White House Announces Health IT Grants

BY JOYCE FRIEDEN

The White House is trying to get health care workers ready to help physicians in computerizing their medical records.

Nearly $1 billion in American Reinvestment and Recovery Act awards will be made to help health care providers become "meaningful users" of health information technology and to train nurses and other allied health professionals for careers in health information technology. Jobs created will include nurses, pharmacy technicians, and IT technicians and trainers, according to Health and Human Services Secretary Kathleen Sebelius and Labor Secretary Hilda Solis. "These investments will serve to train almost 50,000 workers in Department of Labor programs plus thousands more hired for HHS regional extension centers in the months ahead," Jared Bernstein, chief economist to Vice President Joe Biden, said in a teleconference. "By providing seed capital, we are helping to seed an emerging industry that will create new jobs well after the Recovery Act has ended."

Under the HITECH (Health Information Technology for Economic and Clinical Health) Act, physicians who treat Medicare patients can receive up to $44,000 over 5 years for the meaningful use of a certified health information system. Those whose populations are made up of at least 30% Medicaid patients can earn up to $64,000 in incentive payments for their use of the technology.

The awards, announced Feb. 12, include more than $750 million in HHS grants. Of that, $386 million will go to 40 states and their designated entities to help develop state-level health information exchanges (HIE), and another $375 million will be awarded to 32 nonprofit organizations to support the development of regional extension centers (REC), which will aid providers in using health information technology. Additional HIE and REC awards will be announced soon, according to a statement.

The grants will make it easier for physicians who are just getting started with electronic health records, Ms. Sebelius told this publication. "The people who will be trained by the grants … will actually provide the kind of hands-on technical support we think providers need to make this transition. It's not just that the act gives physicians financial incentives to buy a computer and plug it in; we understand the steps along the way of reorganizing workflow and retraining staff that are going to require hands-on support. So the money going out is to establish an on-the-ground program for that kind of personal technical assistance and help."

Ms. Sebelius noted that the grants target smaller providers.

In December, HHS issued a proposed regulation defining "meaningful use" and explaining how providers can meet criteria for being meaningful users. In response to a question about physician concerns that the regulation is too complex, Dr. David Blumenthal, national coordinator for health information technology, noted that the regulations are only a proposal at this point.

"We are anxious to hear what physicians have to say about it and the ways in which they feel it needs to be changed," he told this publication. "I can certainly identify [with physicians], because as an internist, I had to go through the process of learning how to use an electronic health record, and I know it's not easy, but we're going to be providing support nationwide—the kind of support doctors have never had before." ■

For more information, see www.hhs.gov/news/press/2010pres/02/20100212a.html and edocket.access.gpo.gov/2010/pdf/E9-31217.pdf.

States Pick Up the Slack on Cancer Care Reform Issues

BY JANE SALODOF MACNEIL

SCOTTSDALE, ARIZ. — Health care reform may be stalled on Capitol Hill, but states are stepping up to tackle some areas of concern, cancer care advocates said at the annual Community Oncology Conference.

Two key issues gaining traction in state legislatures are parity in payment for oral and intravenous cancer drugs, and a requirement for payers to cover supportive care for patients in clinical trials. In addition, some states are looking for models of what they can do if Congress fails to enact comprehensive reform, experts said at the conference, which was sponsored by the journal Community Oncology. "The momentum toward the states' doing something is increasing," said Shelagh Foster, government relations director at the American Society of Clinical Oncology.

"We are going to see more of the states taking control of health care reform. … The state reps are a little closer to the people because they are the people. They are concerned; they hear about it more," agreed John F. Akscin, vice president for government relations at McKesson Specialty Care Solutions of La Vergne, Tenn.

Parity in Payments for Oncolytics

The Community Oncology Alliance lists five states (Hawaii, Indiana, Iowa, Oregon, and Vermont) as requiring payers to cover oral cancer drugs at the same level as intravenous chemotherapy drugs.

