New Option for Buying Injectables to Start Soon

BY JENNIFER SILVERMAN
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A new Medicare program to start next year will take some of the gamble—and administrative hassles—out of providing injectable drugs to patients.

The arrangement, known as the Medicare Competitive Acquisition Program for Part B Drugs and Biologicals, "provides an important alternative method of drug acquisition for rheumatologists and other physicians for whom the [current] payment methodology is burdensome and, in some cases, does not cover their acquisition costs for drugs," Joseph Flood, M.D., government affairs committee chair of the American College of Rheumatology (ACR), told this newspaper.

Under the current acquisition system, physicians purchase the drugs themselves from a distributor or manufacturer and then bill Medicare for reimbursement, which is set at a statutorily mandated payment rate of 106% of the manufacturer's average sales price (or ASP + 6%). Medicare pays 80% of this rate, and the physician collects a 20% coinsurance payment from the beneficiary.

Given fluctuations in what distributors and manufacturers charge for the drugs, however, in some cases Medicare's reimbursement can fall short of what the drugs actually cost.

Physicians who elect to participate in the competitive acquisition program will obtain drugs from a preselected list of vendors, and these vendors will take on the responsibility of billing Medicare for the drugs and collecting coinsurance or deductibles from patients. At this point, it's not clear how many vendors will be participating in the program, but all will have to meet certain quality, program integrity, financial stability, and service standards.

Once a year, physicians who provide health care for Medicare beneficiaries will have the option of electing to participate in the program and at that point select a vendor to be their primary drug source. All physician participants will continue to submit procedural claims to Medicare for the cost of administering the agents. (For a list of the rheumatology-associated drugs included under the program, see box.)

Having fewer administrative and financial burdens should free doctors "to focus more on providing treatments for their patients," Centers for Medicare and Medicaid Services (CMS) administrator Mark McClellan, M.D., said in a statement.

Taking physicians out of the drug administration's financial chain should help insulate them from price fluctuations that can occur under the current system, a CMS spokeswoman noted in an interview. While it's true that physicians may miss out on profits if acquisition costs from the supplier are less than the average sales price, physicians can also take a hit if the acquisition costs exceed that price, she explained.

Officials at ACR praised the fact that the competitive acquisition program wasn't created exclusively for oncologists. "All physicians participating in Medicare have the opportunity to participate" in this voluntary program, according to a statement from the law firm Patton Boggs L.L.P., the government affairs representative for the ACR.

Physicians who decide not to participate in the new program may continue to purchase drugs directly from the suppliers. "We support our members' right to choose the method of drug acquisition and payment that makes the most sense for their particular practice," Dr. Flood said.

The American Society of Clinical Oncology (ASCO) lobbied for the competitive bidding process to be available for all drugs, "and CMS went pretty far down that road" to meet that request, Joseph S. Bailes, M.D., cochair of the government relations council for ASCO, said in an interview.

One drawback of the program is that for vendors and CMS to have enough time to reconcile claims data—and thus for vendors to get paid—physicians have just 14 days to submit to Medicare carriers procedural claims, including all necessary codes, for the administration of the drugs. That quick turnaround time may prove to be too challenging for some physician practices. Individual providers should seriously consider whether they have the staff resources to meet that deadline before enrolling in the program.

Noting that "14 days was too short a period of time" for practices to process the claims, Dr. Bailes said that ASCO and the ACR tried but failed to convince CMS to extend the deadline to 30 business days.

Another possible wrinkle, Dr. Bailes noted, may occur because vendors can elect not to ship a drug if the patient has not met some of the copay obligations. "This could raise a problem," he said.

Drug distributors themselves don't seem comfortable with the idea of collecting deductibles and coinsurance from the beneficiaries. "Distributors typically do not have direct patient contact," Scott Melville, senior vice president of government relations at the Healthcare Distribution Management Association, a trade group representing full-service drug distributors, wrote in comments on the proposed rule to the new bidding process.

