Part B Drug Acquisition Program to Begin in July

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Starting next month, physicians will have an alternative to billing for Medicare Part B drugs under the average sales price system.

Officials at the Centers for Medicare and Medicaid Services are launching the Competitive Acquisition Program (CAP) for Part B drugs starting on July 1. The new voluntary program will allow physicians to obtain selected Part B drugs from vendors chosen by CMS through a competitive bidding process.

During the initial phase of the program, CMS has selected one vendor—BioScrip—to provide drugs. Physicians who participate in CAP will be paid for the administration of the Part B drug or biologic on an assignment-related basis, according to CMS, but will not have to take on the financial risk of purchasing the drugs first.

The program should help to cut down on physician paperwork, according to CMS officials, because CAP vendors are responsible for collecting coinsurance and deductibles from Medicare beneficiaries once drug administration is verified. Physicians who participate in the program will submit claims for drug administration services to their local carrier within 14 days and provide their vendor with beneficiary supplemental insurance information.

But the program may not offer the relief being advertised, some physicians said.

CAP is likely to be a plus for Medicare because it will allow the agency to reduce costs, but there are still not enough details available about the program to ensure that there won't be adverse consequences for physicians, said Dr. Richard Hellman, president-elect of American Association of Clinical Endocrinologists.

Once physicians sign up, they must obtain all drugs on the CAP drug list from their drug vendor, except in certain cases such as emergency administration, according to CMS. This year there are about 180 drugs on the CAP drug list.

Dr. Hellman said he is concerned that CAP will affect access to medications if it makes it unprofitable for physicians to deliver these services in their offices. "[CMS officials] need to be careful that they do not restrict access in their zeal to cut costs."

Dr. Alfred Denio, a rheumatologist in Norfolk, Va., said CAP could be an alternative in areas where it has not been financially feasible for physicians to purchase infused therapies on their own. However, even going through a CAP vendor, there will be a significant administrative burden, said Dr. Denio, who serves on the American College of Rheumatology's Committee on Rheumatologic Care.

For example, physicians must submit written orders for drugs to the CAP vendor, notify the vendor when a CAP drug is not administered or the full supply was not administered, and maintain a separate electronic or paper inventory for each CAP drug. "That's added cost to the practice that you will not be reimbursed for," he said.

This year CAP will run from July 1 to Dec. 31. Starting in 2007, the program will run year-round. Physicians can opt into the CAP program each year and will be required to stay in the program for a full calendar year.

More information on the CAP program is available online at www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp. ■

Defensive Medicine, Malpractice Consume 10% of Premium Dollars

WASHINGTON — The costs of malpractice insurance and defensive medicine account for about 10 cents of every dollar spent on health care premiums, several speakers said at a press briefing sponsored by America's Health Insurance Plans.

Medical liability and defensive medicine represented the "lion's share" of cost increases in the physician and outpatient areas, Michael Thompson, principal at the New York office of PricewaterhouseCoopers, said at the briefing.

Litigation and defensive medicine also accounted for about a third of the costs associated with poor-quality health care, said Mr. Thompson, noting that the cost of poor-quality care was spread throughout the health care system.

Overall, the rate of increase in health care premiums was 8.8% in 2004-2005, down significantly from 13.7% in 2001-2002, noted Jack Rodgers, managing director at PricewaterhouseCoopers. One factor contributing to the slowdown was a decrease in the rate of cost increases for prescription drugs, according to Mr. Thompson. "It's now trending in line with overall premiums," he said.

Part of the reason for that decrease is employers' increasing use of three-tiered or four-tiered drug programs, in which patients pay a larger share for brand-name drugs, especially if there are generic equivalents. In 2000, only 27% of patients were in drug plans with three or more tiers; in 2004, the figure was 68%, he said.

In addition, cost trends were helped by a drop in the number of state mandates that are being added each year, from 80 in 2000 to less than 40 in 2004, Mr. Thompson said.

Outpatient costs rose significantly last year, Mr. Rodgers said. "Those are the services that are really growing rapidly." The increase in outpatient services accounted for more than a third of the 8.8% increase in premiums, he noted.

Despite these problems, Mr. Thompson said in an interview that he did not expect premium increases to go higher next year. "We're looking at the same number or maybe a little lower," he predicted.

