

# policy impact

CSL Behring Public Policy Newsletter  
Winter 2008

## CSL Behring Launches Local Empowerment for Advocacy Development (LEAD) Program



*CSL Behring partners with local patient organizations to help empower those impacted by a particular issue.*

The Local Empowerment for Advocacy Development (LEAD) Program is a novel program that will allow CSL Behring to partner with local patient organizations in the pursuit of advocacy initiatives. CSL Behring believes that successful advocacy results from the empowerment of those that are impacted by the issue being addressed. Many public policies that affect the users of blood plasma and recombinant therapies are now typically being developed at both the state and federal level; therefore, local organizations need to develop the capability to address this pressing need.

CSL Behring recognizes that many local patient advocacy organizations wish to expand their advocacy capabilities in order to address both present and future needs. CSL Behring's LEAD Program will assist both local and national organizations in the development of their advocacy capabilities.

The LEAD Program has two specific initiatives:

- LEAD Grants
- Raise Your Voice!

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### CSL Behring Public Affairs

*CSL Behring is committed to educating decision-makers and impacting public policies that affect patient access to care. The company has an active public affairs group in the United States including Dennis Jackman, Sr. Vice President for Public Affairs; Patrick Collins, Sr. Manager Public Affairs; and Kim Isenberg, Manager State Government Affairs. All three have extensive public policy backgrounds and work closely with affected stakeholders and political thought leaders to affect change. Please contact them with any questions regarding public policy issues.*

### LEAD Grants

LEAD Grants will help promote and develop advocacy on the local and state level. The grants are intended to be \$10,000 each and would assist in furthering existing advocacy efforts, developing new initiatives, building grassroots databases, or supporting other advocacy initiatives.

In February 2008, CSL Behring will announce and circulate requests for proposals for LEAD Grants. Additional information on the grants and proposal requests may be obtained at [www.cslbehring.com/leadgrants](http://www.cslbehring.com/leadgrants).

### Raise Your Voice!

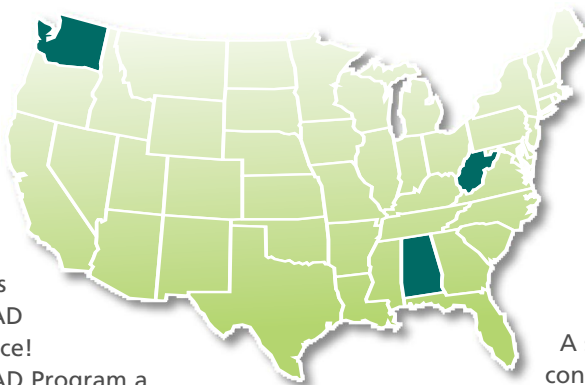
Raise Your Voice! is a youth advocacy training program, administered in collaboration with local patient organizations and sponsored by CSL Behring. The training program will serve as an introduction to advocacy for youth, aged 16 to 23 years, and will be held at a state capitol or in Washington, DC. CSL Behring will partner with state advocacy organizations to develop training programs, schedule legislative visits and provide interesting political speakers.

Raise Your Voice! will assist in the development of the next generation of advocacy leaders for local organizations. By funding, organizing and structuring the initial program, CSL Behring will help local organizations create a program construct, which can be easily replicated in the future.

As advocacy becomes a core strategy for patient organizations, securing adequate funding becomes more challenging. CSL Behring wants to help and continues to explore new and creative opportunities for partnerships. Both LEAD Grants and Raise Your Voice! make the CSL Behring LEAD Program a dedicated resource for patient advocacy.

The LEAD Program is the latest initiative in CSL Behring's continued commitment to patient advocacy. This commitment includes support at both the state and national level in pursuit of securing patient access to care.

