

Medicare and ESAs: feedback from the community

A random sampling of community practitioners and what they are saying about Medicare's policy on reimbursement for erythropoiesis-stimulating agents

Since we implemented Medicare's national coverage decision [NCD] guidelines that will be applied to our Medicare patients only, our usage of erythropoiesis-stimulating agents [ESAs] has dropped by 30%. Currently, we have two sets of standards: one for Medicare patients and one for non-Medicare patients. I don't think we are doing justice to our Medicare patients. It appears that the academic institutions can risk not getting paid until there is a definite determination, but we can't.

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We have tweaked our Aranesp guidelines based on the NCD; we aren't starting the drug until a patient's hemoglobin level is less than 10 g/dL. Although the local coverage determination has not come out yet, we are still dosing to hemoglobin levels of 12 g/dL before holding. We are doing this for Medicare and non-Medicare patients alike. We've based our practice on clinically published data, ASCO [American Society of Clinical Oncology] and ASH [American Society of Hematology] guidelines, as well as good common sense. I don't think we will ever have two standards—that is, one pathway for Medicare patients and another pathway for others.

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Patients deserve to have fixable problems fixed so that they can be at their best functional level. Transfusion independence is only one goal of ESAs. That's important, of course, but so is a patient's ability to function and live free of symptoms such as dyspnea and fatigue.

We are treating Medicare patients based on the CMS [Centers for Medicare & Medicaid Services] guidelines, but we are not treating other patients based on these guidelines because we have not been pressured by insurers to do so.

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I am not convinced more people will be transfused, since we typically transfuse people below 8 g/dL and, based on my clinical experience, even the CMS guidelines allow you to treat below 10 g/dL. I do believe that there are patients who benefit from a hemoglobin level between 11 g/dL and 12 g/dL who are not able to get ESAs. My interpretation of the new guidelines from ASH and ASCO is that they don't want ESAs started unless the hemoglobin is approaching or less than

10 g/dL, with the exception of certain comorbidities or functional compromise. The NCCN has a higher cutoff based on individual characteristics and patient symptoms when the hemoglobin level is 10 g/dL to 11 g/dL. Clearly, there are patients who benefit from the use of ESAs when the level is over 10 g/dL. These are patients with symptoms, other comorbidities, or whose hemoglobin trend is downward. I think the ASH/ASCO proposal is a little restrictive. The studies where there have been problems have had higher target hemoglobin or patients without anemia who were being treated. Provided we keep the hemoglobin at 12 g/dL or less, I think the risks are minimized. We must be judicious in the use of these agents. I do think the ESA decision by Medicare will be changed. The question is when.

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Recently, I met with staffers on the House Ways & Means Committee. They admitted that the logic employed by CMS is this: "If patients don't require a transfusion at 10 g/dL, then why do they require ESAs above 10 g/dL?" It seems that they are trying to equate apples and oranges. There is no clinical evidence that supports their contention that a hemoglobin level of 10 g/dL is okay. But that doesn't seem to sway them.

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