INFUSION PROVIDERS ALLIANCE

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IPA Comments on Energy & Commerce Health Subcommittee Hearing on "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care"

April 26, 2023

The Infusion Providers Alliance (IPA) is pleased to offer testimony for the House Energy & Commerce Health Subcommittee hearing entitled "Lowering Unaffordable Drug Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." The IPA's testimony specifically addresses:

- A modified approach to site neutrality legislation that aligns payment rates across sites of care based on volume;
- Support for a Part B co-payment cap rate for physician offices and freestanding infusion centers; and
- Support for oversight of the pharmacy benefit management industry

Background on the Infusion Providers Alliance

The IPA is the leading voice for in-office and freestanding ambulatory infusion providers, with nearly 1,000 community-based, non-hospital infusion sites across 43 states. IPA members represent two types of settings: physician offices and freestanding ambulatory infusion centers. Our facilities are major access points of safe and efficient care for non-cancer patients with complex chronic health conditions like Crohn's Disease, Multiple Sclerosis, rheumatoid arthritis, and many others. Most importantly, our facilities offer a more convenient, more efficient, safer, and less expensive alternative for patients than receiving infusions in the hospital and, in many cases, the home setting.

Site Neutrality

The Health Subcommittee is considering draft legislation that would implement MedPAC's recommendations to align HOPD rates for certain services that can be provided safely at other sites of care with the physician fee schedule (PFS) and/or ambulatory surgery center (ASC) payment rates. As such, that approach would cut reimbursement to hospitals to the physician office rate for procedures or services that are performed at a higher volume outside the hospital and leave the physician office rate unaffected. For example, Medicare's payment of $325.64 to hospitals for complex drug administration (CPT 96413) would be cut to the physician office level of $140.16.

While the IPA is supportive of the Energy & Commerce Committee's efforts to reduce payment disparities between different sites of care for the same services for patients, we believe simply cutting the hospital payment to the physician office rate is not the most thoughtful or effective approach. Instead, we suggest reducing the payment disparities between sites-of-service but not entirely equalizing the payments. As such, the committee should consider a policy that produces net savings to Medicare by modestly reducing the hospital payment and modestly increasing the physician office payment. Such a policy provides greater incentive for the more efficient setting to adopt more volume and continue to do so over time, while also not being overly punitive to the hospitals.

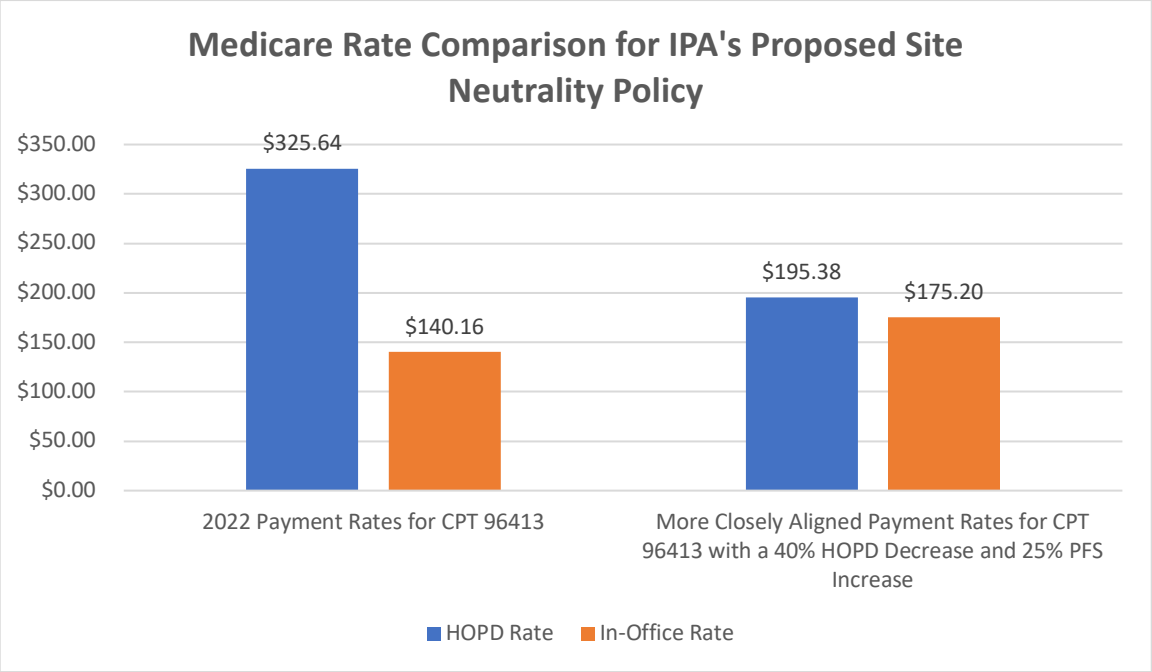
Importantly, this policy change would more closely align the appropriate payment rates between hospital outpatient departments (HOPDs) and physician offices while generating savings for Medicare, which are the goals of site neutrality policies. It would also provide incentives for physician practices and freestanding infusion centers

to expand their capacity, remain independent and counter troubling consolidation trends whereby hospitals are rapidly acquiring physician practices and other outpatient providers.

