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## Dual enrollment at Aetna should spike with national presence; plan adds 28 states for 2007

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Aetna, which we profiled in an interview with its national medical director Randall Krakauer on October 4, is on the map, so to speak, in Part D. The insurer is qualified to receive dual eligibles in 28 new states in 2007, for a total of 36 plus the District of Columbia, reports **Betsey Sell**, Aetna's communications officer (for a list of states in which Aetna is qualified to receive duals, turn to p. 2).

Aetna becomes a more important player for access and, given its forward-looking medical management approach (see the October 4

MRAW). The plan is a good fit for pharmaceutical companies that can demonstrate that their products can generate savings and quality. Two of Aetna's plans will offer open formularies in 2007, compared to just one in 2006. In addition, it will now offer a \$0 copay for generic drugs in most individual plans. "We are enhancing our 2007 formulary with the addition of a number of brand name drugs, including Nexium, Vytorin and Crestor," Sell said. "These will be listed as preferred brand drugs on both our open and closed formularies." 

## Cost over quality: Where does your therapy fall?

*Several losers as ASP intersects with carrier cost policy*

If Congress' intent behind the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) was to take the financial decision out of drug and biologic product selection at the point of care, then why are drugs losing access from quarter to quarter if they aren't the least costly alternatives available to physicians under Medicare Part B?

A reimbursement department can act in one of the following two ways:

1. Use a Band-Aid approach by helping your small physician customers understand how to use advance beneficiary notices (ABN) to cover their costs
2. Take a policy stance by communicating the access and quality risks to Medicare's Payment Advisory Council (MedPAC).

Always choose option number two. MedPAC

is conducting a study that addresses MMA reforms on beneficiary access and quality of care for several specialties, and a November 8 meeting could put the spotlight on Part B products—particularly those in crowded categories affected by the government's least costly alternative policy.

### BACKGROUND

During its most recent meeting, MedPAC came out against pharmaceutical price bundling (e.g., when a manufacturer offers a purchaser a pair of drugs with a discount on the second drug.) MedPAC said bundle pricing drives physicians to select drug therapy based on economic factors, not clinical ones.

The advisory group may now apply this thinking to a Part B policy that could hurt patient access to a range of therapies. Intended to be a fix for the average wholesale > p. 2

### Live audiconference: December 14

"DRA Enforcement: State laws, pricing guidelines, and compliance best practices." For faculty/agenda information, go to [www.hcmarketplace.com/prod-4886.html](http://www.hcmarketplace.com/prod-4886.html).

### Survey snapshot

#### Aetna dual eligibles

Aetna is eligible to receive dual eligibles in the following Medicare regions/states:

- 1 (ME/NH)
- 4 (NJ)
- 5 (DC/DE/MD)
- 6 (PA/WV)
- 7 (VA)
- 8 (NC)
- 9 (SC)
- 10 (GA)
- 12 (AL/TN)
- 14 (OH)
- 15 (IN/KY)
- 16 (WI)
- 17 (IL)
- 19 (AR)
- 20 (MS)
- 22 (TX)
- 23 (OK)
- 24 (KS)
- 25 (IA/MN/MT/ND/NE/SD/WY)
- 27 (CO)
- 30 (OR/WA)
- 31 (ID/UT)
- 34 (AK)

If you missed our interview with Aetna national medical director Randall Krakauer, e-mail [bcote@hcpro.com](mailto:bcote@hcpro.com) for a copy.

### Cost over quality

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price-based reimbursement system, the least costly alternative rule potentially limits Medicare reimbursement.

Take for example Cahaba, a Medicare carrier: Let's say it sets its reimbursement policy for quarter one 2007 for all prostate cancer products. The maximum allowable physician payment in this class is \$50 for an administration of the drug ViaDerm, which in quarter one is the least-costly alternative.


Higher average sales price (ASP) drugs in this category will likely lose out in that quarter. The lowest priced drug in a category often changes from quarter to quarter, so physicians are forced in many instances to switch patients every three months to the cheaper drug. The other options are risky:

- Give the patient the higher priced drug and eat the cost
- Give the patient an ABN, forcing him or her to pay a higher portion of the bill

Eighty-four percent of 141 physicians whom

we polled last week said they choose the least costly alternative in more than half of cases because, some said, the ABN process is not always fair, and “we can't afford to cover the costs.”

Several urology societies, including the American Association of Clinical Urologists (AACU), suggest that Medicare eliminate the policy, according to a joint letter dated October 26 from the Urology Society of America and other groups. Some patients may be able to pay the difference through the ABN process, but was this the MMA authors' intent when they enacted the law?

Doesn't this create a system of “haves” and “have nots?” Switching some therapies during a regimen may not be a clinical problem, but switching modes of administration could be, says Dr. Edgar Fairchild, a retired urologist from New Haven, CT. Drugs administered through the stomach, through the backside, or implanted take an emotional toll on the patient. 

#### Exclusive analysis for HCPro

### HCPCS coding decisions affect product planning

*Editor's note: In this article, the second of a two-part series, Howard Tag of Tag & Associates, Inc., examines CMS' recent coding decisions and their effect on new product access.*

Attention product teams: In a Medicare reimbursement group decision in October, an intravenous immune globulin (IVIG) with clinically significant differences in concentration, osmolarity, pH, and salt/sugar

composition was not determined to be different enough from other IVIGs to warrant a new code. The work group—which has the ability to close the door to access to a new drug, biologic, or device—said that no insurer identified a national need to give this product its own code.

