DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADVISORY COMMITTEE ON BLOOD SAFETY AND AVAILABILITY

Twenty-Seventh Meeting

Volume I

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9:00 a.m.

Bethesda North Marriott Hotel
and Conference Center
5701 Marinelli Road
North Bethesda, Maryland 208852

PARTICIPANTS

Mark Brecher, M.D., Chair

MEMBERS:

Judy Angelbeck, Ph.D.
Celso Bianco, M.D.
Arthur W. Bracey, M.D.
Paul F. Haas, Ph.D.
Jeanne Linden, M.D., M.P.H.
Karen Shoos Lipton, J.D.
Gargi Pahuja, M.P.H.,J.D.
Susan D. Roseff, M.D.
S. Gerald Sandler, M.D.
Merlyn H. Sayers, M.D., Ph.D.
Mark W. Skinner, J.D.
Pearl Toy, M.D.
Wing Yen Wong, M.D.

NON-VOTING EX OFFICIO MEMBERS:

Food and Drug Administration:

Jay S. Epstein, M.D.

Department of Defense:

CDR Michael Libby

Health and Human Services, CMS:

James S. Bowman, III, M.D.

C O N T E N T S

C O N T E N T S (Continued)

P R O C E E D I N G S

Call to Order, Roll Call, Conflict of Interest

Minutes, Introduction of New Committee Members

DR. HOLMBERG: Good morning. Welcome to the 27th meeting of the Advisory Committee for Blood Safety and Availability. In just a few minutes we will have roll call. As you have seen the agenda for this meeting, we have purposely dedicated a lot of time for deliberation, for discussion. We have had many speakers over the last couple of times and I think it is time that we sit down and just really deliberate on some of those discussions.

First of all, I want to introduce everyone--probably she doesn't need any introduction--but Dr. Pearl Toy is with us today. She is a new member of the committee. She could not be at the spring meeting, and we are pleased to have you with us. Very good.

Now if I can go through the roll call, Judy Angelbeck?

DR. ANGELBECK: Here.

DR. HOLMBERG: Celso Bianco?
DR. BIANCO: Here.
DR. HOLMBERG: Art Bracey?
DR. BRACEY: Here.
DR. HOLMBERG: Mark Brecher?
DR. BRECHER: Here.
DR. HOLMBERG: Paul Haas?
DR. HAAS: Here.
DR. HOLMBERG: Andrew Heaton is absent. Jeanne Linden?
DR. LINDEN: Here.
DR. HOLMBERG: Karen Shoos Lipton?
MS. LIPTON: Here.
DR. HOLMBERG: Gargi Pahuja?
DR. PAHUJA: Here.
DR. HOLMBERG: Susan Roseff?
DR. ROSEFF: Here.
DR. HOLMBERG: Gerry Sandler is going to be here, from what I understand. He is just delayed a little bit. Merlyn Sayers?
DR. SAYERS: Here.
DR. HOLMBERG: Mark Skinner?

DR. SKINNER: Here.
DR. HOLMBERG: Pearl Toy?
DR. TOY: Here.
DR. HOLMBERG: John Walsh is absent. Wing Yen Wong?
DR. WONG: Here.
DR. HOLMBERG: James Bowman?
DR. BOWMAN: Here.
DR. HOLMBERG: Jay Epstein?
DR. EPSTEIN: Here.
DR. HOLMBERG: Harvey Klein is absent. Matt Kuehnert is a Public Health Service officer who is deployed to the hurricane-affected area and he will not be with us today. Mike Libby?
CDR LIBBY: Here.
DR. HOLMBERG: Just a word about conflict of interest. On an annual basis we do a review of the conflict of interest from each one of the committee members for the special government employees. However, I would recommend and advise that any person that speaks at the microphone, if there is a potential conflict of interest, I would

appreciate you declaring that and also stating your affiliation.

The minutes of the last meeting have been posted on the web site. I have already introduced the new committee member, Dr. Pearl Toy. Also to let you know, I know that we have had a lot of discussion about the membership and the change in membership effective at the end of this meeting. Once again, I do want to remind the people that will be rotating off the committee that if the bureaucracy does not move as fast as we would like it to move, we do have, according to our charter, the opportunity to ask you to return for the next time until we can get a replacement for your position. Once, again, our meeting will be in January, our next meeting after this, and we will reconfirm those dates at the end of the meeting tomorrow. But if, for some reason, you get a phone call from us, we may ask you to come back. I will turn the meeting over to Dr. Brecher.

Chairman's Comments

DR. BRECHER: I would like to welcome

everybody to the meeting. I am just going to quickly review the recommendations from the last meeting. When we last met, May 16-17, we considered three topics. The first was strategic actions for emerging infectious disease to reduce the risk of transfusion-transmitted disease and its impact on availability. The second was an update on current status of bacterial detection methods as a release platelet concentrate procedure. The third was an update on current issues, including access and availability to IGIV products.

Taking them one at a time, in terms of the strategic actions, the committee decided that numerous questions surrounding that needed to be resolved prior to making a specific recommendation and the issue was tabled until this meeting. So, we will hear a lot more about this.

In terms of bacterial detection, the discussion on the FDA position to require bacterial testing as release criteria--we thought that there was no recommendation needed and the manufacturers of various platelet collection systems presented

their approach to FDA-required testing and postmarket surveillance. Actually, that is moving along nicely I think right now. Actually, the New York Blood Center will be the first to go live with seven-day platelets next week.

An update on current issues, including access and availability to IGIV products, was the third topic. The committee found that, one, since our prior recommendation of January, 2005 there was a worsening crisis in availability of access to IGIV products that is affecting and placing patients' lives at risk, e.g., patients with immunodeficiency.

Two, changes in reimbursement of IGIV products under MMA since January, 2005 have resulted in shortfalls in reimbursement of IGIV products and their administration.

Three, immediate interventions are needed to protect patients' lives and health, the committee, therefore, urged the Secretary to, one, declare a public health emergency so as to enable CMS to apply alternative mechanisms for

determination of the reimbursement schedule for IGIV products and, two, otherwise to assist CMS to identify effectively short- and long-term solutions to the problem of unavailability of and access to IGIV products in those settings.

The Acting Assistant Secretary for Health, Dr. Beato, responded to those recommendations on August 8. Clearly, you cannot read that letter but she thanked us for the letter. She was encouraged by the progress reports on standardization of protocols for detection of bacterial contamination and the extension of platelet product dating. She said this is an excellent example of the private sector and the Department working together to increase product safety and efficacy. The committee's continued evaluation of strategies for vigilant detection and management of emerging or reemerging infectious diseases is a necessary first step toward the goal of reducing the risk of transfusion-transmitted diseases. The work has potential impacts on blood and blood products, as well as other vital products such as bone marrow,

progenitor cells, tissues and organs. Please continue your discussions and deliberations on this important issue.

In terms of IGIV, she wrote that we--being HHS--have investigated the current status of IGIV highlighted in your comments. After extensive discussions, we have concluded that at this time there are sufficient supplies available to patients. However, there do appear to be ongoing marketplace adjustments related to how manufacturers and distributors are managing their respective inventories and we will continue to monitor the situation. Our examination of the allocation process indicates that physicians and providers might best serve the patients by communicating supply needs directly to manufacturers and distributors. Review of the current utilization of IGIV also indicates that there is increased use of this product for off-label use that may also be increasing pressure on supplies. Therefore, we believe that physicians should ensure that priority be given to IGIV

treatment for FDA-labeled uses in those diseases or clinical conditions that have been shown to benefit from IGIV based on evidence of safety and efficacy.

While HHS has no control over the prices manufacturers or supply distributors may charge, the Centers for Medicare and Medicaid Services, CMS, will continue to monitor the average sales price on a timely basis, as mandated by Congress, to ensure that the reimbursement reflects 106 percent of manufacturers' average sales price.

She then wrote that she was encouraged by the price reports on standardization of protocols for detection of bacterial contamination--we already went through that one. Then, she wished to express her appreciation to the committee.

A few days after that letter, on the web site of this committee a status of immune globulin intravenous IGIV products was posted, and we are going to hear more about this from Dr. Holmberg in a little bit. Basically, the position that was presented in the letter was reiterated and there was a section at the bottom that spoke to where to

report acute problems to the FDA.

So, we are now going to move on to the rest of our agenda. We will fist hear about varicella zoster immune globulin, VZIG, from Dr. Dorothy Scott, from the FDA.

Varicella Zoster Immune Globulin (VZIG)

DR. SCOTT: Good morning. I am just going to give you a brief update on the availability of varicella zoster immune globulin. I think this is a new topic for this committee and we do have a potential problem with shortage of this product.

Just a very brief background on VZIG--

DR. HAAS: Dr. Scott, excuse me for a second. That mike is not at all clear. We are not hearing well.

DR. SCOTT: Is that better? Can you hear me better? Not really? How is this? Better?

Well, starting back again, I will give you a brief update on this product, varicella zoster immune globulin. It was licensed in 1981. It is an intramuscular preparation that is made from selected high anti-varicella zoster virus plasma

units from normal donors. The indications for this are prevention and modification of severe varicella disease. This includes pneumonia, hepatitis, encephalitis and mortality. The people who are predisposed to this, and for whom this product is indicated, are immune compromised children and adults, premature infants, infants less than one year of age because they are at greater risk of severe disease, and selected non-immune pregnant women and healthy adults that have never had varicella, again, because they are at greater risk of severe complications. It should be administered within 96 hours of exposure to varicella. I didn't mention that varicella is really chicken pox. It also causes shingles.

We have only had one manufacturer of this product, Massachusetts Public Health Biological Laboratories. They are scheduled to close their plasma fractionation facility and they are not making anymore VZIG. They have a number of other products. We are also working with them on these other products to provide supply through other

companies.

The VZIG supply that we have, based on usage in the past several years, is anticipated to last until 2006. The approximate number of vials per year that are used are 10,000 of the smaller vial, so larger size for adults which is 625 units. It is a weight-based dosing scheme so 10,000 vials treat, at a minimum, 2000 adults or 10,000 of the smallest patients, and that would be 10 kg or less.

What have we done so far? We have encouraged new INDs and BLA submissions for VZIG. There are several companies not licensed in the U.S. that make this product already. We defined a path to licensure, or at least discussed it at the Blood Products Advisory Committee meeting on July 21 of 2005. I will go into that in just a moment. We are monitoring the supply. Fortunately, there is only one distributor so that is easy to do, and they are familiar with shortages of other products. We are in communication with CDC to look at other options and to help them make decisions about VZIG and IGIV usage in substitution and we have a public

communication effort.

Very briefly, these are the Blood Products Advisory Committee meeting questions. We asked them to discuss what laboratory and clinical data would be sufficient to demonstrate efficacy of a new product. The subset questions are which target populations would be most informative to study? I think I have shown you that there are a number of indications for this in different patient populations. What surrogate markers might be appropriate for assessment of efficacy? We also asked for other considerations about how to do a clinical trial for licensure. In addition, we asked them to comment on whether the available data support use of IGIV or acyclovir as a substitute for VZIG for prophylaxis against severe infection.

This is the outcome of their discussion. The target populations are only present in low numbers because there are not a lot of susceptible people anymore due to childhood vaccination against varicella with the vaccine. It is also difficult, therefore, to study this in a short time frame due

to the variety of clinical situations but small numbers of any particular kind of subject.

They discussed the use of surrogate markers for licensure, and the committee agreed that a PK equivalence in normal subjects compared with the licensed product, combined with a laboratory demonstration of equivalence compared to the licensed product, would be sufficient for licensure under a surrogate marker strategy. And, this comes with a Phase 4 commitment to further study for its efficacy and validation of the surrogate marker. A surrogate marker, for example, would be anti-varicella zoster titers in people who received this product.

The other question was could IGIV substitute. Obviously, people are being vaccinated and there are still plenty of donors that have been naturally infectsed So, what are the titers against varicella in IGIV? We were able to help CDC look at this, and it looks as if they are somewhere around 4-8-fold lower than what is seen in the licensed product. But from lot-to-lot there

is no particular titer tested for any of the immune globulin products. That makes sense because they don't carry this indication. However, there is variation between manufacturers and among lots within the same manufacturer so it would be difficult to give IGIV as a substitute unless you knew the titer and could give the right dose.

In addition, titers of IGIV in general may diminish as vaccinated donors replace naturally infected donors. The titers in general in vaccinated people are lower than they are in people who are naturally infected.

The other question was could acyclovir just be a substitute for prophylaxis of severe disease? There is not sufficient efficacy evidence for this particular indication with acyclovir. It may be helpful, but it appears to be more helpful in later stages of the disease, whereas VZIG is expected to prevent the viremia in these patients.

These were the speakers we had from Massachusetts come to speak about the VZIG manufacture or potency testing and the current

supply status. Dr. LaRussa came and talked about the disease correlates of protection and the different options of post-exposure prophylaxis and antivirals in immune globulin. CDC also provided a speaker, Mona Marin, who talked about the recommendations for post-exposure prophylaxis of severe varicella. In addition, we had a special member of the committee, Jane Seaward, also from CDC.

So, what is the current situation? We do have ongoing supply monitoring. We are in communication with the distributor, FFF Enterprises and Massachusetts. We believe we have enough supply to last at least through January. We are requesting that only people who need this product order it. It can be shipped right away and arrive within 24 hours. In other words, of those 10,000 vials that were used last year, it seems that people believe that a lot of that sat around in pharmacy inventories and was never used. So, it is important to get this product to people who need it and not to have it sitting around outdating in

somebody's inventory.

FFF Enterprises has agreed to do this, that is, to inquire whether or not the product is needed for a specific patient in order to ship. This was their decision but it seems like a wise choice from the standpoint of preserving supply as long as possible.

We have agreed to review INDs and BLA submissions. I would note that this product would be eligible for orphan drug classification. There is a very small number of people that need this in the U.S. relative to regular IGIV. They would be eligible to request cost recovery for an IND product and we will consider treatment protocols. In other words, we want to get a product to people before January, a new product, and one of the ways to do that, even if the license is not yet approved, is to have a treatment protocol under an IND.

We also have a web site posting planned. We expect it will be up this week, and this will tell everybody about the licensed uses; request

them to only use it for specific patients and not to order for inventory; and give the information on how to obtain VZIG.

Clinicians and pharmacies should only order for identified patients. This product can be ordered from FFF Enterprises at this number, and it can be delivered quickly. FFF Enterprises is also keeping track of which hospitals they have sent inventory to in the past, which gives us the potential for hospital-hospital transfer of VZIG if needed. In other words, there is some product out there. It has already been shipped and there is probably a way to move it around. They have agreed to track this.

So, thank you for your attention and I will take any questions.

DR. BRECHER: Art?

DR. BRACEY: Yes, I had a question in terms of the amount of product that may be outdated and, therefore, gone to waste. It strikes me that in terms of the need for resource sharing I think one option, of course, is the option that you

presented, but the regional blood centers are pretty good resources for sharing inventories and I wonder if you, all, had given that some thought in terms of making these regional blood centers depositories of product.

DR. SCOTT: That is a very good point I think and maybe we should talk about it a little more afterwards because I am not sure I understand what would be involved. But FFF right now is the sole repository and they do have a very rapid shipping plan for this and for other products. They have worked on shortages before. But I think we should consider all options and I would like to discuss that further.

DR. BRECHER: Jay?

DR. EPSTEIN: Thank you for the update. Another issue on which we have been getting inquiry is whether it is reasonable for pharmacies to aliquot smaller quantities from these larger vials since really only the adult size vials are available. Do we have any opinions about the safety of that practice, and can it be frozen after

it is aliquot'd?

DR. SCOTT: Right. Thanks, Jay. I should have mentioned that there are only 625 unit vials left, which is the dose for an adult. The doses for children come in 125 and you give 1-4 of those to a child depending on its weight. We think that it is reasonable to consider aliquot-ing the correct dosage amount if you receive this product for a child. The other question was about freezing of the material.

DR. EPSTEIN: Well, if you aliquot it, then there is always the risk of breaking sterility.

DR. SCOTT: That is right.

DR. EPSTEIN: Which is the question of whether you should freeze the aliquots.

DR. SCOTT: I think it is a good question, but we tend to hesitate when it comes to manipulating a product that way and it is supposed to be used within a certain period of reconstitution.

DR. BRECHER: Is there any way to extend

the outdate? Is it stored liquid or is it frozen normally?

DR. SCOTT: It is not frozen. It is 2-8 storage and, actually, I don't think the outdate will be a problem because we expect to run out of this before the outdate. But is there a way to extend the outdates in general? Absolutely there is. We just need a submission and the data on potency and other aspects of the product. It is not difficult to do at all.

DR. BRECHER: Celso?

DR. BIANCO: Thank you for the update. Is there hope to have companies approach FDA that could replace the Massachusetts Lab?

DR. SCOTT: We have two companies that have approached FDA and expressed interest, and we are working hard with these companies so that we can have product provided before we run out of it.

DR. BRECHER: If there are no further comments or questions, thank you, Dr. Scott. We are now going to move to an update on IGIV supply and reimbursement. First we will hear from DHHS,

Dr. Holmberg.

Update on IGIV Supply and Reimbursement

Update from DHHS

DR. HOLMBERG: Well, part of my update was to go through some of the recommendations but this has already been done by Dr. Brecher. You have the committee recommendations from the last time, and from the recommendations that were put forward I have to say that the Secretary and the various agencies such as CMS were very concerned about the recommendations and how do we move forward with these recommendations.

What we did shortly after the recommendations were received, we did have discussion with the distributors. We talked not only at the distributors but we also talked to the manufacturers. We have had discussions with the Plasma Protein Therapeutic Association, CMS, Immune Deficiency Foundation, various providers and the pharmacist groups and, of course, patients.

The providers indicated difficulty in obtaining specific brands of IGIV for some

patients. This is not only for the privately insured but also the Medicare. A lot of the concerns that came from the providers was the fact that rates that were set by Medicare were quickly accepted by the other insurers and that this was having a great impact on the location of where the product was being infused.

The shift in treatment location, of course, followed. We saw that very quickly after January 1, and the pharmacists were the first--I should say the healthcare providers--to really feel the effects of this. Once the physicians moved the patients over to the hospital outpatient setting, the hospitals that did not have an allocation or had a lower allocation than in previous years were starting to really scramble to try to get their product. Hospitals have reported difficulty in obtaining physician IGIV product of choice for the patient and we have followed up on many, many of those calls and comments. There is an upward trend in the price, most notably in the secondary market.

Some of the findings that we uncovered

were that there was an increase in off-label use of IGIV. This was as a result of our discussion with the industry. We came to the realization that there was a consolidation of the market; that there are now five manufacturers. The American Red Cross is shortly going to be removing itself from the business. Change in business practices was that companies had decided that they did not need to keep a large inventory on the shelf and that they could meet the needs with a shorter inventory. This shorter inventory then had direct impact on the distributors' quantity. So, there was an overall reduction in inventory, smaller numbers to the distributors.

As I already mentioned, the MMA, effective January, 2005, changed the Medicare Part B to 106 percent of the manufacturer's average sales price. I stress that that is the manufacturer's average sales price plus 6 percent. That does not take into consideration what the distributor adds on. So, my understanding in investigating this is that the 6 percent is for the physician storage and

maintenance of the product. We also have seen that the Medicare payment rate is updated quarterly and that there was an increased nine percent for lyophilized IGIV in July of 2005.

What we also uncovered was that there were sufficient supplies of IGIV for patients who needed the treatment. From our discussions with the manufacturers we also came to the conclusion that it was under the manufacturers' allocation process that sometimes there were shortages at the hospitals and that the physician would do best in communicating that supply need directly to the manufacturer. If there was an emergency need, the manufacturers were very willing to establish an emergency supply.

I know that PPTA is going to be talking in a few minutes. I will let them talk a little bit more about that, but with my colleagues in the Food and Drug Administration, Dr. Weinstein and Dr. Nippon, we did contact the manufacturers. We talked to many of the executives at the manufacturers for the fractionators and discussed

some of the concerns out there that we were hearing and seeing, and one of the things that we stressed upon them was a need for an emergency inventory supply being available for patients that truly needed it.

We also found with the pharmacy groups that to ensure that IGIV treatment was prioritized correctly many pharmacies have established a prescription review, and they prioritize towards the FDA-labeled use in those diseases or clinical conditions that have been shown to benefit from IGIV based on evidence of safety and efficacy.

One of the things that I can mention here is that there is only a handful of labeled indications for use and, yet, the CMS does permit--I think it is 30 different clinical entities for reimbursement of IGIV.

Some of our action plan that we did was, as Dr. Brecher mentioned, shortly after the letter that he received from Dr. Beato, we did post on our web site a report of our view of the status of IGIV. When people ask me to really talk about

this, I think that I use the phrase that maybe somebody brought up at one of the last meetings, "the perfect storm." I think that that was the phrase that was coined at the advisory committee, but it was a perfect storm in the fact that we had a difference in supply; we had an increased demand, and we also had a change in the reimbursement process.

The web posting states that if there is a report of a denial of treatment or delay of treatment or forced reduction in dosage, we want to hear about it. We have put in there the FDA web site and also the 800 number. Dr. Nippon is responsible for monitoring that and she keeps me posted on a regular basis as far as what the status is of the calls that have come through. CMS also has an 800 Medicare number that they have a script written for that they can start collecting data on, and they have been collecting for several months the information on any denial.

On top of that, I have to say that any time somebody calls in with a complaint to my

office, I personally have followed up on it. It is very interesting going back and talking to the pharmacists, and also people at CMS have talked directly to CEOs of different medical facilities and have gotten care to the patients that are needing it. So, there is merit in making sure that the government is aware of any denial of service, especially for Medicare patients.

As I mentioned before, I will leave it for PPTA to discuss but the supply channel and the emergency reserves have been identified with PPTA. Also, each one of the manufacturers has established a 1-800 number, a toll-free number, for the physician that is having difficulty in obtaining the product to talk to the medical director of the fractionation company.

Another aspect, and this is more of a long-term approach, is that we are seriously looking at an evidence-based study to try to determine what are the clinical uses of IGIV and what are the data out there to support the clinical use. So, that is an ongoing study that I am in

discussion about with CMS and the agency for Health Research and Quality.

CMS has been challenged by Dr. Beato to continue to monitor the cost. As I have mentioned, it is monitored on a quarterly basis. Something else that we have initiated internally is IG assistance, Inspector General assistance, in looking at the IGIV problem. This has been reiterated by support by Congress. I am aware of at least two congressmen, and I believe I incorporated those letters in your package. I have requested that Secretary Leavitt enlist the help of the Inspector General. This has been one of our long-term or our investigational approaches also.

So, that is a quick update on the status. As I can tell you, this is the letter that Dr. Brecher has already mentioned. This was our web posting of the situation, the status of the IGIV. So, if anybody has not been to our web site, I would encourage you to go to that. We have not posted the 1-800 numbers on the government web site. I refer people to the PPTA web site to get

the 1-800 numbers.

Then also, just to give you a quick update, and maybe Dr. Bowman could probably speak to this a little bit better than I could but, Jim, if you would like to jump in at any point, please feel free to. The 2006 acute hospital inpatient payment, the final ruling is out. The date of publication was August 12. The 2006 HOPPS proposed rule was out July 25 and the comments were to be back last week, on September 16. Then also, the 2006 HOPPS correction went out on August 26 and, again, the comments to those corrections were to be back in the middle of September.

The 2006 physician fee schedule proposed went out on August 8 and comments are due back on September 30, as well as the corrections that were published on September 1.

There are also some locations where you might want to get some more information. For the audience, they may want to take this information down, the web site for CMS for the providers and also the federal registry notice. You can go to

the GPO access.gov/federalregistry. If you ever want to find a federal registry, that is a good place to look for it. Then also, payment for Part B drugs, there is a web site listed there also. I believe that is in your handouts. Are there any questions for me or for Dr. Bowman?

DR. BRECHER: Sue?

DR. ROSEFF: I have a question, Jerry. When I read the letter that was in our packet that you just talked about, the physicians are supposed to directly feed back to the manufacturers. That is recommended. Is there a mechanism to make that easy and to track the physicians giving input to the manufacturers?

DR. HOLMBERG: Well, from the government side, you know, what they report back to the manufacturer is really out of our domain. But the 800 numbers have been provided and they can call back and talk directly to the medical directors there. However, if there are problems, especially with a Medicare patient, then we strongly encourage that that gets funneled through 1-800 Medicare and

that way we can keep track of it and we can follow-up on it. The other mechanism, as I mentioned, is the FDA and this would be both for Medicare and privately insured people if they are experiencing some delay in getting product. But direct input from the manufacturers, I don't get that unless the manufacturers offer it directly to me.

DR. BRECHER: Merlyn?

DR. SAYERS: How much traffic did that web site pick up that you posted?

DR. HOLMBERG: That is a good question and I don't have the answer for that, but I have heard a lot of people refer to it and I have referred it to the press wanting to know a little bit more of what is going on in the status. As I mentioned, I have not posted the 1-800 numbers for the manufacturers and, you know, that is probably something that we need to do, to put that on our web site so that there is greater dissemination of those telephone numbers, but I have been directing people to the PPTA.

DR. BRECHER: Thank you, Jerry. Now we can hear from the PPTA.

PPTA IGIV Summit

MS. BIRKHOFER: Thank you and good morning. It is a pleasure to be here in Bethesda again before the advisory committee to talk about the reimbursement issues. The topic today is intravenous immune globulin access. Dr. Holmberg did an excellent job providing a summary of where we are currently. I was asked to talk about a summit meeting that PPTA convened on September 7.

Even though I am not an attorney, I just want to start with a disclaimer. The summit meeting was not intended to be a defined group that PPTA, you know, is sanctioning as the IVIG group. This was done rapidly, in about a ten-day period, where PPTA went out and took a cross-sector of the IVIG community and invited leaders from those organizations. So, I just want to be really clear that the summit group participants that were a cross-section of the physicians, the consumers, industry and distributors, was in no way meant to

be perceived as the be-all and the end-all of a defined group. It was simply a working group that convened on an issue-specific Hospital Outpatient Prospective Payment System, short-term, to address the access in the hospital outpatient system. So, I just want to really be clear on that.

Just to give you a sense of the impact of the new proposed reimbursement in the hospital outpatient rule, you can see there the rates as they impact lyophilized, the powder and the liquid. PPTA submitted comments on Friday, the 16th, and this joint summit group also submitted comments. As you can see, there is a short window period between the 16th and November 1 but realistically by mid-October CMS will begin to make decisions. So, PPTA and interested parties are working to impact the agency to have them focus on the need to assure the adequacy of the rates to sustain patient access.

Currently, we have seen the impact of the Medicare Modernization Act's broad, sweeping legislation. When we were here in May we focused

on the impact of that legislation in the physician office, which is Part B. HOPPS technically is Part B as well. But we see a switch in the Hospital Outpatient Prospective Payment System of 83 percent of ASP, which is currently the $80.68 reimbursement, to an ASP plus 8 percent. Again, looking at lessons learned from the physician office, will the ASP plus 8 percent be sufficient to sustain patient access to care? That is really what this discussion is all about.

We have looked at the definition of ASP and we have tried to offer some insight into what may be the cause of the limitations of ASP, and there is a lag time. Currently, there is a six-month lag time in physician office and a nine-month lag time in the hospital outpatient. We just had a meeting with CMS on September 15 and we were able to clarify that they do intend to balance or equalize that lag time, which should have a positive impact on the calculation.

Additionally, as has been discussed, this is a very fluid and very dynamic market. You know,

prices may fluctuate. They can, and they do, fluctuate within a six-month period and a CMS calculated ASP may not always reflect the current market dynamics. We have also respectfully asked for validation or verification of the rates by a third-party auditor simply because we see the immediate impact these rates have on the ability of Medicare beneficiaries to access therapy, and we all know from previous presentations that there are no generics; there are no alternatives; there are no substitutes. It is not a one-size-fits-all therapy.

So, lessons learned: We have seen that ASP plus 6 percent and likely plus 8 percent has restricted the physician/patient freedom of choice, and that is really what PPTA and its member companies are all about. PPTA member companies--Baxter, Talecris, Octapharma, Grifols, ZLB Behring, those are the five companies that manufacture IVIG and Bayer is also a member. They are currently manufacturing a recombinant factor. But those five companies are committed to making

therapy. They are committed to making product available. They leave the decision to the physician and the patient and that is the sanctity of that relationship that my member companies are committed to preserving.