Last September, the California legislature passed a parity law (SB 161) that was vetoed by Gov. Arnold Schwarzenegger, noted Mary Kruczynski, director of policy analysis at COA. In his veto message, the governor noted that the bill "limits a plan's ability to control both the appropriateness of the care and the cost by requiring [insurers] to immediately cover every medication as soon as it receives federal approval … placing them at a severe disadvantage when negotiating prices with drug manufacturers."

In addition, parity measures are under consideration in at least a dozen more states. "Parity bills—they are going to spring up all over the place," said COA Executive Director Ted A. Okon.

At issue are higher copayments that many insurers require of patients for oral drugs, which tend to be newer and substantially more expensive than intravenous drugs. COA looked at 11 widely used, oral oncology drugs and how they are covered by leading insurers, Ms. Kruczynski said. Three were covered by Medicare Part B; the rest by Medicare Part D. All but one was placed in formulary tiers that require patient copayments as high as 25%-35%. "All had roadblocks, time on the phone to get them approved. All had quantity limits," she said. "Some had step plans. … To be sure [that the patient] needs that infusible antiemetic, he needs to throw up for 3 days first."

As part of a project assessing the impact of these policies on cancer care, COA analyzed a database containing information on 5 million prescriptions issued to 500,000 patients from January 2007 to June 2009. It found that 21% of claims for oral oncolytics were rejected and 9% were "reversed," she said. A reversed claim is one that is approved by the payer and filled by the pharmacy, but not picked up by the patient. The study followed patients for several months after the reversals, she said. Many patients did pick up medicines for heart disease, diabetes, and anxiety. "So we knew they were still alive," she said. "They were making a conscious decision, or their hand was forced, not to take lifesaving medication."

When made public, the full parity study will include best practices gleaned from interviews with physicians, nurses, patients, pharmacists, pharmacy benefit managers, medical directors, and staff of copayment assistance foundations that help patients who cannot afford cancer drugs, Ms. Kruczynski added.

Oral cancer drugs are a growing issue, according to Dr. Justin P. Favaro of Oncology Specialists of Charlotte (N.C.), who chaired the study. He counted 34 oral

With oral cancer drugs, both the high financial burden and the responsibility for compliance shift to patients.

DR. FAVARO

drugs—some off label—that were being used in cancer treatment, and estimated that 25% of new drugs in the pipeline are oral agents. As virtually all are still under patent, prices are high and "all over the map," Dr. Favaro said, citing the multiple myeloma drug lenalidomide (Revlimid) as a widely used example. The average cost is $74,000 per year, he said; after looking at two different Medicare part D programs, he estimated the average cost to patients to be $8,300 per year. In addition, Revlimid takes a lot of time to prescribe, he said, with a utilization management program for providers, mandatory counseling for patients, extensive paperwork to be filled out, and distribution restricted to specialty pharmacies.

Although easier to administer than in-office infusions, oral drugs pose many challenges, he said. More of the financial burden is being shifted to patients, as payers try to figure out how to cover the higher prices of these drugs. Responsibility for compliance also shifts to patients, as they are expected to take their medications at home and call their oncologists if they are experiencing side effects. And practices must have staff to take those phone calls and manage those side effects.

One of the strategies is having an in-office pharmacy, which helps community oncologists to make sure that their patients are receiving the prescribed oral drugs, and to find assistance if a patient can't afford them. A challenge, however, is that some state laws bar pharmacies in medical practices.

Access to Clinical Trials

Another issue being addressed first by the states is making sure payers cover routine patient care for patients in clinical trials. Typically, trials pay for the cost of a patient's medications, but they do not pick up other expenses that are routine to cancer care. Without such laws or regulations, some payers refuse to cover supportive care, even though they save substantially on medication costs for patients in trials. "I think misconceptions about clinical trials are prevalent both with payers and with federal policy makers," Ms. Foster said.

Federal Action Expected

Although the speakers agreed that health reform was stalled in Washington, the consensus was that something would pass. "The issues being discussed before [Republican Sen. Scott Brown's] election in Massachusetts are not going away. … The prospects for health reform in some small fashion are good; in large fashion, they are going to be very, very difficult," Ms. Foster said. Moreover, reforms will come about through regulatory changes regardless of Congressional action, according to Mr. Okon. ■

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