*patrick.collins@cslbehring.com*



## Three States Preserve Access to Care

Access to plasma therapies was secured in Alabama, Washington and West Virginia in the second half of 2007:

- Alabama instituted rules for establishing Hemophilia Standards of Care and implemented a reimbursement methodology to reflect Medicare Part B rates.
- Washington and West Virginia adjusted reimbursement for Alpha<sub>1</sub>-Proteinase Inhibitor that would preserve access to care.

### Alabama Medicaid Establishes Standards of Care for Blood Clotting Factors

As rising health care costs impact state budgets, leaders often seek restrictive measures to contain health care expenditures. People living with bleeding disorders face the very real threat of restrictions to access of their life saving therapies.

The bleeding disorders community in Alabama was confronted with such a threat in November 2006 when the Director of Pharmacy issued a letter to hemophilia providers announcing "a change to reimbursement for factor replacement therapies based upon Public Health Service (PHS) rates." This proposed reimbursement structure would prevent providers without access to PHS pricing from serving their patients enrolled in the state Medicaid program. A coalition of concerned stakeholders quickly came together to confront this threat. Not only did the stakeholders meet the challenge, they turned the threat into an opportunity to achieve two very important victories for people living with bleeding disorders enrolled in Alabama Medicaid.

A successful joint effort was undertaken in conjunction with the National Hemophilia Foundation (NHF), the Hemophilia Federation of America (HFA), local and national homecare providers and the industry trade association (PPTA) to convince Alabama

Medicaid to reverse the decision to move to a PHS-based reimbursement. This effort included letters, meetings with the state Pharmacy Director and outreach to the regional office for the Centers for Medicare and Medicaid Services. This partnership expressed concern that the proposed reimbursement methodology could jeopardize patient access to their life saving therapies.

In January 2007 the agency reversed its decision concerning PHS style reimbursement rates. The agency continued to seek input from the coalition partners while it worked to identify a reimbursement methodology that would meet the needs of Medicaid recipients with bleeding disorders. As a result of those discussions, the agency implemented a reimbursement methodology based upon Medicare Part B pricing, which includes a \$0.16 furnishing fee on top of a volume weighted Average Sales Price plus 6% for the class of blood clotting factor. This new formula should allow all providers to continue making blood clotting factor available for Medicaid beneficiaries.

While advocating for adequate reimbursement, the coalition partners worked to educate the Pharmacy Director about the unique needs of people living with bleeding disorders and in doing so were also able to convince the agency to adopt standards to ensure access and quality of care through state regulations. The Standards of Care legislation in Pennsylvania and Minnesota for which CSL Behring has been partnering with patient organizations served as a model during those discussions, as did similar legislation already enacted into law in New Jersey.

Patients, industry and providers came together in 2007 to ensure adequate reimbursement and access to clotting factor therapies and services. Through this collaboration, a model has been developed for communities to work together to protect patient access to all therapies and services.

#### **Alpha<sub>1</sub> Access Improved in Washington and West Virginia**

CSL Behring has been focused on efforts in the states to ensure access to all brands of Alpha<sub>1</sub>-proteinase inhibitor. For example, in Washington and West Virginia, specific outreach was conducted with the Medicaid Pharmacy Services divisions to address concerns that each state's

reimbursement methodology was inappropriately applied to Alpha<sub>1</sub>-proteinase inhibitor therapies.

Both states were reimbursing pharmacies at the generic rate rather than the appropriate single source (brand/innovator drug) rate. This practice negatively impacted patient access because providers are unable to obtain adequate reimbursement for all brands of therapy. Both Washington and West Virginia have corrected and updated their price lists.

The West Virginia Director of Pharmacy Services has declared that providers "may reverse and resubmit any claims paid in error for up to one year from date of service."

*kim.isenberg@cslbehring.com*



## **Congress Approves Limited Medicare Bill**

*Delays Physician Reimbursement Cuts; No Action on IVIg Reimbursement or Medigap Access for Disabled*

In one of the last acts of their 2007 session, Congress passed Medicare legislation that delayed pending cuts to Medicare physician reimbursement.

