definitions of the market or take it in other directions as you see the need for such research.

So to conclude this representation, that's just to give you sort of a taste, I'll go back to the recommendations and we'll open up the discussion.

MR. HACKBARTH: What I would suggest is that we take these in turn. Let me ask first whether there are any questions or comments about the CABG demonstration?

MR. FEEZOR: Glenn, just two comments generally, sort of more of an amplification, I think, of the findings.

First off, Anne and Sharon, good job, and I'm comfortable with the general direction of the recommendations.

In our description of the competitive bidding process, I'm not sure that we might be simplifying things a little bit too much. I think there is two thresholds of competition. First, is to be the approved vendor, which is a competitive procurement at the governmental level. And then there, in fact, is a second level competition if you are an approved vendor, to in fact for those services.

Certainly, cost is very easy to tease out at that first level. But at that second level, competition may happen at more than just cost and quality and price. And I

think just simply clarifying that or making that a little more explicit might be helpful.

The second, and Mr. Chairman, this would go to probably the second recommendation, just a concern that I have as far -- certainly expanding competitive bidding is appropriate. But I think there are categories of services beyond the two that you focused on here where, in fact, the results of competition may, in fact, begin to cut into critical core services that a community or a medical system might have, would be an area that I think you would at least have to think about that, as far as saying is that an appropriate new category in which competitive bidding might apply.

So that's just, as we go forward and as perhaps the Secretary -- assuming that the authority is granted -- begins to explore that, I think there would be a word of caution for those areas or categories of services that might be injurious to fundamental infrastructure of other health care services that might be provided in the area.

MS. MUTTI: If you had any examples of what you were thinking of?

MR. FEEZOR: I'm thinking, and I should defer to the true experts in terms of Mary and Ray in terms of rural areas, but there may be certain services that are provided by your medical centers to some rural areas that sort of are able to make sort of the economies of scale necessary to maintain either core services or other services that simply may not be as adaptable to competitive bidding as you might thing.

In the report, I think you were very clear talking about that certain rural areas may not be appropriate for that, and I guess that may cover it.

MR. HACKBARTH: I'm a little bit uncertain about this Allen, so let me just pursue it for a second. If in fact, it's a service, sort of a sole community provider, and essential to the community, it wouldn't lend itself to competitive bidding to begin with. There wouldn't be competitive alternatives. So it wouldn't be a prerequisite for it. By definition we're talking about markets where there are multiple alternatives readily available so that no one supplier is essential, almost by definition.

MR. FEEZOR: Yes, when you start by defining it by market, which of course the last slide talked about identifying areas, at least as far as these categories of services.

DR. NEWHOUSE: This isn't directly on the recommendation, so if Bob and Nick want to talk about the recommendations, I'll pass.

MR. HACKBARTH: In fact, let me just leap in here and say a word about the recommendations, specifically draft recommendation one. At the end of the first paragraph, we have the clause saying that unless the third evaluation presents significantly different evidence. Unless there's an objection from the commissioners, what I'd like to do here is drop that clause, go ahead and vote on the basic recommendation that the Congress should give the Secretary authority, hold the recommendation until the final evaluation comes available, which by statute as I understand it should happen sometime this summer.

Once we have the final evaluation in hand, the staff will review the analysis. If it is, in fact, consistent with the earlier evaluations, consistent with the analysis included in this draft chapter, then we would go ahead and proceed to issue a final recommendation, provided the Commission approves that when we vote. So specifically what I want to avoid was issuing a final recommendation before we have seen the final evaluation.

Without objection, that's how we'll proceed on this, so we'll drop the unless language and we will vote but then hold the recommendation in abeyance pending the final evaluation.

DR. NEWHOUSE: This goes to the comment about markets because there was something in the text that I found confusing about, in the comment on price, there was a statement that bids may need to be adjusted to promote comparability. And then it said the two most significant factors are input costs and relative health status.

I assumed if we're taking bids for a given geographic market, in which case there wouldn't need to be an adjustment for those factors. What I'm concerned about is an issue where say, like a lab where I bid for a market, say Dallas, but I'm actually located somewhere else, my lab is somewhere else. And I say gee, I have higher cost because I'm in a higher wage area than Dallas. It doesn't seem to me we want to adjust for that.

