POLICY & PRACTICE

Bill Seeks Increased IVIG Pay

Legislation seeking to increase reimbursement for intravenous immunoglobulin (IVIG) has been introduced in the U.S. House of Representatives. Patient groups and IVIG manufacturers have said that Medicare's current coverage is so low that many physicians have stopped administering the therapy. A survey by the Immune Deficiency Foundation found that since January 2005, almost half of surveyed Medicare beneficiaries with primary immunodeficiency diseases had their treatments postponed by a physician, and 26% had serious health consequences because of the delays. The bill (H.R. 2914) would increase payment for IVIG and for ancillary services. It would also maintain the preadministration fee that physicians have been receiving and provide management fees for home IVIG infusion. H.R. 2914 was introduced by Rep. Kevin Brady (R-Tex.) and, as of press time, had 19 cosponsors, but no companion legislation in the Senate.

CMS Considers PET Coverage

Officials at the Centers for Medicare and Medicaid Services are considering whether to provide Medicare coverage for positron emission tomography (PET) for the diagnosis of chronic osteomyelitis, infections associated with hip arthroplasty, and fever of unknown origin. The agency opened its review of the issue at the end of June after receiving a national coverage decision request from Dr. Javad Parvizi, an orthopedic surgeon at Thomas Jefferson University, and Dr. Abass Alavi, a professor of radiology at the University of Pennsylvania, both in Philadelphia. A decision is expected in March. In a letter to CMS, Dr. Parvizi and Dr. Alavi argued that PET is more sensitive and specific for detecting infection and inflammation than are conventional imaging techniques. The combined use of PET and CT would allow physicians to determine the precise location of sites of infection and inflammation, they wrote. The request letter also included specific clinical criteria to limit overutilization.

Within Our Reach Grants

The American College of Rheumatology Research and Education Foundation recently awarded 15 grants to fund innovative research in rheumatology. The awards are the results of a new fundraising campaign that aims to raise $30 million to fund rheumatoid arthritis research that is not normally supported by the National Institutes of Health or other peer-reviewed funding sources. Since 2006, the "Within Our Reach" program has raised about $17.9 million from the pharmaceutical industry, biotech companies, physicians, and patients. The grants, which began in July, cover the areas of innovative basic research, translational research, and clinical practice. Each of the 15 recipients will be funded for 2 years at $200,000 per year. More information on the grant awards is available at www.withinourreach.info.

CMS Releases Medicaid Rule

CMS has unveiled a new method of setting limits on what the federal government will reimburse state Medicaid agencies for prescription drug payments. As part of the new regulation, states will be required to collect information from physicians about prescription drugs administered in their offices so that the state can collect any rebates offered by drug manufacturers on those products. The final rule will take effect Oct. 1. The regulation is expected to save states and the federal government $8.4 billion over the next 5 years. The change is in part a reaction to a series of reports showing that Medicaid payments to pharmacies for generic drugs were much higher than what pharmacies actually were paying for the drugs. Pharmacies, the reports showed, made the most profit on those generic drugs with the highest markup, creating an incentive to dispense those drugs.

Americans Buy Drugs Overseas

More than 5 million Americans adults, or more than 2% of the U.S. population, have recently purchased prescription drugs from another country, such as Canada or Mexico, according to a survey by the Pharmaceutical Research and Manufacturers of America. The vast majority of consumer importers said they were looking for the best price for medicines, but about half decided to buy their drugs in another country because they didn't have a physician's prescription for the drugs they wanted, the survey found. Importers were more likely to be younger than age 35 years, to be Hispanic, to live in a southern border state, and to spend more out-of-pocket money on prescription drugs than do nonimporters, PhRMA reported. Most of the drugs imported were to treat chronic ailments. PhRMA President and CEO Billy Tauzin said in a statement that importation increases a patient's risk of being exposed to "dangerous counterfeit medicines."

HHS Expands Vaccine Capacity

The Department of Health and Human Services has awarded two contracts to expand the domestic influenza vaccine manufacturing capacity that could be used in the event of a potential influenza pandemic. The 5-year contracts were awarded to Sanofi Pasteur Inc. ($77.4 million) and MedImmune Inc. ($55.1 million). The contracts provide funding for the renovation of manufacturing facilities and for manufacturing operations for 2 years, with options for an additional 3 years of operations. Upon completion, these facilities will expand domestic pandemic vaccine manufacturing capacity by 16%, according to HHS. In addition, the facilities will expand vaccine availability for the national stockpile.