Providers currently are reporting that ASP plus 6 percent is not a sustainable business model and there are reported disruptions in site of service. Marsha Boyle, from the IDF, will give you further detail on a more current survey but there is plenty of data from the IDF that show 67 percent of patients receive IVIG under the physician payment system in the physician office.

So, what has been the impact on consumers? Who are we talking about? Let's really put a face to Medicare beneficiaries that use IVIG. We are talking about 7,000 human lives, 7,000 people that need access to this life-saving therapy. There are no alternatives. Again, 67 percent of those receive infusions in the physician office; 32 percent receive infusions in the hospital outpatient setting.

So, when you look at consumers and what the impact has been--my column should be aligned; I apologize it is not--we see in 2005 a shift from the physician office to the hospital setting, and in 2006 we can predict a volume of patients--migration if you will--from home care, from physician offices, into the hospital outpatient setting and that is an immediate problem and the opportunity to fix it is now. Again, CMS is in the rule-making period. They do have discretion.

So, how can they fix it? What can be done? PPTA, working in unison with the IVIG community--and these proposals are not anything that PPTA has come up with on their own. There is a group of people that all deserve credit for these recommendations. We recommended classifying IVIG as a biologic response modifier. That would affect the physician payment side. That would get it into a higher category. Right now IVIG is classified in a low complexity category, similar to that of saline. Those of you on the advisory committee

that are physicians know that IVIG is a complex therapy. Infusions need to be monitored. Expert nurses deliver that infusion. It is a four- to eight-hour process. There is the chance that during an infusion there could be reactions. This is not a low complexity drug. It is high complexity and should be classified as a BRM. We are working on that.

There are political hurdles. Everything is political when it comes to this issue. The AMA is involved. The AMA has issues with physician payment reform if they classify IVIG as a BRM and reduce the rate for something else. Congress has told CMS to look at it. CMS says we can't decide if it is a BRM unless we hear from the AMA. So, it is this real classic game of political ping-pong. At the same time, the imperative need is to assure consumer, patient access. So, this back and forth needs to stop and IVIG should be classified as a biologic response modifier.

In addition, we are recommending that the HCPC codes be de-bundled; that you have

product-specific reimbursement based on the NDCs, the National Drug Codes. Some groups have said, you know, classify IVIG as a blood product. Again, to you experts in blood- and plasma-related issues, it is probably very apparent to you that IVIG is a blood product. However, there is a disconnect. Although the FDA recognizes and regulates IVIG as a blood product, CMS does not because they say IVIG is so highly manufactured that the end product is not a blood product. I think they are thinking along the lines of platelets, red cells, more of the pure--although albumin is a blood product. Again, it is a little bit of a disconnect but that is what makes this reimbursement issue fascinating and complex.

Additionally, we have suggested that a demonstration project be conducted--similar to what was done for chemotherapy, done for dialysis, renal--that would result in additional payments to providers that participated in conducting the survey.

CMS did take action. You know, they are

trying to solve the problem. It is a complex problem. If any of us had the solution that was easy maybe we wouldn't all be here talking about IVIG on a quarterly basis. But CMS divided codes, liquid versus lyophilized. It is not a complete fix. That is why the industry and the IVIG community, recognizing the distinct, unique nature of each brand of IVIG think the better solution would be to de-bundle entirely and to again have the NDC-based reimbursement.

Of course, all of these recommendations we have raised with CMS in comments; we have raised with CMS at meetings. I know Dr. Holmberg has had several discussions with CMS. They tell me now they call him Jerry and they see Jerry all the time.

The 2006 HOPPS impact on access--again, I don't have a crystal ball. I can only look at the experiences from the physician office and predict it will be negative. The window of time to act is now. Medicare is seen as a model, also Medicaid. You know, let's not forget CMS has jurisdiction

over Medicaid. And, we know that Congress is looking at a ten billion dollar package of savings, reductions in Medicaid, and we know that Medicaid will likely move to an ASP model. So, the reverberations negatively on patient access to care could be catastrophic.

So, we want to draw upon conclusions from the physician office. We ask ourselves the question, you know, can or will ASP plus 8 percent be sufficient to sustain access to care in the hospital outpatient settings, which is clearly not the optimal setting for someone who is immune compromised and it is also the setting of last resort. As I showed you in that chart earlier, the hospital outpatient setting will soon be over-saturated and the question is and then what?

So, collectively PPTA convened a summit on September 7 to come up, as I said, with a short-term solution, issue specific, and to immediately focus on the Hospital Outpatient Prospective Payment System. Some major outcomes of are that--aside from the fact that 30, 40 people

were able to sit in a room and come to consensus and act in a unified voice, which was I think unprecedented--there was a recommendation that there should be an add-on for IVIG. There should be a dampening provision applied that some calculations with regard to ASP should be modified to include the prompt pay discount; and that IVIG should be classified as a biologic response modifier.

Additionally, there is precedent for this group recommending that there be an increased reimbursement or an add-on for IVIG. MedPAC, the Medicare Payment Advisory Commission, recommended 25-30 percent of ASP. CMS, their own APC committee, recommended that the 2 percent add-on would not be sufficient and that industry data on additional reimbursements on the pharmacy overhead should be considered.

So, the 2006 HOPPS situation does present an urgency and opportunity. Dr. Holmberg mentioned PPTA's companies' commitment to access and the fact that the companies have made manufacturer toll-free

numbers available. Manufacturers are reporting a robust emergency supply. But, again, the reimbursement situation is really defining the ability for Medicare beneficiaries dependent upon life-saving IVIG to access care. If there are any questions I would be happy to address them.

DR. ANGELBECK: Could you just expand a little bit for me? Your statement about providers reporting ASP plus 6 percent is not a sustainable business model, and even potentially at the plus 8 percent level it is questionable, is that providers throughout the whole system? Does that include physicians? Does that include companies? Can you just define that a little bit more for me, please?

MS. BIRKHOFER: When I use the term providers I am really meaning physicians and maybe home care companies to a certain extent. But in the Medicare settings I do know that in the physician office that is causing a migration to the hospital setting. The ASP plus 6 is not sufficient to cover the cost of the drug.

DR. ANGELBECK: What about the

manufacturers? Do you think that they are beginning to look at this and wondering if it is a sustainable business model for them for this product?

MS. BIRKHOFER: The companies are committed to manufacturing life-saving therapies and, you know, we have had some consolidations, some shifts, some changes in the market. I would like to think that there has been an equilibrium or a balance brought to the market but, you know, I certainly can't predict what the future will be. But I can say with certainty, based on our supply data, that the companies are manufacturing to capacity.

DR. BRECHER: Mark?

DR. SKINNER: I guess two things, I am curious about the system where physicians are urged to contact the manufacturers to report shortage of use, how you see that system working and if PPTA has any kind of aggregate information from its members from the reports that doctors are making to your member companies.

MS. BIRKHOFER: PPTA does not interject themselves into the relationship between the manufacturer and the customer. These numbers were put out there very publicly, and because it is customer information the companies have numbers available, not just for IVIG but for each and every therapy that they manufacture. The situation currently with IVIG is not any different than other therapies, the factor, the alpha-1, and the need to have access to care. So, we don't see a role for PPTA as an association, for any variety of reasons, interjecting into that customer/manufacturer relationship.

DR. BRECHER: Jerry?

DR. HOLMBERG: Julie, I saw on your slide that there was one comment about the NDC-based reimbursement. Can you explain that a little bit more?

MS. BIRKHOFER: Sure. Medicare and Medicaid, the federal payers, have systems in place, coding systems. They have HCPC codes, Healthcare Common Procedure Codes; they have

Ambulatory Payment Classification codes, APCs. Each drug, each brand, each dosage size has a specific National Drug Code, an NDC. It is down to the incremental level of vial sizes. That is why we think to assure access and the adequacy of reimbursement to have an NDA-based reimbursement, rather than everything under one HCPC code where it is susceptible to volume-weighted averages, and that can impact access by brand. We know that consumers need access to the brand that works best for them. We would like to get it down to the very specific NDC-based reimbursement. So, it is really a coding issue.

DR. BRECHER: Art?

DR. BRACEY: Could you clarify one thing for me? Has the industry looked at the actual cost of producing the product? In other words, we know what the sales prices are and the wholesale prices but what does it cost actually to make the product?

MS. BIRKHOFER: Well, I can tell you that for plasma-derived therapies such as IVIG it is a very capital-intensive investment. It is very

costly from the raw material that is used, the source plasma, through the manufacturing and the fractionation process there are a series of steps. These facilities are huge structures that require filtration HEPA filters; the infrastructure of employees, the range of employees that you need to have from highly skilled down to people that keep things absolutely clean so that you can be in a clearance 1, air clearance 2 zone.

So, I can tell you that these therapies are very different than traditional chemical synthetic therapies and they are very costly to manufacture, again, from the starting material through the process. The regulatory environment constantly impacts the cost and, again, there is a good reason for that just to assure the safety and quality of therapy. So, the companies totally align themselves with the process of the regulatory hurdles and thresholds and there are costs involved with that.

Specifically, again from an association perspective, I can't speak to price but I can tell

you that it is a costly therapy. Depending on the weight of the person and the amount of IVIG they need, it can be approximately a $5,000 infusion every three weeks. And, we don't hide behind the fact that it is costly or expensive. It saves lives. It is necessary. And, again, the entire process--there are reasons for these costs. It is very, very different from manufacturing pills and tablets.

DR. BRECHER: Jerry?

DR. HOLMBERG: Julie, I have two questions. Let me give you the first question and then I will come back and ask you the second question. Back at the May meeting of the Advisory Committee for Blood Safety and Availability there was a web posting from the FDA on the use of albumin. Has that influenced the demand of albumin and improved any of the use of the product or the quantities, and also the manufacturers' production of this to offset the cost of some of the other products?

MS. BIRKHOFER: Yes, the information

posted on the FDA site was helpful. I have not seen an immediate impact but it has been incremental, as would be expected. As you note, the integrated product portfolio within the plasma therapy products, the alpha-1, the albumin, the IVIG, the plasma-derived blood clotting factor--how much you can manufacture of one depends, you know, on the economics of how much you can sell of the other because there are storage costs, handling costs. You know, you can't manufacture IVIG and what do you do with the paste? What do you do with the proteins that you have taken from the plasma for the other therapies? But, clearly, the need to have a strong albumin demand and market would impact in a positive manner the IVIG situation. So, we do appreciate what the FDA did and we are hoping to see an upswing.

DR. HOLMBERG: My other question is a question that I ask a lot of pharmacists when I talk to them. They comment about their allocations and most recently I heard from a pharmacist that was responsible for two hospitals. One hospital

had a small amount of allocation; the other hospital had zero allocation and, yet, they saw an influx of patients in both of the hospitals. The pharmacists are very concerned. They get the physician banging at their door and the complaints--and the question that I have, especially from the infusion services, is what is happening to the allocations? If the physician is no longer infusing in the infusion center or in the physician's office, what is happening to allocation? Is it being moved over to the hospital where it is now being infused?

MS. BIRKHOFER: Well, I do know that some distributors, and that is really where this question gets to, do have mechanisms in place where the product tracks with the user. Again, I think that is kind of a function of the market, if you will, as to how those determinations are made. Allocation, as we have talked about in the past, is an effort to assure that there is sufficient product where it needs to be and it takes into account historical order volumes. So, currently if

a hospital or an entity has not, for their own business practice decisions, chosen to engage in contracts it is difficult at this time, given the dynamics of the market, to get the therapy. But, again, some distributors do have, from what I am aware of, mechanisms in place where the product tracks with the patient.

DR. BRECHER: Paul?

DR. HAAS: Julie, as a follow-up to Jerry's first question, if there is an increased demand for albumin I would assume that would help spread the capital cost between albumin and IVIG. Does that then have a lowering effect upon the IVIG price?

MS. BIRKHOFER: I really can't comment on what impact that would have on pricing.

DR. BRECHER: Merlyn?

DR. SAYERS: Thanks. I didn't hear all of your talks so if I missed this, my apologies. But do you know what proportion of the overall use of IVIG is for off-label indications, and to what extent that segment of the market has grown?

MS. BIRKHOFER: I know those figures from data from the Immune Deficiency Foundation and I have ranges that anywhere from 40-60 percent of the IVIG is for off-label use. But, as an association, we work with the consumer groups and we work with the users of the labeled indications so I don't really, you know, track that.

DR. BRECHER: Thank you, Julie. We are now going to hear from Marsha Boyle, from the Immune Deficiency Foundation.

Immune Deficiency Foundation

MS. BOYLE: While this is being set up I just want to thank the committee so much for paying attention to this issue. I am the president of the Immune Deficiency Foundation. I am a co-founder. And, I have an adult son who is married and healthy, working very hard, a productive member of society because he was diagnosed early. He gets his IVIG and his immunologist dictates how much he should get; where he should get it; and how often he should get it. Not reimbursement. So, this is something necessary for every patient who requires

IVIG.

Thank you so much for acknowledging the crisis that many Medicare patients are facing and not being able to get IVIG. It is a life-saving therapy, as you know. I know you took a rather controversial position in May in recommending a public health emergency. We know that no one likes this terminology but, as far as I understand, it is one of the only mechanisms to allow CMS to increase reimbursement rates for IVIG to a purchasable rate and to allow patients to receive the appropriate brand at the most appropriate site of care by the best trained professionals in the administration of IVIG.

You are certainly not alone in this recommendation. Over 30 members of Congress have recently signed a letter to Secretary Leavitt that follows your recommendation to ensure patients receive access to IGIV in all sites of care. We have a little packet. That letter is enclosed, if you would like to look at it. So, thank you again.

Congressman Israel and other members of

Congress have contacted CMS about patients not being able to receive IVIG in their physician's office. The first response was to have the constituents call the 1-800 Medicare or go on-line to find another physician to administer IVIG. That really was not a successful response. When CMS was further pressed by continued inquiries from senators and congressmen, CMS wrote back to members of Congress to have patients go to hospitals. That also is not acceptable. The problem certainly is not getting better.

As you have heard from Julie, PPTA did host an IVIG summit to develop recommendations to prevent the reimbursement crisis from occurring under the hospital outpatient setting. IDF is very supportive of these recommendations and is proud to be part of this group. But as we work to prevent access to care in the hospital patient setting from being reduced for so many patients, we must not forget that the other important sites of care, such as physician offices, infusion suites and home care settings, need to be available to our patient

population immediately.

For many of our patients these really are the most important settings for care and for the ability to lead healthy and productive lives. Aside from undue stress and negative health outcomes from being switched, in my opinion the long-term impact of physicians not being reimbursed to cover the cost of treating patients is that fewer specialists will be available in the future to provide proper diagnosis and treatment to patients whose health depends upon early diagnosis and state-of-the-art care.

At IDF, since January 1, we have been getting daily phone calls about this situation, but we wanted to quantify the impact this has had on the community. Therefore, we did survey our community, both physicians and patients, Medicare patients. I personally want to thank Jerry Holmberg who has been in touch with us regularly and has followed up on many of the phone calls and problems that we have seen that have been quite upsetting, to put it mildly.

First I would like to spend a couple of slides going back to a survey that we did in 1997 that really shows the impact of IGIV on the primary immune deficiency community. This was a national patient survey that was a follow-up to another survey, a survey of patients who are treated with IVIG.

As you can see, prior to diagnosis 90 percent had unusual or repeated infections. This is not your typical situation. As far as the health impact before diagnosis, something like 44 percent had irreversible, permanent functional impairment before diagnosis and the onset of therapy. As far as the health status before treatment, in less than 20 percent was it good to excellent after you show the impact of intramuscular, which certainly was an improvement, but after being on IVIG almost 75 percent indicated good to excellent health. I think this is self-evident but I think at times we just need to be reminded of the tremendous impact of this wonderful therapy for our patients.

What we did, we conducted a telephone survey of Medicare patients. These patients had been selected from our 2002 national patient survey that we knew were on IGIV and also were Medicare patients. The response rate was very good, as good as any survey you will find conducted by the government. Really only 9 percent declined. We think the results are quite indicative of the impact of this reimbursement problem. Of these Medicaid patients, 81 percent are now on IVIG. As you can see, their current source of health insurance is Medicare but some certainly do have alternate sources of health insurance.

This is a summary of several slides, but of this patient population, patients who have any problems with their health because of reimbursement problems is 39 percent, so almost 40 percent of Medicare patients surveyed. Some of the problems include less tolerated product; lower dose; less frequent; changed locations, 12 percent; stopped infusions, 3 percent. We receive calls on every one of these.

This slide was a single slide kind of at the end of many of the questions, just kind of asked a little differently and of these, 22 percent have had to pay more; had their doses reduced; interval increased; switched to less preferred brand; postponed infusions. Again, we have had many phone calls on postponing infusions; having to pay more. In many cases in the private pay or in the physician office or in the home care setting, the co-pay is not taken. In the hospital it is always taken and we know of patients who no longer can afford to have therapy because of that situation.

Change in site I think is rather dramatic. As you can see, of the people who had reported changing site, 51 percent had been in physician offices, with 9 percent since January 1. Then, the other slide is the increase in hospital outpatient. So, we know where our patients are going and what is happening to them.

Why do they change the site of infusion? It is pretty self-evident. We have had quite a few

verbatims but the one I like is the explanation I got from my doctor which is that Medicare had started not reimbursing enough to cover the doctor's office cost. That sort of floored me because Medicare and my insurance is paying about $648 more than they were paying to the doctor's office so, certainly, this is not saving money and it is causing undue stress to the patients.

Why less frequent infusions? Now some local carriers are dictating that trough levels be at a certain amount--"because the hospital was having problems with Medicare for this and they would not treat me unless my level was below 600 and normal is 1,000. My doctor decided to extend it to eight weeks, hoping levels would stay below 600 but I am having sinus infections," and it goes on. Less frequent infusions--well, they are going to get sick and now some carriers are, you know, trying to practice medicine.

Why they were changed to a less tolerated product, "well, because I had to change locations because of the Medicare pricing. I also didn't

react well to the last medication at the doctor's office which was changed due to pricing." So, you know, when they go into the hospital, you have heard Julie talk about the allocations. If they can get the product, they are getting a different product and they are having reactions.

Some of the side effects from new products, as you can see, that were reported in the survey are high blood pressure; rashes; headaches, 85 percent; nausea; fever; shortness of breath. Again, this is all because they had to change product from the one that, you know, was safe for them and that they were used to.

Negative health effects as a result of problems in getting IVIG, of those who had problems which was 15 percent of all Medicare patients, 40 percent reported having negative health effects. Some of these health effects--they went on for pages but trying to get it down to one slide, although I don't think many people can read this, but the one I highlighted is, "before I went to Criticare I went to another hospital for treatment

and they gave me the wrong kind and I had little spots on me. I had a really bad reaction and the doctor mentioned kidney failure." Other infections are pneumonia, bronchial infections, stomach infections--you know, it goes the gamut. Again, this product is important for our patients and if they have to delay getting it or not receiving it their health is going to be compromised dramatically.

Well, this is kind of scary. Who is responsible for the problem in getting IVIG? Forty-four percent blamed the government in one way or another, and I don't think the government likes to be in that position.

As far as confidence in future treatment by experience of IGIV problems, less than half who have had treatment experience are confident that they will be able to get their product in the future.

Rating of the U.S. healthcare system by experience with IVIG problems, again, less than half the patients who have had problems think the

U.S. healthcare system is doing a good job in getting proper treatment to the patient.

Now, these results closely reflect our fact survey that we did earlier in a national sample of 558 physicians who reported having primary immune deficient patients in our 2003 physician survey. As you can see, the number of patients treated by these physicians who responded to our facts survey was over 4,000 primary immune deficient patients and about 935 other patients receiving IVIG.

As far as asking if they had significant difficulty obtaining IVIG products for patients because of reimbursement, 33 percent reported having difficulty and this corresponds with the 39 percent that we reported in our patient survey--significant difficulty in obtaining IVIG products by number of PID patients. I think it is no surprise. It tends to go up with the number of patients.

Patient impact of problems because of availability, again, these are quite reflective of

what was reported by the Medicare patients--postponed infusions; different site of care; interval increase; brands less preferred; alternate therapy.

Adverse health events, 18 percent of all doctors reported them but 43 percent of doctors had patients with reimbursement problems and this, again, corresponds to the patient survey with 40 percent of all patients having problems and 15 percent of all patients.

So, you know, with this survey we are trying to give information that is not just anecdotal. Our anecdotal stories are heart-breaking and they are not going away. I think you can see that the health of patients is being needlessly compromised. Although we know it certainly wasn't the government's intention, it is the unacceptable outcome.

Patients should not have to die to get attention, which has already been reported in one case. We are certainly working within the system to bring about change for our patients and we will

continue this effort. However, we can't do it alone. We need your help. We need the help of this committee. We will do whatever it takes to get the attention of the American public that an FDA-approved product is being denied to some patients who have federal insurance because of reimbursement rates. This isn't acceptable and we all know that private payers tend to follow Medicare rates, as does Medicaid, and that jeopardizes even a larger percent of our very fragile population.

So, thank you for your concern, and we hope that you will continue working on this and recommend solutions to ensure that our patients and all patients who require IGIV are able to obtain it in all sites of care and all brands. Thank you very much, and do you have any questions?

DR. BRECHER: Marsha, I noticed from you slides that in your survey of the doctors it implied that 20 percent of the patients were for other indications. What is your estimate of off-label use?

MS. BOYLE: Again, I can't say I know. Generally, for the primary immune deficient patients the figure is usually around 30, 34 percent. Off-label, we have heard from other sources that it is over 50 percent or close to 50 percent. I don't think anyone really knows. We have a sense of our population and I actually think it is larger than what the estimates have been.

DR. BRECHER: Other questions or comments?

MS. BOYLE: Thank you very much.

DR. BRECHER: We are now going to enter one of our public comment periods. I guess we will first hear about the medical needs of Katrina-affected areas, Ms. Jan Hamilton, from the Hemophilia Federation of America.

Public Comments

Hemophilia Federation of America

MS. HAMILTON: Good morning and thank you for the opportunity to tell you a little bit about what is really going on in Louisiana. Some of the comments that I am going to make, you may wonder if that really has anything to do with healthcare and

I am going to tell you that it really does because I want you to really think as I mention each one of these things what would really happen under these kind of circumstances.

First of all, there are things in the 21st century that we take for granted--a roof over our heads; food to eat; ability to earn a living; access to healthcare; transportation to wherever we want to go whenever we want to do it or whenever we need it. Up until now no one has ever experienced the wrath of a hurricane like Katrina. I have been in the hurricane belt virtually all of my life. I have heard the warnings. We have all heard the warnings. We all know how to go out and buy batteries and do all that kind of stuff, and we have a tendency to feel complacent about what we know we can handle and what we can't. No one has ever experienced anything like what Katrina brought to the Gulf Coast. I heard Sen. Mary Landrieu say she had been to the tsunami area and there was a difference. With the tsunami the water came and it left. With Katrina it came and it stayed and it

created havoc.

The reaction and response to the hurricane--warnings were given. Evacuation--we had a beautiful evacuation route planned. We had widened highways. We had made contra-flow. We had done all these kinds of things and some people followed the advice and left early. Others had no means of transportation. The City of New Orleans had access to hundreds of school buses and MTA buses. They didn't move them to higher ground. They were under water at the time they needed to be used for evacuation.

I have heard a lot of people say it is a black/white issue. It is not a black/white issue. The mayor of New Orleans is black. The fire chief is black. The police chief is black. But 67 percent of the population is black. So, you know, with that kind of percentage there are going to be a lot of those people that are not able to be reached. The problem is they didn't start soon enough. President Bush started asking on Wednesday before the storm for Governor Blanco to

allow them to move in and start helping. She declined until well after the storm. So, that is part of the problem.

For the people that left on time it went pretty well. For others that waited, the two-hour drive as far as Lafayette turned into a 14-, 16-hour drive. People ran out of gas. The gas stations along the way didn't have any gas because there had been so many people that needed to take advantage of it. They didn't take enough food or water or even flashlight batteries with them so that created a problem.

Again, when you think of the population of New Orleans, and everybody says around 500,000, that is just New Orleans. That is not St. Bernard Parish or Plaquemine's Parish or all those other parishes that were involved in the evacuation. State leaders really delayed in asking for federal help, causing all kinds of delays in assistance. Communication didn't exist. Telephone towers were wiped out. There were no cell phones. There was no way to communicate. We knew and the rest of the

state knew what was going on because we could watch in on TV. The people in New Orleans couldn't watch it on TV and many of them didn't have radios. With communication gone, how do you even find patients?

This is a really strange story. There was one hospital that continued to operate even long after the hurricane had hit. Nobody knew there was anybody in that building, treating patients. Finally, about three days later, one of the nurses went to the window and was just waving out the window and finally they realized that there were people in there. There were actually still patients in this hospital, working on just batteries.

Another thing that happened, and this is not funny; it is really kind of stupid and I hate to say this but a lot of hospitals had generator power. Guess where the generators were--in the basement. It makes a lot of sense, doesn't it for a city that is as far under sea level as New Orleans is.

I am going to use an example, a model set

up at the Cajun Dome in Lafayette. That is my home and I do know a lot about what happened there. I talked with all of the leaders, Lafayette Medical Society, American Red Cross, churches, United Way, Salvation Army, city parish government. All of them got together and they put things into motion. In the beginning it worked really well. The first shelter was set up at the Cajun Dome and it was for people. Then they realized that a lot of people had brought their pets and, for sanitary reasons, they couldn't allow the pets to stay there. So, they took another facility, another arena, and set it up for the pets and they got the SPCA involved, all the animal care people, and everything, and people were donating all kinds of cages, and everything, so people could get pets over there. Dog food was donated. Veterinarians were there. This is very important because of the mental health of these patients and they had lost everything, they needed their pets with them. Some of them even smuggled them inside their clothes on the buses that were allowed to leave with them.

Members of the medical society I am very proud of. They were able in some way to get in touch with the interns and residents from LSU in Tulane that were evacuated to Lafayette and they put them to work immediately, along with volunteers from the parish medical society. They emptied all of their sample closets. They got donated supplies, compassionate care supplies from the manufacturing companies and they set up a beautiful triage clinic in the Cajun Dome. You can imagine the kinds of things--infections, asthma, along with the just day-to-day things that people deal with like diabetes, dialyses, heart patients, cancer patients, all these kinds of things. Then there was a special needs center that was set up in another facility that was right next door to a hospital so those patients who needed even stronger care could be treated there.

A lot of the chain pharmacies even agreed to fill prescriptions. They would take on some of these compassionate care products and use them to fill prescriptions for people because they didn't

have any money. Many of them thought they were leaving home for two or three days. It has now been three weeks and some of them will never go back and some of them may be able to go back at some time or another.

The university hospital system in Tulane lost all their records. They didn't lose them all, they just couldn't be accessed. So, you have patients presenting with--yes, I take this little white pill in the morning for my blood pressure, and then there's this little red pill that I take for this. Oh, there's this little yellow one that I take for this. You have no records. You have nothing to go on by what they are telling you. The more educated people were able to--some of them even had their bottles of medicines on them or a list but, sadly, the majority of them, really they didn't know. So, these physicians were starting from ground zero.

This is the first part where I just want to cry. There was friction between the Red Cross and the medical volunteers because the kind of

treatment they were giving didn't fit the protocol of American Red Cross so they made them leave. Now there were these thousands of patients who were being cared for beautifully within this shelter who are now--they have no cars and they now have to access the emergency rooms and the walk-in clinics to get care. It is really sad. For instance, in our city we experienced in 15 days the growth that any city is expected to do in 15 years. So, just think about that, and think about the fact that even to get a prescription filled in a pharmacy sometimes took as much as 24-36 hours because they just couldn't get enough of the drugs.

Our office happens to be in Lafayette. It is right on I-10, the southern part of the state between Mississippi and Texas, and a lot of people came there. There were a lot of people that had relatives there and our office is set up there. So, we set up a conference call with clotting factor manufacturers, along with representatives from NHF, and we identified what to do with some of the hemophilia patients. We identified United

Blood Services in Lafayette to house and distribute compassionate factor. They already have an existing system, delivery system set up and they carried some product anyway so it was a natural for them to do it, at no charge. And, the Gulf States treatment center in Houston was identified for those people there. There was also a place in Dallas they could go and a place in San Antonio. They could go to treatment centers there. In our treatment center we couldn't even find Dr. Lessinger from Tulane for a while. Then she showed up and guess where she showed up. In Lafayette. So, we opened our doors to her and she and her social worker and her staff were housed in our offices. And, we seem to have become the center for distributing all of these goods and services that are coming in from anywhere and we truly, truly, truly appreciate it.