More adequate payment for the professional services provided for drug administration is warranted because the current professional fee covers only a fraction of the cost of drug administration and means these providers are largely reliant on the add-on payment related to the cost of the Part B drug. According to a study by the National Infusion Center Association, current administration fee payments only cover a fraction of actual costs required to furnish infusion services.[1] In addition, providers face an indefinite Medicare payment freeze under the PFS while hospitals continue to receive market basket updates compounding between 2-4% annually. Additionally. freestanding infusion centers and physician offices, unlike hospitals, are not eligible for 340B discounts, which puts them at an even further disadvantage. All these factors, coupled with the rapidly increasing practice expenses due to inflation and health care workforce shortages, makes this payment situation untenable for the long-term and will likely result in reduced patient access to these vital physician-administered drugs unless Congress acts to promote access to more efficient settings. In short, we believe Congress can pursue a policy that addresses the payment disparities, encourages competition and results in net savings without entirely equalizing payments by simply cutting reimbursement to hospitals.

Hypothetical volume data for the complex drug administration code CPT 96413, referenced above, can be used to demonstrate this proposal and the savings it would still generate for Medicare. If the code was used 100,000 times in 2022 and 52% of that use was in physician offices compared to 48% in HOPD setting, then this proposal would apply. The current $325.64 HOPD payment rate would be reduced by 40% to $195.38 and the $140.16 PFS rate would be increased by 25% to $175.20. This would greatly reduce the payment disparity, as illustrated below.

Medicare would still receive savings, because total Medicare reimbursement for the 100,000 times that CPT code 96413 was used in 2022 (using current payment rates) would total ~$22.9 million (~$15.6 million for HOPDs and ~$7.3 million for physician offices). However, with the 40/20 percent changes, Medicare reimbursement would be reduced to total ~$18.5 million overall (~$9.4 million for HOPDs and ~$9.1 million for physician offices). Medicare would still see a net savings of about $4.4 million.



[1] Medical Benefit Drug Economics: The Price of Furnishing Part B Drugs". National Infusion Center Association

Part B Co-Payment Cap Rate

The IPA supports the draft legislation that would cap the beneficiary copayment for expensive Part B drugs in the physician office at the HOPD cap. This policy will protect patients and encourage migration to the more cost-effective setting. Our organization has long advocated for a statutory cap for Part B drugs equal to the current hospital inpatient deductible, which is currently $1,600 per encounter.[2] While beneficiaries receiving care at HOPDs have a cap on their cost-sharing, those who receive the identical Part B drug in physician offices face unlimited 20 percent co-insurance liability. This results in higher OOP liability for patients for certain high-cost Part B drugs, even though Medicare saves money when they receive their care at physician offices and outpatient infusion centers. The bill addresses the perverse incentives to provide care in the more expensive hospital setting and also assists patients needed, nondiscretionary access to their complex medications. It is also worth noting that this issue primarily impacts those beneficiaries who lack supplemental coverage, and about 50% of that population have incomes below 200% of the federal poverty level and are more likely to be black, disabled, and have functional limitation.[3] Implementing this legislation and putting forth a cap on Part B OOP costs for beneficiaries would help to alleviate this issue and make medications more affordable for fee-for-service Medicare beneficiaries.

PBM Transparency

While we recognize the role that PBMs play in the healthcare continuum, we believe there are far too many instances where certain PBM practices can be opaque, overreaching and supersede the valid clinical decisions of healthcare professionals and the clinical needs of patients. The reporting requirements of the Health Subcommittee's legislation will impose much-needed transparency on the industry.

The IPA again wants to thank the Subcommittee for taking on the important issues of transparency and competition in health care. We look forward to working with the Subcommittee, full Committee, and the rest of Congress to implement meaningful change to site neutrality and provider reimbursement, in order to benefit patients across the country and improve access to affordable health care.

[2] The Infusion Providers Alliance. IPA Comments to the Health Futures Task Force Treatments Subcommittee. March 11, 2022. https://www.infusionprovidersalliance.org/wp-content/uploads/2022/03/IPA-comments-to-GOP-Treatments-Subc.pdf

[3]Nolan Sroczynski and Juliette Cubanski, "Medicare Part B Drugs: Cost Implications for Beneficiaries in Traditional Medicare and Medicare Advantage" (Kaiser Family Foundation, March 15, 2022). https://www.kff.org/medicare/issue-brief/medicare-part-b-drugs-cost-implications-for-beneficiaries-in-traditional-medicare-and-medicare-advantage/.