

Drug Discount Program Offers Lessons for CMS

BY JOYCE FRIEDEN

Associate Editor, Practice Trends

The experience of the drug discount card program that Medicare beneficiaries participated in prior to the launch of the Medicare drug benefit offers some lessons for the Centers for Medicare and Medicaid Services, the Government Accountability Office said in two reports.

In its first report, the GAO said that al-

though the Centers for Medicare and Medicaid Services (CMS) had identified and corrected some problems with the entities that sponsored the drug cards, it also "had some limitations with respect to the timeliness of oversight activities and the guidance provided to sponsors."

For instance, the report noted, "CMS finalized guidance on how drug card sponsors should report data on price concessions from manufacturers and pharmacies in November 2004, about 5

months after the program began. According to CMS, as of August 2005, the overall quality of that data remained questionable, with problems such as outliers and missing data."

The report also noted that a CMS contractor requested two preenrollment information packets from six drug card sponsors.

"All the packets were noncompliant with program requirements," the report said. "Most packets were missing materi-

als required by CMS and some materials had not been previously approved for distribution by the CMS contractor. The contractor never received several requested packets." CMS told the GAO that it had worked with the sponsors to resolve the problems.

For its part, CMS said in a letter to the GAO that the report "did not paint a full picture of the depth and breadth of the actual monitoring and oversight activities." Dr. Mark B. McClellan, CMS administrator, acknowledged that with the discount card program, "we have learned many valuable lessons that will inform our future efforts as we plan for the drug benefit in 2006."

The second report looked at CMS's beneficiary and outreach education efforts for the discount card program. In general, the GAO found that "CMS's efforts did not consistently provide information that was clear, accurate, and accessible, and they collectively fell short of conveying program features." The report did add, however, that the GAO got this impression by looking at assessments that CMS has done on its own programs, and "these assessments acknowledge the actions taken by CMS to address some of these problems."

Beneficiary confusion about the discount card program was a particular problem, the report said. In spite of CMS's outreach efforts, "beneficiaries confused the drug card with the 2006 prescription drug benefit, and some beneficiaries did not enroll because they were under the impression that Medicare would be sending them a card. Furthermore, the concept of a private drug card sponsor was difficult for many beneficiaries to understand."

Beneficiaries also were confused about eligibility, the report said. CMS's own research found that some beneficiaries might not have enrolled because they thought they were not eligible for the discount cards. "Specifically, many beneficiaries incorrectly thought that the drug card was only for low-income people, and those who likely qualified for the \$600 in transitional assistance did not believe they qualified for it, even after having the income criteria explained to them," the report noted.

In response to the second report, Dr. McClellan said that it, like the first report, did not address the "full picture of the depth and breadth of the actual activities undertaken." Dr. McClellan said that the number of education and outreach activities was "unprecedented for a program of limited duration."

As he had done in the first report, Dr. McClellan said that the lessons learned from this portion of the discount card program would be applied to the drug benefit.

But he also added, "From a public service perspective, the most important question about the drug discount card is whether the program provided discounts and access to prescription drugs for any beneficiary who wanted help. The answer is yes, immediately." ■

The reports are available at www.gao.gov.



ENCYSIVE™
PHARMACEUTICALS

levels are at least partly associated with impaired ET_B receptor-mediated clearance.¹³ Furthermore, the long-term administration of a selective ET_B receptor antagonist was found to have unfavorable effects on vascular remodeling.⁴ This is in sharp contrast to the benefits of selective ET_A antagonism.¹⁴

THE DIFFERENCE LIES IN ET_A SELECTIVITY

Vasoconstriction, cellular proliferation, and vascular remodeling are the hallmarks of PAH.¹² Studies have demonstrated that selective ET_A antagonists play a pivotal role in the regulation of ET-1 levels in PAH and have been beneficial for vascular remodeling.^{4,7,13}

ET-1 AND RECEPTOR-MEDIATED ACTIVITIES

Highly selective ET_A blockade maintains ET-1 clearance, NO and PGI₂ levels, and reduces or maintains circulating ET-1 levels, resulting in vasodilation, increased blood flow, and repair of remodeled vasculature compared to less selective agents.^{5-7,14} (See Figures 1,2)

HOW SELECTIVE TO ET_A SHOULD TREATMENT BE?

The more selective, the better. One should always be aware of the varying degrees of selectivity, as they equate to differences in blockade of the ET_A and ET_B receptors and resulting levels of ET-1.^{8,15,16} Figure 3 illustrates the difference between a less selective agent and highly selective agents. These in vitro selectivity ratios demonstrate the stark differences in ET_A selectivity. Figure 4 depicts how agents with low selectivity of the ET_A receptor (<2400) increase ET-1 levels whereas highly selective ET_A receptor (>2400) antagonists have been shown to

