Part B Insider (Multispecialty) Coding Alert

Drug Acquisition: Dealing With CAP Vendors May Be More Trouble Than It's Worth

CMS refuses to recognize program's administrative burden

The **Centers for Medicare and Medicaid Services** is doing its best to make the Competitive Acquisition Program (CAP) for Part B drugs attractive to physicians, but many practices say it won't be worth the hassle of dealing with private vendors.

"I'm still not convinced that a lot of people are going to sign up for the CAP," says **Sam Shepard**, director of health policy with the **American Association of Clinical Urologists.** Even with rock-bottom drug payments, it's hard to see any incentives to join the program. But Shepard welcomes the omission of leuprolide, because he believes urologists would be better off obtaining it directly.

"There's too much at risk with the patients" to sign up for the CAP, says **Carolyn Davis,** director of reimbursement with **Oncology Hematology West** in Papillion, NE. If the patient has a reaction or isn't responding to a drug, and you need to change the treatment plan completely, it would be a nightmare changing the treatment plan with the CAP vendor. "There would be a lot of rescheduling the patient."

"I'm sorry, you're cut off"

In the new interim final rule, CMS states that if a patient is unable to pay his or her copayment and can't obtain assistance from a charitable foundation, "then the vendor can cut off chemotherapy for the patient. I think that is reprehensible," says Albuquerque, NM oncologist **Barbara McAneny**. This policy could deny potentially life-saving medications to patients. It also shows more concern for the profitability of vendors than for physicians who've struggled with bad debt.

The vendor may make the decision to cut a patient off, but "I have to be the person who tells the patient, 'I'm sorry, you're cut off. You have to die now,'" says McAneny.

It's unclear from the 457-page regulation who pays if a physician has to send an unused or defective dose of medication back to the vendor. CMS states at one point that the vendor owns the drug until the physician administers it, and advises physicians to call the vendor and ask what to do with the unused medication. Like many other parts of the regulation, McAneny says this will be an administrative nightmare.

Practices that choose to sign up for the CAP program should expect to hire at least one extra person to deal with the bureaucracy at the vendors, McAneny advises. Meanwhile, you'll still be buying drugs directly to bill private insurers, so you'll still have all the old storage and administrative concerns. And even with CAP drugs, you'll have to store them for up to seven days and provide tons of information to the vendor, note experts.

"A number of physicians have commented that this was going to be an added administrative burden, and CMS dismissed it as really not an issue," complains **Ted Okon**, executive director of the **Community Oncology Alliance**.

Physicians urged CMS to "beta test" the CAP with a demonstration program, but the agency says the law calls on it to implement the program by January 2006. The interim final rule includes financial and quality standards for nationwide CAP vendors to ensure that only reputable companies participate. Vendors will have to provide at least one drug per HCPCS code.

The regulation includes an emergency process by which physicians can obtain a drug if they need to provide it right away to a particular patient, either because they received a defective dose or because there's no time to order a drug for a patient in an emergency situation.

If the CAP vendor is shipping a patient's entire course of treatment at once, the vendor will be able to split it into multiple shipments, despite some physicians' concerns that this could delay the arrival of part of the treatment. CMS will require the vendor to ship drugs so they arrive at least two days before the physician expects to administer them.