In the time that we couldn't locate Dr. Lessinger we contacted two groups of hematologists in Lafayette who treat patients with hemophilia, one group at University Medical Center and another

in private practice. They agreed to do whatever they could do for those patients within that area. In our area the city limits are 100,000 but our trade area is 500,000 so there were a lot of people in the surrounding towns that were able to get care that way.

Then on September 12 Dr. Lessinger and her staff moved in. We gave them telephones, desks, and so forth, and they have been set up there in our offices. We have also set up a hemophilia disaster relief fund for patients who have needs other than medical. If you can just imagine trying to start over--one day you wake up and your house is two sticks and you have nothing. You don't have a family picture. You have some of the pictures on TV that showed the missing children and it is just a little black profile. Some of them have nothing. They had nothing when they left.

Even connecting family members separated during the evacuation became a major problem. Ham radio operators have been a big, big, big help but they were also located in the Cajun Dome and the

Red Cross asked them to leave because they wouldn't allow the room that they were working out of to be locked at night when they weren't there. If I was a ham radio operator I wouldn't want to leave my tens of thousands dollars worth of equipment there either with about 10,000 people in the building.

During all this time, I guess it was about the day after the hurricane, Rep. Bobby Jindal's office called me and asked for input on the healthcare needs in the face of Katrina, and they helped put together the next phase of relief, actually tried to cut through as much red tape as possible. This, again, doesn't really have anything to do with healthcare treatment and, yet, it does because the results of not doing it do result in healthcare, and that is the fact that those buses sat there in New Orleans without any drivers, the metropolitan buses and the school buses that should have been moved to higher ground, and the answer was that the reason they weren't used is that they couldn't find any drivers. Well, hello! In times of an emergency you shouldn't have

to have a CDL to be able to drive a bus to get people to safety and drive them as far as need be.

So, this began my survey of all of the things that we saw as obstacles. Here are some of the obstacles: Defiance of individuals not wanting to leave their affected areas. This was home. It is New Orleans and it is home. The same thing with Biloxi. There is sort of a compassionate feeling; generations had been there.

Lack of adequate search and rescue personnel and delay in requesting federal aid. The delay in requesting federal aid from the state was a big, big, big mistake and that is another place where we feel that the red tape should be cut. I do know that at one time President Bush was considering evoking the Insurgency Act and maybe there should be something that could be done to not have to wait for a governor to come in to help in a situation like that. In the first place, just in an everyday situation, you don't have enough people to be able to deal with this sort of immense emergency. In the second place, when a lot of them

have already left you sure don't have the facilities. So, you need help from somewhere.

There was a very slow response in our area of the state by FEMA and the Red Cross to get the individuals registered and get aid to the evacuees. Not until a couple of days ago did the Red Cross start distributing any finances to the people, and it was $350 per person or up to $1,500 for a five-member family.

The clothing and all of the other things were being done by the Salvation Army and by local organizations. FEMA was absolutely non-existent in Lafayette. We knew that there was FEMA in Baton Rouge. We could not find any FEMA in Lafayette. They were in Houston. They were all over Texas but they weren't in Lafayette where we had about 40,000 to 50,000 worth of evacuees.

Then my answer was, well, I will start sending out e-mails to the delegation and say, you know, find them. Where are they? And the next day, on Sunday, I got a call from a lady in Baton Rouge who was with FEMA and she said, well, we have

60 contract employees in Lafayette but none of them really work for FEMA. So, there was no one that was calling the shots. It was just a bunch of hired help and they didn't know what to do.

There needs to be some sort of better screening process to identify the people with medical problems and to keep families together. There are still children who don't know where their mothers are, and mothers and grandmothers who don't know where their children and grandchildren are. Parents of hospitalized newborn babies weren't notified where their babies were air-lifted to and it has taken until this past week--actually, I think there is still one baby that has not been united with its parents. If you can imagine going through a birth during that kind of a situation and then having your baby taken from you and flown out some place and you are not even told where they are!

The evacuees were not given a choice of which city to go to. They were just put on a bus and sent somewhere. A lot of the families were

separated and put on different buses.

All of these things lead to mental health issues. They may not be actual medical issues but they are mental health issues that really create a major problem. I just can't even imagine, you know, losing everything you have and then not knowing where the rest of your family is. The special needs portions of the population, whether it is hemophilia, diabetes, high blood pressure, multiple sclerosis, immune deficiency, alpha-1, whatever it is, it has a major impact upon their condition just under normal conditions. But if you can imagine going through this and still having that problem!

So, what do we do next time? Make sure that the state officials invite federal help immediately, before the storm hits. Mayor Nagin said that he did not really want to make the evacuation mandatory because some of those people had been there all their lives. But nobody had ever seen anything like this. The levee was built for category 3 hurricanes and nobody knew what

would happen. They should have been made mandatory. There should be a sound plan in place prior to onset and started at least two to three days earlier. You know, it is better to be safe than sorry.

Some kind of backup communication methods. The TV stations had satellite communication. Why couldn't that have been used by the people who were in charge? Each vulnerable state, Atlantic Coast, Gulf Coast, West Coast, wherever they are should have in place a really good plan in order to be prepared and to not face the kinds of things that are being faced right now.

And to be sure to incorporate outside help, be ready to incorporate outside help. For instance, from our city there were 100 boats and 300 people that left at 4:30 one morning to go down there to try to help evacuate the people. They got down there and they weren't allowed to go because they didn't have anybody to direct them where to go.

There needs to be mass transportation

strategy for evacuation beyond the areas of the storm's path, and I don't mean just 30 miles outside but far enough away that it doesn't have such a tremendous impact on the population, especially for those that don't have access to personal transportation, and identify in advance medical centers outside of the storm's path to be designated as the triage centers for the various patient populations and have computer backup available. Every hospital should have off-campus backup somewhere safe, in a vault, doctors' offices in hospitals, somewhere where that can be reached when it needs to be.

In a recent statement released by the OMB, they stated that proper response to disaster relief should be unified, coordinated and effective. Boy, that sums it up and that is what it has not been.

Some of the things that have happened--I mentioned that I had e-mailed the delegation with the problems and gotten responses. The first response came back from FEMA. Then I got a call just a few days ago from the Vice President for the

Quality Assurance for the Red Cross. He said, "I've gotten all these e-mails with your name on it that said to call you and find out what was going on," and I kind of let her have it about some of the things, even the distribution of food that was going to the outlying centers. It was being prepared in Lafayette and taken in a U-haul truck with no refrigeration, no heat control, very unsanitary conditions, and that was being taken out to the outlying centers. There you have another health problem. What is going to happen from these people eating food that hasn't been properly handled from the time it was prepared? Sometimes it was as much as three or four hours before that food was consumed by the people in the centers.

There is still a lack of coordination between the city officials and the federal officials on what should be done and what is next. Just today I heard on the news this morning that there is a difference of opinion. The mayor really wants to get the city back up and running. He wants at least half of the population back in

within a short period of time.

There are major parts of the city that still do not have electricity or running water, clean running water, potable running water. There is no infrastructure. The joint commission of healthcare organizations has stated that there is no New Orleans hospital infrastructure right now. It is gone. It doesn't exist. There are one or two hospitals operating but they have minimal staff. There is no 911 situation. How do you send a population back in to pick up and start over again when you don't have grocery stores that are open? You don't have pharmacies that can give drugs? It is just not there. So, it needs to go much, much, much slower.

There is just a lot of disappointment in what happened. Do you remember 9/11? Do you remember when this group got together and we talked about what would be the actions taken if we had another terrorist attack? Katrina was not a terrorist attack; it was an attack by Mother Nature. But some of those same plans could have

been put to use. We still have a lot of work to do and I would hope that this group could be involved in any emergency planning process for the future. The healthcare, the access to blood and blood products, the access to physicians, access to hospitals is absolutely imperative in a disaster of this type.

I know you have all been inundated where you live with the accounts of what is happening in that area, in the affected area. Let me tell you, you are only seeing a microcosm of what is happening. I also distributed to you an eyewitness account of a friend of mine from White Charles who went down later and was able to go in and help rescue people and it shows you all the stumbling blocks that even this just one person came across, and they were with a group as well. It is sad. It shouldn't happen. And I am hoping that if nothing else comes out of it, in the future, the next time North Carolina or Florida or Mississippi or Louisiana get hit with anything close to this immenseness, there are better plans in place to

help. Any questions?

DR. BRECHER: Thank you, Jan. I think we all appreciate what happened there and what it is like to go through that. I am personally from North Carolina so I know what the hurricanes are like. We are going to move on to Miss Tamie Joeckel, I hope I said that right, ASD Healthcare.

ASD Healthcare

MS. JOECKEL: Lack of planning, lack of timely response, lack of coordination--interesting, that is what happened with Katrina and I guess what I am here to talk to you about, and be a little bit redundant, are the issues surrounding IVIG and access to care. I don't have a presentation to project, I just have the speech. However, I think all of you received a copy of a rather long Power-Point presentation that I prepared, but I am not going to bore you going through all of that.

Thank you for giving us the time to speak to you about the issues with IVIG reimbursement. I am Tamie Joeckel, from ASD Healthcare. For those of you not familiar with ASD, we are a Dallas,

Texas-based division of AmerisourceBergen that specializes in the distribution of blood derivatives, especially pharmaceuticals. AmerisourceBergen is a publicly traded Fortune--we are number 23 on the Fortune 100, one of the largest drug distributors in the country, employing over 14,000 people.

ASD distributes about a third of the United States supply of blood derivative products. We serve over 4,000 providers of this life-changing therapy. Our customer base encompasses physician offices, home care providers. We are the Department of Defense provider of specialty pharmaceuticals; hospital inpatient and hospital outpatient providers. Our providers serve primary immunodeficiency patients, neurology and autoimmune-deficient patients.

We are deeply committed to ensuring that the highest level of patient care is available to all patients at their choice as far as site of care, and we have had a lot of conversation today and there has been a lot of allusions to the

distributor community. Well, we are the distributor community and we would be happy to work with any of you to gather any level of data that you need to evaluate this crisis that is happening in our industry.

We do ask for your assistance once again in helping us convey and urgent message to CMS about this issue related to both patient care and quality of life. We ask that CMS reevaluate the impact of both the Part B and the January, 2006 Medicare reimbursement changes that are related to IVIG. It is not just the cost of the drug; it is the cost of the services reimbursement that needs to be reevaluated as well.

Currently, Medicare reimbursement rates and the required infusion services have dramatically changed the landscape of our industry and our patient access to care. Because the reimbursement rates by Part B do not cover the actual costs of the drug or services physicians and home care providers have been forced to shift Medicare patients to the hospital outpatient

setting. I receive those calls every day. For a long time I only received calls from providers. I am now receiving calls--as a distributor, I receive calls from patients and, obviously, it is a violation of HIPPA that I even engage in those conversations but, you know, the issue has escalated to the level that we have the patients themselves calling us, begging us to help them continue to receive their care in a physician office.

We feel that the quality of care accessible by Medicare patients has significantly eroded, and it is going to continue on this downward spiral if we don't do something about it. To make matters worse, the redirection of patients into the hospital outpatient setting has caused supply issues. Hospitals traditionally contract with manufacturers for pre-established allocations of IVIG based upon their historical demand. This new, unplanned drain on their supplies has caused considerable issues with access to the drug.

While we feel that some of the supply

issues will self-correct because manufacturers are increasing their production of the drug, the reimbursement rate deficit between what the therapy costs versus what they are reimbursed remains an issue. So, we feel that that redirection of patients into the hospital outpatient setting, in the hospital setting, is going to continue.

Infusing IVIG is a complex undertaking. Conversations that we have with our physician providers speak to the unplanned incidence of life-threatening adverse events. You have to have medical supervision throughout an infusion, and an infusion can be, as earlier referenced, as short as two to three hours but as long as eight hours, depending upon the patient, depending upon the drug. Reimbursement rates have to cover those costs.

I know that the IDF--Marsha spoke to you about some of the surveys that they did. I received some information from Dr. Orange about an IDF survey that they did of 1,070 patients as it related to adverse events. It found that 61

percent of patients have infusion rate-related adverse events and 44 percent have had serious adverse events. Unfortunately, the incidence of these adverse events is not predictable. The IDF survey also found that 34 percent of adverse events occurred during the first infusion with a new product, but the remainder occurred in patients who previously tolerated that particular brand of IGIV. I think that speaks a little bit to Julie's point about possibly looking at un-bundling the reimbursement and having and NDC-specific reimbursement rate.

But today we know that reimbursement rates are dictating where Medicare patients receive therapy. Patient migration from a nurse- or physician-supervised home therapy and physician office therapy to the hospital outpatient settings has the potential to increase adverse event risks to patients. Prior to the implementation of the Medicare Modernization Act, according to IDF, about 30 percent of the PID patients relied on hospital outpatient facilities and, you know, anywhere from

60-70 percent were actually--I think Marsha used 67 percent--were actually receiving their infusion in a physician office. Since the implementation of MMA, we know that that number is reportedly increased due, at least in part, to the fact that the cost of the drug and the services are not being covered by reimbursement.

When you look through the primer--and I kind of have that as an IVIG primer to talk to you about some of the distribution and some of the manufacturing costs--the economics of IVIG, there are some physician testimonials in there that talk to the point of how they, in fact, have had to stop treating Medicare patients. Some of them are not for-profit; some of them are for-profit physician offices. But even the non-profit providers have basically said they have had to use a financial model to establish how many Medicare patients their practice or their cost and overhead can absorb. So, they kind of have an allocation of we can only have X number of Medicare patients, and they have to turn away and redirect the balance of those.

We have to get the message that CMS has to prevent the elimination or the restriction of access to care, to all of these other sites of care--home care, physician office inclusive. It is our belief that CMS has the authority and flexibility to address the existing reimbursement problems that are going to continue to escalate, especially if the proposed HOPPS reimbursement rates are implemented.

We know that CMS has taken the latitude and has worked with other industries to help carve out their drugs to change reimbursement rates, and we hope that IVIG is going to be able to obtain that same latitude.

I had the unfortunate personal experience of witnessing a patient being turned away. Unfortunately, I was at the multiple sclerosis research and treatment center in New York and, basically, that particular practice had reached their quota. This was not a PID patient. It was an off-label indication that was being treated, but the woman was sobbing and had basically indicated

that since she had been receiving the IVIG it meant the difference between her being wheelchair bound versus being able to walk, albeit with the assistance of a walker. But that mobility was going to be lost if she did not receive that treatment.

I know that there has been a lot of discussion about off-label indications. We have been doing a little bit of a survey of our own for some of the patients and would volunteer that we would be happy to assist you in helping obtain some of that data but, you know, at what point does Medicare insurance reimbursement dictate whether a treatment is medically necessary if it improves, in fact, the quality of life of a patient?

All of these patients deserve treatment, and they deserve to choose their site of care. So, we ask once again that this committee help us convey the sense of urgency to CMS. Thank you for your past efforts and, again, we don't want it to be lack of planning, lack of timely response and lack of coordination that prevents us from

addressing this very important issue. Thank you. Are there any questions?

DR. BRECHER: Questions? Comments? Merlyn?

DR. SAYERS: Thanks. Can I ask you a question about some of the information you have in this booklet?

MS. JOECKEL: Yes.

DR. SAYERS: There really is some valuable news here. One of the illustrations though speaks to the expense associated with testing for hepatitis D. What did you mean by excessive production waste driving up the price of IVIG?

MS. JOECKEL: Well, again, I am not the expert and this is information that we use to illustrate the fact that we know that there has been, for instance, with recombinant factor demand versus plasma demand for these other products that are made from a liter of plasma. You know, the manufacturer has to recover those manufacturing costs somewhere. I know there were a lot of questions about why is the cost of IVIG continuing

to go up, and why the ASP look-back period sometimes--you know, 90 days may not be sufficient because the market is dynamic. It is changing and it is changing rapidly. These are businesses after all. They have to cover their overhead.

I happen to be a CPA who runs a sales organization, but I understand PNLs and I understand the fact that you have direct and indirect costs of manufacturing. You have to be able to cover those costs. If your byproducts or the finished goods that you are manufacturing--and in this case a liter of plasma and there are multiple finished goods that are derived from that and if all of a sudden the demand for one of those finished goods start diminishing you have to recoup those costs somewhere.

DR. BRECHER: If there are no other questions or comments, thank you. Are there any other comments from the public?

Immune Deficiency Foundation

MS. VOGEL: Hi, I am Michelle Vogel, from the Immune Deficiency Foundation. First, I want to

echo Marsha Boyle by commending this committee for its continued support to improve access to IVIG. I would like to underscore IDF's data on the switch and location for treatment for patients. Prior to January 1, 51 percent of these patients were being treated in physicians' offices and 17 percent were in the hospitals. Now only 9 percent are in the physicians' offices and 49 percent are in the hospitals. These numbers are increasing every day because the physicians and the home care companies that had been holding onto the patients, hoping to see the reimbursement rates increase are not seeing those numbers and are trying to transfer them at this point. But hospitals at this point are over-burdened, and either they do not have enough IVIG, they don't have enough staff to administer it, or the facilities or personnel aren't qualified to administer IVIG, which is leading to waiting periods and denial of coverage or care. This includes the unlabeled patients and the primary immune deficient patients. We get calls every day that a patient is being put on waiting lists of up

to six months. They can't wait for six months to get product.

This is under the current reimbursement rate. When the rates drop in the hospitals--I mean, the hospitals are being reimbursed at $80.68 and can't take care of these patients. When they drop to match the physician's office I don't know what is going to happen to these patients.

I know your recommendation for a public health emergency was controversial, but I applaud you for trying to do the right thing for patients and make sure that they receive the life-saving therapy and the right site of care. I think many members of Congress have joined in your efforts, not only with that one letter that had over 30 signatures but phone calls and individual letters going in.

I can't tell you how many letters we are seeing from individual patients going to CMS with phone calls and getting feedback saying call 1-800 Medicare. Marsha said this but I have to reinforce this. They are saying, well, if your doctor won't

treat you, find another doctor that will. There aren't any. Saying to the members of Congress we will have the patient go to the hospital, they can't. There is not enough product in the hospitals to treat these patients or there are not enough people to administer it.

So, this is just going to escalate on January 1. I think it is important for this committee today to continue to show its concern over the growing problem and the catastrophic outcome pending if the hospital reimbursement drops to the same rates as the non-hospital provider settings. I know you guys have taken a lot of heat for your recommendations. But I really, really think it is important for you to continue, and I am not saying coming out with another public health emergency but making a statement showing your growing concern that access is continuing to be an issue and that we are going to have a serious problem come January 1 if the HOPPS rates go forward that Julie Birkhofer showed you on that slide.

We have proposed some solutions and the whole group has come together with those solutions. If CMS doesn't accept those solutions we are in trouble. These patients are in trouble. Therefore, I am requesting that this committee sends a letter to Secretary Leavitt regarding your continued concern, as well as the need to keep the hospital reimbursement for IVIG as stable as possible by not dropping to the level of Medicare Part B or ASP plus 8 percent. Thank you.

DR. BRECHER: Comments? Questions? Yes?

Advanced Medical Technology Association

MS. LEE: Hi, good morning. My name is Theresa Lee, I am with the Advanced Medical Technology Association, representing our blood products and technology sector. My member companies manufacture a wide variety of blood products that screen and process blood.

This morning's discussion on IVIG reimbursement has highlighted, at least for me, the significant impact that Medicare reimbursement has on patient access and the availability of blood and

blood products overall. In that vein, my members continue to have significant concerns about overall Medicare reimbursement for blood and blood products, and we have been working in coalition with the American Association of Blood Banks, the American Red Cross and America's Blood Centers in pursuing appropriate reimbursement for blood and blood products.

Dr. Holmberg mentioned several recently published Medicare payment regulations either in proposed or final form at this juncture. I would like to bring just three developments to your attention in those regulations.

First, I would note that in the inpatient final regulation the Medicare program rolled blood and blood products, which had previously been a separate category, into sort of a catch-all category of miscellaneous items. Previously, you may recall, blood and blood products had been attached as an index to blood derivatives, and I think some of the fluctuations in the plasma derivatives market caused blood reimbursement to

decline in that context. Now they have attached it to a separate producer price index that is completely unassociated with blood and the concern is that fluctuations in that index could lead to further cuts. I wanted to just bring it to your attention.

It also highlights the fact that we need to stay on top of the issues related to blood reimbursement, particularly in the inpatient setting where, as I understand it, over 80-90 percent of all blood and blood products are used.

Second, I would note that in the outpatient proposed rule the Medicare program has proposed to cut leukoreduced red blood cells by approximately 10 percent. I would note that the APC advisory panel, which is an advisory panel that specifically advises CMS on outpatient reimbursement, has proposed that CMS freeze blood and blood product payment at 2005 levels. As I understand it, the American Red Cross and AABB and America's Blood Centers are also behind that recommendation, and I hope that this committee

would support that recommendation to have payment levels frozen.

Finally, I would like to thank CMS and this committee for issuing transmittal 496 which has attempted to provide additional consolidation clarification in blood reimbursement guidance to hospitals and billers and coders nationwide. I would note that we are working in coalition with ABC, AABB and the Red Cross to provide some additional recommendations to refine that guidance and further clarify the regulations. Thank you very much for your time.

Committee Discussion

DR. BRECHER: Thank you. Any additional public comments? If not, the committee will go into a discussion period regarding the morning presentations. Before we begin, I want to stress that I think it is clear that HHS has heard the message about IVIG. They are continuing to monitor the situation. I don't want to speak for CMS, but I think that they are also hearing the message. So, comments? Questions? Proposals?

I guess one question is does the committee need to send another message to the Assistant Secretary and the Secretary, or has the message already been delivered? Jay?

DR. EPSTEIN: I can't answer your second question. I think the committee might have to discuss that a bit. I guess my take on what is going on is that the problem hasn't been solved. I think what we have heard is that patients are continuing to suffer the kinds of disruptions in care that were described to us months ago and, although there has been movement at CMS to update the reimbursement schedule, there are underlying problems that remain to be solved.

I guess one question in my mind is how one might react to the consensus proposal that was brought forward by the PPTA. I personally do not feel sufficiently expert--in fact, I am totally ignorant--to understand how these might help the situation, but it does strike me that if a thoughtful group got together and looked from a collective standpoint among stakeholders on how to

make things better, that these suggestions warrant some consideration.

DR. BRECHER: Karen?

MS. LIPTON: I agree with Jay. I don't feel competent myself to evaluate the proposals. I think we do need to send a message that the issue, even though they are taking steps, isn't resolved and perhaps we could specifically request that they sit down and look at some of the proposals that have been put forward. I think there is something going on that is a lot bigger. And, I do think it was very interesting, looking at the ASD, and I was trying to run through it very quickly while she was speaking, but it does appear to me that we are also seeing a shift in manufacturing and I don't totally understand how switching the recombinant is affecting all of this, but I suspect that we are stuck in a place perhaps where the model and the return for these companies is shifting dramatically and we don't understand how that is affecting both the reimbursement policies and the effect on patient accessibility to these products. But I

think it is something that we need to pay attention to, and I think in looking at the reimbursement they really do need to go deeper and look at how the market is shifting.

DR. BRECHER: Celso?

DR. BIANCO: Well, I want to support Jay and Karen and say that we should send a message or at least a reminder that this is unresolved.

DR. BRECHER: It sounds like that, at a minimum, what we are going to do is at least say that the problem is ongoing and requires further attention and consideration of other solutions, such as perhaps what PPTA has suggested. Do we want to draft that at this time, or do we want to save the draft wording until tomorrow? Tomorrow? Okay. So, why don't we take a break now, a 15-minute break?

[Brief recess]

DR. BRECHER: We are going to resume if everyone will take their seats. We are now going to move on to a strategic plan for improving blood safety in the 21st century. This is in some ways a

continuation of topics covered in our last two meetings. We will start with a subcommittee report from Jeanne Linden.

Strategic Plan for Improving Blood Safety in the 21st Century

Report of Subcommittee Activity

DR. LINDEN: If you recall from the previous meeting, the subcommittee had been established to look at infectious risks--

DR. BRECHER: If everyone in the back could, please, sit down and be quiet so we can hear the speaker? Thank you.

DR. LINDEN: The subcommittee was also tasked with looking at some of the issues about risk reduction in blood safety and availability that had broadly been discussed by this committee on several different occasions at different meetings. The subcommittee looked at these issues and pondered discussions of would it be most productive to write sort of a report; what sorts of actions could we take given the resources that we have? It was thought that really what we needed

was a strategic plan that would supplement the existing FDA blood action plan that has been in existence for several years to be more current, and specifically address s some of the issues that had arisen, both in the area of infectious diseases, both in known pathogens and unknown agents that may be emerging, as well as some of the non-infectious risks which continue to be out there.

We took the basic issues that had come up before and looked at eight different issues that had been identified. One, the need for a structured, open and transparent process for policy and decision-making; the integration of the blood system in the public health infrastructure; the surveillance of adverse events related to blood transfusion and blood donation, including the known infectious diseases, the unknown or emerging infectious diseases, as well as non-infectious adverse reactions. A question for this was should focus on blood only also include tissues, organs, HPCs and coordination of risk communication to be effective, accurate and timely; error prevention

and other non-infectious risks and, in terms of blood availability, donor recruitment and retention issues and coordination of those. Also, clinical practice standards to address the judicious use and, therefore, availability issues, as well as, obviously, decreasing risks if people are not transfused as much. Also, the importance or a research agenda to address a variety of relevant issues, including measuring outcomes of any strategies that are taken to address risks. Also, disaster planning and what further efforts could supplement the existing task force.

What we did was take these eight items and each member of the subcommittee was tasked with specifically reviewing those particular subjects--some of the things we learned; some of the things we might already know from other sources; some of the issues and questions that have come up. So, the idea of what we wanted to do today is recommend that the committee consider a recommendation of putting together a strategic plan and considering what elements might be in that

plan, and who would be involved, and what role HHS could play in the committee possibly. So, that is what we sort of wanted to put on the table.

Some of the members are going to be making very brief presentations of the issues, posing some questions which are not intended to be answered at this committee or we would be here for weeks, but really just to provoke some thought and discussion for consideration in the overall scheme of what we are talking about. So, our thought was, with the Chair's permission, to take questions on the presentation for, say, something that wasn't understood without getting into discussion at this time of the individual presentations. So, that was our recommendation to the committee.

DR. BRECHER: Thank you, Jeanne. First we will go to Jerry Holmberg.

Review of January and February 2005 Meetings

DR. HOLMBERG: My task on this was to go back through and try to identify and review for you the activities of the last couple of meetings. But I do want to raise the questions that the

subcommittee has put together to address this issue. We will be discussing these at the very end but I wanted you to start thinking about these questions.

Does the committee believe that there is a need for the Department to develop a strategic plan for detecting and preventing transfusion-transmitted complications? That includes both infectious and non-infectious complications in the 21st century.

If a strategic plan is recommended by the committee, what scope of issues does the committee believe that the plan should address, and what role should the ACBSA and its subcommittees play in the development of the strategic plan?

Jeanne already mentioned the HHS blood plan that has been in effect for several years, and one of the things that the strategic plan has really helped was to really pave a path for future direction. So, if we go back and even look at the HHS strategic plan that was first initiated by the Food and Drug Administration and then taken on by

the HHS, you can see that many of those things have been accomplished. I did put that in your handouts, to take a look at that because, by no means, I don't think what we want to do is to take away from what has already been done but I think it has come to a point where we need to look, for the future, where do we move from here.

I just want to go pack to August of 2004, over a year ago, and I know that we have on the committee several people that have experience now with the transfusion-related acute lung injury and we did talk about TRALI at that time; the implementation of clinical education; the model for impact of deferral on screening interventions and the research that may come along with that. So, I bring that out and I think that Dr. Bracey will talk a little more about that in his presentation of clinical outcomes and then maybe also in the research and this may be discussed also.

The response from the Secretary was to continue to monitor progress of the scientific

community. Some of the action that has already been taken is that the National Heart, Lung and Blood Institute has moved TRALI to a top priority of all non-infectious transfusion complications and there are two institution-supported investigations that are currently being pursued.

The other recommendation from August, 2004 was access to treatment for individuals with rare bleeding disorders. From there, we have actually looked at some of the research. We have also developed a workshop. Not only did FDA develop a workshop, HHS helped support it in trying to determine what kind of pathways needed to be put into place and then what kind of new products needed to be out there. Then, of course, the reimbursement issue.

