Part B Drug Program Put on Hold

BY MARY ELLEN SCHNEIDER
New York Bureau

Medicare officials have pulled the plug at least temporarily on their Competitive Acquisition Program for Part B drugs, including infused biologics.

The program was put on hold because of "contractual issues" with the successful vendor bidders for the 2009 cycle of the program. The Competitive Acquisition Program (CAP) will remain in effect until the end of this year, but after that, physicians who had participated in the program will have to go back to purchasing drugs using the average sales price (ASP) system. CMS has not announced a time line for resuming the program.

The CAP was mandated by Congress under the 2003 Medicare Modernization Act. It was launched in July 2006 to give physicians an alternative to obtaining Part B infusion and injectable drugs through the ASP or "buy and bill" system.

The voluntary program took the purchase of these drugs out the hands of physicians. Those physicians who enrolled no longer took on the financial risk of buying drugs up front and being reimbursed by CMS later. Instead, they received drugs from an approved vendor who was selected by CMS through a competitive bidding process. Under the program, physicians were paid only for the administration of the drug.

BioScrip Inc., an Elmsford, N.Y.–based specialty pharmaceutical health care organization, has been the only approved CAP vendor throughout the history of the program. The company announced over the summer that it would not sign a new contract with CMS for CAP because the terms of the contract presented an "unacceptable short- and long-term profit risk."

For 2008, nearly 5,000 physicians were enrolled in the CAP. The program included more than 200 drugs.

As currently designed, the CAP is "totally untenable," said Dr. Karen Kolba, a solo rheumatologist in Santa Maria, Calif., and a member of the American College of Rheumatology's Committee on Rheumatologic Care. The delay in the program will give CMS some time to consider possible changes that could encourage more participation from rheumatologists, she said.

Dr. Kolba, who has not signed up for CAP, said the biggest problem with the program is the "all-or-nothing" requirement for ordering drugs.

BioScrip Inc., the only approved CAP vendor, will not sign a new contract with CMS because the terms presented an 'unacceptable short- and long-term profit risk.'

Once enrolled, physicians are not allowed to choose what drugs they want to obtain through the CAP. If a drug they administer is available through the vendor, they must get it through the CAP. This is simply impractical for inexpensive, commonly used drugs such as cortisone injections, Dr. Kolba said, because CAP drugs must be ordered for specific patients and administered only to them. "It becomes something of an accounting nightmare," she said.

But Dr. R. Mack Harrell, an endocrinologist in Fort Lauderdale, Fla., said the postponement of the CAP is likely to result in serious access problems for patients.

Many endocrinologists rely on the CAP to obtain expensive injectable drugs like thyrotropin alfa (Thyrogen), a drug that allows physicians to test for recurrence in thyroid cancer without having patients withdraw from their thyroid hormone treatments.

Without the CAP as a source of these drugs, Dr. Harrell said he fears that endocrinologists won't be able to provide these drugs in the office, forcing patients to go off their thyroid hormones for weeks at a time in order to undergo necessary testing.

Between now and the end of the year, physicians who are enrolled in the CAP must obtain drugs from BioScrip if the administration date for the drug is before Dec. 31, 2008. Any drugs that will be administered on or after Jan. 1, 2009, must be obtained through the regular ASP method.

If a physician has unused Part B drugs obtained through the CAP after Dec. 31, 2008, those drugs are considered the property of the vendor and must be purchased through the ASP system or returned to BioScrip. The drugs cannot be given away to the physician by BioScrip.

As physicians return to the ASP method of procuring drugs in 2009, they should keep in mind that they will once again be responsible for collecting deductibles and coinsurance from Medicare beneficiaries and that they should not use the CAP modifiers (J1, J2, J3, M2) when submitting claims.

CMS is also advising physicians to contact BioScrip as soon as possible to minimize the amount of unused drugs and facilitate uninterrupted access to Part B drugs.

While the program is on hold, CMS will be asking physicians to provide feedback on the program. Agency officials are looking for information on the categories of drugs provided through the program, the distribution of areas that are served by the CAP, and any procedural changes that could make the program more flexible and more attractive for vendors and physicians. ■

For more information on the CAP postponement, go to www.cms.hhs.gov/CompetitiveAcquisforBios.

Survey Findings Challenge 'Digital Divide'

HONOLULU — The "digital divide" separating society's haves and have-nots may not be as deep as many fear.

