MedPAC Looks at Smaller Cuts to Avoid SGR Cliff

BY FRANCES CORREA

FROM A MEETING OF THE MEDICARE PAYMENT ADVISORY COMMISSION

WASHINGTON – To avoid a nearly 30% physician pay cut Jan. 1, Congress should instead adopt a 10-year plan that freezes primary care pay and cuts specialist pay by 5.9% three years in a row. That's according to a proposal presented by staffers.

While such a solution is expensive – with a $200 billion price tag – it reduces the estimated cost of replacing the current Sustainable Growth Rate (SGR) formula by $100 billion, according to the MedPAC staff presentation.

In formulating their proposal, MedPAC staffers sought to address four key concerns:

► To cut the link between Medicare fee schedule updates and cumulative spending called for by the SGR.

► To replace the SGR with a predictable 10-year system of fee updates.

► Halt the nearly 30% pay cut on Jan. 1.

► Balance the cost of reform with maintaining access to care.

The proposal would result in a 2% annual increase in federal spending per Medicare beneficiary, but is budget neutral based on a number of possible savings identified.

For example, the proposal outlines $235 billion in possible savings from pharmaceuticals ($75 billion), post-acute care ($49 billion), beneficiaries ($33 billion), hospitals ($26 billion), labs ($21 billion), Medicare Advantage ($12 billion), and durable medical equipment ($14 billion).

While specialists bear more of the costs, they also rely on a higher percentage of Medicare patients and will likely benefit from the expected steady increase in beneficiaries in the market, according to the proposal.

Response to the proposal was swift and vehement.

Cuts to specialists will ultimately mean cutting access to gynecologists, who often serve a dual role providing both specialty and primary care, said Dr. Lisa Hollier, chair of the Texas district of the American Congress of Obstetricians and Gynecologists.

With further cuts, we could "see a decrease in the ability to provide care to an increasing population of elderly women," Dr. Hollier said in an interview. She added that any physician pay reform proposal should emphasize new measures for rewarding quality and efficiency over volume. "I think we need to not look simply at cutting but rather a redesign of the entire system."

Other specialty groups had similar arguments.

"This proposal simply devalues the expertise and critical care that specialists provide to Medicare patients and will further restrict access to care for them," Dr. Alex Valadka said in a statement. Dr. Valadka is a neurosurgeon from Austin, Tex., and spokesperson for the Alliance of Specialty Medicine.

"There comes a point where if you keep cutting specialists' reimbursements, we can't maintain our practice, keep our doors open, and employ staff," Dr. Valadka added. "The end result of that means we can't properly take care of our most vulnerable patients."

The American Medical Association

called the proposal "misguided."

"The new cuts are inconsistent with MedPAC's previous recommendations to stop cuts to physicians who care for Medicare patients, because they threaten access to care for patients and would have severe consequences for the Medicare system," AMA President Peter Carmel said in a statement.

"Drastic cuts pose a very real risk to physicians' ability to retain staff, care for Medicare patients, and make the investments needed to modernize their practices and participate in care delivery models intended to improve quality while reducing costs in the Medicare system," Dr. Carmel said.

MedPAC commissioners will consider the report and finalize the commission's recommendations at its October meeting.

Regardless of whether Congress adopts this proposal, the current system must be addressed, MedPAC Chairman Glenn Hackbarth said at the meeting.

"If large Medicare savings are used for other purposes … and SGR is not addressed, we could end up with long-term destabilization," Mr. Hackbarth said. ■

from the pooled dataset. The most common treatment-emergent adverse reactions (≥ 2% of users) were: headache/migraine (5.9%), menstrual irregularities (including vaginal hemorrhage [primarily spotting], metrorrhagia and menorrhagia) (4.1%), nausea/vomiting (3.5%), and breast pain/tenderness (3.2%).

PMDD Clinical Trials

Safety data from trials for the indication of PMDD are reported separately due to differences in study design and setting in the OC, Acne and Folate Supplementation studies as compared to the PMDD clinical program.

Common treatment-emergent adverse reactions (≥ 2% of users) were: menstrual irregularities (including vaginal hemorrhage [primarily spotting] and metrorrhagia) (24.9%), nausea (15.8%), headache (13.0%), breast tenderness (10.5%), fatigue (4.2%), irritability (2.8%), decreased libido (2.8%), increased weight (2.5%), and affect lability (2.1%).