The recommendations are being considered. As mentioned numerous times last year, just before Secretary Thompson left his position he did sign off on his medical innovation process and each one of the agencies has a part in this medical innovation process. For instance, the FDA has the

Critical Pathway and also, as I mentioned, we did have a workshop put on by the FDA on this issue of rare blood disorders.

In 2004 we also looked at bacterial detection in plasma concentrations and seven-day platelets. I don't really think we need to spend much time on that. We have seen progress over the last year and it was good to hear today that the New York Blood Center is moving forward with this.

The recommendations on platelet detection were that--of course, the Secretary's response was that recommendations are being considered. The FDA innovative regulatory pathway allowed collection of post-approval information on the QC data, and they modified the field study. AABB task force put together two guidance documents and also put together a survey, which Dr. Brecher is one of the primary authors on that will be considered for transfusion. I think it was very enlightening, that survey, to see the impact of this and also some business model changes that took place within the blood field. Then, of course, we had activity

with the manufacturers.

One of the things too in August, just to reflect back, in August, 2004 we talked about the minipool nucleic acid test for blood donor testing. This was a topic that was discussed at BPAC. It was discussed at our internal blood safety committee, and then also the Acting Assistant Secretary referred this to the Advisory Committee for Blood Safety and Availability.

The recommendation or the actions that took place, as I already mentioned, were discussed at the various advisory committees and finally the Blood Safety Committee concurred with the FDA policy and made the recommendation that came out that current data do not support a recommendation for routine use of the Roche molecular system minipool NAT to screen blood donors and plasma donors. Existing donor tests appear to be adequate and the new test appears to provide very limited public health benefit at this time. However, public health officials will reconsider possible recommendations for routine donor screening for HBV

by nucleic acid tests based on experience with voluntary use of the test, further technology developments, and any other factors that might affect the public health benefits expected from such testing.

In January of 2005 we had our meeting where we talked about different issues. Topic one was the bacterial detection and the progress reports on seven-day platelets; the reimbursement issues associated with plasma and recombinant analog therapy. Then we started our discussion which the subcommittee are really going to be presenting today, and that is the current and emerging infectious pathogens, sharpening our approach to the 21st century to reduce the risk of transfusion-transmitted diseases. As you can see from that topic and from how Jeanne has already introduced today's discussion, there has been some evolution in our thinking and, hopefully, that will come out today in some of the discussion. I will quickly go over this. I really don't think we need to spend time on the bacterial issue again.

Reimbursement issues--I just want to say that although at the last meeting the Secretary did not respond to the recommendation, it was picked up on and incorporated into the response that Dr. Brecher got this summer and also some of the comments that were referred to this morning by Ms. Lee as far as the transmittal 496. A lot of that was rolled into some of the endeavors that we were working on.

Let me just quickly go through some of the discussion that we had back in January on the current and emerging infectious pathogens. We looked at the IOM report on microbial threats to health. This has been a very good guiding document for a lot of us. I think that what we have seen even over the last nine months has been that some of the comments made in the IOM report as far as the transmission of diseases have really magnified or come to light, and that is that one of the things that the IOM report talks about is natural disasters.

Since then we have had the tsunami and we

have also had hurricane Katrina. We have to constantly be thinking about how can some of these natural disasters affect the way we do business. Most recently, the AABB Transfusion-Transmitted Disease Committee was even considering a voluntary deferral for those people that were in shelters to reduce the risk of hepatitis A virus. But I just brought that out, that we need to keep going back to the IOM report and take a look at some of those recommendations. There is a lot of good information in there.

We looked at an overview of current blood-borne threats systems approach and we did a case study of various disease entities and how did we respond. I think everybody recognizes that for the West Nile virus the stars were aligned and I think that is one of the models that we really did well. There have been papers written on it that really explain some of the progress that was made. But some of the issues, like with Chagas disease, are still an unmet challenge; some of the HIV, the evolving changes, HHV-8 still is unresolved; and

also the vCJD is a good example of risk communication. So, we had a presentation of model responses, unmet challenges, evolving challenges, unresolved scientific evidence and risk communication.

The IOM report, just to highlight some of the things in the IOM report, talked about enhancing global response capacity; rebuilding domestic public health capacity; improving domestic surveillance through better disease reporting; explore innovative systems of surveillance; develop and use diagnostics; educate and train the microbial threat work force; develop vaccines and production capacity; appropriate use of antimicrobial drugs and new antimicrobial drugs; vector-borne and zoonotic disease control; comprehensive ID research agenda; and interdisciplinary ID centers.

With that, at the end of that meeting we sort of had a direction that we were looking at, and that is that for future discussion we wanted to look at surveillance, appropriate research, product

development, global information sharing, transparency in policy process, and also risk communication.

Just to show you some of the progress that we have made, I think sometimes as a committee we all--and I will use the collective "we"--we don't realize the progress that we make. We make one set of recommendations and move on and, at the same time, government is still working in the background so you don't see the impact of some of your recommendations until much later. But this was a request to CMS that talked about some of the problems with reimbursement and plasma and recombinant issues, and also some of the language that was used within the MMA that needed to be corrected.

I know this is hard for you to see but I did incorporate this in your package. On May 13--and, unfortunately, I didn't get this before the last meeting so I didn't have it to share with you, but this was a response from Dr. McClellan, thanking Dr. Beato for bringing a lot of these

issues to his attention and also, as you have already heard from Ms. Lee this morning, the CMS manual, the transmittal 496 which explains to hospitals how to charge, and it incorporated some of the corrections in some of the terminology. So, we have made progress, and there is still more progress that we need to make.

As I mentioned before, we identified these issues as far as the different aspects of surveillance, appropriate research, product development, global information, transparency in policy, and risk communication, and at the May meeting we looked at approaches to reducing the risk. We had Dr. Scwhartz, who talked about the pandemic action plan, and he did a very good job. At that point of his discussion the federal government was still in a draft mode and I understand that at the beginning of August the draft action plan was submitted to the Secretary.

We also had discussions from various public health officials, state and local. We had discussions from the National Association of County

and City Health Officials, Association of State and Territorial Health Officials, and the Council of State and Territorial Epidemiologists. All three of these groups came and talked to us. I think that what we gleaned out of that discussion was that there was a need for active communication and that one of the things that the IOM report brought out was that we have a very fragile grassroots public health system. I think that is a problem that has been mentioned over and over again in a lot of the literature, but the discussions with these three groups really brought to mind that we really need to have active dialogue with them.

We also looked at various models of disease reporting and adverse event surveillance. We had the hospital epidemiology surveillance system from CDC and also the hemophilia treatment center database. They have some very unique ways of tracking all of the patients that receive products within the hemophilia treatment centers. We also had some discussion on orphan test development. Some of the other organisms we talked

about with Chagas and malaria and different organisms--how could we move forward and develop--instead of an orphan drug test or orphan drug, is there a way that we could foster the orphan test development?

Then, one of the things that I know Dr. Beato appreciated very much was that the committee did not rush into a recommendation. One of the things that Dr. Beato has said numerous times is where is the evidence to backup the recommendations? And, has this been given adequate thought? So, I really do appreciate that the recommendations were tabled until the committee could further discuss and concur on something to put forward to the Secretary.

So, once again, I just come back to the questions that I would like you to consider at the end of our discussions over the next couple of days: Does the committee believe there is a need for the Department to develop a strategic plan for detecting and preventing transfusion-transmitted complications in the 21st century?

If a strategic plan is recommended by the committee, what scope of issues does the committee believe that the plan should address, and what role should the ACBSA and its subcommittees play in the development of this strategic plan? Thank you.

DR. BRECHER: We have time for a couple of content questions, if there are any. If not, we will move on to the second speaker, Jay Epstein, talking about a structured process for policy and decision-making.

Structured Process for Policy and Decision-Making

DR. EPSTEIN: Thank you very much, Mark. As your agenda shows and as Jeanne Linden suggested, the subcommittee on EIDs considered the question of whether there ought to be a recommendation in favor of developing a new strategic plan for blood safety and availability. A set of elements was posed which are reflected in a set of introductory talks, of which this is the first.

So, the first element of a candidate plan is a structured process for policy and

decision-making. Let me start by suggesting that effective action depends on making good decisions, and this leads to the idea that one ought to review the decision-making process itself to figure out whether it has characteristics that would lead to making good decisions.

The rationale for this is that ensuring an adequate supply of safe blood is an essential national responsibility that requires support at the national level. Additionally, the cost, complexity and evolution of the blood system necessitate an ongoing process of decision-making in order to set priorities and to address newly recognized and emerging risks.

Additionally, the structured process can foster better public health outcomes by promoting the integration of scientific, economic and social factors into the decisions while, at the same time, enhancing their general acceptance.

Now, we did hear a presentation at the January, 2005 committee meeting on the elements of a good policy process based on work from expert

groups. Without, of course, the ability to go into this in any detail, I am simply going to hit the high points.

The experts in this field have suggested that elements of a good policy process include an outcome orientation based on a needs assessment; at least within a democracy, a clear and open decisional process of procedure; the development of robust scientific evidence to support selected policies and actions; the efficient use of both human and financial resources; active engagement of stakeholders as partners; and clear communication of risks and benefits, including their uncertainties.

Now, within that framework there is also a concept that a structured process can lead both to better decisions and better acceptance and awareness of those decisions. These essentially are formal tools. We call them assessment tools that can be used to analyze the feasibility, the likely benefit, the projected cost, the risks and tradeoffs, equity, sustainability and timeliness of

these actions, and the use of these tools then plans a role in a cyclical process of assessment, action and reassessment that works more or less in the following way:

One comes upon a situation. The first step is to analyze the situation. Then one moves to the construction and analysis of policy alternatives, followed by a deliberate choice of preferred options, presumably preferred on a rational basis integrating the data that comes out of these formal assessments. One must then communicate the policy decision so as to encourage not just understanding but also endorsement and active participation. There is then the implementation phase and, in a good quality process that is inevitably accompanied by outcome monitoring which then leads to reevaluation. So, the cycle then repeats itself in essence continually.

Once again, the experts in this field would be quick to say that nothing in the real world actually follows this schema; that you may

find yourself concurrently at different phases of this process. But the conceptual model is helpful because it gives you a road map of what you are trying to do as you are in the midst of a problem solving situation.

So, within this framework we are proposing for consideration by the committee as issues that might be incorporated in the tasking of a group to develop strategic plan questions of this sort, and these do reflect the characteristics of what I have described as at least an academician's description of a good policy and decision-making process:

First, is our national investment in blood safety and availability sufficient to meet its objectives? Second, are our policy and decision-making processes adequately transparent and inclusive? Third, do we utilize analytical tools appropriately in our decision-making? Lastly, are our decisions sufficiently evidence-based?

Let me see if there is another slide--yes, additional questions: Can we enhance the

effectiveness of communication of our policies and their rationale, and do we monitor the outcomes of our decisions and actions sufficiently?

So then, this, hopefully, will provide the committee with an introduction to what the subcommittee thought about this element, should it become an element of a strategic plan. I am happy to answer any questions or we can just move on.

DR. BRECHER: Gerry?

DR. SANDLER: Dr. Epstein, in leadership for the last couple of decades the nation hasn't done very badly in terms of a strategic plan for preventing this kind of a complication. Are you, in front of an open mike, in a position to give us your opinion as to whether such a plan would best be accomplished by expanding the resources of the team that you have been working with or whether, for some reason, you think it would be necessary to go external to your office to create such a thing? I know it is a difficult question to answer but it is the one that I would see as pertinent.

DR. EPSTEIN: Well, this is a personal

opinion and I am not speaking on behalf of my agency, but my opinion is that we do have structures in place that would permit us to do all of the things that I have described at an even higher level of proficiency, and that it is more a question of putting forward the principles under which we seek to operate in enhancing our ability to do so, in other words, removing encumbrances. But I do think that our structures are adequate to the task. Others may debate this, of course.

DR. BRECHER: Karen?

MS. LIPTON: Jay, thanks. This is actually a very good presentation to start us off in again thinking about some of these issues. As I look at it, I just wanted to respond that I think what we have been saying around the table is that our national investment isn't sufficient. As you said, we may have the structures in place but we really haven't managed to garner sufficient resources to do what we all think we need to do, both in the government and the private sector.

I would answer the second question in a

very positive framework. I think that we are transparent and inclusive, and maybe that is because we have this committee. I think that FDA at the BPAC meeting has been successful in getting the right people to make the decisions, and the entire revamping that went on several years ago of the advisory committee structure I think is effective.

The one that I am not as clear about is the analytical tools that we use in decision-making, or at least I am not aware of all of them and how evenly they are used in all of the decisions. Actually, Jay, you may be able to respond to that. From my perspective as a committee member I am just not certain about that.

Are decisions sufficiently evidence-based? I think they are when they can be. There are a number of decisions that we sometimes have to make because of maintaining public confidence in the safety of the blood supply and adequacy. That is how I would answer those questions. But, Jay, could you comment on the analytical tools?

DR. EPSTEIN: My feeling is that they could be utilized more. Analytical tools are difficult to use. They generally require gathering and analyzing data, and that always raises an issue of resources. Also, there is the balance between studying problems and doing something about them. And, using these kinds of tools is often also time consuming and unless you planned well in advance you find yourself in a situation where you need to make a decision and you can't wait for that kind of modeling. So, I tend to agree with you--and, again, this is a personal opinion, not an agency opinion--that that is an area where we could do better.

DR. BRECHER: Celso?

DR. BIANCO: I just want to reinforce a little bit of what was said. But, Jay, I think the most important question that I feel is number one is are national investments in blood safety and availability sufficient to meet its objectives? I think that we have to define a little bit better the objectives. We talk in a generic sense about

safety and availability but we need to work on that, and that would be part of the work for a strategic plan.

The second thing is we have a combination of approaches and groups that participate in the process. There is the private sector of blood collecting agencies, there is the private sector of hospitals which manage the blood administration and utilization, and we have regulatory agencies and government. And you have this somewhat schizophrenic thing in which we have the site of collection being a volunteer site--sacred, white hat, and always depending on the funding that is obtained from the activities that follow blood collection and the difficulty of placing itself within the system. So, I think that we need to expand a little bit that question. But I think this is wonderful, what you just did.

DR. BRECHER: Last comment, Merlyn?

DR. SAYERS: That was outstanding. Reference was made earlier by Karen to revamping of the FDA's advisory committee, Blood Products

Advisory Committee. I saw that in a slightly different light. It looked to me like a reduction in opportunity for inclusiveness. I was wondering what your opinion was. How does one get around the sense that individuals can do with that specialized knowledge, and by virtue of that knowledge, inevitably find themselves in a conflictive position? And, is it possible to get contributions from those individuals without the decisions being tainted by what might be seen as conflict on the part of those contributions?

DR. EPSTEIN: I am not sure that that is really a question for me, Merlyn. You know, how we charter advisory committees is a very delicate matter because the committees have to be free of taints and, at the same time, they have to be sufficiently expert to do their business. As you know from all the orientations you have had to live through, there is a body of regulations that attempts to deal with that inherent tension, and whether there are other ways that we could do business I am not sure. I think one thing that we

do is have workshops where we can bring in experts to speak freely as experts from their various vantage points and try to separate that, as it were, from the policy-making process per se so that, at least at the stage of information gathering and play of ideas, we don't have to worry about who is speaking and why. But I think that this is a very large issue and it has been the subject of many, many deliberations over the years by the Congress, by the agencies, by the IOM, and it is just not a simple one.

DR. BRECHER: All right, Karen.

MS. LIPTON: Just one quick comment. I think that, yes, the issue is the regulatory structure and I think then it is incumbent upon us to make sure that we participate in the process as fully as we can, you know, giving the information we can to the panel. I also think the workshops are extremely helpful, and I know that that is quite a stress on the staff. Do you feel that you are adequately funded and resourced to do the number of workshops that you would like to see take

place?

DR. EPSTEIN: Well, I think that we would like to be able to do more workshops than we can afford, put it that way. In any given year, we do as many as half a dozen. Generally they are very well received. There is the opportunity also for the industry or other outside parties to sponsor workshops to which FDA and other government agencies will bring participation. I think that if there were more of a shared agenda, it might facilitate the process of finding sponsors, co-sponsors and alternative sponsors. So, we live in a world where we have significant resource limitations and we attempt to leverage out efforts through these co-sponsorships but, certainly, there is room for more but it would require them to step up.

DR. BRECHER: Thank you, Jay. We are now going to move on to integration of the blood system within the public health infrastructure, Judy Angelbeck.

Integration of the Blood System within

the Public Health Infrastructure

DR. ANGELBECK: In considering this topic, integration of the blood system within the public health infrastructure, I certainly went back to documents and talks that we had heard in the past two meetings and reviewed that information an considered the topic not only as one who participates in the private sector of the blood industry, but as a citizen who requires from time to time perhaps healthcare--although I have never required a blood transfusion but may at some point in the future--and tried to understand how best to address this topic.

So, what I tried to do here was to provide just an overview strictly by identifying entities that now participate in the current structures. For the oversight of blood safety and availability within the Department of Health and Human Services, of course, there is the advisory committee. There is the U.S. Public Health Service, the CDC, the FDA, the NHLBI, and that is in cooperation with the Department of Defense. Then, in the private sector

is the American Association of Blood Banks, America's Blood Centers, the American Red Cross, the Plasma Association and there are select state health agencies, again back in the government sector.

On the public health structure side, as I saw what I reviewed, we are looking at government agencies at various levels, from the United States Public Health Service, the CDC, the FDA at the federal level, state health agencies, territorial health agencies, tribal health agencies, county health departments, city health departments and local health boards. A challenge, from my perspective, to this integration is that the U.S. blood and plasma collection and distribution is a free enterprise network of non-profits and for-profits. They are not governmental agencies.

In addition to that, from some of the presentations at the previous meetings, what have we learned about how those two structures interact? 9/11 underscored the need for a coordinated message to the public about the need for blood. The

pre-event smallpox vaccination program emphasized the need for advanced planning and consideration of the impact of new vaccine programs on the blood supply. Transfusion-associated West Nile virus transmission required public health and blood collection agency cooperation with the emergence of a new infectious threat for the blood supply and perhaps a place where all the stars were aligned for what appears to have been a very successful collaboration. Now, we are faced with situations such as hurricane Katrina with what appears to be a complete breakdown of the system, much less in our future--we hope not--a pandemic.

So, questions to consider: At the national level, state level or the community level, what would integration of the blood system into the public health system add to the blood safety and availability?

Since the U.S. blood and plasma distribution is a free enterprise network or not-for-profit or for-profit, how could they be integrated into a government public health

infrastructure?

In a major public health event, does blood safety and availability have any real priority now and would integration change that?

Is a collaboration rather than an integration of the blood system into the public health infrastructure a more realistic goal? If so, then what strategies and tactics will aid in building on the collaborative efforts that succeeded in developing the response to transfusion-associated West Nile virus?

Would integration of the blood system within the public health infrastructure provide a more coordinated approach and funding to dealing with the threat of transfusion-transmitted diseases and complications? That concludes my presentation.

DR. BRECHER: Content questions?

DR. BIANCO: A quick one, simple, very easy to answer, what do you mean by integration? How do you define integration?

DR. ANGELBECK: Well, that is a good question and it is one that I struggled with. I

think integration of an organization could mean that they are more closely aligned in their structures and their development. If you look at countries--for example one that I am most familiar with as a customer of ours is Canada which has a national blood system. It has a means of risk assessment. It has a means of taking that through the regulatory process and then interpreting that into actions or recommendations to the blood collecting organizations. Here, I feel our system is much more fragmented and does not allow or permit, for example, that level of coordination or integration. When you have the blood collecting and the blood supply essentially in the private enterprise and you have public health in the government, be it at the federal level or the state level, they can partner but they cannot necessarily integrate, in my view. They can be collaborative in what they do but I don't see that in my definition of integration. If that helps? I am open to anyone else's definition of integration.

DR. BRECHER: Jay?

DR. EPSTEIN: Well, one point that I think you have made and that we have heard discussed at previous meetings is that the public health infrastructure itself, at least at present, is fragmented.

DR. ANGELBECK: Yes.

DR. EPSTEIN: So, one could possibly take the point of view that the blood system--probably mainly because of two things, regulation and the force of the voluntary trade organizations--is actually much less fragmented than the public health system. So, I wonder what exactly it means to integrate the blood system in the public health infrastructure.

That said, I couldn't agree more strongly that we do need a better interactive dialogue to make decisions about blood safety and availability in the larger context of public health planning, but how you get there in the current state of affairs I think is a little bit puzzling.

DR. ANGELBECK: I think it would be very challenging. I think you would need to go outside

the box perhaps to figure out how to do that.

DR. BRECHER: Any other questions or comments? It is interesting that, despite having such a fragmented system, I think we have been more successful than almost any other country in protecting our blood supply. So, we shouldn't lose sight of that. Thank you, Judy.

Jerry Holmberg is going to fill in for Mat Kuehnert, who could not be at this meeting to talk about surveillance for adverse events related to blood donation and transfusion.

Surveillance for Adverse Events Related to Blood Donation and Transfusion

DR. HOLMBERG: I am sure that Matt would do a much better job than I am going to do but he sent me his information by way of blackberry from where he was deployed in the South so I will try to give it justice.

Some of the things that he wanted us to look at are, first of all, with surveillance there appears to be a need to define what we need by surveillance. As we know, in other countries there

are programs in place for hemovigilance, and his comment here is either as part of or distinct from hemovigilance.

Some aspects of surveillance are monitoring the known pathogens that are tested, and that seems to be what many other countries do; monitoring adverse events; outcomes in recipients; and then monitoring availability and transfusion practices which, again, I think Dr. Bracey will refer to.

The thing that I think we all learned from our last meeting was that there are some surveillance systems that already exist at CDC, FDA, Health and Human Services and also at NIH, NIH with the research at NHLBI with repository of samples that they have. But some of the weaknesses that have been identified are a fragmented or absence of integration. I don't know so much of fragmented but definitely, from my point of view and from what I have heard, it just seems like a lot of these surveillance systems do not talk together and share the information.

Also, another weakness is that there is passive reporting. Definitely, we have a lack of denominator in trying to determine how large of an issue we are looking at.

Few approaches to unknown pathogens, and that is something that we are constantly really looking at, that is, how do we look beyond the horizon? There is also little emphasis on clinical education of transfusion-transmitted infections.

What we also learned from our previous meetings is that we need to consider both domestic and global needs. Again, partnership in public health needs to be identified and encouraged, and this might go along with the collaboration or the integration of the public health system. Matt also laid out that the possible interventions include integration and standardization of existing tools, in other words, can we ride along on some of the other systems that are currently out there but just enhance them? Analyze analysis of data on currently screened pathogens; use of repositories for pathogens and disease discovery; coordination

of transfusion adverse event systems; connection between blood availability and adverse event systems.

Again, I think that Art will talk more about this but creating a link to clinicians for feedback of data and, at the same time, educate on transfusion-associated adverse events and transfusion utilization.

I think that over the last couple of years we have heard a lot of discussion about the hemovigilance versus biovigilance, and I think the general conclusion or some of the comments that have been brought forward are that all transfused and transplanted human-derived products need to be considered in an integrated response.

Some of the questions and, again, these are questions that I created; Matt did not create these but I throw them out to you: In a perfect world what would surveillance to ensure blood safety include? Should blood safety surveillance include HPC organs and tissues? If so, how would a case for this be developed to support it?

DR. BRECHER: Questions for Jerry?

DR. BRACEY: Well, one thing I think we really should focus on is that a lot of the effort has been focused on surveillance of infectious diseases and non-infectious problems that we encounter. I think it is a very important part of our task. I am a bit concerned about the involvement of the end-user, the hospitals. You know, the surveillance that we talk about is surveillance that has been sort of government structured and required reporting. But for many of the non-infectious complications and other complications of transfusion there really isn't a driving force that would, in essence, make the hospital share that information. So, I think one of the things we need to consider is a way to engage that group of folks as well.

DR. BRECHER: Yes, we have talked about this in the past, that maybe some sort of sentinel hospital program that aggressively went out and looked for complications as opposed to passive reporting might be one solution. Thank you, Jerry.

Now we are going to move on to coordination of risk communication, Karen Shoos Lipton.

Coordination of Risk Communication

MS. LIPTON: Thank you. We really haven't, in the committee as it exists today or as it is presently constituted, had any formal presentations on risk communication so what I am going to talk about today is really some of the presentations and public comments that we have heard that have raised the theme of risk communication, and then move on to my own research, thanks to Judy Angelbeck and to Jerry Holmberg, on some of the principles of risk communication that I have looked at for the committee.

I think we can all say that the NGO and the federal agency representatives have all described the difficulties that are inherent in effective communication to physicians and patients about emerging risks to the blood supply. The subcommittee actually included risk communication as one of the proposed elements in the strategic

plan for blood safety and availability that is going to be put forth before this committee today. Current barriers to effective risk communication that have been identified in presentations are, first, lack of a formal and integrated process for risk assessment process. That is, what are we going to say the risks and benefits are? What do we not know about a topic? What do we know and who is responsible for bringing that assessment together?

Risk assessment is not optimally harmonized or coordinated on a global level. We are seeing more and more that some of the things that are happening outside of the United States where people are taking actions and making pronouncements to the public are coming into our country and it is not always clear that we are in advance of that, having appropriate discussions.

Timeliness of risk communication is a tremendously big issue for all of us. Sometimes I believe that some of the associations and other patient advocacy groups feel that they need to make

communications that have to occur in advance of federal agency action or information, and it is just because they have an advocacy group or a constituency that is really waiting for information and getting it tomorrow is really critically important.

Then accountability for risk communication is not well understood. I mean, certainly we have a legal system that tells certain organizations that they have an obligation to inform of risk but I think that generically we don't quite understand among all of us, whether it is the AABB, ABC or FDA, who has the primary role in communicating risk.

Application of risk communication principles--again, I went back and started looking at some of the scientific literature and it is true that risk communication is a science-based approach, and it is a science-based approach for communicating effectively in what they call high concern situations. There are a lot of things that were said about risk communication but I thought

perhaps the most important was that risk communication is a two-way, interactive process that respects different values and treats the public as a full partner. Sometimes what that means is that you need to communicate with the public in some way through focus groups or something else to understand what their concerns are before you even develop the message.

Major barriers to effective risk communication--well, it is conflict and lack of coordination among the stakeholders; inadequate risk communication planning, preparation, resources, skills and practice. We heard a number of presentations that commented on, well, the message might have been right but it was the wrong person stating the message. We have also heard that sometimes even the skill of the person presenting the message--are they a credible person to the public or to the patient population is very, very important.

Incomplete understanding and application of models that are highly predictive of how people

react to communication of risk, this is really where the scientific principle comes in because there is a lot of literature out there and a lot of scientific modeling around specific words that should be used when you talk about risk communication; specific words when you talk about lack of information but you still need to communicate. And, we probably could do a better job of integrating those into our own risk communication process.

So, the questions for this committee to consider: Are the roles for communicating risk in various circumstances clearly defined? How should the message be developed? Who is the target audience and who should deliver the message and in what media?

Two, are the principles of effective risk communication clearly understood by the parties responsible for creating and delivering the message?

Three, should there be a risk communication plan relating to threats to safety of

the blood supply? I called it safety of blood processes for lack of a better word but that is really around the issue of things like glucoreduction and bacterial detection? And, should there be a risk communication plan relating to threats to blood availability? That concludes my presentation.

DR. BRECHER: Content questions?

[No response]

I guess that was perfectly clear. Thank you, Karen. Our last speaker before we break for lunch is Jeanne Linden on error prevention in blood collection centers, transfusion services and clinical transfusion settings.

Error Prevention in Blood Collection Centers, Transfusion Services and Clinical Transfusion Settings

DR. LINDEN: This topic, although it wasn't discussed recently, has been discussed previously by this committee and we have had some presentations focused not solely on the infectious risks but significant risks, particularly in terms

of mortality currently that continue to be acute transfusion reactions due to errors in blood administration or preparation, and so forth, and also TRALI, which we have talked about previously.

Many of the errors, based on analysis to date, appear to be preventable. Therefore, we may be able to do something about those. And, there tend to be underlying systems factors in many cases, what are be called latent systems pathogens that may be present that predispose to some of these active errors, and identification of those may facilitate preventing errors and just making the process of transfusion safer. We tend, in this committee, to look at infectious diseases and blood safety in terms of the product itself but transfusion is really a process. It goes from the donor's vein all the way to the recipient's vein and the product could be completely sterile, but if it is the wrong component for the wrong person, then that can be just as deadly as an infectious disease.