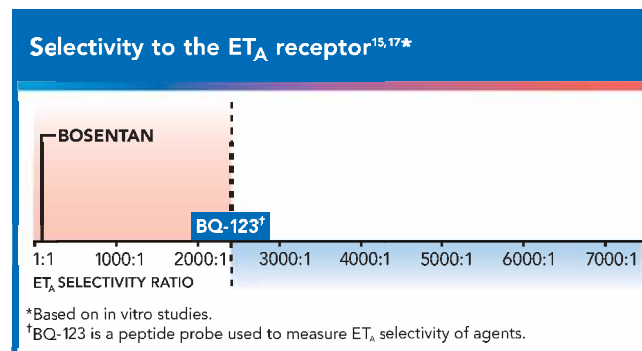


Figure 3

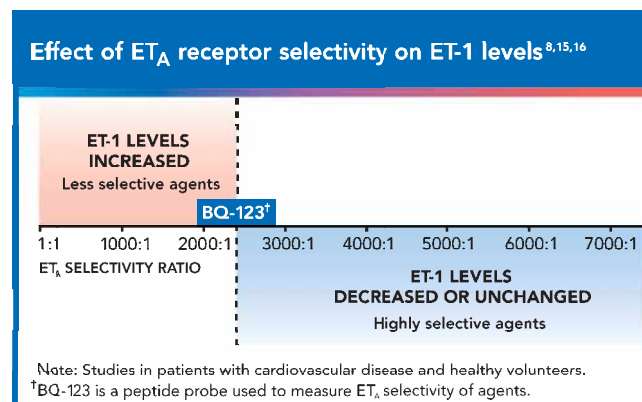


Figure 4

decrease ET-1 levels or leave them unchanged.^{6,8,15} The benefits of ET_A selectivity are being recognized.

TOWARD BETTER OUTCOMES IN PAH

Currently, there are no highly selective ET_A antagonists available for the treatment of PAH. In vivo studies have shown that highly selective ET_A antagonism may lead to better overall outcomes.^{7,8,12}

References: 1. Rubens C, Ewert R, Halank M, et al. Big endothelin-1 and endothelin-1 plasma levels are correlated with the severity of primary pulmonary hypertension. *Chest*. 2001;120:1562-1569. 2. Lüscher TF, Yang Z, Tschudi M, et al. Interaction between endothelin-1 and endothelin-derived relaxing factor in human arteries and veins. *Circ Res*. 1990;66:1088-1094. 3. Yanagisawa M, Kurihara H, Kimura S, et al. A novel potent vasoconstrictor peptide produced by vascular endothelial cells. *Nature*. 1988;332:411-415. 4. Murakoshi N, Miyauchi T, Kakinuma Y, et al. Vascular endothelin-B receptor system in vivo plays a favorable inhibitory role in vascular remodeling after injury revealed by endothelin-B receptor-knockout mice. *Circulation*. 2002;106:1991-1998. 5. Peacock AJ, Rubin LJ, eds. *Pulmonary Circulation: Diseases and Their Treatment*. 2nd ed. London: Arnold; 2004. 6. Fukuroda T, Fujikawa T, Ozaki S, Ishikawa K, Yano M, Nishikibe M. Clearance of circulating endothelin-1 by ET_B receptors in rats. *Biochem Biophys Res Commun*. 1994;199:1461-1465. 7. Verhaar MC, Strachan FE, Newby DE, et al. Endothelin-A receptor antagonist-mediated vasodilation is attenuated by inhibition of nitric oxide synthesis and by endothelin-B receptor blockade. *Circulation*. 1998;97:752-756. 8. Halcox PJ, Nour KRA, Zalos G, Quyyumi AA. Coronary vasodilation and improvement in endothelial dysfunction with endothelin ET_A receptor blockade. *Circ Res*. 2001;89:969-976. 9. Giaid A, Yanagisawa M, Langleben D, et al. Expression of endothelin-1 in the lungs of patients with pulmonary hypertension. *N Engl J Med*. 1993;328:1732-1739. 10. Hankins SR, Horn EM. Current management of patients with pulmonary hypertension and right ventricular insufficiency. *Curr Cardiol Rep*. 2000;2:244-251. 11. Spieker LE, Noll G, Ruschitzka FT, Lüscher TF. Endothelin receptor antagonists in congestive heart failure: a new therapeutic principle for the future? *J Am Coll Cardiol*. 2001;37:1493-1505. 12. Jeffery TK, Wanstall JC. Pulmonary vascular remodeling: a target for therapeutic intervention in pulmonary hypertension. *Pharmacol Ther*. 2001;92:1-20. 13. Lüscher TF, Barton M. Endothelins and endothelin receptor antagonists: therapeutic considerations for a novel class of cardiovascular drugs. *Circulation*. 2000;102:2434-2440. 14. Chen SJ, Chen YF, Oppenorth TJ, et al. The orally active nonpeptide endothelin A-receptor antagonist A-127722 prevents and reverses hypoxia-induced pulmonary hypertension and pulmonary vascular remodeling in Sprague-Dawley rats. *J Cardiovasc Pharmacol*. 1997;29:713-725. 15. Ihara M, Noguchi K, Saeki T, et al. Biological profiles of highly potent novel endothelin antagonists selective for the ET_A receptor. *Life Sci*. 1992;50:247-255. 16. Williamson DJ, Wallman LL, Jones R, et al. Hemodynamic effects of bosentan, an endothelin receptor antagonist, in patients with pulmonary hypertension. *Circulation*. 2000;102:411-418. 17. Clozel M, Breu V, Gray GA, et al. Pharmacological characterization of bosentan, a new potent orally active nonpeptide endothelin receptor antagonist. *J Pharmacol Exp Ther*. 1994;270:228-235.