MR. HACKBARTH: That makes sense to me. Anne, Sharon, any reaction?

MS. MUTTI: Yes, we wrote that originally very broadly, but I see your point.

DR. WOLTER: A couple of things. I guess I'll address the bypass surgery demonstration.

I think one interesting aspect of that's related to the upcoming conversation on incentives and quality because in essence there's a merging of Part A and Part B payments that goes on there, which I think is a good thing, at least in the sense that it fosters people having to come

together and work together in care. So just to point that out.

Then a little bit to support Allen's comments. I think that we do have to recognize with projects like this that there is a universe of DRGs around which there's a pretty healthy margin. And then there's a universal around which there is not such a healthy margin. And to the extent that in a market, care is shifted to a given organization where that margin is healthier, it becomes more difficult for the organizations not chosen perhaps to continue to provide the full array of services. And I don't know how one follows that as these projects are done, but I think it should be kept in mind.

Then the other thing, I think, is the things that happen after projects like this become more common, and I'm thinking of we already know there's variation in utilization that varies substantially. In one part of the country bypass surgery has a much higher utilization rate per thousand Medicare recipients than in other parts of the country. And angioplasty similarly.

So one could imagine responses, in terms of substitution of care, angioplasty for bypass surgery, et cetera, as projects like this are implemented. And I think those things should be kept in mind and followed.

DR. REISCHAUER: We're talking about them in order? I have an observation or a question for Anne about the CABG demonstration, which struck me as a confused demonstration in the sense that it was trying to maybe pursue two objectives which couldn't be pursued at the same time. One is sort of the question of is this a better way to structure payments? Can we do it cheaper this way without compromising access or quality?

And in that case, we come up with how the bids were lower overall and as an organization that says we're trying to set Medicare payments for the efficient provider it should be provided in the efficient way. But it that kind of experiment or demonstration, one would want to include high-quality, medium quality, and low quality and look and see if we went to a payment mechanism like this, is current quality maintained? Or not degraded?

This demonstration didn't do that because it only took the high-quality folks and then it really can't say anything about the impact on quality because they were there already, and they're there for some other reason. So I don't think we've shed any light on that.

The other objective could have been to shift demand to high-quality providers. And on that score it failed. That's really the only thing that was demonstrated,

it strikes me, in this demonstration.

So if we are to encourage CMS to go ahead with demonstrations, I'd want it to go ahead on ones that we really learned answers to important questions on, rather than confusing the issue.

MS. RAPHAEL: I had the same observation on the CABG one, which is it didn't stimulate increased demand and increased volume for the providers selected. And I was kind of interested in that, because in your chapter you talk about several things, part of which had to do with CMS's reluctance to give some incentives to these selected providers, like a designation of centers of excellence or waiving of coinsurance. To me that was important. I'd like understand why there was an absence of those incentives. Some of the other variables had to do with the difficulty of breaking referral patterns.

But could you comment on this policy toward giving incentives towards the selected bidder?

MS. MUTTI: I don't know that I can speak definitively but I can imagine -- and there's been a lot of controversy about using the title centers of excellence, and whether overall that there was a comfort level among the industry that that was the appropriate title to use. They felt that some of the very good excellent facilities didn't even apply to participate in the demonstration, and they therefore didn't like the idea that this would be named centers of excellence. They didn't think it was as inclusive as it could be.

And actually, when this demonstration was done it wasn't even in the title of the demonstration. So I don't think that CMS or HCFA, at the time, had ever even promised that they could use the centers of excellence moniker in marketing this.

It was never the agreement -- there was concern on waiving the deductibles and coinsurance because the participating sites just wanted to do it for those people who didn't have supplemental coverage. And there was a concern that that was inequitable in how they treated that.

But I think certainly internally that's been an issue that we had talked about. If you wanted to redo this, is this an area that maybe you could get some real improvement on, if CMS wanted to take more of a leadership role and be out in front and make a more public statement about those winners. But so far that has not been their choice.