We also have heard that many of the issues

identified in the transfusion process have commonalities with other industries, including some with very significant adverse events such as the aviation industry and the nuclear power industry. Some of these other industries have done a very good job in having good error reporting systems and identifying factors that can be addressed. So, what could we, in the blood industry, in a plan use from those other industries as lessons that could be incorporated?

One difference, however, is that the blood transfusion process does involve many different individuals with different types of expertise. As Dr. Bracey just mentioned, here the input of the clinicians has often not been incorporated as much as it could be and they, on the front line, are very critical to this process and, in fact, several studies have shown that over half of the transfusion-related errors are outside the blood band, are on the clinical side and that is where it may be productive to focus some of our efforts.

There certainly are quite a few existing

surveillance systems. They are not really coordinated or comprehensive. There is a lot of focus on fatalities and morbidities as sentinel events. As has been mentioned with infectious disease surveillance, there is often not a lot of denominator data available with many of these systems. A couple--you know, the U.K. system has some fairly good data. A lot of the rest are estimates at this point and this is another place where we could put further efforts.

Assuming that strategies to prevent errors can be identified in this process, if they are to do any good they need to be implemented. They must be acceptable to the individuals, the stakeholders who are going to be using them. Thus, their input needs to be incorporated into the process. They can not be too cumbersome. They should make it easy to do the right thing and difficult to do the wrong thing, when possible. They need to address human factors issues in their design, and how can that be accomplished and applied to the blood transfusion setting to promote blood safety?

So, some of the questions to think about are how can surveillance of non-infectious risks, and specifically errors that are identified, increase the knowledge of these risks and facilitate the identification of the underlying systems factors through a root cause analysis type of approach or some other approach to identify these underlying problems?

What else can we learn by looking at some of these other industries? How can we apply these lessons to this particular situation? And, how can we get input and involve the clinicians in the process of determining what the goals would be and, once those goals are determined, to raise the awareness of these problems so that they feel that they are involved in the process, accept the strategies that have been identified, and also to increase the recognition of adverse reactions when do occur to facilitate early intervention which may be possible?

Who exactly are the stakeholders that need to be involved? What is the role of the Department

and this committee and how could these issues, even the transfusion process, the non-infectious risks perhaps be incorporated into surveillance systems that we are discussing for infectious complications? Can those be more integrated as a total human vigilance type of approach as is done, for example in the United Kingdom where they look at all of the serious hazards of transfusion and not only the infectious ones? Thank you.

DR. BRECHER: Content questions for Jeanne? If not, we will adjourn for lunch for an hour.

[Whereupon, at 12:50 p.m., the proceedings were recessed for lunch, to reconvene at 1:50 p.m.]

A F T E R N O O N P R O C E E D I N G S

1:51 p.m.

DR. BRECHER: If everyone will take their seats, we are going to get started again.

We are going to begin with Dr. Bianco talking about donor recruitment and retention.

Donor Recruitment and Retention

DR. BIANCO: As I started working on those questions to the committee, as part of this kind of strategic thinking for our program, I went back and reviewed the committee recommendations pertaining to blood donors.

We hear a lot about blood donors, or heard at least in the past, there was always the theme of the blood shortage, the concern whose responsibility was the blood shortage, what could be done to alleviate it, and what was the role that this committee could have, and government in general, in terms of helping with that.

So, it starts in April '99 when we reviewed actually the discussions on hemochromatosis and was the timing when FDA also

looked at those questions and ultimately, came with ways by which individuals with hemochromatosis could donate, and their blood could be used for transfusion.

There was somewhat of a fantasy that this was going to resolve the problems of the blood supply, but certainly we all know that their contribution, while it is meaningful, it was not enough to really resolve it.

The second thing was the discussion that we should, because of the shortages, and maybe to better understand the blood system in the country, that we should collect data. There wasn't enough data, and there isn't enough data, and there aren't too many models that can predict blood shortages.

We know, on Mondays, what is the total that was collected by all the movie houses in the country per movie, but we really don't know how many units of blood are in our shelves except that now organizations are working harder to try to collect that, and the market has found a system of balancing supply, and actually, we are in a period

in the last couple of years after all the investments of a reasonable blood supply.

In January 2002, we continued discussions, but now they were tainted by the September 11 disaster, and the concern that we all had that we should have mechanisms to fund the development of a reserve that could make sure that in case of need, we would have that blood.

There was a recommendation from this committee for funding, not only funding, but to evaluate in a recommendation to the Secretary, and to really make the blood donor and the blood donation a national service, and recognize it as many of the other public services that are performed by the population.

I remember someone mentioning at that time, I believe it was Ron Gilcher, if we have volunteer fire departments, if we have volunteer ambulances, we should, in the same way, have enough people dedicated to blood donation.

In September 2002, we continued to discuss the promotion of blood donations through a number

of mechanisms that could help raise the level of the blood supply, but again, we did not resolve at that time who was going to be in charge of that. There was the hope that sometimes was interpreted as whining that government would take a fundamental role in funding this approach.

In 2004, in January 2004, we again decided that it was very important to take steps to develop a 5- to 7-day inventory of blood components in all blood centers to stabilize the blood system.

Again, here, we identified CMS through reimbursement as an agency that could contribute to that effort, and that a national blood reserve should be funded as a government-private sector partnership. That has not happened.

So, I think that the questions that come, and those discussions very much reflect over time, all the issues that were raised regarding blood donors, is what is the blood safety and availability role of each of the responsible parties.

We are, and I think that integration was

the word that Judy came with, but essentially, what is the role of the blood providers, should they do it by themselves, should they fund entirely the donor recruitment, or is there some government, social responsibility in that sense?

I think that that question is unanswered, and we have let it to go through market forces that not always works. I believe that this should be discussed in detail, what is the role of transfusion services--and we will have Art discussing some of that in a few minutes--the role of government and each one of its agencies, HHS, this committee, FDA, CDC, National Heart, Lung, and Blood Institute, and CMS, and then Homeland Security and FEMA that have been very much in the news in the last few days, state and local authorities.

Who should participate of the process, what is the responsibility of each one regarding blood donations?

The second question is what is the ideal blood supply? We had concerns or have concerns

from time to time about the supply, shortages, and the impact that it has in the whole healthcare system, but we don't have an answer what is the ideal blood supply - is it 3 days, 5 days, 7 days, 25 days? How many days inventory are necessary and sufficient?

This is a short-lived product, we don't want wastage, but at the same time, we don't want to be in a situation where we don't have what we need, and that has to be decided.

And then, what is the additional inventory of red cells, platelets, and plasma needed to be maintained to ensure availability during times of the collection, and here, we can talk about Christmas, summer, and emergencies. There is localized epidemics, public health actions like mass vaccinations for it could be smallpox, massive donor deferrals, or a disaster like happened with Katrina, that is there, not so much the need of blood was the issue, but certainly the blood center in New Orleans, the building was destroyed.

They are working out of their--they moved

their operations to Baton Rouge, and they have a contribution from Dallas, from Carter Blood Care, that is actually housing some of its staff, but their collections were totally disrupted, as were the collections of several blood centers in Mississippi and in Louisiana.

Finally, how do we fund that? Is it still even if the donor is a volunteer that is donating blood to us, and if the rest of the system has to work under market forces, who should fund it, is the hospital and payer that will pay for that effort of having these donors, or is there a role for more of society to invest in this process?

If there are any questions, I will be glad to attempt to clarify them.

DR. BRECHER: Any comments or questions?

[No response.]

DR. BRECHER: Perfectly clear, Celso. Thank you.

We are now going to move on to the Clinical Practice Standards for Transfusion, Art Bracey.

Clinical Practice Standards for Transfusion

DR. BRACEY: By way of background, the committee has not discussed the actual clinical indications for transfusion in previous meetings, so I would have a blank as my first slide.

But I think one of the things that we all know, and many of us around the table have invested a lot of time in this activity, is that many transfusions today aren't necessary. If one surveys the literature, you can find papers that report anywhere from 20 to 50 percent inappropriate transfusion incidents, and that is a problem.

In addition, in medicine, one of the mantras is first do no harm, and really, the inappropriate use of blood increases the risk of the transfusion therapy irrespective of how safe the unit is.

You know, much of our focus has been on minimizing the infectious risk of blood, but we must be certainly aware of the fact that as the infectious risk decreases, that alters physician behavior. The physicians then may begin to

transfuse more liberally, and then to perhaps enhance other risks associated with transfusion.

Clearly, as in driving SUVs and consuming lots of gas, unneeded transfusions will have a direct impact on blood availability. You know, it's amazing. Many transfusion services, if you talk to folks out in the hallways at national meetings, they will see, "Well, what do you do during a blood shortage?"

Well, you know, I just go around and tell the guy that he doesn't need to give that transfusion today, but we don't do this on an ongoing basis. So, we have a system that really is a permissive system, but not a system that is very proactive in terms of controlling how blood is used.

Transfusion practice is highly variable. Dr. Toy and other members of the Transfusion Medicine Academic Awardee Group had a very interesting study of one select group of patients, and these are cardiac surgery patients, and they have demonstrated that depending upon the hospital

that you are in, your risk of transfusion varied anywhere from 25 percent up to 100 percent, and this was in 1992.

What is amazing to me is that if you look at a follow-up study done by a group of anesthesiologists, well, it's about the same. So, there is a great degree of variation in terms of practice, and I think it really behooves us to look at why is there such wide variation.

Now, one big part of the problem is that there are really no uniformly accepted guidelines. The NIH, recognizing in the early '80s that we really did have problems in terms of, you know, when one needed to use blood components, set up a series of consensus conferences, and there was some good information that came out of there.

A lot of the information really basically said that we need more information, but what happened then is that various subspecialties or societies developed guidelines, so you had all these--really, the guidelines weren't divergent, but they still weren't uniform.

They weren't not one and the same. So, for the physician, one would have to decide whether to use the ASA guidelines, or whether to use ASIM guideline. There is no single guideline.

Even worse is if you are in a hospital, if you practice in a city and go from hospital A to hospital B, between those two entities, there could be totally divergent guidelines for transfusion, so it would really be helpful to have a uniform guideline.

Sonny Dzik recently published a paper looking at the use of FFP, and the paper's title, I think really speaks the problem that we have. Its title was A Paucity of Clinical Trials Exists--I can't remember the exact title, but he captured the scenario. There is a paucity, there is a dearth of clinical trials related to transfusion decisions.

Now, there is help on the way, because the NIH and the NHLBI has a Transfusion Medicine and Hemostasis Clinical Trials Network that is in progress to address some of these issues, but still, in this point in time, there are very few

clinical trials that we can use.

Beyond that, if one looks at systems--and we talked before about communication systems, public health talking to, et cetera--if you look at operations within a hospital, the way things work, our systems, to predict transfusion requirement, really need to get improved.

If you look at certain facilities or publications where they have designed a near-site testing systems' ready access to data, so that one could transfuse based upon data-driven decisions, you always see improvement, but that is the exception. Hospitals that have that sort of a system are the exception rather than the rule.

Even further, if you look at the tools that we have to diagnose a deficiency in the blood in terms of its function or the need of a given patient, we are also limited, very limited.

I mean there was the meeting of the Hemoglobin Oxygen Carriers Group, and they just couldn't decide, you know, what was a reasonable hemoglobin. If you look at evolving issues in the

field now, there are patients that are getting very potent anti-platelet drugs. Most hospitals don't have a way to test for the effect of those drugs.

So, our diagnostic systems are: (a) really not geared up, and (b) they are just inefficient.

A big problem for me, because what happens in many hospitals, is that the accountability for blood use resides in the Pathology Department. Now, wait a minute. I don't write the orders for the blood, the physician that is caring for the patient writes the order, so there are problems in terms of having really an accountable situation for the person that is prescribing the blood transfusion.

There have been some interesting approaches to that, that other centers have had, such as indexing physicians related to blood utilization, but that again is the exception rather than the rule.

Clinicians--and when I say "clinicians," I am taking in the broad sense, I am talking about

nurses, and I am talking about physicians--are poorly trained in transfusion medicine.

If you look in an ICU, and you ask a nurse about dose of dopamine or how to deliver dopamine, they actually know more than many of the early trainees. If you ask them a few questions about blood or blood transfusions or how to administer blood, you often get sort of a blank look.

So, we really have I think an important role to play in terms of enhancing the education of those within the field.

Then, one real pet peeve of mine is that there are resources that the AABB has put together and various other organizations, but those resources aren't getting to the end user.

A classic example is the Circular of Information. It is sort of a treasure trove of facts and figures about how to use blood. Whenever I show this to a surgical resident, you know, their eyes light up. These things are unknown, they are uncovered, so we have to figure out a way to get those resources to the people that really need

them.

So, what I was thinking about, questions along the lines of clinical practice, there are several questions that came to mind.

One is--and one can demonstrate in the short term when you publish a paper, that educational efforts in fact do improve blood transfusion--but the question that exists is how durable is this and are we using the right educational efforts, the ones that we are investing in today.

The second is, you know, this is the world or this is the time now of benchmarking. One thing that my hospital, and I am sure all hospitals pay attention to right now, is where they are benchmarked, and the benchmarking is largely related to certain outcome measures.

In fact, one of the benchmarks is bleeding, for example, for cardiac surgery, but is there some way to tie in transfusion to this benchmarking activity, and can that in some way improve performance or practice or blood

utilization.

I read recently a trial, the PACMAN trial, which is a trial of patients using pulmonary artery catheters, and there was an editorial to it, which I found very interesting.

In the editorial, it said, well, even though there are clinical trials that prove a given point, what is it that will make the practitioner actually pay attention to that trial and adopt the finding of the trial, the point being that the people that perform trials and read the literature, that is one group, but there is whole other universe of people out there.

So, the question is how do you get that information, when you have the trial, how do you best disseminate it to impact practice.

Another element is, is the blood community really effective in implementing change, and by that, what I mean is are we insiders or are we outsiders. I was really very much impressed by a statement that was made.

I was at an international meeting in

hematology, and a well-known figure in platelet function--the discussion was, you know, what sort of tests one would order in advance of surgery--and the point that was made is that, you know, whatever this individual said, or people that were sort of outside of the sphere of a given area of practice, was largely ignored.

So, the question is how can people within transfusion get out of a shell and begin to branch out to the other prescribers or users of blood.

Last, is what really is appropriate role for government in enhancing transfusion practice. It is interesting because, you know, there is this, well, this is the practice of medicine, so the government should not interfere with the practice of medicine, but on the other hand, if there are practices that aren't optimal, that impact safety and that impact availability, then, should the government get involved.

So, I would end with that in terms of my considerations, in terms of practice. I think there is much to be done, and one thing that I

didn't mention is that there are governments where this is now evolving after the vCJD issue in the UK. There is a huge effort there to impact practice in blood utilization.

So, I will stop with that and open up for questions.

DR. BRECHER: Content questions?

[No response.]

DR. BRECHER: Okay. Thank you, Art.

We are now going to move to the Research Agenda. Merlyn Sayers.

Research Agenda

DR. SAYERS: If you go to your agenda, it says Research Agenda, and then it says TBD, and I confess to being TBD.

Jerry approached me to make some comments about the research agenda because Harvey Klein and Andrew Heaton are out of town, so I did not attend any of the sessions that they had, I certainly had access to their notes, but I said to Jerry that I would take up this task if he recognized that this would give me an opportunity to sprinkle my

interpretation of what the group thought about, sprinkle those thoughts with my prejudices.

Against that background, if you suspect that you hear echoes of what Celso has said, what Art Bracey has said, what Jeanne Linden has said, your suspicions are well founded.

So, let's start out with this preface. I have said here that research in blood banking and transfusion medicine from the safety point of view is particularly strong in certain areas. An example is red cell immunohematology and transfusion-transmitted diseases.

From the point of view of availability, there certainly have been investigators, and Jane Piliavin is somebody that came to mind who made important contributions here, that research is much less focused on an understanding of pro-social behavior, on altruism, and on motivation.

As far as our national inventory is concerned, we seem to lurch between surplus and insufficiency, and at the moment, our inventories are full as a result of the outpouring from the

community in response to Katrina, but we do know from emerging evidence that crisis responders are not the individuals who are promptly converted to regular donors.

We have been saying for something like 40 years now that something like 60 percent of individuals are eligible, but only 5 percent do donate, and so long as we persist with that lament, as long as we have been doing that, we really haven't been assured of a stable inventory.

I think that is just a reflection of our ignorance as to what the key elements are in understanding behavior, pro-social behavior, and motivation.

So, there is this disproportionate emphasis then, and it was really revealed by a review of the research issues that were discussed at recent meetings here. I have listed some of those issues - optimal treatment for rare blood disorders, bacterial contamination, the risk of transfusion-related acute lung injury, universal leukoreduction, mad cow disease, HHV-8, babesiosis,

Chagas, pathogen inactivation, and the risk of contamination of the blood supply with bioterror agents.

I don't want my remarks to be construed as criticism of anyone who would want to eliminate even the remotest risk associated with transfusion, but we really do need to develop a script that addresses the common, as well as the rare.

We have heard even today, take Chagas, for example, that this is a quote, "unmet" challenge, but are seven cases in the United States and Canada since 1987 really of such dire consequence that we could label that risk as an unmet challenge.

I mean that is one case every two or three years. It does reflect, though, the devotion to research that is intended to further reduce the risk of transfusion-transmitted infection, and while we are witnessing that drive to the zero risk blood supply, the major contributor to fatalities associated with transfusion has really not enjoyed the same research intensity, and patient misidentification persists and patient

misidentification accounts for more acute deaths than all the other transfusion-transmitted infections combined.

So, why does that risk persist? It may be that we are just not good at multi-disciplinary approaches. How do we bring together hospital administration, nursing, information management, physicians, pharmacy, the blood bank?

As far as the availability is concerned, if maintaining availability is going to earn equal research attention, then, recruitment needs to be based on an understanding of donor behavior.

I don't want to sound melodramatic, but when the patient says, "Is my transfusion safe," the patient has to be reassured, first, that the blood is going to be available should he or she need it, and that, secondly, we have to respond to the question about safety with, well, we have to be assured that we are not going to confuse you with some other equally deserving recipient.

In fact, this committee actually had a recommendation which goes back to January of 2003,

urging the Secretary to take steps to encourage and facilitate implementation of measures that could prevent errors in the transfusion setting.

So, here are a couple of questions, then, to consider, just at a very plodding level.

Should the Department encourage research into systems that would ensure something as simple as the right unit of blood goes to the right patient?

It might have been a little more intellectually satisfying to have worded that question along the lines of should research be encouraged to ensure that the common risks are addressed, as well as the esoteric.

Having dealt with the safety side of things, then, the other question to consider is: Should the Department encourage interdisciplinary approaches to understanding altruism?

I am afraid that if we don't understand altruism, we are going to have the pitfalls and the troughs in the national blood supply, and an interdisciplinary approach would achieve something

that we have not really achieved well, and that is bringing together the sociologists, the behavioral psychologists, the motivational psychologists, and those individuals that would help us understand what really is behind the active volunteer donation.

End of sermon. Thanks.

DR. BRECHER: Questions for Merlyn?

[No response.]

DR. BRECHER: Then, we are going to move on to Disaster Planning. Dr. Sue Roseff.

Disaster Planning

DR. ROSEFF: I am here to discuss disaster planning, and I am at a little bit of a disadvantage since I just joined the committee at the last meeting, and there were extensive discussions about disaster planning after September 11th, so I am relying on a little help from my friends.

I want to thank Jerry and Mark and Karen for supplying me with much of the information I will be discussing. I would also like to invite

the members of the committee who were here or anyone else involved in the discussions to feel free to add anything that I have omitted or changed the focus of what I am discussing.

After the September 11th attacks, the Interorganizational Task Force on Domestic Disasters and Acts of Terrorism was formed in December 2001 in order to develop a response plan for future national disasters.

One of their charges and one of the things that they felt was important was to have a smooth process in place for blood collection efforts, and as we all know, after September 11th, we lost a great deal of trust with the public and donors after it was discovered that much of the blood that was collected, or not much, but a certain amount of it was thrown out and never used.

So, therefore, it was very important, according to this task force, that we develop a policy that would allow a central coordinating effort to give a consistent message to all blood donors and to the public.

They also recognized a need for a national inventory management program, and Southwest talked about this in a little bit of detail, and again, the question of should this be a 5- to 7-day inventory, and also the importance of having adequate inventories at all times in order to respond to disasters.

As we know, the blood that is used at the time of a disaster is not the blood that is collected the next day. It is the blood from donors who have donated to maintain the supply up to that point. So, therefore, the question was do we need to encourage this in some form to have a supply that will be there in case of a disaster, not after the disaster.

Finally, the AABB was tasked with coordinating this entity, and I have listed here the alphabet soup of organizations that are involved in the task force.

After September 11th, in the winter of 2002, this committee met, and their task was to look at lessons learned after September 11th, and

ask can we strengthen the safety and availability of the United States blood supply.

As a result of the meeting, the committee then wrote a letter to then Secretary Thompson and brought up the following points. First, the committee endorsed the role of the AABB Task Force.

They also recommended the incorporation of the task force recommendations and members into some of the federal structure that is involved in disaster response, so that there would be a more coordinated effort.

Again, they discussed the need to build blood reserves and to have a system that monitored blood availability on an ongoing basis, so we could detect if there were shortages that might affect the need or the ability to respond to a disaster.

In addition, they discussed the importance of an infrastructure for transportation in times when a certain part of the country is affected, how can we move blood around, how can we move reagents around, how can we move testing around in order to meet needs, the need for an integrated

communication facility or group, so that again, we get a consistent message out that is able to speak to all the stakeholders during these times of disaster.

Also, redundancy. We need to have redundancy in case, of course, certain parts of the country are destroyed and the capability of collecting, transporting, and testing blood can't be done in one region, we need to obviously be able to move that very rapidly, so that there isn't a loss of resources at that time.

Also, it was recommended that if there are any regulatory revisions, either permanent or temporary, that these should only be addressed in terms of what was needed for patient care at the time.

As part of this letter, too, the committee recommended to the Secretary that blood donors be considered a national resource.

Finally, some questions to consider for discussion. Should disaster planning be part of any kind of strategic plan that this committee

comes up with? What is the current role of the AABB Interorganizational Task Force on Domestic Disasters and Acts of Terrorism?

One thing I would like to add is that during Katrina, we did have a good, consistent message about blood, the need for blood or the lack of need for blood, and we didn't see the same rushing to blood centers of donors as we saw after 9/11, so that was very effective.

Also, is the structure of the task force and its funding adequate currently? Is there currently a structure in place to move resources in times of disaster, and is what is the status currently of a national blood reserve?

DR. BRECHER: Content questions or comments besides the open question of what reserve?

Maybe this might be a good time to get an update on the Interorganizational Task Force. Maybe Karen might say something about that.

MS. LIPTON: Yes. Well, we were operative during Katrina and most of our issues I think were trying to help our facilities that were affected

physically in the area to deal with some of the issues.

We don't have a full report because our usual process is we actually afterwards go through a whole process of evaluating. I will see that I think one of the things that did happen is, because the other problems were so immense and so overwhelming, that I believe it was a little bit difficult at times for us to get the attention that we needed, and we didn't have massive amounts of blood required, but we did have ongoing operations for some of the centers that were affected.

So, we will promise to bring back a full report at the next meeting, if that is all right with you.

DR. BRECHER: One other quick question. What if the hurricane had hit Washington? The Interorganizational Task Force is basically run out of AABB, is there provision for an alternate site?

MS. LIPTON: Well, one of the issues related to that, that we have been struggling with, is trying to get enough money for redundant

resources within AABB. We have a server that is in Virginia, but we do have to worry about, if one of those servers goes down, how do we communicate with everyone else.

We are not as much people dependent in the sense that we have people all over the country, and actually, in different parts of the world, who could step into the position of being a communication person and the point person, but I do think that the systems are the things that we need to worry about, and we need to worry about redundancy.

We have not gotten any funding for this activity, as you probably all know, so it is really something that the blood organizations and the AABB do on top of everything else that we do, but we have been in dialogue with the Department, and I think they understand our needs, and we will continue to work on the issue.

DR. BRECHER: Thank you. Any other comments or questions?

If not, we are going to move into another

public comment period. So, if anyone has a public comment, could they come to the microphone and identify themselves.

The first one is Corey.

Public Comment

MR. DUBIN: Our thanks to Jerry, the committee, for getting the opportunity to speak. I am Corey Dubin of the Committee of Ten Thousand. I think what makes us unique in the process is we have been around since the beginning, previous to this committee. It was the committee of Ten Thousand that approaches Senators Graham and Kennedy, which resulted in the IOM study.

We asked for a congressional investigation. They gave us the IOM study. It turned out to be a very good one and a very wise choice on their part. We were around for the founding of the committee, and we have been here throughout the process.

Our comments today are rooted in our perceptions and our board of directors' and community's perception, and distinct from the NHF

or other hemophilia organizations, our primary constituency is those infected with HIV and HCV from tainted blood.

We really grew out of the disaster. We grew out of services not being available. We started as a support group.

The IOM recommendation establishing this committee talked about interagency coordination, it talked about coordinating the federal response, and those are things that we think are very important. We saw that as the mission of the committee, and we saw the committee's client as the Secretary of HHS, Health and Human Services.

The question our board would raise today is, if we would all agree that the client of this committee is the Secretary, has there been a breakdown in recent years between the committee and the Secretary, has the value of this committee and what this committee brings to the table been lost on seniors at HHS, are seniors at HHS clear about what this committee is about and what it can do.

We think it is a unique history of this

committee, a history born of the epidemic, born of everyone's frustration, and as a result of that frustration, a willingness to think out of the box, to do things different.

Our board this past week asked the question do seniors at HHS understand that unique history and what was accomplished between government and all of the stakeholders - industry, community, Red Cross, the public health structure, and we continue to question that, and we believe that it's most important to nurture the all stakeholders' grass roots community participation model.

We think that that is the model is what is in trouble right now. We are concerned that the trust we had, and continue to have at this level, may not be shared above, and it may just be a question of understanding that history.

It is our hope that it is not that that history is not valued in this particular historical period, but that it is not understood.

We are also concerned that the question of

keeping our eyes on the prize has also been a problem, that we have drifted. Some of the ideas that originally came up in the IOM, that we feel are on the table and haven't been worked on, no-fault compensation for those that are injured by blood and blood products, and even more important, a national blood policy which we went into the IOM report asking for in the hearings and through the process, talked to Congress and believed that this was the committee where the framework, if you will, could be knocked down, the hard knocks part that had to be discussed had to be worked between communities, had to be negotiated, could ultimately be worked out with an eye towards taking it towards Congress.

We see this as kind of the model of how the committee is structured today and how it works, and we are more concerned in seeing this kind of model that has a more clarity of communication loop.

I come from the radio world, radio journalism, and we always talk about loops, be they

60-cycle hum loops, or be they communication loops between reporters in different places.

We think the loop outside the community, outside of this room and the committee, is not strong like it used to be. Our board has expressed a real concern about that, and a desire that I stay focused on that point with the committee today in our presentation.

These are the stakeholders as we see it, and this slide is just putting them on paper, really, you all know - the blood-banking industry, both the voluntary and for-profit, the manufacturers from the fractionators to biotech, the health and medical community, and the end users, consumers, advocates, organizations, such as the NHF, the Committee of Ten Thousand, Hemophilia Federation, the Immune Deficiency Foundation, all of us representing the community.

This is how our community, and I suspect through our work with the plasma users coalition, how some of the other communities view the mission, to coordinate the Federal Government's response to

threats to the nation's blood supply, using the interagency tools at its disposal, to evaluate supply and allocation of blood, blood product resources, ensuring available, safe supplies for communities and individuals in need, to bring relevant federal agencies together to ensure safety to the greatest degree available, and ensure availability through strategic planning for today and the future.

This is our sense of what works. The IOM report worked because it stressed the work between communities. The establishment of the ACBSA and the presence of grass-roots community representatives at the table worked.

Those were some fairly heady days in '96, '97, '98. There was a real sense of urgency and an openness on all sides of the table to listen to each other, to learn from each other, to help educate each other to move through what was then considered a crisis.