—Joyce Frieden

POLICY & PRACTICE

Thyroid Cancer Record

Thyroid cancer diagnoses are expected to set a new record this year, according to the Thyroid Cancer Survivors' Association. The number of newly diagnosed cases is expected to reach a new record of 30,180, which is 17% higher than last year and nearly 50% higher than 4 years ago, the association said, citing information from the Department of Health and Human Services and the American Cancer Society. Association board chair Gary Bloom of Olney, Md., urged doctors to contribute to early detection of thyroid cancer, one of the few cancers that is increasing in incidence. "Done properly, a neck check can be as simple as touching the neck and watching the patient swallow. This can be done very quickly and won't cause any delays for the medical office, but those few minutes could make all the difference in the world when it comes to thyroid cancer."

Multiple Imaging Pay Cut

Endocrinologists will soon begin feeling the effects of a new Medicare reimbursement policy affecting multiple imaging procedures, according to the Endocrine Society. The policy reduces the payment for the "technical component" of a service when performed on a contiguous body part on the same day and in the same patient. That would include such procedures as dual-energy x-ray absorptiometry scanning or ultrasound on the thyroid, according to the society. Medicare is also capping rates for imaging services that are performed in a physician's office at the same amount as the rates paid to hospital outpatient departments. The portion of the Medicare payment that goes for professional services will not be affected. The provisions are expected to save $3 billion over 5 years, according to the Congressional Budget Office.

ICD-10 Fraud Concerns

The Blue Cross and Blue Shield Association and the Medical Group Management Association are among those objecting to the planned implementation of ICD-10, the newest version of the comprehensive list of diagnostic billing codes used by health care providers. A bill currently being considered in the House would require payers to switch from the current ICD-9 codes to ICD-10 by Oct. 1, 2009. Blue Cross/Blue Shield argues in a statement that the deadline should be pushed back to 2012 "because much has to be done before a switch to ICD-10 can be started … and providers need time to automate their offices and be trained." The Blues are particularly concerned because the switch comes at the same time that Medicare is shrinking the number of its claims processors—many of which are Blues plans—from 50 to 15. At a press briefing, the association released a report by D. McCarty Thornton, former chief counsel to the HHS Inspector General, which found that forcing the switch to occur in 2009 "will not give the contractors who administer the Medicare fee-for-service claims process and payments systems sufficient time to upgrade their antifraud tools. Without additional time to switch to ICD-10, risks are high that improper and fraudulent Medicare claims will increase substantially." The Federation of American Hospitals and several other groups disagree; they argue that the update is overdue.

J-1 Visas for Underserved Areas

J-1 visas remain the primary tool for recruiting physicians to work in underserved areas, according to a report by the Government Accountability Office. The GAO surveyed 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands regarding their waiver requests for fiscal years 2003-2005. States and federal agencies reported requesting more than 1,000 waivers in each of the 3 years, although the number requested varied by state: About one-fourth of states requested the maximum number of 30 visas, while slightly more than a quarter requested 10 or fewer. About 80% of states said the 30-waiver limit was adequate for their needs, the report noted. Nearly half of the states' waiver requests were for physicians to practice primary care exclusively, while about 41% were for specialists, such as anesthesiologists or cardiologists. An additional 7% were for psychiatrists, who have different waiver requirements. One state commented that most communities in the state need physicians trained in family medicine and that few physicians with J-1 visas have that training. Similarly, another state noted a lack of demand among its health care facilities for the types of medical specialties held by physicians seeking waivers, the report said.

Medicare Formulary Guidance

If officials at a Medicare Part D drug plan change the preferred or nonpreferred formulary drugs, remove dosage forms, or exchange therapeutic alternatives, they must allow beneficiaries currently taking the drug to be exempt from the changes for the rest of the year, according to guidance from the Centers for Medicare and Medicaid Services. Abby L. Block, director of the CMS Center for Beneficiary Choices, issued a memo to Part D sponsors in April outlining policies for formulary changes made after a beneficiary has signed on to a plan at the beginning of the plan year. In addition, Part D plans can change therapeutic categories and classes in a formulary only at the beginning of each plan year, except to account for new therapeutic uses or newly approved drugs. CMS also noted that after March 1, Part D drug plans are only allowed to make "maintenance changes" to their formulary, such as replacing a brand-name drug with a new generic drug. All proposed formulary changes, except for expansions, must be submitted to CMS for review and approval, according to the memo.

—Joyce Frieden