MR. HACKBARTH: So we've made a specific recommendation with regard to DME. We have not on CABG. The reasons that we've discussed here are basically the

reasons for not saying something specific in support of the CABG demonstration.

MS. MUTTI: Can I just follow up on Bob's point?

Are you expressing interest in any kind of demonstration that would more broadly test the idea of doing a bundled payment for A/B but do it across all types of facilities, high quality, low quality?

DR. REISCHAUER: That's one demonstration that it would be interesting to find out the answer to. Another one would be one in which you're asking can you improve the quality of care across the board, meaning change low quality into higher quality people by changing the way we structure payments? But that wasn't tested in this, it was a closed samples of participants.

MS. MUTTI: Actually, they have talked about going forward with this consortium of Virginia cardiac hospitals, some of which are much higher quality than others, or at least have had better results than others. And so if they do end up going forward with that we may get a little insight into that.

MR. SMITH: On Bob's point, I think it's tough to imagine, Bob, how you would organize competitive bidding among low quality providers.

DR. REISCHAUER: The question is are you trying to change quality or are you trying to save money without degrading quality? Those are the two questions.

MR. SMITH: But you are trying to do both. And it seems to me, that assuming that this works, you would only reward high-quality providers in the first round of competition. If the market works, competing suppliers' quality ought to improve so that they can play in the next round.

DR. REISCHAUER: You're in the next chapter, though.

MR. SMITH: I understand. But it shouldn't be an objective of a competitive bidding demonstration to see if it works down the quality ladder. The question should be can you save money without having quality degraded?

And an interesting related question is does the quality among non-winning competitors improve so that they become eligible for the next round? That would be the testify of whether or not this market is producing higher quality.

DR. REISCHAUER: We didn't do that with this hospital thing. We didn't have a second round.

MR. SMITH: I agree, but we ought to maybe observe in the text that if we proceed with additional demonstrations, they ought to be structured so that they

test that.

Glenn, I have one other minor comment. There's sort of an aside, which I've now lost, where you suggest that there may be other market objectives protecting access of small providers, more comprehensive providers. I think I'd get rid of that suggestion. Senator Durenberger will understand, it is so tempting to write these things -- and particularly for his former colleagues to write these things -- so that everybody is protected, set-asides and carve-outs and hold harmless provisions. Congress will take care of that without us encouraging them to. I'd get rid of that reference.

DR. REISCHAUER: That's not CMS or MedPAC's responsibility. We're not elected by the people, at least I don't think we are.

MR. HACKBARTH: You're in deep trouble if we are.

DR. REISCHAUER: I am.

Can I ask Sharon a question? You use the term throughout the section on DME about suppliers and I'm just wondering what is a supplier here? We talk about Polk County, 92,000 beneficiaries and 120 suppliers of hospital beds. I'm thinking, not more than 10 percent of Medicare folks could be in the market for hospital beds in a single year, and that's probably even less. So that's 9,000 divided by 120. These providers are selling 92 beds a year?

Where are they located? They might not sell any. So I'm wondering, is this really any kind of measure of market? The notion of supplier. Because some of this stuff you can probably buy on the Internet.

MS. CHENG: Certainly some suppliers are mail-order. And one of the challenges that we had in trying to describe markets for DME is to account for the fact that the suppliers for DME range from really -- even more than in home health -- from one end of the spectrum to the other. There are some suppliers that are very, very small.

And in fact, when we use a 5 percent sample to look at nation-wide claims, we picked up 50,000 suppliers. I think that I might have missed another 10,000, 20,000, even possibly 30,000, because their volume is very, very small. Also, because you don't have to have a presence in the market physically, my definition of a supplier was someone who had supplied something to someone in that market. So all you had to do was buy something from the supplier one time and that was a supplier in the market.

DR. REISCHAUER: We should just have a couple of sentences somewhere in the chapter saying that.

MR. HACKBARTH: Let me just go back to the CABG issue for a second. I just want to be clear about what I

think is the message, and correct me if I'm wrong.

We're not saying that this is an idea that couldn't be made to work. What we're saying is that there are a lot of loose ends that would need to be resolved. And the thrust of what we're doing here is saying, trying to identify the highest priority opportunities. Given all the loose ends surrounding CABG, we don't see that as at the same level of development, if you will, as DME. Moving ahead with DME is much more straightforward at this point.