The inter-stakeholder dialogue and discussion that resulted, the interactive learning

that occurred on all sides of the table, the respectful and thoughtful dialogue discussion, it happened here. It also happened at FDA in the Blood Products Advisory Committee, and it was a very interesting period.

The openness of government to allow and nurture this creative and unique process to go forward, all parties working together to ensure adequate funding for the continuation of this interactive process and the inter-stakeholder process, and a key point - historical continuity.

We don't want 1997 viewed in a vacuum, or 1998 viewed in a vacuum. That was a moment that was important, but we saw that as the beginning of a new historical reality, a new mission, a new way government and communities that we impacted and affected by government decisions, industry as the producers, blood bankers, everybody could come together and talk to each other in a way they had never done before.

We are concerned, and our board talked about this, as well, is what we loosely called, and

we wrestled very much with how to communicate this in a way we felt would be effective, but resist the logic of power and a narrow professionalism in order to keep the committee alive, and we don't mean to take a swipe at professionalism, we do believe in it, but we think there is a natural thrust of government to move towards more centralization, less community involvement, and a narrowness to make sure everybody at the table has a DR in front of their name, Doctor, Ph.D. after, which is a good thing, but what we are concerned about is the exclusion that those who don't have that, who are the recipients of the decisions made here, made it to Food and Drug Administration, and made it upstairs in HHS, and we are very concerned about that.

Government and community support for grass-roots advocacy, we think advocacy has lost some of its value, at least upstairs at HHS. We don't necessarily see that in the committee because we still feel an openness from you all to work with us in a continued presence on the committee, people

like Mark Skinner, Paul Haas, people who come from our community.

One of the things that really worked in terms of this model for positive change, that I had the honor of being a part of, was the HIV Prevention Program, the Cooperative Exchange Program that went on between the Centers for Disease Control and the states.

We had 56 people sitting at the table in California from every community over 6 years, and we wrote a prevention plan that won numerous awards, and it really was the authorship of all these communities.

In the first few meetings, everybody had their own agenda including me, and we got nowhere, and by the third meeting, a group of us sat down in one of the hotel rooms and said this is going nowhere, people are dying, what do we do, and everybody's guard came down, and everybody's posturing stopped, including mine, and everybody got with the mission.

It was an incredible experience. I did it

for 7 years. I ended up 2 years as chair of the statewide committee. I think it's a model we should look at and understand, because it's one that really works.

Learning from the past, HIV. Obviously, everyone knows this, but I am going to walk through it. It is important to revisit it. It is not if new and unknown pathogens will present themselves, but when.

The issue is coordinated response and the time frame. Inaction ultimately leads to serious injury and potential death for the end users, as we found out with HIV and we are finding out right now with HCV.

Openness to new approaches is critical, be they medical approaches, be they policy approaches, principle of self-criticism as very distinct from denial and obfuscation on all sides of the table.

Hepatitis C, where did this epidemic originate? We are still not getting answers. How did we get such a high caseload, roughly 4 million we hear from CDC, and we still have not understood

the landscape from where.

Long-term historical decisions and assumptions were made and never revisited. I heard talk of acceptable risk or risk communication today. None of us communicated about the risk of hepatitis C. Decisions were made probably in the 1960s that resulted in hepatitis C as being seen as an acceptable risk.

I can tell you, as those of you that know me know, it is not an acceptable risk. I have lived with it for 35 years, and I am in pretty good shape. People are dying quietly in hemophilia again, in the darkness, without treatment, without care, and without any discussion about it, and we have a problem with that, and we will continue to raise it.

Decisions regarding risk must include the consumers. We have made progress in that area, but we need to underline how important it is. CJD, we have been unhappy about the response of this government to CJD right along. We think the British and the Europeans are ahead of the game.

I heard how wonderful our system is. There is no doubt we have a wonderful system. There is no question we have made serious progress. I don't worry about lipid envelope viruses anymore. I do worry about CJD, variant CJD, and other unknowns, and I do worry about the lack of what we perceive of coordination between the blood side and the food side, between FDA and blood, and FDA and food, between FDA and USDA.

We are testing a small amount of our cattle. I can get the specific number, it's in my notes, but given the size of the herds, it is way too small in number, and doesn't give us enough.

Grass-roots advocacy. The object of the system evolves into the subject of change. We became agents of change. We were the subject of a problem--we were the object of a problem, an epidemic HIV.

We transitioned ourselves to become agents of change. Direct access to end users and consumers allows for a clear vision and view of the material conditions on the ground in various

communities.

It also allows for the ability to present solid anecdotal information and data regarding end user communities, creative thinking, not narrowed by traditional norms and boundaries is important, peer advocacy programs that emerge from the conditions in the ground in end users' communities, and a needs assessment from those who are actually in need.

That is what we did in California, and we still put it on the table as really important. The creation of interdisciplinary approaches better suited to the natural conditions that traditional models may not be. A well-honed psychosocial program that addresses the emotional soul needs for end user communities.

I have heard a lot about communication of risk. I have heard a lot also about the IVIG problem. I am not sure, and I think those of you that are clinicians do know this, but I wonder if a lot of you understand the impact on us when we can't get IVIG or we are told we can't get factor.

I am lucky. I haven't had that problem except for once. When I was told by Blue Cross on a Saturday that I had capped out, I had no more coverage, I melted down for two days. Luckily, my father was there, and he had plenty to say, but the fear, the effect on my health.

About a week later, I had the bane of my existence with hemophilia, iliopsoas bleeds. I had a rip-roarer. I believe it was directly tied to being told I had no insurance because there was no injury, but there I was back in the hospital.

I think when we look at the whole client, not just the physical client, these kind of messages can be deadly. If you are immune-suppressed, you will get sick. Odds are you will pick something up. I think we can't underestimate.

I was glad to hear I think, Dr. Linden, you referred to this in risk communication, and someone else did. I was very glad to hear that. I think it is very important. I think there has to be a continued active role regarding empowered

communities, be they NHF, be they the Federation, be it COG, be it IDF, the value of all these communities.

Now, I want to say the most difficult thing I have to say. To all of you that are parents, that is my little girl, that is my youngest daughter. That is her quote. I have a hard time not coming to tears when I look at that, because unlike my twins, who are 32, she never had me without HIV hanging over us.

The twins never thought hemophilia would kill me, they figured he will bleed, he will hurt, but when we talk, they say we never thought you would die until we were 13 and you told us. This little girl never knew any different.

This is one of the little girls we are servicing. She's a carrier. What about her children yet unborn? She has been lucky. She has one child that is okay, a little boy, but she rolled the dice and I just about freaked, but she explained it to me and I understood.

The point is are we still focused there.

Here is what I see, and this is kind of a not too long a conclusion, but a bit of a conclusion. I told our board I do believe this is a committee cut off from its client, and I don't think it's the committee's fault.

I told the board I thought the committee was being a bit insular when I saw the words "strategic planning." In my seven years on the California Prevention Committee, I had the honor of working with Patricia Franks, Ph.D., heads up strategic planning for the University of California, and is a brilliant woman, and I had the honor of her deciding that she liked me and saying stick with me and you will learn a lot about planning.

Well, I did, and for seven years, from being a chair to a committee chair, I learned about strategic planning. I have seen the word "strategic" today, but I haven't seen the meat of what strategic planning is really all about.

I feel, and this is more a feel comment, the committee feels like it doesn't believe it has

the power to change things, and granted, from our perspective, we have had two clients, two Secretaries of Health, that didn't seem as interested as Dr. Shalala was in these issues, and we have all had a rough time trying to keep health on the agenda.

But I think what is lacking is leadership, leadership about these issues, leadership about strategic planning. The discussion I heard about IVIG this morning, about immune globulins, I mentioned to Marsha Boyle, we had that discussion in 1998, when the committee was meeting I think right on the Rockville Pike at one of the other hotels.

Those discussions were deep. That is when everybody was upset that some of the home care companies may have been hoarding or manipulating supply. They were incredibly contentious meetings. Where have we come since '98 on this issue, why are we still talking about allocation of IVIG and supply?

If we are really strategic planning, then,

we are going to develop a plan that we pray is a national blood policy and addresses these issues now, so we are not reactive, we are not reacting to a crisis, we are not reacting to a situation, we have this overall plan for the nation.

How important is blood to this nation? I can't answer that, but I think we have got to strive harder to find out together. The committee has to believe it can make change, and we have to believe that we can work with you to do it, and if that means those of us in hemophilia that did it for the Ricky Ray bill back on the Hill, and beat the pavement until we get a response, we are ready to do that, but we need an ally.

We need an associate, someone to work with, and we are not always going to agree on everything, but I think we do agree that a national policy is called for, and a nation of this size, the world's leading nation does not have a national blood policy.

I am not sure how you all feel about that, but we continue to be shocked by that, and

frustrated and ready to go do what we need to do to make it happen, because at the end of the day, even if she wasn't my daughter, I would want to do something about it, but the fact that she's my daughter makes it all the more critical that I have some answers if she has a son with hemophilia.

So, I urge the committee to look at some of these issues. I again thank you, Jerry, for the time, and everyone else on the committee for listening, and we are always appreciative to be a part of this process, and have been here since the beginning, and we will continue to be here.

The only issue is can we find enough young people to reinvent ourselves and mentor ourselves, because coming in today, I was saying, well, I was a young turk 15 years ago coming in here, and now I am getting to be an old man. It's a little scary.

Thank you very much. I really appreciate your attention and your consideration.

DR. BRECHER: Any questions or comments for Corey?

Okay. Thank you, Corey.

Are there any other public comments at this time?

Committee Discussion

DR. BRECHER: If not, we can begin sort of our committee discussion. We have several things we can talk about. We can go back to IVIG from this morning. We can talk about the strategic plan. I think it is probably worth spending a few minutes talking about what Corey has just discussed.

So, what is the committee's pleasure, where would we like to begin? Let's talk about some of the issues that Corey has brought up first. I think we can move that off the table first.

I think that his committee's perception that the senior management at HHS is not particularly paying attention to this committee is an interesting observation. I was wondering if the other consumer groups have that same feeling. Maybe Mark for the National Hemophilia?

MR. SKINNER: Well, Paul is actually president of NHF now. I don't want to usurp him.

DR. BRECHER: Sorry. Paul, go right ahead.

DR. HAAS: I guess I am a little sorry to admit that we haven't had this discussion as an organization, but I personally would agree with what I heard Corey say.

MR. SKINNER: The only comment that I would add is i mean I think the committee in general was extremely disappointed a couple of years ago with the silence when we put committee recommendations forward and we weren't getting formal responses.

I do think that has changed, that we are getting responses. Whether they are actually translating into the actions that the committee had contemplated, I think there is something still missing there, but at least we are getting an acknowledgment that we put a recommendation forward, and there was a period where that wasn't even occurring.

DR. BRECHER: Additional comments?

Why don't we move to the IVIG question. I

am sorry, Jerry?

DR. SANDLER: I will give a personal opinion that when we had a movement toward a national blood policy, I had the feeling that the Assistant Secretary of Health was given the charge of a leadership position.

I don't see any leadership coming in this area transfusion safety from above. I think we are more engaged with them with Jerry Holmberg's initiatives than we ever have been, and we are exchanging an awful lot of communication, recommendations, and we get the most wonderful blowoffs I have ever seen, but I don't believe that there is any major leadership in blood safety and availability coming from above.

They are responsive to our initiatives with communications that haven't taken a leadership position.

DR. BRECHER: Celso.

DR. BIANCO: I am trying to be careful with my words.

DR. BRECHER: Aren't we all.

DR. BIANCO: I am going to say what Jerry said, but from a different perspective. I don't think that the Secretary or HHS understands the role of this committee. It has been a long time between the IOM report and what the committee was designed to do today, and I think that we are just one of the committees that raises issues, comes with points, but I don't understand that they see the importance of what we do, and this is my last meeting, so it's okay, I can say that.

DR. BRECHER: That's what you think, Celso.

MR. SKINNER: I just want to make one other comment, because I do think Corey's comments were very timely, and sometimes silence can be misinterpreted either as agreement or disagreement, and I think Corey's comments, particularly at a time when we are talking about strategic planning, bringing the committee back to why we were originally created and for who we were originally created is extremely important.

I mean there was very much a compelling

need for the committee at the time we were created, and the IOM study gave us that blueprint, and we have been struggling with what is that blueprint that we are working through an agenda, so we take up a series of ad-hoc issues which are very important, and we have drifted from perhaps that original rallying cause that brought us all together.

It may be a natural evolution, but the purpose of why we exist, I mean also comes from the top down. It came from the outside in, and it was created through the IOM study, and now keeping that agenda focused.

So, hopefully, through this kind of strategic planning process, we are going to be able to get back to a template of issues then that we are going to be able to work through, but I think that is what has been missing, is that overriding theme that has compelled us from each meeting to meeting.

DR. BRECHER: Judy.

DR. ANGELBECK: I have to say, as one who

is charged with the topic on integration, I think Corey's comments about the exclusion of the grass-roots community in strategic planning is one that we really need to take to heart, because ultimately, if they are the receivers and the citizens, they need to be part of the process, in my view.

I have not been a participant in the committee as a member since its inception, but I have been an observer since its inception, and with respect to that, I would say I think the committee has lost its intensity and direction towards that community.

DR. BRECHER: Sue.

DR. ROSEFF: I have one question and a comment.

First of all, what is the ability of the committee to do something when we feel we are not being listened to? We may talk about this tomorrow, but with IGIV, we have seen that nothing has changed since our last meeting, and there is concern that things are going to get worse in

January, and we have got no response from the Assistant Secretary, so my first question is, well, what do we do.

My second comment is basically I am thankful that one of the issues that didn't come up during Katrina was that there wasn't a blood availability issue, but in a way, that sort of puts blood in the background again.

I think what we are always doing is responding to the disaster, and the hope is that with the strategic plan, that we will not be responding to a disaster, that we will have something in place to be proactive.

So, I think it is our job to keep the level of the blood supply, availability and safety high on the agenda because again, I don't hear as much about it as I did after September 11th, because it doesn't seem that that has come up to the same intensity.

So, first, my question is about what do we do, and, second, is just a comment that I think that the level of looking at the blood supply keeps

dropping when there is not a big disaster upon us that is affecting the blood supply.

DR. BRECHER: Jay.

DR. EPSTEIN: I think that there is an inherent paradox, if you will, about the role of the committee. It is true that the committee was established in the wake of the IOM report about decision-making in the HIV era.

It is also true that the IOM recommendation was for the establishment of an advisory council to the Secretary or to the Department, and I think we need to remember that the committee serves at the pleasure of the Department and that essentially, the Department decides that on which it wishes to be advised.

I think that the paradox and the tension comes from the fact that the committee members realize that they also need to lead the charge, that they are not there just to answer the questions posed by the Department, but that they have taken upon themselves, or the committee has taken upon itself a role of sort of taking a

birdseye view and being more proactive on issues.

I am just not sure that that role and mission is what is central to the committee charter, and I think that is part of where the tension comes from.

On the question is whether the committee is effective, you know, we have had a number of meetings where we have reviewed recommendations and outcomes of recommendations, and I think that what you really have is sort of a good news/bad news story, that on some issues we have been able to prompt quite a bit of response in not just government, but also the private sector, and then on other issues, there has been frustration because we have not been able to see the outcomes that we might have liked or the responses that we might have liked.

But I guess my view is just a little bit more colored because I just don't see it as all of one stripe. I simply think we have had our successes and failures.

DR. BRECHER: I would tend to agree with

you, Jay. I think just in the last few years, the Interorganizational Task Force, I think it has been a success partly from this committee. I think a lot of the issues over bacterial testing were worked out in this committee. HCV lookback years ago came through this committee.

So, I think there have been a lot of successes, a lot of issues of reimbursement have come out of this committee. Not all of them have been resolved to the satisfaction of everyone, but at least it has been in the avenue of getting those opinions out there.

Any further comments or questions? Paul.

DR. HAAS: It's half a question and half a comment, I guess. I think a major part of what Corey was just saying to us was how do we, as a committee, or maybe the Secretary, receive this information from the grass roots.

I think as much as I agree with what I heard Jay just say, and you have just said, in terms of some successes, again, I am going to be a little repetitive here, but the intensity of the

original committee meetings, of which I guess I am one of the few that is still here, that has changed, and maybe that's good, but as it has changed, I will use Mark's term, the focus of what this committee is doing I think has changed.

Without the crisis out there, as we had with AIDS first, and then understanding hepatitis, what can we, as a committee, generate that type of focus again, so that we have that type of--I won't say the word excitement--that we had in the earlier years, and I don't know if we can do that, but I think it is an important part of I think what I see this committee doing is keeping aware of those issues just like the IVIG business coming through here, and we want to stay focused on that.

DR. BRECHER: Yes, it is sort of like do we really want to live in interesting times.

Other comments, questions? Merlyn.

DR. SAYERS: Corey and I go back to the circumstances that you were talking about when tension filled the air, and an urgent need to be active was felt by everybody.

I think one of the things that has happened during the embryology of this committee is that the sense of urgency has been reduced largely because of gains in transfusion safety.

When we were talking about transfusion-transmitted HIV, there was an understandable national anxiety. It is not as easy to develop as much energy talking about transfusion-transmitted ehrlichiosis.

I think that is one of the sets of circumstances which distinguishes our behavior now from then. One other thing, Corey, and I have said this to you before, when I have heard you talk, I am sometimes left with the sense that somebody that has an M.D. immediately has a net degree of filter, which prevents him or her from understanding what the issues are at the grass-roots level, and I can't agree with that, essentially because many physicians are themselves transfusion recipients and dependent on transfusions, and many physicians are treating physicians, and they certainly are sympathetic, if not because they are transfusion

recipients themselves, but certainly because they might be treating individuals who are transfusion dependent.

So, I don't think an M.D. degree or Ph.D. degree really superimposes some sort of censure on your understandings.

DR. BRECHER: Art.

DR. BRACEY: One of the things that I have just been thinking about as we have had this discussion, clearly, what sparked this was adverse outcomes released to transfusion, but the other reality is that blood is to medicine as oil is to armies. You can't fight a war without oil. There are many things that you can't do in medicine without an adequate blood supply.

I would think that the higher ups, if they began to have some sort of strategic vision, would see this and therefore would see that the work of this committee, perhaps, you know, they are focused on its origin as opposed to other possible destinations, so again, to me, I think the key now is to look at blood as a resource and to begin to

focus on the good things that it can do and the needs.

You know, we are in an era of advancing aggressive medical therapies. We won't be able to provide those therapies if we have an inadequate supply. This is something that I think that the higher ups would understand.

DR. BRECHER: Unfortunately, sometimes it seems like you have to have a headline in the Washington Post of the New York Times to get their attention.

Jay.

DR. EPSTEIN: I tend to think that it's a good thing that the committee has evolved to taking a global perspective about our system as a whole and how it works in all its parts. I think that we are in a position to do more long-term good from that perspective than dealing, you know, urgently and in a crisis mode with particular issues that are pressing, not that that is unimportant when important issues are pressing, we deal with them, and we should, but isn't it a good thing to be able

to take a step back and ask what are the problems with our system and how can we make our system run better.

The second point I would make is that a strategic plan for the Department to undertake shouldn't be thought synonymous with a strategic plan for the committee. I think it's an open question what role this committee is advisory to the Secretary should play in any such plan should it emerge. It is not at all clear to me that it's a plan that the committee should assemble, or the committee should oversee, or the committee should try to establish. I tend to think not.

Lastly, I think that Corey has again reminded us of a very important thing, which is that we shouldn't be out in the ozone, that the concerns of the patients and the product end users are our core business, and I think that is correct, and I think that if we approach the development of a strategic plan, it can't be in a vacuum. It has got to be with a very real-world consideration of how are people being affected in their daily lives

by what we are doing with the U.S. blood system and all its elements.

So, you know, I resonate to that very strongly, and I agree that the empowerment of the consumer community, the patient community, and the advisory committee processes has been a tremendous advancement in public policy.

I think that we don't want to lose that element even if we now find ourselves, you know, speaking calmly.

DR. BRECHER: Celso.

DR. BIANCO: Corey woke us up, and I think that this is a wonderful opportunity, coinciding with what we think now in terms of a strategic plan.

I slightly disagree with Jay on who should conduct such an effort, not necessarily the day-to-day of getting days and nights talking about the actual strategic plan, but I think that it is necessary. This committee is supposed to set national policy in blood, and it is necessary that at least a guiding principle is the overall strokes

be set by this committee.

It, I believe represents a lot of the people involved, is an open committee. There are many patients in the committee. By the way, I am a transfusion recipient and lots of units, and the public has access to this committee. So, at least I think that the effort that we had this morning, even if possibly or probably we didn't hit all the right keys, is an initial effort, and we have to put out, not necessarily the answers, but all the right questions.

We don't have to respond to emergencies only. That is what we have done always in the past. I think that we have to ask ourselves are those questions going to help us if we answered them to do things right in the future, and I think that is our role.

DR. BRECHER: Other comments or questions on the subject? Corey, we are listening. We have been listening to you.

MR. DUBIN: Two things. Merlyn, I would never draw a line. You protected me on the podium

when Paul Holland wanted to make a mess, and you stepped up and said it wouldn't happen, and it is not that I see a difference, because I don't, because at the height of the crisis, you and I were delivering a talk together when most people thought we and you guys wouldn't talk to each other.

So, I didn't mean to juxtaposition it in that way. I think we need to continue to work, docs, us, researchers, CMS. Dr. Bowman, I would love to hear more from you. I would love to understand CMS better.

I look out. Jay, you know how I feel. I think you are one of the best people out there in the government, and it is not that I think the committee should be the be-all, end-all, but I think it screams for leadership, and I know there is such good people at this table that know how to lead - Celso, Jay. I mean I could go down the list around the table.

So, I think we are calling for leadership. Maybe guidance would be a better word, Jay, that would be more comfortable, because I agree with

you. The Secretary can wave his or her hand, and it's over. We know that, but we also think you all have so much credibility in the game, so to speak, and we are ready to do what we can to support that with the Hill, and, look, we may be small, but we accomplished something on the Hill nobody said we could ever do, and together we did it, all of our groups.

So, I think from us, it's just a call, and I don't want to go back. Somebody said thank God, it's not I think the dialogue of the late '80s and '90s.

I don't want to go back to HIV, but there are two crises out there. One is reimbursement, and reimbursement is almost like the controlling for allocation, and that is a crisis, and we are all frightened about that, and hepatitis.

I really appreciate that you all considered our words very carefully. That is clear to us, and we will continue to be in the process as long as we have got some breath going, and then hopefully, my daughter will be standing up here,

and she's tougher than I am, look out, but thank you.

DR. BRECHER: Jan, did you want to say something?

MS. HAMILTON: Thank you. I just wanted to say several things were said this afternoon about blood policy, and I was just trying to ask--I can't remember how many years ago it was, but a comment, I don't know, Celso, if it was you, or somebody over here, said that this group should be setting the blood policy.

I went to a meeting, I believe it was in 2000, if I am not mistaken, it was held by the CDC, and a whole bunch of us sat in a room all day long and talked about whether the national blood policy needed to be updated, and nothing was done.

I sat here thinking why wasn't that being done here. So, I think, if nothing else, you know, I mean we support a lot of Corey's statements, and things that Paul and Mark and everybody have said, and I sat here and listened a lot of times when this committee deliberated for long hours and never

got an answer from one meeting to the next, to the next, from the Secretary.

I see that changing to some degree, and I am delighted with that, but maybe that's a good project for 2006 for this committee, is to look at the national blood policy. I mean it still says something about plasma, and doesn't go any farther than that, and that is sad.

We should be talking about the future and about the things that we have, instead of just going back just to plasma. I think you are right, whoever said it, this is the place for that to be.

DR. BIANCO: Jan, it hasn't been revised in 35 years.

DR. BRECHER: Any other comments or questions? Why don't we take a 15-minute break.

[Recess.]

DR. BRECHER: Could the committee members take their seats, please.

We have two major topics to cover of the remainder of today and basically, all day tomorrow,

and that is, number one, coming to some conclusion about the message we want to put forward about IVIG, and, number two, the strategic plan and policies for mitigating adverse diseases and other things that could come into the blood supply.

So, I would suggest that we start with the IVIG question. We have made strong recommendations from this committee to the Secretary on two occasions. I think that they have heard the message, although we do not see definitive action as yet.

I see us as having two choices. One, we can come up with yet another resolution; or, two, in the letter to the Secretary, well, we are going to almost certainly make some sort of resolution about the strategic plan.

We could simply state that the committee remains concerned or even gravely concerned regarding availability and reimbursement for IVIG, and request that policy alternatives be considered, and that is not a resolution, but I think it would get the message across.

So, I would be interested in hearing opinions.

Mark.

MR. SKINNER: I do think there is one thing that is new since we last met. I mean other than there is more information than that, you know, the pricing system does not work to support the needs of the patients, the reimbursement system, but the piece that I honed in on in the Secretary's response, in the April 8th letter, was that they find that there is sufficient supplies available for the patients and that is marketplace adjustments.

I am not sure whether or not the information that we have heard agrees that there actually is a sufficient supply out there. If it is sufficient, it undoubtedly is extremely tight, and there isn't much margin. So, I think the word "sufficient," probably is overly generous.

There may be a supply out there if you are in the right place at the right time, but I think the evidence is it is getting tighter, and I think

the new piece that we learned at this meeting, or that has at least transpired since the last meeting, we may have learned it before this meeting, is that the companies have gone onto allocation, which is further evidence that, in fact, there is a supply problem. The companies wouldn't have got into an allocation or a rationing system in terms of the distribution of the product if there was a supply problem.

So, the point that the Secretary came back on, which I assume is the reason, then, that they didn't choose to go forward with declaring a public health crisis, was the supply piece.

So, my thought was that we should respond by saying, you know, that there is, in fact, a supply program, and it is further evidenced now by what is happening in the marketplace in terms of allocation, and then underscore and go back and ask them to revisit the alternatives, which may include declaring a public health emergency, so that we can take short-term action until the reimbursement pieces and the pricing and the data can catch up

with what is occurring in the marketplace.

DR. BRECHER: Paul.

DR. HAAS: This really follows on Mark's point. I think another piece that was driven home today was the issue of where the treatment is taking place. It is shifting, and those of us that are accustomed to home treatment type of phenomenons know that that shift is not good for the patient.

And then to your question, Mark, about should we attach this concern onto another, if we think the IVIG is a is a significant concern, and I happen to think it is, I prefer separate messages.

DR. BRECHER: Art.

DR. BRACEY: One other part that concerned me is that in terms of the shift, there is an assumption that the shift will, in fact, occur, and one of the things that I was thinking of is that clearly, since there is the capability of contacting places where this shift would occur, i.e., at the hospital settings, et cetera, would be to ensure that we are not working on an assumption,

so that we would end up in a reactive mode, but if we could sort of prospectively go out and find out if, in fact, this new business model would be acceptable to those places where the shift is assumed to go.

DR. BRECHER: I think also we have to be clear to state that this is a non-sustainable shift, that come January 1st, 2006, even this shift will not support the patients.

Karen.

MS. LIPTON: That is my concern, that looking forward we don't really know what is going to happen, and we are assuming that the shift is occurring, but no one really was able to answer the question that I think Jerry posed, which is are those supplies that we previously went to the physicians' offices, are those indeed being allocated now to hospitals, and are they being allocated to hospitals where they expect those patient populations to show up.

You just have the feeling that there might not be an overall supply problem, but you just get

the feeling it is not showing up either where it is supposed to, and it is causing serious problems for those patients.

I will say it again, I said we keep taking actions, and we don't realize what the tail is on the end, and I almost think we are harming things without stopping and saying, look, you have to look ahead here, and if we don't think ASP plus 6 is going to work in the primary care setting, why do we think ASP plus 8 is going to even remotely work in the hospital setting.

DR. BRECHER: Jerry.

DR. HOLMBERG: Julie, are you in the back there? Can I ask you a question, please? Allocations, when did they go in effect? I thought that they were in effect way before our May meeting.

MS. BIRKHOFER: Yes, each company has made their individual decisions based on their business practices to put in place allocation, which again is based upon historical order volumes. PPTA, as you know, maintains a data gathering program, and

for IVIG, since January, the data has been in the yellow light, which is approximately four weeks of inventory is available.

Comments made to the fact that the market is dynamic and changing, and that companies have streamlined their distribution practices is evidence that four weeks in this market may be sufficient.

So, from PPTA's industrywide data, there is not a shortage, there is not a supply issue. We are in the yellow. Yellow means four weeks. It does not mean that there are shortages.

