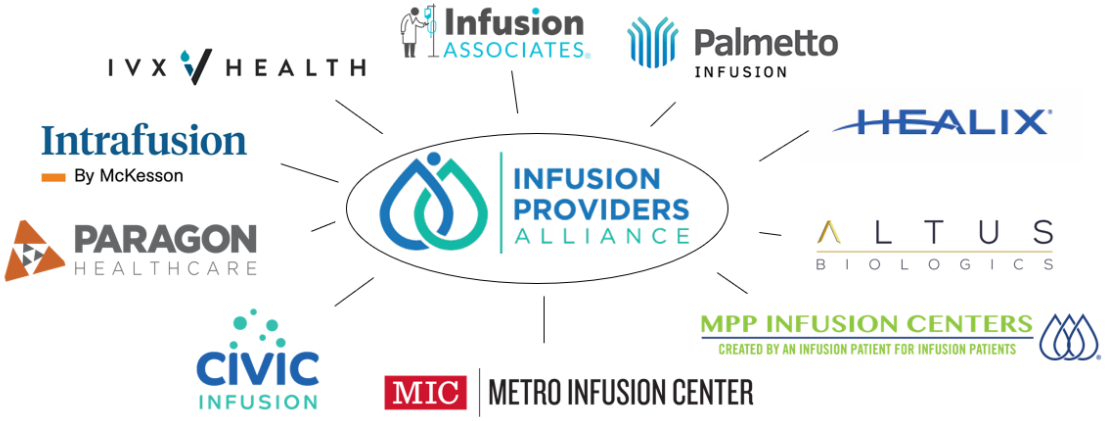
Member and Partner Newsletter
July, 2021

Update from Doug Ghertner, President of IPA

It is hard to believe that it has been almost a year since we founded and launched the Infusion Providers Alliance (IPA). We started with just a few companies and now have 10 corporate members who collectively manage over 930 facility locations across 43 states.[1] Moreover, we could not be more excited and grateful for the support we've received from our industry partners, each of whom is aligned with and supportive of our approach to advocacy.

The vision of the IPA, then and now, is an organization that can advocate thoughtfully and persuasively with policymakers for our clinic-based model that delivers care in a high quality, lower cost setting. Foremost in our advocacy is protecting our patients who have complex and chronic conditions that require frequent drug and biologic infusions. We know that if patients are unable to obtain care in our clinics, they may not be able to get the care they need at all or be relegated to the hospital setting where treatment can be difficult to access and typically twice as expensive.

IPA membership and partner support of our efforts is absolutely essential to our success, whether through contributions to our lobbying and public relations campaigns or direct engagement with hometown congressmen and women. We thank you and want to provide a brief overview of the issues we've chosen to engage on over the past year as well as the critical challenges that lie ahead.



[1] IPA Footprint

Issues of Engagement:

Sequester Payment Relief

Soon after launching the IPA, we embarked on an educational campaign with Congress on our delivery model and the need to suspend the two percent Medicare "sequester" payment cut during the Public Health Emergency. Our companies connected with over 40 bipartisan legislators and their staff on key committees of jurisdictions where they had facilities. Our messaging on this topic was critical because the physician community was embroiled in an internecine fight over resource redistribution on the physician fee schedule while hospitals were focused on COVID relief.[2] That effort bore fruit in sequester relief provided in the Omnibus Appropriations bill and a subsequent package in the spring of 2021, which suspends the payment cut through 2021.

Trump's Most Favored Nation Part B Proposal

After Congress failed to successfully enact legislation reforming prescription drug pricing in 2019, Congressional focus on health care turned to pandemic relief and keeping the health care system afloat in 2020. That inaction on drug pricing reform led the Trump Administration to issue a series of executive orders in August of 2020 with hopes of bringing the pharmaceutical industry to the table to negotiate a deal. But negotiations collapsed when the industry refused to fund "Trump discount cards" before the election. Shortly after the election (and after Pfizer's COVID vaccine was approved), the Trump Administration issued an Interim Final "Most Favored Nation" Rule tying Part B drug reimbursement to the lowest price in 24 developed countries for implementation January 2021.

The IPA sprang into action. It issued a thoughtful set of comments decrying the radical, nationwide approach that would decimate patient access to needed medications used to manage and control patients' complex medical conditions for diseases ranging from multiple sclerosis and Crohn's to rheumatoid arthritis and macular degeneration[3]. The comments cited CMS's own actuarial analysis that conceded nearly one in five patients would no longer receive their needed drugs. The comments took particular aim at the CMMI approach to slash reimbursement to healthcare providers that have little influence over the pricing of drugs.

The IPA then reengaged many of the same Congressional offices we had lobbied on sequester and informed them of the devastating impact of the regulation on our patients. These meetings generated many phone calls from our Congressional champions to senior Trump Administration officials in the White House and the Department of Health and Human Services. Several of our members also submitted affidavits in the litigation that eventually blocked the ill-thought and illegal regulation.