—Mary Ellen Schneider

Moratorium on Marketing Halts Fee-for-Service Plans

BY MARY ELLEN SCHNEIDER
New York Bureau

Several Medicare Advantage fee-for-service plan sponsors will voluntarily suspend marketing their plans until officials at the Centers for Medicare and Medicaid Services can verify compliance with certain management controls.

The moratorium is part of an effort to halt deceptive marketing in the private fee-for-service Medicare market.

"While most agents and brokers are helpful and responsible in describing and explaining choices to beneficiaries, there are a few bad actors," Abby Block, director of the Center for Beneficiary Choices at the CMS, said during a press briefing. "This voluntary agreement demonstrates that the plans are stepping up to ensure that deceptive marketing practices end and that beneficiaries fully understand what they are purchasing."

From last December through April, CMS officials received about 2,700 complaints from beneficiaries regarding Medicare Advantage plans. Many of those complaints related to private fee-for-service plans. Ms. Block pointed out the 2,700 complaints are a small fraction of the 1.3 million Medicare beneficiaries enrolled in such plans.

Problems range from agents encouraging the misperception that private plans are just like Medicare and are accepted by all providers who accept Medicare, to cases in which agents told beneficiaries they are still enrolled in Medicare and are purchasing a Medigap supplemental insurance policy.

The private fee-for-service Medicare plans that agreed to suspend marketing are United Healthcare, Humana, WellCare, Universal American Financial Corporation (Pyramid), Coventry, Sterling, and Blue Cross Blue Shield of Tennessee. They account for about 90% of enrollment in private fee-for-service plans, said the CMS.

The plans were not singled out because of problems with their marketing practices. The concern is with rogue brokers and agents with whom these and other organizations may contract, she said.

The moratorium does not apply to enrollment and does not affect the employer market, where CMS has not received complaints of issues with marketing tactics. It will be lifted on a plan-by-plan basis when the CMS certifies a plan has management controls in place that meet conditions spelled out by the agency earlier this year. For example, plan sponsors must show all of their advertising, marketing, and enrollment materials and include model disclaimer language provided by the CMS that private fee-for-service Medicare plans are not the same as Medicare or Medigap and not all providers will accept the plan. All representatives selling products will have to pass a written test demonstrating familiarity with Medicare and fee-for-service plans. Plans must also provide a list of individuals who are marketing the plan upon request by the CMS or state agencies.

The CMS will be monitoring all private fee-for-service plans to ensure that they are not engaging in deceptive marketing practices. ■

Medicare Part D Authorization Hassles Still Plague Physicians

BY MARY ELLEN SCHNEIDER
New York Bureau

SAN DIEGO — In the second year of Medicare Part D, physicians still struggle with prior authorization requests and other hassles, Dr. Kay M. Mitchell said at the annual meeting of the American College of Physicians.

For example, physicians still see requests for prior authorization and step therapy, said Neil M. Kirschner, Ph.D., ACP's senior associate of insurer and regulatory affairs. In addition, in 2007, several drugs were approved under both Medicare Part B and Part D, which could create denials, he said.

Officials at the Centers for Medicare and Medicaid Services recommend that physicians write the diagnosis and "Part D" on the prescription, Dr. Kirschner said.

Physicians might experience some relief in terms of prior authorization and exceptions if their patients haven't changed drug plans, said Dr. Mitchell, a geriatrician and a professor in the department of community internal medicine at the Mayo Clinic in Jacksonville, Fla. CMS officials said prior authorizations and exceptions approved by a drug plan in 2006 are expected to continue this year if the beneficiary is in the same plan and the expiration date hasn't occurred by Dec. 31, 2006. However, if the beneficiary changes plans, physicians might have to go through the same process again. And even if patients remain in the same plan, some physicians have still received prior authorization requests, she said. When faced with prior authorization, have the patient collect the authorization forms and bring them into the office, said Dr. Mitchell.

Some physicians have decided to deal with the extra Part D paperwork by hiring additional staff or designating staff to deal solely with Part D prior authorizations, denials, and appeals, Dr. Mitchell said. Dr. Mitchell prefers to have one of her nurses work on Part D issues because the nurse is already familiar with the patients and their medications. She also recommended staff members working on Part D issues attend continuing medical education meetings that focus on Part D.

Dr. Mitchell said that insurers may ask for documentation justifying a switch in medications. To simplify that process, she recommends, keep a sheet in the front of the chart with information on medication changes and the reasons for the switch. ■