In a study of 120 parents of adolescent patients and the patients themselves, more than 60% of parents and adolescents of low socioeconomic status (SES) from a Boston pediatric practice indicated a willingness to contact physicians via e-mail if given the option, according to Dr. Tarissa Mitchell of Boston Medical Center.

Of the respondents, 66% stated they had access to e-mail and/or computers at home. But only 19% of the parents had their health care provider's e-mail address, and only 3% had ever used e-mail to contact their provider.

Dr. Mitchell and Dr. Shikha G. Anand of the Whittier Street Health Center, Roxbury, Mass., conducted a survey of 120 parents of adolescent patients and the adolescent patients at an urban community health center in Boston over a 4-month period. At the clinic, five pediatric providers serve 3,876 low SES children, of whom 84% are publicly insured and 82% self-identify as black or Hispanic.

Compared with respondents without e-mail at home, those with home e-mail were significantly more willing to contact their physicians: 77% vs. 33%. Respondents who used e-mail more frequently also were significantly more willing to contact their provider this way. For example, among respondents whose e-mail was always on, 89% were willing to e-mail their physicians. This declined to 60% among respondents who used e-mail weekly and to 43% of those who used e-mail monthly or less frequently, the authors wrote in a poster presented at the annual meeting of the Pediatric Academic Societies.

Only 13% of the respondents said they would never use e-mail to communicate with their provider. The most common reason was a desire to telephone the office, but they also cited lack of e-mail access, difficulty with the English language, and concerns over bothering the doctor. Dr. Mitchell and Dr. Anand stated that they had no conflicts of interest.

—Robert Finn

Hospitals Slow to Subsidize Electronic Medical Records

BY MARY ELLEN SCHNEIDER
New York Bureau

The federal government's relaxation of self-referral and antikickback laws has had a "modest" effect in encouraging hospitals to subsidize physician purchases of electronic medical record systems, according to an analysis by the Center for Studying Health System Change.

Some hospitals are proceeding slowly, offering subsidies on electronic medical record (EMR) software to small groups of closely affiliated physicians, while other hospitals are offering only IT support services or extending their vendor discounts, according to the analysis of 24 hospitals. The analysis was funded by the Robert Wood Johnson Foundation.

In 2006, the Health and Human Services Department announced that it had created two safe harbors that would allow hospitals to subsidize up to 85% of the cost of EMR software and IT support services for physicians. For their part, physicians would be responsible for the full cost of the required hardware. The regulations are scheduled to sunset at the end of 2013.

The analysis by the Center for Studying Health System Change, which is based on in-depth interviews with executives at 24 hospitals, found that 11 of the 24 hospitals were considering offering some type of subsidy to physicians to help cover their EMR costs. The remaining 13 hospitals were not planning to provide direct subsidies to physicians, but some were considering extending their EMR vendor discounts or offering IT support services.

Hospitals that chose not to offer direct financial support to physicians had differing reasons. For example, some opposed the idea of offering EMR subsidies to physicians. Others said that granting access to vendor discounts was a sufficient incentive for physicians preparing to adopt EMRs. And other hospitals were interested in providing the financial subsidies directly to physicians but couldn't afford to do so.

For those hospital executives who were considering a direct subsidy to physicians, improving patient care and forging closer relationships with referring physicians were the top reasons cited for moving forward with EMR assistance. "Hospital executives expected physicians would be more likely to maintain, and even expand, their relationship with the hospital because of the improved efficiency from interoperability with the hospital's IT systems," the researchers wrote.

One factor that appears not to be driving the trend toward hospital subsidies is interest on the part of physicians. The arrangement has some potential drawbacks for physicians, according to the analysis.

For example, under the safe harbors physicians are still responsible for 15% of the software costs and 100% of the hardware costs associated with setting up the EMR system. Plus, physicians using the hospital-sponsored EMR may have difficulty storing records for patients who are treated at other hospitals where the physicians provide care for patients. Also, the hospital-sponsored EMR could serve as a barrier if physicians later wanted to switch their hospital affiliations, according to the analysis.

"While hospitals have strategic incentives to provide support, particularly to tie referring physicians to their institution, the effects of the regulatory changes on physician EMR adoption will ultimately depend both on hospitals' willingness to provide support and physicians' acceptance of hospital assistance," Joy M. Grossman, Ph.D., one of the study authors, said in a statement. ■

The study is available online at www.hschange.org/CONTENT/1015.