Adverse Reactions (≥1%) Leading to Study Discontinuation:

Contraception Clinical Trials

Of 1,056 women, 6.6% discontinued from the clinical trials due to an adverse reaction; the most frequent adverse reactions leading to discontinuation were headache/migraine (1.6%) and nausea/vomiting (1.0%).

Acne Clinical Trials

Of 536 women, 5.4% discontinued from the clinical trials due to an adverse reaction; the most frequent adverse reaction leading to discontinuation was menstrual irregularities (including menometrorrhagia, menorrhagia, metrorrhagia and vaginal hemorrhage) (2.2%) .

Folate Clinical Trial

Of 285 women, 4.6% who used Beyaz or YAZ discontinued from the clinical trials due to an adverse reaction; no reaction leading to discontinuation occurred in ≥ 1% of women.

PMDD Clinical Trials

Of 285 women, 11.6% discontinued from the clinical trials due to an adverse reaction; the most frequent adverse reactions leading to discontinuation were: nausea/vomiting (4.6%), menstrual irregularity (including vaginal hemorrhage, menorrhagia, menstrual disorder, menstruation irregular and metrorrhagia) (4.2%), fatigue (1.8%), breast tenderness (1.4%), depression (1.4%), headache (1.1%), and irritability (1.1%).

Serious Adverse Reactions (Definitely, Probably, or Possibly Related to Study Drug):

Contraception Clinical Trials: migraine and cervical dysplasia

Acne Clinical Trials: none reported in the clinical trials

Folate Supplementation Clinical Trial: cervix carcinoma stage 0

PMDD Clinical Trials: cervical dysplasia

6.2 Postmarketing Experience

The following adverse reactions have been identified during post approval use of YAZ. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Adverse reactions are grouped into System Organ Classes, and ordered by frequency.

Vascular disorders: Venous and arterial thromboembolic events (including pulmonary emboli, deep vein thrombosis, cerebral thrombosis, retinal thrombosis, myocardial infarction and stroke), hypertension (including hypertensive crisis)

Hepatobiliary disorders: Gallbladder disease, liver function disturbances, liver tumors

Immune system disorders: Hypersensitivity (including anaphylactic reaction)

Metabolism and nutrition disorders: Hyperkalemia, hypertriglyceridemia, changes in glucose tolerance or effect on peripheral insulin resistance (including diabetes mellitus)

Skin and subcutaneous tissue disorders: Chloasma, angioedema, erythema nodosum, erythema multiforme

Gastrointestinal disorders: Inflammatory bowel disease

Musculoskeletal and connective tissue disorders: Systemic lupus erythematosus

7 DRUG INTERACTIONS

Consult the labeling of all concurrently-used drugs to obtain further information about interactions with hormonal contraceptives or the potential for enzyme alterations.

7.1 Effects of Other Drugs on Combined Hormonal Contraceptives

Substances diminishing the efficacy of COCs: Drugs or herbal products that induce certain enzymes, including CYP3A4, may decrease the effectiveness of COCs or increase breakthrough bleeding. Some drugs or herbal products that may decrease the effectiveness of hormonal contraceptives include phenytoin, barbiturates, carbamazepine, bosentan, felbamate, griseofulvin, oxcarbazepine, rifampicin, topiramate and products containing St. John's wort. Interactions between oral contraceptives and other drugs may lead to breakthrough bleeding and/or contraceptive failure. Counsel women to use an alternative method of contraception or a back-up method when enzyme inducers are used with COCs, and to continue back-up contraception for 28 days after discontinuing the enzyme inducer to ensure contraceptive reliability.

Substances increasing the plasma levels of COCs: Co-administration of atorvastatin and certain COCs containing EE increase AUC values for EE by approximately 20%. Ascorbic acid and acetaminophen may increase plasma EE levels, possibly by inhibition of conjugation. CYP3A4 inhibitors such as itraconazole or ketoconazole may increase plasma hormone levels.

HIV Protease Inhibitors and non-nucleoside reverse transcriptase inhibitors: Significant changes (increase or decrease) in the plasma levels of estrogen and progestin have been noted in some cases of co-administration with HIV protease inhibitors or with non-nucleoside reverse transcriptase inhibitors.

