

Ask the Experts

In this and future issues of *MPM*, we ask a panel of experts to comment on a pressing issue of the day. Let us know if you have suggestions regarding experts you would like to hear from or questions you would like to see addressed.

Despite its benefit, what are the barriers preventing appropriate treatment of anemia in elderly CKD patients?



Todd H. Goldberg, MD, CMD, FACP
Associate Professor and Director of Geriatrics
WVU Health Sciences Center Charleston Division and Charleston Area Medical Center
Medical Director, Edgewood Summit, Charleston WV

In geriatric care settings (outpatient, assisted living, long-term care), provision of erythropoiesis-stimulating agents (ESAs) (epoetin alfa and darbepoetin alfa) can be problematic because of economic/reimbursement factors, knowledge gaps on the part of physicians and other providers, and uncertainties regarding the risks and benefits. These agents are expensive, and cost and insurance coverage may be barriers to administration in outpatient or nursing home settings. As with many injectables, patients seldom are willing or able to self-administer. Medicare and other insurance coverage is limited in outpatient primary care settings. Nursing homes under skilled Medicare Part A will generally prefer to avoid the expense of administering ESAs, which must be paid for out of prospective fixed reimbursement. Patients and geriatric care providers may thus prefer to defer decisions and treatment to oncology or nephrology providers.

It's also not always clear nowadays when treatment is appropriate or helpful or even safe. Although often treatable with nutritional supple-

mentation and ESA injections, anemia in elderly people is often due to multifactorial or unspecified chronic conditions, including myelodysplasia, that may not be responsive to treatment. Although anemia has many adverse consequences, and ESA treatment has been shown to increase hemoglobin and quality of life and reduce transfusion requirements, unfortunately morbidity and mortality may not be decreased and in fact may be increased, according to some recent literature. Thus current guidelines from Medicare, the National Kidney Foundation, and the Hematology Society urge more judicious use of these agents than in the past. Anemia should not be treated with ESAs when the hemoglobin is greater than 10. Treatment response and levels should be closely monitored, and treatment should be reduced or discontinued if the hemoglobin level rises too rapidly or above 12.

Geriatric care providers should keep in mind that these agents are only FDA approved for anemia of kidney failure and cancer chemotherapy, not for other causes of chronic anemia. Further, new black box warnings cite increased mortality, serious cardiovascular and thromboembolic events, and tumor progression. Thus economic and scientific barriers have been set up quite appropriately against inappropriate and excessive use of ESA agents. In patients admitted to geriatric care settings already on these agents, treatment should be reconsidered and perhaps discontinued at least while hemoglobin levels and patient history are being reevaluated. ESA treatment should be discouraged unless the patient is severely symptomatic or needing transfusions.



Richard G. Stefanacci, DO, MGH, MBA, AGSE, CMD
Founding Executive Director, Health Policy Institute, University of the Sciences in Philadelphia
Editor-in-Chief, Medicare Patient Management

Knowledge is critical in eliminating barriers to successful treatments for CKD patients with anemia. Treating anemia successfully requires not only making the correct diagnosis and choosing the appropriate treatment, but also going one ad-

ditional step to ensure access to that treatment for your patients. This is especially critical with regard to the erythropoietin (EPO) products because of the cost associated with some of the standard treatments. By lowering patients' out-of-pocket expenditures, you can help ensure patient access to these important treatment options.

To help patients, physicians must be health-insurance literate, knowing how different Medicare plans cover the EPO products. For example, Medicare Part A places the responsibility of medications on the provider. In a nursing home setting, this means that the nursing facility is responsible for the medications utilized during the Medicare Part A stay—the skilled stay. Medicare Part B covers medications that are provided “incident to” a physician service—including injectables provided by a

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physician in the office or during dialysis treatments. Managed care is the coverage provided under Medicare Part C. These managed care plans are responsible for all of the benefits available under Medicare Parts A and B through one organization.

The newest program of Medicare, introduced January 1, 2008, is Medicare Part D coverage of most medications provided within a long-term care facility. This is because the Medicare Part D program has replaced Medicaid drug coverage of those drugs covered under Medicare Part D for the dually eligible (those with Medicare and Medicaid). Unfortunately the criteria used by these prescription plans in choosing to cover products such as EPO is not based on a standard. Instead each plan has the right to determine coverage criteria. In addition to individualized plan criteria, each plan is responsible for its own prior authorization and appeals and exceptions process to gain access to these important medications. Obviously, understanding the basic rules of coverage and how to work this system is vital for ensuring access to the EPO products for patients suffering from anemia of CKD.

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