Obtaining appropriately descriptive Healthcare Common Procedures Coding System (HCPCS) codes for biologicals and [> p. 3](#)

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## Coding decisions


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some devices continues to be a greater challenge than obtaining codes for drugs. Payers almost never differentiate among drugs, biologicals, and certain devices that act as drugs when developing coverage and payment policies. But CMS' HCPCS work group does differentiate among them, and understanding how it does this is an important part of new product planning. Product teams seeking a code for a new drug have two advantages over biologicals and devices:

**1. Longer deadlines.** Drug coding applications can be filed in advance of the drug receiving Food and Drug Administration (FDA) approval. The application will be considered complete if an FDA approval letter is submitted by March 31, 2007, even though all other information must be submitted by January 3, 2007 (for the 2008 coding cycle). Drugs are granted a waiver from filing three months of marketing data. To be considered for a code effective January 1, 2008, a drug can be FDA approved as late as March 30, 2007, but a biological/device must be on the market no later than October 1, 2006. Go to [www.cms.hhs.gov/MedHCPCSGenInfo/](http://www.cms.hhs.gov/MedHCPCSGenInfo/)

[01a Application Form and Instructions.asp#TopOfPage](#) for details.

**2. Product differentiation.** New HCPCS codes are created only if the new product "performs a significantly different function" or "operates differently and evidences a "significant therapeutic distinction" from currently coded products (see [www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/decisiontree.pdf](http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/decisiontree.pdf)). Your new drug would meet CMS guidelines if it is a new chemical entity, even if a currently coded product is a complete therapeutic alternative. But for biologicals and devices, the difference must be more pronounced (see the box below to understand the effect of CMS' decisions on your new products).

New biologicals and devices with similar processes, dosage forms, and administration modes will not qualify for new codes unless they can demonstrate significantly better clinical outcomes. Drugs, on the other hand, need only be new chemical entities to receive a new code and have at least a six-month advantage in the time between their launch and when they receive a new code. 

### Product access thwarted

- An immune globulin labeled for subcutaneous rather than IV administration was not found to be different enough to earn a new code.
- A recombinant blood-clotting factor that is plasma- and albumin-free was not found to be different, because the application did not establish a significant clinical benefit when compared with other recombinant products.
- Applications from several hyaluronate manufacturers for their injected osteoarthritis treatments to be differentially coded were rejected because none demonstrated different clinical outcomes from the others. CMS opted to keep the existing codes, which distinguish natural hyaluronans from hyaluronan-derived products


## Reporter's notebook

### Center for comparative effectiveness assessments proposed

The United States should establish a center for comparative effectiveness information to better address coverage and spending decisions, former Medicare administrator **Gail Wilensky**, a senior fellow at Project HOPE in Bethesda, MD, says in an article published yesterday on the Health Affairs Web site. The center would not make centralized coverage decisions; rather, it would "provide an independent assessment of the comparative effectiveness of alternative therapies and procedures," for use by payers, patients, and providers. "Since drug spending accounts for only about \$0.10 of each healthcare dollar, the potential payoff for better decision-making is even greater in other areas of healthcare, particularly medical procedures," Wilensky says.

## MCOs to focus on home health as evidence emerges

Home health reimbursement will rise under a Deficit Reduction Act demonstration set to begin next year that gives states incentives to move patients out of institutionalized care and into home care settings. The government pays for about two-thirds of home care today, with 40% of that from Medicare. Private insurance represents only about 12.5%

of the total. Couple that with better coverage of remote monitoring devices for the millions of U.S. residents with chronic diseases (e.g., heart failure, diabetes, and mental illness). Use of home-monitoring devices will result in more effective use of drugs, fewer and shorter hospital stays, and longer stretches between routine visits to providers' offices. 

### PRIMARY DIAGNOSIS OF HOME HEALTH USERS, TOP 10 CONDITIONS

Admissions diagnosis	All discharges	Percent
Circulatory system diseases	1,775,900	22.4
Heart disease	999,100	12.5
Injury and poisoning	974,400	12.5
Neoplasms	948,200	8.6
Malignant neoplasms	923,000	8.3
Musculoskeletal system/connective tissue diseases	629,200	8.1
Respiratory system diseases	639,200	8.0
Symptoms, signs, and ill-defined conditions	578,000	7.4
Endocrine, nutritional, metabolic diseases, immunity disorders	456,200	5.8
Diabetes mellitus	333,400	4.3

Source: 1996 National Home Care Survey, National Center for Health Statistics.

## OH Medicaid: Wellpoint, Buckeye, Centene featured

Health maintenance organization (HMO) Buckeye Health is one of seven plans that will manage healthcare for Medicaid aged, blind, and disabled recipients in one or more of the state's eight regions. As of September 30, Buckeye served 88,300 recipients under Ohio's Medicaid Covered Families and Children Program. Centene Corp. is also expected to win a contract, according to the Ohio Department of Job and Family Services. Centene operates plans in Georgia, Indiana, Kansas, Missouri, New Jersey, Ohio, Texas, and Wisconsin. Meanwhile, Wellpoint's Part D business is "not more than a half-dozen percentage points" of its busi-

ness, according to a company source, but Wellpoint is a crucial player in healthcare today given its traction at the state level. In Ohio, Wellpoint's Blue Cross Blue Shield Partnership Plan may obtain a contract to provide healthcare benefits to the state's aged, blind, and disabled population. This represents the fifth award in four months for WellPoint State Sponsored Business, Anthem's Medicaid-dedicated business unit. The contract covers six geographic regions throughout Ohio with 95,000 eligible recipients. Implementation is planned to begin in December. Anthem is one of three managed care plans per region. 