Antibiotics: There have been reports of pregnancy while taking hormonal contraceptives and antibiotics, but clinical pharmacokinetic studies have not shown consistent effects of antibiotics on plasma concentrations of synthetic steroids.

Effect on DRSP: The main metabolites of DRSP in human plasma are generated without involvement of the cytochrome P450 system. Inhibitors of this enzyme system are therefore unlikely to influence the metabolism of DRSP.

7.2 Effects of Combined Oral Contraceptives on Other Drugs

COCs containing EE may inhibit the metabolism of other compounds. COCs have been shown to significantly decrease plasma concentrations of lamotrigine, likely due to induction of lamotrigine glucuronidation. This may reduce seizure control; therefore, dosage adjustments of lamotrigine may be necessary. Consult the labeling of the concurrently-used drug to obtain further information about interactions with COCs or the potential for enzyme alterations.

In vitro and clinical studies did not indicate an inhibitory potential of DRSP towards human CYP450 enzymes at clinically relevant concentrations *[see Clinical Pharmacology (12.3)*].

7.3 Interactions that Have the Potential to Increase Serum Potassium

There is a potential for an increase in serum potassium in women taking Beyaz with other drugs that may increase serum potassium [*see Warnings and Precautions (5.2) and Clinical Pharmacology (12.3)].*

7.4 Effects of Folates on Other Drugs

Folates may modify the pharmacokinetics or pharmacodynamics of certain antifolate drugs, e.g., antiepileptics (such as phenytoin), methotrexate or pyrimethamine, and may result in a decreased pharmacological effect of the antifolate drug.

7.5 Effects of Other Drugs on Folates

Several drugs have been reported to reduce folate levels by inhibition of the dihydrofolate reductase enzyme (e.g., methotrexate and sulfasalazine) or by reducing folate absorption (e.g., cholestyramine), or via unknown mechanisms (e.g., antiepileptics such as carbamazepine, phenytoin, phenobarbital, primidone and valproic acid).

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

There is little or no increased risk of birth defects in women who inadvertently use COCs during early pregnancy. Epidemiologic studies and meta-analyses have not found an increased risk of genital or non-genital birth defects (including cardiac anomalies and limb-reduction defects) following exposure to low dose COCs prior to conception or during early pregnancy.

The administration of COCs to induce withdrawal bleeding should not be used as a test for pregnancy. COCs should not be used during pregnancy to treat threatened or habitual abortion.

Women who do not breastfeed may start COCs no earlier than four weeks postpartum.

8.3 Nursing Mothers

When possible, advise the nursing mother to use other forms of contraception until she has weaned her child. Estrogen-containing OCs can reduce milk production in breastfeeding mothers. This is less likely to occur once breastfeeding is well-established; however, it can occur at any time in some women. Small amounts of oral contraceptive steroids and/or metabolites are present in breast milk.

After oral administration of 3 mg DRSP/0.03 mg EE tablets (Yasmin), about 0.02% of the DRSP dose was excreted into the breast milk of postpartum women within 24 hours. This results in a maximal daily dose of about 0.003 mg DRSP in an infant.

Studies to date indicate there is no adverse effect of folate on nursing infants.

8.4 Pediatric Use

Safety and efficacy of Beyaz has been established in women of reproductive age. Safety and efficacy are expected to be the same for postpubertal adolescents under the age of 18 and for users 18 years and older. Use of this product before menarche is not indicated.

8.5 Geriatric Use

Beyaz has not been studied in postmenopausal women and is not indicated in this population.

8.6 Patients with Renal Impairment

Beyaz is contraindicated in patients with renal impairment *[see Contraindications (4) and Warnings and Precautions (5.2)]*.

Following administration of DRSP 3 mg daily for 14 days, serum DRSP levels in subjects with mild renal impairment (creatinine clearance CLcr, 50-80 mL/min) were comparable to those in subjects with normal renal function (CLcr, >80 mL/min). The serum DRSP levels were on average 37 % higher in subjects with moderate renal impairment (CLcr, 30 - 50 mL/min) compared to those with normal renal function. DRSP treatment did not show any clinically significant effect on serum potassium concentration. Although hyperkalemia was not observed in the study, in five of the seven subjects who continued use of potassium sparing drugs during the study, mean serum potassium levels increased by up to 0.33 mEq/L. Therefore, potential exists for hyperkalemia to occur in subjects with renal impairment whose serum potassium is in the upper reference range, and who are concomitantly using potassium sparing drugs *[see Clinical Pharmacology (12.3)]*.