MS. VOGEL: Hi. Just to react to that statement, IDF receives calls from all different sites of care. At this point, I mean it is not a matter of just a tightening market. I mean we could talk about it in different terms.

The calls going, in the first place, about shift of site of service, you are right. I mean the allocations, I mean every product is on allocation. When you are shifting a huge number of patients from one site to another, the allocations

don't follow the patients. So, the hospitals are getting increases there.

However, and this is a big however, we are seeing a trend right now of allocations being reported into IDF being cut by 20 percent, and that has nothing to do with the increase in Medicare patients. Don't know why that is happening, it could be with Red Cross leaving, exiting the marketplace, I am making assumptions at this point because I am not an expert on the supply area.

I am just reporting back to you what we are hearing, but there is many, many hospital systems who are taking on these patients who don't have either product because of the increases, or are talking about allocations being cut.

So, in this scenario, the best situation is to get patients back into the right sites of service and to treat them. Until we do that, we won't know the true seriousness, if we have a true supply problem or not. We have to get them where they need to be treated, and at that point, we will be able to tell if there are supply issues.

DR. BRECHER: Julie, did you want to say anything? Okay.

Jay.

DR. EPSTEIN: I would like to ask Julie a question. Can you confirm the assertion that the distributions have been flat for the last six months or so, because I think part of what concerns me is that there was an historic trend of steadily increasing utilization, and what has happened is that in the face of that trend, there has been for at least the last six months, flat distribution.

So, on the one hand, it may be that there is, if you will, not a supply crisis in the sense that there is enough supply for well-established indications, for example, but the problem is, is it sufficient in the face of the historically accelerating demand, or is there a deficient supply relative to the demand that exists, in other words, we can't meet all prescribers' needs even though we probably could for some subset of those prescribers' needs.

I think that is part of it.

MS. BIRKHOFER: I would completely agree with you, Dr. Epstein. Distribution has remained, as you say, flat, somewhat aligned over the past six months. Demand, we know has increased 6 or 8 percent, and the companies, given the manufacturing processes that it takes 6 to 9 months to bring these therapies to market, the companies are all individually looking at ways that they can manufacture more.

But we can't make that prediction. All we can base our comments on is what our supply data, industrywide supply data shows, and also non-PPTA member companies report this data, and again we are showing inventory in the yellow consistently.

DR. EPSTEIN: If I could press the point a little bit more, the yellow zone was defined, after all, arbitrarily. In other words, how is the supply stratification of red light, green light, yellow light, designed in terms of demand? In other words, what makes yellow yellow in comparison to effect of demand? How do you know that what you are calling yellow isn't really red?

MS. BIRKHOFER: That is one of the things that the PPTA North American Board of Directors is looking at. The traffic light system and the ratios that trigger those lights, that was put in place about six years ago, working with member company representatives, as well as Georgetown Economic Services, GES.

Georgetown Economic Services are Ph.D. economists that help look at the market, and basically, they put ratios in place where about 0.25 equals about one week of supply, so right now, when I say we are in the yellow, that is a ratio of between 0.6 and 1.24. 1.25 and above is green and 0.5 and below is a red light.

Again, you know, these ratios were put in place five, six years ago. What PPTA is looking at now is yellow or new green based on the current market dynamics, but that is something that we can't change the ratios now, you know, as arbitrarily. We need to have deliberation, we need to work with the economists, we need to relook at things.

I mean we can't, in the midst of this question of is there supply issue, is it reimbursement, you know, the perfect storm, is it demand. We need to give this time to let the market play itself out.

DR. BRECHER: I guess what people are concerned about, it may not be red, but maybe it's orange.

Celso.

DR. BIANCO: Actually, for Julie, did I understand you correctly that the ratios, they are not adjusted for the increase in demand?

MS. BIRKHOFER: The current system in place was put in place about 5 1/2, 6 six years ago.

DR. BIANCO: So, you are using a week, what was used, the IVIG that was distributed during a week 5 or 6 years ago.

MS. BIRKHOFER: That's correct.

DR. BRECHER: Michelle.

MS. VOGEL: I would also like to make one other comment. The other thing that is being

reported in to us, many hospital systems are starting to put in their disease state management programs and putting pecking orders in place based on who should receive IVIG first because of supply issues in those hospitals.

So, that also brings concern issues to the forefront.

DR. BRECHER: Jerry.

DR. HOLMBERG: Just to point out on that, that fact, in my discussions with the pharmacists that have put in various prescription reviews, that really the labeled uses are going first, and that that is a high priority.

Actually, when they get a request for an off-label use that does not match one of even the 30 that CMS has added to, that what they have done is they then take it internally within their own review process, but the pharmacists that I have talked to in representing large hospital organizations, have said that having this mechanism in place has ensured that the people that need to get the product get the product first.

Can I add another comment? I see two other issues here. We did hear comments--I could guess three different issues that I would like to talk about, and that is that, first of all, we have heard this morning that there has been an increase in the albumin utilization, which also drives the economics on the manufacturer side, which may also help correct the market.

But then also with the ITP, I saw that in the booklet that AmerisourceBergen has given us, that ITP accounts for 8 percent, and isn't there a new course of therapy for the ITP that will be moving away from the use of IVIG for ITP? So, is there a potential gain of 8 percent?

DR. WONG: Are you talking about WinRho?

DR. HOLMBERG: Yes.

DR. WONG: There is a choice between the two, and the side effects are different. So, some patients may opt not to use WinRho even though, in our hospital, it's the first line for ITP, because of the IGIV issue.

DR. BRECHER: Of course, it only can be

used on the Rh-positive individuals.

DR. WONG: Yes, but most people are.

DR. BRACEY: The other thing is that recently, there are some negative reports in terms of risk associated with WinRho, that are beginning to come out, and I would think that that is going to impact, to only increase IVIG requests.

DR. WONG: To clarify, the negative reports were on intravascular hemolysis, is that what you are alluding to? Yes, that is still under investigation right now. Most of us have not seen that. I just came from an expert panel looking into the side effects. So, we are still monitoring that.

DR. BRECHER: I guess there also is another IV preparation of anti-D that is on the market, although I don't think it is approved for the ITP indication as yet.

DR. HOLMBERG: There was a third point that I wanted to make, and that is that we still go back to what is ASP, and ASP is the average sales price coming from the manufacturer.

That is being calculated and monitored. Now, it doesn't take a rocket scientist to be able to figure out what is happening between the manufacturer and the pharmacist.

Obviously, there is somebody in between, and so how do we get a handle on the prices, because I get reports every day that sometimes it is up to $118 a gram, $120 a gram, and so that is not coming from the manufacturer or else we would see an increase in the ASP.

So, there is a problem here in the distributor. Now, the manufacturers have two different choices. They can go either through their distributor or I think the AmerisourceBergen says the unencumbered pathway, and through the unencumbered pathway, that may be the free market or the spot market approach.

But the bottom line is how do we get from a system where it is being reported to CMS one price, but then when it goes through a secondary hand, there is an increase in price, and I think that that is what we are all struggling with.

DR. BRECHER: Karen.

MS. LIPTON: It is interesting you raise that, Jerry, because I was struck by that, too, as I was leafing through, and it says unencumbered, which are mostly the primary care physicians' offices are the ones who do not have a contract price, so they are really floating more and go through the distributors.

But again I think that that situation still comes back to, that means that ASP probably doesn't even work in a setting when you are dealing with a primary care physician, because maybe their prices are so volatile.

No matter what, it still affects where the patients can get care, and I think that is what our concern is.

DR. HOLMBERG: I think of one of the things that I have heard from the grass-roots people have been, especially clinicians treating, is that shifting the patient from one location to another, the iatrogenic problems, the infections, and one physician that I talked to said yeah, you

know, I did get treatment for this patient, but he wound up one month on IV antibiotics. That is another side effect.

So, you know, what are we doing here, and also I think that Marsha Boyle, I think that you did mention in one of your notes there about the cost, that somebody had made a comment that it was like 600-some plus dollars. I am sorry?

MS. BOYLE: It is much more expensive in the hospital from what we are hearing.

DR. HOLMBERG: And that is because it is under the AWP at 83 percent.

DR. WONG: Do we have any idea how much it cost ASP Plus 10 percent, plus 15 percent for the physicians to be able to administer it?

DR. BRECHER: That's a good question, where would it break even?

Jerry.

DR. SANDLER: I would like to make three comments. The first one relates to the letter that we got back dated August 8th, addressed to you, Mr. Chairman, and signed by the Acting Assistant

Secretary of Health.

The third paragraphs says, "that after discussions, we concluded that there are sufficient supplies available." But when you get to the fourth paragraph, the Assistant Secretary says, "We believe that physicians should ensure that priority be given to FDA-labeled uses and those diseases and conditions that have been shown to benefit based on safety and efficacy."

I find a little disconnect here, because that last statement is, in effect, saying that the current conditions require that we tell doctors not to treat patients the way they best attempt to do so. I mean a physician orders IVIG off label is not doing something bad.

The FDA-approved indications evolve from the experience that has been derived by treating people in this way, and there are many people being treated in my hospital with IVIG off label, who are absolutely getting benefit.

So, going off label isn't a bad thing.

The second point I would like to make, I

work in a hospital. I have been working in hospitals most of my career. It is absolutely not the optimal place for a doctor who is following a patient with a primary immune deficiency disease to be sending his patient.

Most patients wait for their appointment to talk to their doctor or to talk to the case manager or to the nurse practitioner, and at that point say, by the way, you know, I have been having this or that happening, and I was kind of waiting until I come in.

The transfer of these patients is putting them in a situation where they are going to be losing contact on a regular basis with their primary caregiver, and this is not a shift that should be driven by economics. It is not going in the right direction.

The third point I would like to make is this whole issue I think underlines what Mr. Dubin was pointing out in his very first opening statement, which is, isn't there some loss of connection between this committee and the people

and the higher ups who make decisions.

This is something we communicated was really urgent. We said this is really urgent, and the people who are making the decisions are handling this with a 5-page paragraph letter saying, well, we heard what you say, but we have done some other stuff, and our advice from what we have done overrides the advice you are giving us, which is exactly what Mr. Dubin was trying to say about the discounting of the importance of this committee at a high level, and this is a very good example of how that discounting is taking place.

DR. BRECHER: Jerry.

DR. HOLMBERG: Dr. Sandler, I sort or take a different view on some of your comments that you have made there, and that is that in taking the recommendation, there was a lot of investigation done on the whole supply and demand and reimbursement issue.

I can say that this is one reason why I follow up on every call that I get on a complaint that supply is not available, because when I do

follow up on it, the supply becomes available.

So, you know, I don't understand why a phone call has to be made to shake something loose, what other dynamics are going on here, and so really based on the evidence that has been presented to the Department, yes, we have a tightening of the market, but I don't think we have a supply issue.

DR. SANDLER: Well, I want to go back to that statement that says physicians should ensure that priority be given to IVIG treatment for FDA-labeled uses and conditions.

Inherent in that statement is it looks like we are in a situation where doctors shouldn't prescribe this medication the way they think they should for all of their patients. That is what that is saying, and it seems to me that it would be really great if it said the United States of America, with all of its resources, has enough IVIG to provide for all of the patients including those that doctors feel deserve it.

DR. BRECHER: All right, Committee, what

are we going to do?

Karen.

MS. LIPTON: I guess one of the things again what we heard today is really this issue of patients moving, so if we said something else, it really is that patients can't receive the care that they need to get in the primary physician's office, and we don't know why, but that trend has not stopped, and there still seems to be an erosion in care.

Now, maybe we can't really weigh in on what we think it's the reimbursement or we think it's the supply problem, because I am beginning to think we don't really know if it's a supply problem.

It certainly seems to be, if it's not supply, an allocation. What we don't really understand is reimbursement driving that issue or is there something else at work. But at a minimum, it seems to me we could still send an urgent message that we have seen no positive change in the very disturbing trend of patients being removed

from their normal primary caregiving setting, which we believe is beneficial to the patient, and it is being transferred over to that hospital setting, and we don't think that is in the best interests of these patients.

DR. BRECHER: We also can reiterate that the impending change in reimbursement in the hospital setting will make this shift to the hospitals non-sustainable, or we anticipate that it is not sustainable.

Michelle.

MS. VOGEL: DR. Holmberg, you have done a great job in following up on all these cases, and I thank you so much. Just looking forward, I mean January 1st, when the prices go down, no matter what the supply issue is, you can make all the calls you want, it is not going to open up the doors to these patients.

So, I agree with what your statement is, going forward with that. The other thing is what we can say we do know is that since this past January 1st was when we started seeing the shift in

patients. When CMS increased their rates a little bit January 14th, we saw a little bit of a hesitation and patients were okay.

Once April hit and the products were separated, and the prices crashed, all of a sudden the shift happened dramatically overnight and continued to spiral downward. So, no matter what is going on with supply, we can definitely say that reimbursement has affected the transitioning of patients, and we know that this transition has happened in Medicare patients, and is not happening in the private insurance market.

So, in that, we can say that ASP plus 6 percent has caused this.

DR. BRECHER: Mark.

MR. SKINNER: Can I ask one more question? I am going to try to ask, and maybe it's what Dr. Sandler was getting to, and maybe this is a question for Julie.

If the companies were not on allocation, would there still be a 4-week supply, would they still be in yellow, or is it the allocation process

that is actually creating the artificial yellow light--I should say is creating the yellow light that is artificial?

MS. BIRKHOFER: That is a very difficult question, and I really don't have a crystal ball, I can't answer it. I can only tell you what I know today, and based on our data today, there is sufficient inventory that translate to 4 weeks, and just to clarify Dr. Bianco's question, although these ratios were put in place 5, 6 years ago, they are obviously updated monthly. The ratio represents distribution divided by the annual 12 month of inventory.

So, they are updated, they are rolling, if you will, but I can't speculate, I just can't.

DR. HOLMBERG: Just to follow up on what Michelle Vogel commented about, and again on what Dr. Brecher has already suggested as far as wording, any of my comments I really, you know, I am trying to address the immediate need, and yet what is in the back of my mind, and what we have to keep thinking about, is what is going to happen

January 1st, and I fully agree with that, is that costwise, what is it going to cost the U.S. Government for Medicare patients when they get shifted over to greater than 24-hour care under a DRG.

I have not been able to get the answers for that, but see, that's the next shift that you are going to see, I mean as far as my opinion, in predicting what is going to happen, is that you are going to see--you have now seen it go from the infusion centers, home care, physicians' office, to the hospital outpatient. Then, it's going to shift to the inpatient under a DRG.

That is a concern, and I don't mean to discount, with some of my comments, the fact that we need to be looking forward to what will happen January 1st.

MS. VOGEL: And I agree with you, Dr. Holmberg, and what is really scary with that is, you know, medical necessity, do you have to be admitted as an inpatient to receive IVIG, and the answer is no, but what will it take before you can

be, and how sick do you have to get before Medicare will cover you as an inpatient to get your infusion.

At that point, it will be too late, so it really gets to the point of how many patients are we going to allow die before something can change. I mean there are certain things that we can try to prevent for the hospital reimbursement, what has happened in the physicians' offices have occurred.

The only thing that can change that immediately is the Secretary either declaring a public health emergency or Congress making a statutory change. I mean those are two options right now for physicians' offices.

The other option for hospital outpatient right now to prevent the hospitals from crashing is for CMS to look during the proposed rulemaking and to state either one of the options that we have talked about, an add-on payment or dampening provision or separating out these HCFA codes if they are willing to do any of that.

If not, they go with ASP plus 8 percent,

we have a disaster on our hands, and then what happens in going to inpatient and when will the hospitals be willing to allow the patients to be admitted. So, we have a serious spiraling effect.

We know that there are many private insurance companies have dropped their rates, Medicaid has dropped their rates, the Federal Employees Health Benefit Program has dropped their rates, and we know Medicaid reform is about to occur, that is going to mirror what Medicare has happened.

So, for a population that is so fragile, that needs this one therapy and can't get it, it is devastating, and I don't understand what we need to do to get this to change, but I am just hoping that this committee will stand strong and stand behind your recommendations that you made in May, and continue to help push this.

We will continue to work with Congress to push their support for whatever needs to go forward and to get legislative change, but it is helpful with your recommendations.

DR. BRECHER: I think it is time to write something, burn up a few pixels. We can either just start by asking for suggestions, that we take a five-minute break pull the subcommittee together, throw a few words together to begin with, and then we can play with that.

I would suggest that we get a core group of maybe five people, maybe Paul, Karen, anyone else, Jay. Jay is writing, even better, let's give Jay five minutes and we will come back.

[Recess.]

DR. BRECHER: The suggested initial wording for this resolution, principally authored by Jay, reads as follows:

The committee remains highly concerned that disruptions to access for IGIV, including a shift to hospital-based therapy, continue to compromise quality of care for many patients. We further are concerned that a change to hospital outpatient reimbursement, to ASP plus 8 percent, effective January 2006, will further aggravate an already difficult situation and that this shift

will not be sustainable.

We therefore recommend that the Secretary take immediate steps to:

1. Increase reimbursement for non-hospital IGIV therapy to a level consistent with current market pricing.

2. Reconsider the current program to hospital outpatient reimbursement to ASP plus 8 percent in January 2006.

3. Re-examine the extent to which current IGIV supplies are or are not meeting demand.

So, we are open to suggestions.

Jerry.

DR. SANDLER: In our letter, we urged the Secretary to declare a public health emergency, so as to enable CMS to apply alternative mechanisms for determining reimbursement schedule, et cetera.

Wouldn't that be a necessary component if we wanted some action, in other words, shouldn't this immediate request get back to that we are requesting a public health emergency, so as to get this stuff done?

DR. BRECHER: I don't know. Jerry, does it require an emergency, a crisis?

DR. HOLMBERG: Well, I think that the letters that you have already seen from Congress, that was provided by the IDF, and then also the letter from the two congressmen, that I provided you, it does show that Congress is very concerned about this.

The thing is, though, that will a public health emergency correct the problem, or will a congressional change correct the problem, and you have to understand that CMS's hands are tied.

Now, the public health emergency can change some things, but it will not be a long-term fix, and the thing is that I am concerned about is that the direction here of calling a public health emergency when we--well, first of all, when Congress needs to look at the issue, and secondly, I think that the letters that have been received from Congress has caused CMS to very carefully consider some of the changes.

Now, saying all that, I would stay away

from a public health emergency, but I think that it needs to be strong enough to be able to get the message across that CMS needs to work through their legislative avenues.

DR. BRECHER: Mark.

MR. SKINNER: I tend to think that the concept of declaring a public health emergency needs to stay on the table at this point. Between now and January, there is not much time, and the problem is only to get worse, and to expect Congress to enact new authorization, or to take action for CMS to change something in three months, and to have it in place, to me, seems a little bit unrealistic.

I do recognize that the public health emergency is a short-term solution or bandaid solution until the real thing can occur, but I am not sure that we shouldn't continue to argue that all of the powers be used, because the situation is escalating.

DR. BRECHER: Jay.

DR. EPSTEIN: Perhaps we need to say

something explicit about short-term measures. I think part of the problem here is that there is, if you will, a reasonable reluctance not to make the system worse in the long haul by doing something in the short haul.

But I think that part of the issue of urgency is that one must do something in the short run, and I think that that is perhaps yet another message that needs to get communicated. We were saying that, in essence, by calling for a declaration of emergency, but we were doing it because we thought that the legal framework didn't allow for another remedy.

I think what the pushback is, which we have heard from Jerry, is that there is a reluctance for the Department to do that, because it might tamper with the system in a way that is adverse for the future.

But I think that the way around that is to call attention to the need for short-term actions independent of long-term solutions. I am just concerned that if we call again for, you know, a

declaration of emergency, it already fell on deaf ears once, what exactly are we going to accomplish.

DR. BRECHER: Julie.

MS. BIRKHOFER: Thank you, Dr. Brecher, if I could just comment. The public health emergency that is language in the MMA, that could be used to address the payment for the drug, and I certainly am not disputing that at all, but another mechanism that is available to CMS in the short term, as well, would be the classification of biologic response modifier, and that is a payment on the physician administration side.

So, you have the payment for the drug, which is the ASP, and then you have the cost of services to physicians, so just respectfully, we would also ask CMS--and I know they have had meetings with IDF and Quad AI, and I believe the AMA, or Quad AI and IDF--went in with a lot of scientific and clinical information of why IVIG is a biologic response modifier, and those of you around the table that are physicians probably know why it is, but that would be short term, as well.

MS. VOGEL: I could further explain that since I was in the meeting with CMS. Basically, you have two different mechanisms. You have got to increase the reimbursement for the drug, and I think you can pretty much say that most providers, physicians, or whoever it is, they are not going to be buying product at a loss especially at the number of grams you are talking about, so you have got to get the reimbursement up to at least the cost. I mean and that is where you are at.

Doctors are like if I could at least break even, I would be taking these patients. Now, on the administration side, they got hit both ways. They have got hit on the drug side, they got hit on the administration side.

The administration side applies to both the physician's office, and is going to apply to the hospitals, and so the highest classification for IVIG is a biologic response modifier. It meets the definition. It's a high complexity administration product. CMS just needs to recognize it as such.

The meeting went well, and I think they are open to it. They can accept it immediately. They could put a transmittal out, and then we could be reimbursed at a higher percentage, but I have to still say with that, if you don't get the drug price up, you are not going to succeed, and with your language on increasing reimbursement in the non-hospital setting, I think it is very important to say that, but the only mechanism that CMS does have currently, on a short-term basis, is through, unfortunately, the language of a public health emergency.

Other than that, it is going to take an act of Congress to change this.

MS. BOYLE: I would just like to reiterate what Michelle has said, but as far as the public health emergency, whether it is actually declared or not, that has really raised awareness. You know, members of Congress are signing on. If you continue with that recommendation, it's putting the emphasis on how important this is.

The biological response modifier, I think

is something you could do right now. I think it makes a lot of sense to put your wording in there, but I still question why not recommending the public health emergency.

DR. BRECHER: Jay.

DR. EPSTEIN: Mark, I would suggest that you make the two points of reclassifying IGIV as a biological response modifier, and exercising the authority to declare a public health emergency to provide CMS with alternative reimbursement scheduling, as subpoints under No. 1, because they are simply specific suggestions under No. 1.

Again, I am not close enough to the subject to know whether those are the only available tools, but there is no reason that those can't be mentioned.

DR. HOLMBERG: I would like to ask a question of our economist here. The way No. 1 is worded, to a level consistent with the local market or current market pricing, when you have a distributor in the place there, in the middle, and you have the pricing being determined by the

manufacturer, how do you guarantee that?

I mean the formulas that are available do not reflect the distributor.

DR. HAAS: Well, the guarantee is an interesting word. As soon as you put it out in the marketplace, the concept of guarantee disappears. You have guarantee only if they are fixed prices, and that, I don't think any of us would want to look very seriously at unless it were--well, I will just stop there. I don't think we want to look very seriously in trying to fix prices.

You know, this is unresolvable problem in the sense that we don't have a situation where the seller and the end user are directly connected to one another.

There are these intervening markets which are not under any type of control, so I think we have got to make the statement in such a way that the doctor that prescribes the IVIG is paid enough to cover the cost of his or her services, and I don't know the right wording there. I am not close enough either to give an answer to that.

Jerry, it's the other thing. I want to continue to reemphasize something Jay said earlier. When we get through with this, I think it ought to be set up in such a way there are short-term points and some long-term points. I think they need to be separated and clear.

DR. BRECHER: Art.

DR. BRACEY: One of the things I guess that I am concerned about is that I would think that on the other side, the decisionmakers perhaps are not as sensitive to the quality issues associated with the shift.

I mean they see it as a neutral. It would be too detailed to go through the entirety of it in this document, but I would wonder, is there a chance for an interface to explain, you know, what the quality issues related to the shift would be. I mean is that something that can be done?

DR. BRECHER: We have done that before where resolutions have gone forward to the Assistant Secretary and felt that additional explanation was needed, and we have had am a

meeting with the Assistant Secretary with a subgroup of the committee and other interested parties. So, that is a possibility.

Jeanne.

DR. LINDEN: This isn't really directly related to that, but it is sort of related to who understands what in terms of our position, but I was looking at this web site printout that says the Advisory Committee on Blood Safety and Availability, but the text has a lot of things that were in Dr. Beato's letter that I don't think we really decided or necessarily agree with.

So, I am wondering if that's misleading to people in how we make our thoughts known, if that's not what is in the record on the web site.

DR. BRECHER: Specifically, are you referring to the recommendation about off-label use?

DR. LINDEN: Yes, in terms of the supply being sufficient, not having concerns in that regard, and recommending that physicians would better serve their patients by communicating their

needs directly and focusing on approved label use, not off-label uses.

DR. BRECHER: I think we have had concerns about that, but I think there are bigger fish to fry right now, which is the reimbursement. If we could fix the reimbursement, I think that it would all fall into place.

Jerry.

DR. SANDLER: I apologize I wasn't here this morning, I wasn't able to be for the presentation. Am I correct that the representatives of the patients have not had a direct audience with the Assistant Secretary of Health?

The purpose of my asking that question is that my advocacy for these patients is driven a lot by the testimony as it is given very effectively by the representatives, and I am hoping that this committee isn't serving as a filter, preventing the Assistant Secretary from hearing the heart-moving stories of these people.

MS. VOGEL: We have not met with the

Assistant Secretary. We have requested a meeting with Secretary Leavitt, and we are supposed to be part of a meeting with him or his chief of staff on Friday.

We have met with Herb Kuhn on many occasions, and we have also put in a request to meet with Administrator McClellan, but, no, we have not met with the Assistant Secretary.

DR. BRECHER: But you do have a meeting on Friday with a high-level official?

MS. VOGEL: Yes, we are part of a group meeting with Secretary Leavitt or his chief of staff.

DR. BRECHER: That should help drive home the message.

Jay.

DR. EPSTEIN: I think we should come back to Art's point about the added negative effects of in-hospital therapy, and at least flag the issue in the first paragraph.

I am not exactly sure what specifically we want to say, but let's see. Perhaps instead of

saying "including a shift to hospital-based therapy," we could say, "which are aggravated by the shift."

DR. BRECHER: Is it that the disruptions are aggravated, or is it that the risk to the patient is increased by putting them in a hospital setting as opposed to a doctor's office?

DR. EPSTEIN: We could add a second sentence saying something along the lines that in particular, we believe that hospital-based therapy adds increased risks and costs to patient care, something along those lines.

DR. BRECHER: Jerry.

DR. SANDLER: I think the words "hospital-based therapy" may cloud a little bit of the issue. Speaking as someone who covers one of the infusion services here in town, I, of course, wouldn't act as the technologist for the patient's doctor and just give the infusions for a person who is so precarious. We would require that such a person transfer care to be using the infusion services of the hospital.

So, it is not just someone out there who has taken care of a patient for the last 15 years will write a prescription and have the person come to the hospital and pay a little bit more and be inconvenienced.

We wouldn't simply infuse. We would expect the person who is being treated is our patient, so it is really going to be the scenario is that people will have to be transferred to persons who will be on site to care for such patients as they have been on site in the doctor's office.

I think we want to make it clear.

DR. BRECHER: Well, which may not be in the best interests of the patient if they have to travel a great distance to get to the hospital.

DR. SANDLER: Of course. I mean, of course, it is not in the best interests of the patient. These people have been cared for, they have been cared for well. They belong in their doctor's office where, in the long run, the United States Government will pay less for their care, and

the patients, as Dr. Bracey points out, are going to get a higher quality of care in a doctor's office.

Hospitals aren't a place for routine maintenance therapy.

DR. BRECHER: So, can we say, in particular, we believe hospital care may not be in the best interests of these patients?

DR. SANDLER: It is a little, it is something my check payers wouldn't like me to approve.

DR. BRECHER: Well, it may not always be in the best interest, how is that, does that soften it enough?

DR. SANDLER: Well, my point is to make it clear that hospitals shouldn't be expected to simply infuse, that if hospitals are going to be the place where people are going to be treated, hospitals are going to expect that the care of the patient will be taken away from the person who has cared for them up to this point, and delivered to an on-site physician who will be there to take care

of a person getting infused.

DR. BRECHER: I am more worried about the immuno-deficient patients going to a hospital setting where they may be--

DR. SANDLER: Oh, I get you, yes, and that is an additional concern.

MR. SKINNER: There is two issues. It's the transfer of the patient, and it's the setting of care, and you only have got the setting of care. I think you could fix it and cover both if you would say in particular, we believe the transfer of patients to a hospital-based care setting may not be in the best interests, so you pick up the notion of transferring the patients from their traditional physician, as well as putting them in a hospital environment.