Hence the recommendation to go ahead with DME and just some discussion of the CABG recommendation. Is that a fair summary? Joe?

DR. NEWHOUSE: I don't disagree with that, but I would have said I thought it important to try to proceed with more integration of A and B, more actually for quality purposes than for cost purposes. I'm a little concerned that we don't shove that kind of demonstration off into a cul-de-sac.

MR. HACKBARTH: In fact, that's why I wanted to go back to the tone, Joe. I don't want the tone to be negative, that we think that this is something that shouldn't be pursued or is fundamentally flawed. In fact, there's a lot that's interesting about it, including the merger of A and B. I'd like to be clear that the reason we're not recommending making the same type of recommendation for CABG as for DME is not because there's nothing interesting or important there. It's simply that it's not as clear cut at this point is we think DME is. So maybe it ought to be pursued --

DR. NEWHOUSE: The example that we talked about was the center of excellence problematic language. But one could still set that issue aside. That's quite separable, I think, when trying to combine A and B in some given local markets and proceed along with some kind of demonstration of that, of a bundled payment.

MR. HACKBARTH: Again, the further exploration through demonstration, not only don't I have any objection to it, but I think it may be worth doing. With DME we're saying we need to be moving towards incorporating this in the program. We think this is so promising that the next step is towards implementation. We don't think CABG is there yet. And that's the contrast between the two in this chapter.

DR. NEWHOUSE: It's a little late in the day, but what about some kind of recommendation on encouraging demos of bundled A and B payment for certain procedures? We can point back to CABG as an example.

MR. HACKBARTH: How do people feel about that?

DR. WOLTER: I'm really supportive of this. I think the intention on the DME is very much driven by looking at costs. I think what we're talking about with CABG conceivably could be extended to other diagnostic areas as looking at ways of creating better coordination of care and ultimately get to better quality measures.

Now in some cases that may save costs. In some cases that could add cost. We wouldn't know until we tried it. So I think the emphasis is a little different. But I think this is an opportunity, maybe, to put this on the table.

DR. REISCHAUER: I think Nick's right, but I don't think this demonstration shed any light on that question.

DR. NEWHOUSE: That's why we want some demonstration.

MS. MUTTI: I guess one thing to think about, too, is whether this fits in the quality chapter more than this chapter? Sharon says it's discussed there, too, in general.

MR. MULLER: But the CABG example is both -- I mean, I think it's well written up here. It's an example of why it takes so long to get these demonstrations going and it had more starts and stops than things like this should have. So I think whatever demonstration should learn from the CABG one, in terms of not spending eight or nine years.

I remember going through that and there's a lot of hope in the beginning of participating in it, and the enthusiasm for it dampened very quickly. And I think the chapter illustrates why.

If we look at more demonstrations, we should learn from the CABG one.

MR. HACKBARTH: We've got two paths that I see, and we need to bring this to a conclusion. We've got a tight schedule this morning.

One is to have the staff draft up an additional recommendation encouraging demos that involve combining An and B, and Joe you could help them do that.

A second is we do have a draft recommendation that currently says Congress should give the Secretary demonstration authority to initiate competitive pricing demonstrations, sort of a generic statement about competitive pricing demonstrations.

We could simply make it clear in the text beneath that that we think that this is a particularly promising, important area and we urge that further consideration be given to it. If that's fine with you, just have the text language.

MS. RAPHAEL: I just wanted to get a little bit of clarification on the role of Congress in authorizing the

demonstration. And then in it both recommendations one and three there's a role for Congress in reviewing the implementation plans, and doing that in a fixed period of time.

So I just would like to know what the current jurisdiction of Congress is in this area and what exactly you have in mind in your proposal?

DR. MILLER: I think what we were thinking of here is that we felt like we needed the Secretary to have clear authority to pursue these kinds of demonstrations, competitive bidding. So that's sort of the first half of the -- if you want a way to focus on it, is recommendation two. So a clarification that the Secretary has the authority to pursue these demonstrations.

