systematic nutritional screening was undertaken on admission. This study demonstrates which patients receive enteral tube feeding and estimates the hospital burden of such patients. METHODS: The CHKS hospital dataset contains aggregated, anonymised information on diagnosis, hospital experience, and patient demographics for over 80 million episodes in the UK, representing 55% of hospital admissions. It was used to identify patients who received enteral nutrition (using OPCS-4 codes) and compared their hospital stays with a control group who had the same primary diagnoses but were not tube fed. Both groups were analysed for comorbidities, procedures, and length of stay (LOS). RESULTS: We identified 14,328 patients who were tube fed in 2001/2002 out of 947,897 patients who were hospitalised for various diseases/conditions: dysphagia, cancer; stroke; neurological, respiratory and GI disorders, cystic fibrosis, feeding difficulties/anorexia, renal disease, and others. Tube fed patients had 28,768 separate episodes compared to 2,502,937 episodes for patients having the same disease/condition who did not receive any tube feeds. Overall, tube fed patients had one additional procedure, i.e. the tube feeding procedure, during their hospital stay compared to controls (average of 2.3 procedures across disease groups for tube fed patients). Daily tube feeding costs vary between £10.20 and £13.18. This represents only 2.8–3.6% of the daily inpatient cost of, for example, £359 in a surgical ward. CONCLUSIONS: Over 26,000 patients who are tube fed are admitted yearly in England. However the number of patients receiving tube feeding is very restricted, even though the cost is a small fraction of hospital costs. Does every patient who could benefit from tube feeding receive it? If not, should tube feeding remain severely restricted when it is known that its use could improve patients’ recovery?

HEALTH CARE POLICY—New Health Technology Studies

PAYMENTS FOR HIGH COST NEW TECHNOLOGY DRUGS AND BIOLOGICALS IN THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM: POLICY IMPLICATIONS

Baker JJ
University of Rochester, Pickton, TX, USA

OBJECTIVE: The Centers for Medicare and Medicaid Services (CMS) computes payment for high cost new technology drugs and biologicals in the hospital outpatient prospective payment system (OPPS) under two methods. This study examines the results of CMS computations over the initial thirty months of the hospital outpatient prospective payment system. METHODS: Phase I: CMS methods used first for payment of high cost new technology drugs and biologicals eligible for initial pass-through payment status and second for subsequent expired pass-through payment status were identified. Underlying assumptions were examined and formal methodology evaluations were collected. Phase II: A thirty-month time line was constructed. The assumptions utilized for CMS changes in payment status at month one, month nineteen and month twenty-eight were examined and analyzed. Analyses employing descriptive statistics identified components of payment assumptions and variations between the assumptions utilized at each of the three time line milestones. Findings were compared to a sample of actual CMS payments received by hospitals. RESULTS: A database of methodology explanations, visuals, and evaluations was created. An evolutionary time line of CMS methodologies and underlying assumptions was created. Study analyses revealed a statistically significant differential between aggregated mean payment amounts for the same high cost new technology drugs and biologicals at the first and the third milestones of the time line. Over one-half of the affected drugs and biologicals sustained payment rate reductions exceeding forty percent. CONCLUSIONS: CMS payment methods and underlying assumptions for expired pass-through drugs and biologicals is flawed. In addition, the basic hospital drug acquisition cost assumptions made by CMS are not consistent with actual hospital data. These findings will be of use to economists, cost accountants, and policy makers interested in arriving at equitable payments for high cost new technology drugs that are essential to modern health care in U.S. hospitals.

MANAGING TECHNOLOGICAL INNOVATION IN THE HEALTH CARE SECTOR

Haycox AR
University of Liverpool, Liverpool, United Kingdom

OBJECTIVES: This outlines the lessons learned by the author who is Director of one of the six units in the UK that undertake independent academic evaluations of Technology Assessment Reviews for NICE. The author provides an insiders’ view of the major issues that arise in managing the evaluation process. METHODS: The Liverpool TAR group assists NICE to provide guidance on appropriate treatment for specific conditions in specific sub-groups of patients. The aim is to standardise clinical practice around the most clinically and cost-effective interventions. The aim is to spread cost-effective new treatments more quickly across the health service to promote successful innovation on the part of the pharmaceutical industry. The importance of this UK initiative goes beyond its national borders as other governments are guided by NICE judgements in their reimbursement decisions and many are developing similar systems of appraisal. RESULTS: The paper analyses the impact of the 6-stage structure of NICE evaluation and assesses how generalisable the process may be to other countries. Issues underlying the targeting of NICE appraisals will also be examined together with the challenges presented.