Medicare beneficiaries may have difficulty keeping track of their coinsurance amounts, "and they may not be inclined to pay a vendor with whom they only have an impersonal business relationship," Mr. Melville cautioned.

The trade group did not make any comments directly on the competitive acquisition program.

The interim rule creating the new program took effect in June, although CMS will be seeking additional comments until Sept. 6. The agency plans to receive bids from vendors later this summer and award contracts in early fall, in anticipation of starting the program in 2006. ■

For more information about the competitive acquisition program, go to www.cms.hhs.gov/providers/drugs/compbid.

A Look at the Covered Drugs

More than 180 drugs billed incident to a physician's service and paid for under Part B of Medicare will be part of the competitive acquisition program. These agents account for 85% of all Medicare spending on physician-injectable drugs and include agents commonly administered by rheumatologists, such as:

► Cyclophosphamide (both lyophilized and nonlyophilized).
► Hylan G-F 20 (for intraarticular injection).
► Infliximab (injection).
► Methylprednisolone acetate (injection).
► Methylprednisolone sodium succinate (injection).

The new program will not apply to drugs included in the new prescription drug benefit under Medicare Part D, nor will it apply to drugs that are self-administered by the patient through a device such as a nebulizer or to certain other drugs, such as intravenous immunoglobulin, immunosuppressants, and hemophilia blood-clotting factor.

Interactive Computer Module Benefits Hispanic Patients Most

BY DIANA MAHONEY
New England Bureau

NEW ORLEANS — Spanish-language users of a bilingual interactive computer program in an urgent care clinic reaped the most educational benefit from the system, a study has shown.

The findings suggest that computerized educational modules may be an important tool to help reduce health care disparities among medically underserved populations, Bonnie Leeman-Castillo said in a presentation at the annual meeting of the Society of General Internal Medicine.

During a 4-month period, 296 adults seeking care for acute respiratory tract infections at an urgent care facility in Denver were referred to a free-standing computer that housed an audiovisual education module that provided information in both English and Spanish. The module prompted the patients to provide information about demographics, knowledge and attitudes about antibiotics and acute respiratory infections, reasons for seeking care for their illness, and a symptom inventory.

"The computer then suggested a likely diagnosis based on the patients' symptoms and provided information about how to best treat the illness," said Ms. Leeman-Castillo, a Ph.D. candidate in the Health and Behavioral Science Program at the University of Colorado at Denver.

After using the program, patients were asked to rate their experience with it in terms of complexity, understanding, and perceived usefulness. The main outcome measures, she said, "were whether the patient learned something new about colds and flu and whether they trusted the computer information."

With respect to demographics, 81% of the users were aged 18-44, 59% were female, 54% were Hispanic, 50% had household incomes of less than $10,000, and 16% completed the Spanish-language version of the module.

Patients who answered questions in Spanish were significantly less likely to report prior computer experience and more likely to require help using the system. In terms of ease of use and understanding the computer messages, the differences between those who responded in English and Spanish were small but significant. About 84% of the English-speaking respondents, compared with 71% of those who responded in Spanish, rated the program as easy to use, and 87% of those who answered in English said they understood the information, compared with 81% of the Spanish-speaking group.

After adjustment for patient demographics and computer module qualities, Spanish-language users were significantly more likely to report learning something new from the program and trusting the information, Ms. Leeman-Castillo said.

"Interestingly, we found that prior computer experience was a strong negative predictor of learning something new and trusting the information," suggesting that populations with the least exposure to and experience with interactive computer media may get the most out of such health learning tools, she said.

In general, the interactive module seemed to be well received by patients and effective at disseminating important health information, particularly to populations that may not otherwise be getting important public health information about such things as antibiotic overuse, she noted. However, "our finding that prior computer experience was associated with less learning and trust deserves further exploration," she concluded.

Ms. Leeman-Castillo stated that she had no financial interests or other relationship with the manufacturers of the commercial products or suppliers of the commercial services relative to the health-information module. ■