8.7 Patients with Hepatic Impairment

Beyaz is contraindicated in patients with hepatic disease *[see Contraindications (4) and Warnings and Precautions (5.4)]*. The mean exposure to DRSP in women with moderate liver impairment is approximately three times higher than the exposure in women with normal liver function. Beyaz has not been studied in women with severe hepatic impairment.

10 OVERDOSAGE

There have been no reports of serious ill effects from overdose, including ingestion by children. Overdosage may cause withdrawal bleeding in females and nausea.

DRSP however, is a spironolactone analogue which has antimineralocorticoid properties. Serum concentration of potassium and sodium, and evidence of metabolic acidosis, should be monitored in cases of overdose.

Levomefolate calcium doses of 17 mg/day (37-fold higher than the levomefolate calcium dose of Beyaz) were well tolerated after long-term treatment up to 12 weeks.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

In a 24 month oral carcinogenicity study in mice dosed with 10 mg/kg/day DRSP alone or 1 + 0.01, 3 + 0.03 and 10 + 0.1 mg/kg/day of DRSP and EE, 0.1 to 2 times the exposure (AUC of DRSP) of women taking a contraceptive dose, there was an increase in carcinomas of the harderian gland in the group that received the high dose of DRSP alone. In a similar study in rats given 10 mg/kg/day DRSP alone or 0.3 + 0.003, 3 + 0.03 and 10 + 0.1 mg/kg/day DRSP and EE, 0.8 to 10 times the exposure of women taking a contraceptive dose, there was an increased incidence of benign and malignant adrenal gland pheochromocytomas in the group receiving the high dose of DRSP. Mutagenesis studies for DRSP were conducted *in vivo* and *in vitro* and no evidence of mutagenic activity was observed.

Long-term animal studies have not been conducted to evaluate the carcinogenic potential of levomefolate. Mutagenesis studies for levomefolate were conducted *in vitro* and *in vivo* and no evidence of mutagenic activity was observed.

17 PATIENT COUNSELING INFORMATION

[See FDA-approved Patient Labeling.]

- Counsel patients that cigarette smoking increases the risk of serious cardiovascular events from COC use, and that women who are over 35 years old and smoke should not use COCs.
- Counsel patients that Beyaz does not protect against HIV-infection (AIDS) and other sexually transmitted diseases.
- Counsel patients on Warnings and Precautions associated with COCs.
- Counsel patients that Beyaz contains DRSP. Drospirenone may increase potassium. Patients should be advised to inform their healthcare provider if they have kidney, liver or adrenal disease because the use of Beyaz in the presence of these conditions could cause serious heart and health problems. They should also inform their healthcare provider if they are currently on daily, long-term treatment (NSAIDs, potassium-sparing diuretics, potassium supplementation, ACE inhibitors, angiotensin-II receptor antagonists, heparin or aldosterone antagonists) for a chronic condition.
- Beyaz is not indicated during pregnancy. If pregnancy is planned or occurs during treatment with Beyaz, further intake must be stopped. However, women should be advised on the continued need of sufficient folate intake.
- Counsel patients to take one tablet daily by mouth at the same time every day. Instruct patients what to do in the event pills are missed. *See "What to Do if You Miss Pills" section in* ***FDA-Approved Patient Labeling***.
- Counsel patients to use a back-up or alternative method of contraception when enzyme inducers are used with COCs.
- Counsel patients who are breastfeeding or who desire to breastfeed that COCs may reduce breast milk production. This is less likely to occur if breastfeeding is well established.
- Counsel any patient who starts COCs postpartum and who have not yet had a period, to use an additional method of contraception until she has taken a pink tablet for 7 consecutive days.
- Counsel patients that amenorrhea may occur. Rule out pregnancy in the event of amenorrhea in two or more consecutive cycles.
- Counsel patients to report whether they are taking folate supplements. Beyaz contains the equivalent of 0.4 mg (400 mcg) of folic acid.
- Counsel patients to maintain folate supplementation if they discontinue Beyaz due to pregnancy.

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