DR. BRACEY: One of the things that I thought that perhaps we could say is that it disrupts the continuity of care, I think people buy into the continuity of care, and exposes the patients to new risks, you know, the hazards of the hospital environment.

DR. BRECHER: Increased risk of what, Art?

DR. BRACEY: Just say "increased risk."

DR. BRECHER: Jeanne.

DR. LINDEN: Instead of saying that the hospital-based care is bad, can we say that the loss of the continuity and benefits of the community-based care could be lost, transferred to less optimal care with increased risks, or something like that?

DR. BRECHER: I don't think people are going to say less optimal care. I don't think Jerry would like to hear that.

Jay.

DR. EPSTEIN: Just some suggested wording, Mark.

In particular, we believe that transfer of care to a hospital or hospital setting may interrupt continuity of routine care and may add otherwise unnecessary costs, logistical complexity, and risk.

If that sounds right, I will read it again slowly.

DR. BRECHER: May interrupt continuity of care and--

DR. EPSTEIN: May interrupt continuity of routine care and may add otherwise unnecessary costs, logistical complexity, and risk.

DR. BRECHER: Logistical?

DR. EPSTEIN: Complexity.

DR. BRECHER: And risk?

DR. EPSTEIN: And risk.

If we want to say infectious risk, that is the main one are worried about.

DR. BRECHER: Does that get the sentiment?

Jerry.

DR. SANDLER: Maybe say care by their primary physician.

DR. BRECHER: Transfer of care to a hospital--

DR. SANDLER: --may interrupt continuity of routine care by their primary physician.

MS. BOYLE: It's not necessarily a primary care physician. Sometimes it's a specialist in the outpatient setting.

DR. SANDLER: By their usual care provider.

MS. BOYLE: Yes.

DR. BRECHER: Okay, we can do that.

Whoever succeeds me as chair of this committee, typing is a prerequisite.

DR. SANDLER: Where it says "infectious risk," do we want to say something like risk of hospital-based infections, or nosocomial infections?

DR. BRECHER: Yes, I think nosocomial.

DR. SANDLER: We are not talking about common colds.

DR. BRECHER: What a surprise, Microsoft Word doesn't recognize nosocomial.

Jeanne.

DR. LINDEN: I am not sure that "routine care" gets across that we are talking about care actually being transferred, because to me, "interrupted" may mean, well, they are getting part of it now at the hospital and part of at the doctor's office, and I wonder if we are really

talking about loss of the benefits of the continuity of routine care.

DR. BRECHER: I think when we put "usual care provider," I think probably the need for the word "routine" has disappeared. I think we can probably get "routine" out of there. Does that make it better?

DR. LINDEN: I guess "interrupt" is what I have the most trouble with, if we are talking about actually discontinuing it.

DR. BRECHER: Well, interrupt or disrupt. Would that be a better fit, say "disrupt" instead of interrupt"?

DR. BIANCO: "Disrupt" is in the previous sentence. "Interfere with."

DR. BRECHER: So, would you prefer "interfere"?

DR. SANDLER: How about "impair"?

DR. BRECHER: I am sorry, "impair"?

Let me just read the paragraph, so everyone hears it again.

"The committee remains highly concerned

that disruptions to access of IGIV, including a shift to hospital-based therapy, continue to compromise quality of care for many patients. In particular, we believe that transfer of care to a hospital or hospital setting may impair continuity of care by their usual care provider"--we certainly say care a lot, don't we--"and may add otherwise unnecessary cost, logistical complexity, and nosocomial infectious risk. We further are concerned that a change to hospital outpatient reimbursement to ASP plus 8 percent effective January 2006 will further aggravate an already difficult situation and that this shift will not be sustainable."

Merlyn.

DR. SAYERS: Any interest in having a preface which says something along the lines of, "After new input from providers, manufacturers, patients, and distributors, the committee remains highly concerned"?

DR. BRECHER: After hearing input?

DR. SAYERS: New input, after new input.

DR. BRECHER: Users or consumers?

DR. SAYERS: Users, patients, consumers.

DR. EPSTEIN: Can we put patients first?

DR. SAYERS: Yes.

DR. BRECHER: Always, patients always come first. Patients, medical professionals, and manufacturers?

DR. SAYERS: Sure.

DR. BRECHER: Manufacturers always come last.

DR. SAYERS: And then remains highly concerned about accelerating disruptions.

DR. BRECHER: Concerned regarding disruptions?

DR. SAYERS: Accelerating.

DR. BRECHER: Oh, accelerating.

DR. BRECHER: Paul.

DR. HAAS: We also heard from distributors this morning, too.

DR. BRECHER: Do they come before or after manufacturers?

[Laughter.]

DR. BRECHER: Jerry.

DR. HOLMBERG: To drop one of the--oh, I am sorry.

DR. BRECHER: Either Jerry.

DR. SANDLER: I want to pick up on Dr. Linden's point about being a little more explicit, and in particular, we believe that the transfer to hospitals for IV infusions may require transfer of these patients' care from their current providers to new hospital physicians or to hospital physicians.

We haven't made it clear that just going to the hospital for an infusion means we are going to take them away from their doctor. I think we should get that in.

DR. BRECHER: I don't know, I think that is a little implicit, Jerry, when we say that impair continuity of care, I don't know that adding those additional words is really going to add that much. I like keeping it simple.

MS. LIPTON: I am having trouble reading that, but I think, should "about" really be a

"that" instead of "about" in the third line?

DR. BRECHER: Wait a minute.

MS. LIPTON: We are concerned that accelerating disruptions, including a shift to hospital-based therapy continue to--

DR. BRECHER: So, where do you want me to change?

MS. LIPTON: The third line down. The word "about," you should replace that with "that."

DR. HOLMBERG: After "concerned."

DR. LINDEN: And you should probably have a couple of comments before and after the including phrase, just to clarify it.

DR. BRECHER: "The committee remains highly concerned that"--

MS. LIPTON: "That."

DR. BRECHER: Okay.

Jerry.

DR. HOLMBERG: I would recommend that you drop some of the "cares" and transfer of patients to a hospital or hospital setting may impair continuity of care by their usual provider or

medical provider, and get rid of some of the "cares."

DR. BRECHER: Why don't we say--to a hospital or hospital setting, I think "to a hospital setting" is sufficient. I don't think we have to say "to a hospital."

MR. SKINNER: I was going to make a comment there. Instead of saying, after the first hospital, insert the word "physician." To say to a hospital physician or hospital setting, that way it picks up Dr. Sandler's comment.

DR. BRECHER: Okay. Now, we have to get rid of some of these "cares," because we care too much. Oh, we transfer to a hospital, that gets rid of one. Thank you. I heard that .

Do we really need "usual care provider," or can we just say "usual provider"? Medical provider or just provider? Okay.

MR. SKINNER: Provider in that context could mean distributor.

DR. BRECHER: Medical provider?

MR. SKINNER: I think that's better.

MS. VOGEL: I have a recommendation. What we are hearing is that they are not seeing a physician in the hospital, they are just being infused with the product from a nurse. So, where you have, "In particular, we believe the transfer to a hospital physician," it really should just be a hospital setting.

DR. BRECHER: I think in Dr. Sandler's case, it would be transferred to a hospital physician, but in other hospitals, it may not be.

MS. VOGEL: Okay.

DR. BRECHER: So, the question is which is the best way to leave it.

DR. EPSTEIN: I think hospital setting, because the reimbursement is geared to the setting.

DR. BRECHER: That's true.

DR. EPSTEIN: It is true that a lot of things go along with the setting, but I think in that sentence, it is the setting.

DR. BRECHER: Okay. The less words, the better.

Merlyn.

DR. SAYERS: I am getting down to the picking of the nits now. You have got, "The committee remains"--this is now the second line--"highly concerned that accelerating disruptions to access of IGIV, which include a shift to treatment in hospital."

DR. BRECHER: Which include a shift to treatment?

DR. SAYERS: In hospital.

DR. BRECHER: That doesn't work.

DR. SAYERS: Why?

DR. BRECHER: Including a shift to treatment in a hospital-based therapy?

DR. SAYERS: Oh, no, you would delete the based therapy.

DR. BRECHER: Okay.

DR. SAYERS: Which include a shift to treatment in hospital. I mean hospital-based therapy sounds like--I mean it could be confused with somebody going to the formulary and deciding--

DR. LINDEN: Then, you need the other comma after hospital or a hospital, the hospital.

Is it access of IGIV or to, and is it IGIV or IVIG?

DR. BRECHER: Treatment in a hospital setting.

DR. BRACEY: I would say if we keep it generic and say, "in a hospital setting," because in truth, the way hospitals are organized these days, they have outpatient activities that are away from the inpatient, and, you know, you need to leave it I think a little more general.

DR. BRECHER: Hospital setting, you prefer? Okay.

Jay.

DR. EPSTEIN: Just picking up on someone else's earlier comment. "Accelerating disruptions in access to IGIV," I think is a little bit better grammar.

DR. BRECHER: Accelerating disruptions--I am sorry?

DR. EPSTEIN: --in access to IGIV.

DR. SAYERS: And it should be, "which include" instead of "including."

DR. BRECHER: Which includes.

DR. SAYERS: Yes.
DR. LINDEN: But it said "accelerating disruptions," I mean that is the subject there.
DR. SAYERS: No, it's "which includes shifts to treatment in a hospital setting."
DR. BRECHER: Let's read it from the beginning.
MR. SKINNER: I think you need an "s" on continues now, too.
DR. BRECHER: Continues. Wait a minute.
DR. SAYERS: The other "s" is silent.
DR. BRECHER: Let's try that sentence from the top. "After new input from patients, medical professionals, distributors, and manufacturers, the committee remains highly concerned"--or do you want to say gravely concerned--"highly concerned that accelerating disruptions in access to IGIV which includes a shift to treatment in a hospital setting continues to compromise quality of care for many patients."
MS. LIPTON: It's "continue." It's disruptions continue.

DR. BRECHER: Continue to compromise quality of care.

Jay.

DR. EPSTEIN: Well, I have a substantive question for the committee. Do we think that the disruptions are accelerating, or just persisting? I am not sure that I heard anything today that was worse than what we heard.

DR. SAYERS: I would go for persisting.

MR. SKINNER: I think what is accelerating is the transfer to the hospital-based setting, not the disruption, so when we reworked the sentence, the word "accelerating" is in the wrong place.

DR. BRECHER: I don't know that we know that it is accelerating. It's continuing.

MR. SKINNER: Well, the percentages have shifted.

DR. BRECHER: It has continued to shift to the hospital. I don't know that it's in an accelerating rate, though.

Jay.

DR. EPSTEIN: We could say, "which

includes a progressive shift."

DR. BRECHER: Yes, we could say that.

DR. EPSTEIN: No, no, "persisting disruptions which includes a progressive shift to treatment in a hospital setting.

DR. BRECHER: That includes a progressive shift in access--no, that's not right.

DR. EPSTEIN: It's the progressive shift to treatment in a hospital. The word "progressive" is part of the shift to treatment in a hospital.

DR. BRECHER: So, progressive shift--where do you want me to move the progressive shift to?

DR. EPSTEIN: The next line, where the word "shift" occurs, just put the word "progressive" in front of it, and now we have to fix "persistent disruptions." Take the article "a" out of that. It says, "a persistent disruption." Persistent disruptions, and again it was comma which include--I am sorry--"disruptions in access." The "that includes" comes out.

DR. LINDEN: Then, the next "includes" needs to be just "include."

DR. BRECHER: Right. Got it.
DR. EPSTEIN: I think it's time to go down to the recommendations again.
DR. SANDLER: Hospital setting is in there twice.
DR. LINDEN: The second time, you could just say "such transfer," and don't have a comma after it.
DR. BRECHER: I guess we don't really need the word "setting." It doesn't add that much.
DR. LINDEN: You need to get rid of the comma after "hospital." We are still saying "transfer to a hospital" twice.
DR. BRECHER: We are. Well, we are saying "shift to treatment in a hospital," and then we are saying "transfer to a hospital."
DR. EPSTEIN: I think it's okay to repeat that.
DR. LINDEN: Yes, but you have to get rid of the comma.
DR. BRECHER: I am sorry?
MS. LIPTON: Between "hospital" and "may,"

you need to delete the comma, next line down.

DR. LINDEN: Yes, it's just the transfer may impair continuity of care.

DR. BRECHER: Okay. Ready to go down? Ready or not, here we are.

DR. EPSTEIN: Capitalize Secretary.

DR. BRECHER: Absolutely. Is there a hyphen in short term? Yes. That was it for No. 1. Let's go to No. 2.

DR. EPSTEIN: In No. 2, the word "change" needs to be added. "We consider the current program to change."

DR. HOLMBERG: It's unclear what your recommendation is there.

DR. EPSTEIN: Oh, it's to withdraw the regulation. I mean right now you have a regulation in place that will cause outpatient reimbursement to go from I guess AWP to ASP plus 8 percent. So, reconsider. I mean we could be more directive and say withdraw.

DR. BRECHER: Well, it's the current plan.

DR. HAAS: Would re-examine be a better

term there than reconsider?

DR. BRECHER: I am sorry? What is the word you want instead of reconsider? Re-examine?

DR. EPSTEIN: Well, again, we could say delay or withdraw.

DR. BRECHER: Withdraw.

DR. EPSTEIN: I mean that's the strongest thing, is just withdraw it. Again, it's a regulation, if I am not mistaken.

DR. BRECHER: Withdrawing the current plan. Does that get the sentiment across?

DR. HOLMBERG: Dr. Brecher, you have a comment from the floor.

DR. BRECHER: Sorry. Yes, Julie.

MS. BIRKHOFER: Thank you, sir. On No. 2, and I am just trying to serve as a resource here, basically, the ASP plus 8 percent is in statute, right? That's in the MMA. So, CMS--no?

MS. WEINSTEIN: Hospital outpatient.

MS. BIRKHOFER: Step up here, please.

MS. WEINSTEIN: Hospital outpatient reimbursement in '06 has to be based on hospital

acquisition cost, but one suggestion might be--I mean a couple of the ideas, PPTA, excuse me, the group together decided on was the dampening effect. There is a precedent for that, but basically, it would prevent the rate from dropping by more than 15 percent from the 2005. The current rate now couldn't be reduced by more than 15 percent for '06, and that would hopefully mitigate some of the turmoil there would be, you know, if you reduce a rate by more than that, that might create.

MS. BIRKHOFER: So, the MMA put in place a provision that the hospital outpatient reimbursement had to be based on hospital acquisition costs, and that was to be done by the General Accounting Office, the GAO.

The GAO transmitted their report in April, and it was up to CMS to look at the GAO's methodology to see if they wanted to use it or not, they had flexibility. They chose not to use it, which was a very good thing for access, because the rates were abysmal, because of the trouble that the GAO had was survey data.

So, then, CMS put in ASP plus 6 percent plus 2 percent, which comes to a total of ASP plus 8, so what Anna Weinstein, my colleague, just explained, is that PPTA and this group of IVIG community came up with these alternatives because the framework of ASP is here to stay, and it's accepted, and it's a shift away from AWP.

So, this group, along with PPTA, that's where we put forward the concept of a dampening provision, which Anna just explained. You could freeze current rates until further knowledge was gathered, data.

PPTA is working to collect data. The biological response modifier, separating the J codes, those are the types of things we discussed. So, I just wanted to offer that.

DR. HOLMBERG: Mark, can I ask a question, please?

DR. BRECHER: Sure.

DR. HOLMBERG: Again, a question for our economist. If you have one setting being given this price, doesn't it have to be consistent in all

of the settings, or else you are going to continue to have the problem?

DR. HAAS: I would tend to think so, yes.

DR. HOLMBERG: I mean this is where we have gotten the problem or CMS has gotten themselves into a problem, is that it has shifted and instead of the MMA making all the changes at once, there has been a gradual shift, and so therefore, the market is not going to--if I would understand the economics correctly--the market is not going to stabilize until all of the places that it is being used is stabilized, are stabilized.

DR. BRECHER: Well, it is going to stabilize to the point of least resistance to those people who are willing to pick up the loss at the current rate.

DR. HOLMBERG: The thing is that with what is being recommended on the dampening, it is still not going to correct the inpatient or the office infusion sites.

DR. EPSTEIN: I agree with what you said, Jerry, but I think again it's a short-term problem

we are trying to, in this case, prevent, which is that a sudden and precipitous drop in reimbursement in the hospital outpatient setting can only make the current situation worse.

Now, that in itself is not going to create parity for the non-hospital setting, let alone how it might reconcile the inpatient care, but the short-term issue is not to have the precipitous drop.

MS. LIPTON: And then we have to address the long-term issue, which probably encompasses what Jerry, that you said is it needs to be stabilized at a reasonable reimbursement in all settings.

DR. EPSTEIN: Right. That may be yet another point, but I think we ought to modify Recommendation 2 to say, "Modify the current plan."

DR. BRECHER: Consider modifying the current plan?

DR. EPSTEIN: Yes, or consider modifying or modify. Consider modifying the current plan, and I would for the moment remove the

parenthetical, and then to change, singular, to change hospital outpatient--take out the word "to"--to change hospital outpatient reimbursements to ASP plus 8 percent in January in such a way as to prevent any sudden and large decrease in reimbursement.

DR. BRECHER: Jerry.

DR. SANDLER: Mr. Chairman, about three occasions now, people have suggested that you take the word "consider" out. On three occasion, you very politely have kept it in.

DR. BRECHER: Not intentionally.

DR. SANDLER: I am here representing the American Hospital Association, and I can tell you that their response to this is hell, no, and if they were here, administrators in hospitals would tell you, you don't want to be polite about this.

DR. BRECHER: Modify it.

DR. SANDLER: Yeah.

DR. EPSTEIN: You want to go back up and do the same?

DR. BRECHER: Just because we are such

caring people, we like to be polite.

MS. LIPTON: I thought this was different because we weren't sure of what the right thing to do, there are a number of options.

DR. BRECHER: That's right, we are not sure.

MS. LIPTON: I think that No. 1 itself may be--I will have to read it--well, we did say it, we said flat out, increase reimbursement. I think that's what we want to say.

DR. BRECHER: I think No. 1 can stay as consider, but No. 2 is stronger as modified. We are just giving them some options.

Okay. No. 3. Do we have a No. 4?

DR. SAYERS: This is about No. 3. Can we just way "whether" instead of "the extent to which"?

DR. BRECHER: I am sorry, modify it?

DR. SAYERS: I was going to say, "re-examine whether" instead of "the extent to which."

DR. BRECHER: Oh, I see. Okay.

DR. LINDEN: Is this something we want to do just once, or do we want to say continue to examine like on an ongoing basis versus a one-time thing?

DR. BRECHER: Do we have to say are or are not, or just say "are meeting demand"?

DR. LINDEN: You don't need are not.

DR. HAAS: Mark, I think there is further questions as to what we mean by demand. There is the demand for the label use, and the demand for the off-label use, and since that came up in the Secretary's letter, it would seem to me we should be a little more clear.

DR. SAYERS: And say what?

DR. HAAS: Don't ask me.

DR. HOLMBERG: Mr. Chair, may I?

DR. BRECHER: Yes.

DR. HOLMBERG: The concern here, label and off-label use, is the off-label use, are there studies, clinical studies, to support the use of this?

DR. BRECHER: Some, some better than

others.

DR. HOLMBERG: Exactly, and the concern here is where is the evidence-based medicine to support the use of the off-label?

DR. BRECHER: What I hear you saying, Jerry, is don't open this can or worms to say use, demand, to meet demand?

DR. HOLMBERG: I would say demand, just leave it as demand.

MR. SKINNER: I have two comments about this. I am wondering if, instead of saying "demand," the polite way to say it would be to say talk about meeting prescribed treatment. That way, you are saying the physicians should be in control of the medicine perhaps.

The other thing that bothers me about this is because the Secretary has already said we will continue to monitor the situation, so basically, what we are saying is do what you said you were going to do.

So, I thought what we were doing here is saying we are skeptical that there isn't a supply

problem and that we think that there might be an underlying supply problem that you haven't detected, so go back and look again, not just to continue to monitor it until you find one shows up.

So, I am not sure this says anything different than what the Secretary responded in the letter that they were already going to do.

MS. LIPTON: But, Mark, I think if you look at the beginning where we said there is new information, and then that, in combination with the word "re-examine," it isn't just continue to monitor, it's re-examine, and I think that that's--

MR. SKINNER: Okay.

DR. BRECHER: That is what I like to hear, one lawyer talking to another lawyer.

Paul.

DR. HAAS: The way we started to write label and off-label, I was uncomfortable with that, too, but I guess I am still a little concerned that the Secretary's letter and what we heard from PPTA is if there is a four-week supply, that that seems to suggest that this statement doesn't say a whole

lot.

DR. BRECHER: But it's a four-week supply based on use five or six years ago.

DR. HAAS: I guess my thought would be that they are looking for us to give directions, we maybe want to be a little more specific in our statement, because leaving it alone, then, I would come back to you and say, well, what I am getting from the manufacturer is that there is plenty of supply out there.

DR. BRECHER: Why don't we move the word "current," whether IGIV supplies are meeting current demand," not demand five or six years ago would be the implication.

MS. WEINSTEIN: Sorry, could I add one point of clarification? The whole issue of the yellow, red, and green light, it was decided five or six years ago what each of those means, the amount of supply available at each of those different lights, but we are not talking about the same amount, overall amount of supply that there was back then.

DR. BRECHER: The ratio?

MS. WEINSTEIN: Yes, it's a ratio of the inventory to the 12-month average distribution.

DR. BRECHER: Okay.

MS. WEINSTEIN: So, just to clarify for you.

DR. LINDEN: I just have a question, because I noticed in her letter, she talked about being sufficient for availability to patients, and I don't know enough about this, but were there concerns that with decreased reimbursement, that people might not have access, and therefore, it's not available to them even though there is some out there, but at twice the price, they can't afford it?

DR. BRECHER: Yes, that is the concern.

DR. LINDEN: I wonder if we want to get that across, and she didn't just say total supply. She said the supplies are actually available to patients.

DR. BRECHER: Well, I think that gets to the reimbursement costs with the prices going up,

and you have to somehow match that, and what they are currently paying is not enough, so that people do purchase it.

DR. LINDEN: Right, but I am wondering if we want to talk about this in terms of being available to patients as opposed to just the supplies.

DR. HAAS: May I just add to Jeanne's comment that when Jerry mentioned he would make phone calls and then they would become available, that, to me, is an indication that the patients aren't getting it.

DR. BRECHER: It is certainly a red flag.

DR. HAAS: Yes. So, I like the idea of getting the patient.

DR. BRECHER: Meeting patient demand, is that where we would put it in there? I yield to the economist in the group.

DR. HAAS: I can go into the economist jargon just like medical doctors go into your jargon. That word has a very specific meaning in economics, so I think what we are talking about

here is a need, and I would get away from the economic term and just talk about the need.

DR. LINDEN: That is what Karen and I were suggesting, maybe patient needs.

DR. BRECHER: Art.

DR. BRACEY: Back to Paul's point, I think that if we don't hit this piece about off-label use, I mean a big part of their argument is that, well, you know, really, the reason that there is increasing demand is that there are allow these bozos out there using the off-label, the components for off-label use, and perhaps we could add a statement, "Although off-label use is a factor in demand, there are a number of studies to support the use of this agent in selected patients," you know, something to support.

It just seems to me that their position is that all off-label use is wrong, and I am not sure that's something that should be left standing.

DR. LINDEN: Have we seen those studies presented to this committee, Art?

DR. BRACEY: Well, not in the two times I

have been here.

DR. BRECHER: No, we haven't specifically looked at that data, but I think a number of us reviewed papers on specific diseases, and it's a mixed--the evidence is mixed. Some is better than others for particular indications.

MS. LIPTON: Is it really the issue of off-label use, or is it the issue that we don't think that off-label use totally accounts for all of these disruptions that we are seeing?

DR. BRACEY: Yes.

MS. LIPTON: I don't want us to get tied up personally in off-label use, but I think that we could send in a message that although we recognize there is off-label use of this product, we don't believe that that is--I don't know what the last words are--but that isn't the sole reason that patients are not getting access to this product.

DR. BRECHER: Celso.

DR. BIANCO: I would leave it as is. Patient need is not determined by CMS or by some authority. It is determined by the physician that

prescribed, so I think it covers everything.

DR. BRECHER: Going once--does we need a fourth point? Jay, you had mentioned a possible fourth point.

DR. EPSTEIN: Well, I do think that we need a fourth point, which has something to do with the long term, and not being an economist, I am not sure exactly what is the right thing to say here, but it's along the lines of working together with the Congress to establish a more stable pricing and reimbursement structure for IGIV.

Now, again, others may get this a little bit more on target, but I think that is what Point 4 is about.

MS. LIPTON: Stable and sustainable? I mean we talked about sustainable.

DR. EPSTEIN: Yes, sustainable is good, but the problem here is that you have got dislocations of pricing and reimbursement that are resulting in disruptions in the care system including distribution and access, and that it's a reflection of the legal construct presently in

place.

I think we have to recognize that the Department, under the present law, is only capable of the bandaid fixes, and that what is really needed is for Congress to re-examine the system.

You know, Congress had a legitimate goal of cost containment, but in this particular area, it has had an unanticipated negative effect, and I think what we are asking for is for the Department to work with the Congress to achieve a more stable and sustainable pricing and reimbursement scheme.

DR. BRECHER: I used the word "government," but that would encompass Congress.

DR. EPSTEIN: Well, again, we are advisory to the Secretary, and the Secretary has the ability to lobby the Congress and introduce legislative initiatives. The agencies do not, incidentally, CMS cannot do this, but the Secretary can do this.

So, I think that is really what we want to ask for.

MS. VOGEL: Can I make a suggestion? I mean there is one vehicle that can be used during

the fall, and that is reconciliation where we can make the changes to the reimbursement structure for IVIG, so it can be, you know, that the committee recommends that the Secretary work with Congress during reconciliation to establish a long-term stable and sustainable reimbursement structure for IVIG, something like that, because this is a vehicle that can be done during the fall.

DR. BRECHER: So, you are suggesting that HHS should work with Congress?

MS. VOGEL: During reconciliation.

DR. EPSTEIN: Could I just suggest that where you are saying as a short-term measure because reconciliation is a presently available mechanism, but there are other ways, too. I mean they could just introduce new legislation. I am not sure that we want to narrow it. Maybe that's a subpoint.

MS. VOGEL: Yes, I mean the only thing, just looking at the climate, Congress doesn't want to open up the MMA, so this is a way to be able to make a fix for a specific problem, such as IVIG,

which is a unique problem that is not occurring in all the other products.

If we want to even mention the uniqueness, and I know with Amy Pisano, when she testified in May, she said, you know, of all the 450 products out there, IVIG is the one product that they are seeing problems with.

But, on the other hand, they don't want to pass a technical bill, which is typically where you would see a change in the Medicare, but they are going to pass a reconciliation act, and that is the vehicle where this can occur, if you want to get that specific.

MS. LIPTON: But it still falls under work with Congress, doesn't it?

MS. VOGEL: It does, it does fall under the work of Congress.

DR. BRECHER: I think we don't have to be that specific. We just tell them to do it, fix it somehow.

Paul.

DR. HAAS: Mark, I think we do want that

fourth one to read that the Secretary should work with Congress, so it's direct.

DR. BRECHER: Okay.

DR. LINDEN: Mark, that is not parallel construction, though. The other things are just second person, you need to do this, so it really should be work with Congress.

DR. BRECHER: Work with Congress, okay.

MS. LIPTON: We already instructed the Secretary to take the following steps, the last of which is work with Congress.

DR. LINDEN: Really, I mean it's not just strive to. I mean it is to establish.

DR. BRECHER: Right.

Is everybody happy? Jerry is not happy.

DR. HOLMBERG: Should it be needs, plural, or should it be patients' need? Needs probably.

DR. BRECHER: Okay.

All in favor of happiness, voting members, raise their hand.

[Show of hands.]

DR. BRECHER: All opposed?

It's unanimous.

It's 5:30, it's time to adjourn.

Tomorrow, we take on the hard part. I believe it's 9 o'clock. Yes, 9 o'clock.

[Whereupon, the proceedings were adjourned at 5:32 p.m., to reconvene on Tuesday, September 20, 2005, at 9:00 a.m.]

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