Due to major differences of opinion between the Democratic leadership in the House and Senate and veto threats from the Bush Administration about the costs of more expansive proposals, Congress was only able to agree on a narrow piece of legislation. A key provision of this legislation was a 6-month temporary increase of 0.5% in Medicare reimbursement for physician administration of therapies, including intravenous immune globulin and Alpha<sub>1</sub> proteinase inhibitor.

Without Congressional action, Medicare reimbursement for physician administration was scheduled to receive a 9.9% reduction from the 2007 rate. This increase will only be in

effect until June 30, 2008. Congress and the Administration will resume negotiations over a longer-term physician administration reimbursement model and other Medicare provisions during the first half of 2008.

Because Congress decided to pass a narrow Medicare bill, two specific initiatives for which CSL Behring has been advocating in partnership with patient advocacy organizations were not included in the Medicare legislation. These two initiatives are the Medicare IVIg Access Act (HR 2914) and the Medigap Access Improvement Act (HR 1282). CSL Behring will continue to work with these organizations to advocate for their inclusion in 2008 Medicare legislation.

**Medicare IVIg Access Act (HR 2914)**

This legislation, sponsored by Rep. Kevin Brady (R-TX), would address inadequate Medicare reimbursement for intravenous immune globulin (IVIg) by providing an additional reimbursement payment. The current inadequate reimbursement has led to continued patient access difficulties for IVIg among Medicare beneficiaries.

This legislation currently has 35 cosponsors. A push was made to incorporate it into the 2007 Medicare legislation. Notable support came from Senator John Kerry (D-MA) and Representative Michael McNulty (D-NY) in their respective Senate and House committees of jurisdiction.

While HR 2914 was not incorporated into the 2007 Medicare legislation, grassroots work to date has put us in a better position for its possible inclusion in a 2008 Medicare bill.

**Medigap Access Improvement Act (HR 1282)**

HR 1282, sponsored by Rep. Phil English (R-PA), along with 44 cosponsors would allow disabled Medicare beneficiaries the same access to Medigap supplemental insurance plans as those who are 65 years of age or older. Currently, no federal requirement exists for Medigap plans to be made available to disabled Medicare beneficiaries for purchase, leaving it to each state to determine whether such supplemental coverage is necessary. A federal Medigap standard is in effect for Medicare beneficiaries who qualify for the program due to age.

CSL Behring continues to partner with patient advocacy organizations to seek inclusion of this legislation as part of a 2008 Medicare bill.

*patrick.collins@cslbehring.com*

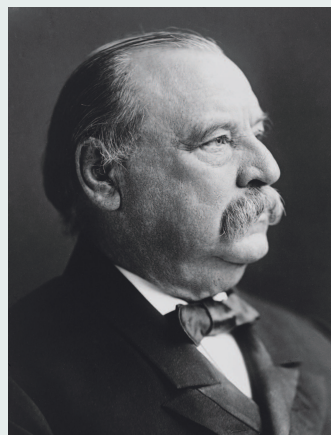
**Did You Know?**

*The presidential primary season is in full swing to see who will succeed George W. Bush after two terms. Only one person in the history of the United States has served two non-consecutive terms as President.*

*Grover Cleveland served as the 22nd and 24th President of the United States. President Cleveland served from 1885-1889 and from 1893-1897. He was defeated by Benjamin Harrison in the 1888 election before coming back to defeat President Harrison in the 1892 election.*

**Two interesting facts about President Grover Cleveland:**

*President Cleveland won the popular vote in the 1888 election, but lost the electoral vote. President Cleveland's loss of his home state of New York by less than 1% cost him the electoral vote.*



*President Cleveland's portrait is on the \$1,000 bill. This bill was last printed in 1945 and was officially discontinued through an executive order by President Richard Nixon in 1969. Nevertheless, the bill is still legal tender if you have one.*