Then, when demonstrations like this get to the implementation stage, presumably you have positive results and you're moving to implement in a given market area. But because these would often represent significant changes in the way Medicare pays and purchases services, we felt that there should be at least an opportunity for Congress to have some review of this before it goes into the field as it's implemented. That was the line of reasoning.

DR. REISCHAUER: Congress would have to give CMS authority to implement, as well as to demonstrate. And that's the big jump. But they would probably be reluctant to give that authority without some notion that when the results came back and the project was moving forward they didn't have some ability to say hey wait.

DR. MILLER: Just to say, in number three it does say the Secretary should have the authority to implement, and then there's that second thought.

MR. HACKBARTH: We're trying to create a bias in favor of action, but recognizing the Congress has legitimate, important prerogatives here and ought to have the opportunity to say no, that's just outside the delegated realm, we won't accept that.

MR. DURENBERGER: What's missing for me -- first, I think this conversation is really, really helpful to the final product. As I approach the age where it's either a wheelchair or a CABG, I don't mind competitive bidding for wheelchairs, but I don't want competitive bidding on response to my -- I ain't buying on money, I'm buying on something else. So whatever we can to be helpful would be helpful to me.

But the most help to Congress, because Congress is not Congress is not Congress, if it can be done is to give them some advice in response to using market competition in the transition from an administrative pricing system where

everybody makes their own choices and what not, to a "competitive model."

And those of us who served on the competitive bidding pricing commission, whatever it was called for Medicare+Choice, learned some valuable lessons which are not necessarily reflected in the advice we're giving the Congress on using market competition. I'm sure that the experience between 1997 and today has given us some valuable experiences about how do you identify the product? How do you identify who is supplier, provider, whatever it is? How do you deal with the realities of a marketplace that's used to operating in one kind of a system, transitioning to this thing called competition?

And I won't try to belabor the point now, but I do think people in Congress, before they jump to the conclusion that competitive bidding is a solution to a problem, need some advice about the experience that we've already had in trying to transition certain phases of this from administered pricing to a competitive, what they can expect.

Obviously some of these recommendations have a short time line, and I think that's a reaction to the fact you don't want people messing around with the Congress between the time you make the recommendation and so forth.

So I'm trying to suggest that if there are some "lessons," process-related lessons that we've already learned, from this competitive -- that we need to speak to that.

MR. HACKBARTH: Could you give an example of what you mean by a process-related lesson?

MR. DURENBERGER: First, I've already mentioned, how do you define products so that there's a common agreement on the product? How do you define the producer or the seller or the supplier or something like that? How do you build in the right set of the communication, the politics of it? And I'm trying to avoid going into the experience that we had on competitive pricing, but we started out on what many of us believe was a right track and we ran into a lot of political impediments which some of us, Bob included, anticipated at the first meeting, I think, because we knew they existed.

Rather than spending four or five years going down a particular tracked called market competition or competitive pricing without the benefit of that experience, I am simply suggesting that if we could define that experience in some way it would be a valuable add-on to this whatever the report is that's going to come out sometime later in the year.

MR. HACKBARTH: The way I conceive of this is

there is a large and very important philosophical debate about the virtues of competitive pricing versus administered pricing, and that is very important. What we're trying to do is go to a lower level of abstraction and say wherever you stand on that major philosophical question, there may be targets of opportunity within the Medicare program that do not raise such complicated, sensitive issues. DME being an example of that, an example of low-hanging fruit where we may have less of an ideological divide, because of the nature of the product, the nature of the markets involved, the implications for quality, service, access, et cetera.

MR. DURENBERGER: If you say that I'm fine with it. I'm just arguing the context here.

MR. HACKBARTH: Do people agree with my characterization of where we're trying to be?

We do need to move ahead with our votes so we don't fall too far behind schedule. So again, as a reminder, we are deleting the clause that begins with the word unless.

All opposed to the recommendation as amended? All in favor? Abstain?

Okay. As I said earlier, we will hold that pending a review of the final evaluation.

Draft recommendation two. All opposed? All in favor? Abstain?

And draft recommendation three. All opposed? All in favor? Abstain?

Okay, thank you very much.