Engagement with FDA Re: Manufacturing Capacity During Vaccine Production

When the IPA witnessed drug shortages for an orphan infused product due to the FDA repurposing of manufacturing capacity for vaccine production, we engaged the FDA to demand expedited approval of alternate manufacturing sites. Our letter, social media engagement and subsequent dialogue helped result in a favorable outcome and access to the drug was eventually restored.[4]

IPA Corporate Partners

Gold Level

Biogen HORIZON

Silver Level

PhRMA RESEARCH · PROGRESS · HOPE Genentech CuraScript SD

Engagement with Private Payers

The IPA is also focused on protecting our commercially insured patients. Last fall, the IPA engaged directly with Anthem regarding a proposal to require "white-bagging" of a long list of products and lead to an approach that would fundamentally disrupt the reliable distribution system. IPA explained to Anthem that if its proposed specialty pharmacy mandate was extended to community-providers, and those providers are no longer free to procure medications in the competitive marketplace, many will be unable to provide infused medications to Anthem California enrollees[5]. Under Anthem's policy, these providers would be forced to use one supplier, the CVS specialty pharmacy. Moreover, the providers would not bill or be reimbursed for the medication; they would only receive the "administration charge," a fee which is

[2] IPA Sequester Whitepaper
[3] IPA MFN Comments
[4] IPA Letter to FDA
[5] IPA letter to Anthem

insufficient to cover the cost to providers of administering these medications. Anthem subsequently clarified that this proposal was primarily targeted at hospital-based infusions and not the clinic-based model that IPA members offer.

Downcoding of Complex Drug Infusions

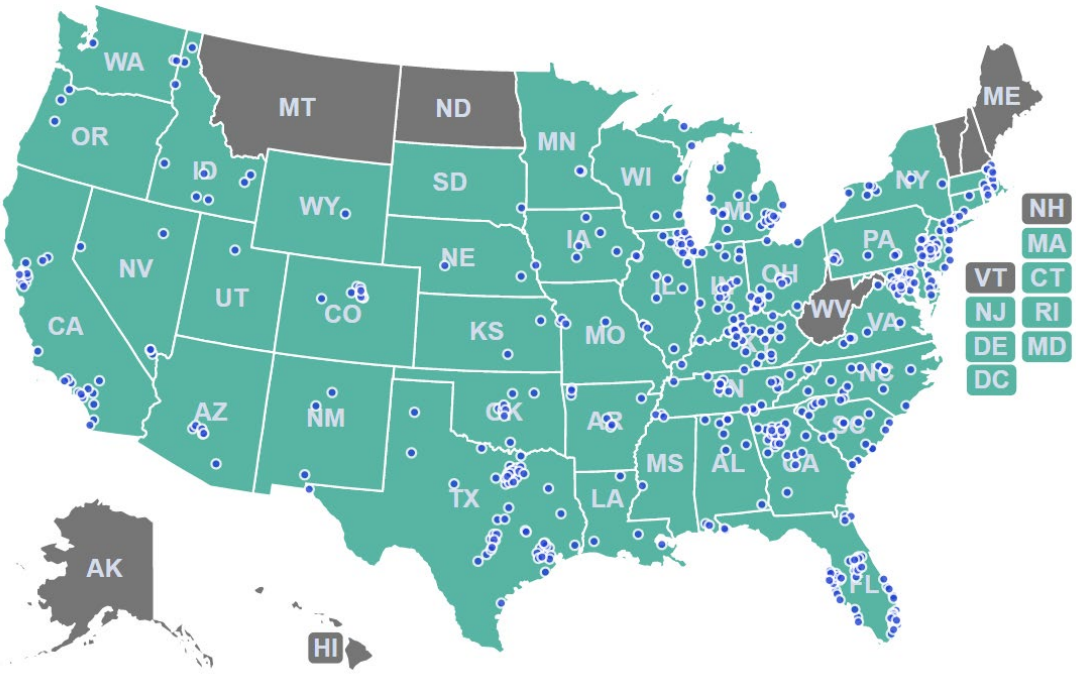
IPA is presently engaged with four Medicare Administrative Contractors (MACs) regarding their recent decision to "downcode" the administration and payment of certain complex biologic infused drugs. IPA contends the decision on which drugs were chosen for the lower-level codes was made on an arbitrary and inconsistent basis. The change in reimbursement methodology under-values the patient care resources needed to provide these complex drug administrations to beneficiaries and may endanger patient care by failing to compensate providers for the many steps that must be taken to ensure these drugs are provided in a safe manner, warranting their previous Chemotherapy Administration CPT coding. We sent detailed letters to all four MACs and will be meeting each of them in the coming weeks on these inappropriate clinical decisions that threaten our ability to devote appropriate clinical resources to the administration of these products[6].

Engagement in 2021 Drug Pricing Debate

As the drug pricing debate heats up, the IPA believes proactive engagement with policymakers with thoughtful ideas to reform drug pricing and reimbursement is essential. As such, we developed several bold ideas that will constrain drug costs and lower patients' out-of-pocket liability[7]:

1. Reduce the payment disparity for drug administration of Part B drugs between hospitals and clinics by cutting hospital drug administration by at least 50 percent of the differential;
2. Transform the 6 percent add-on payment in Part B to a tiered approach where more expensive drugs would receive a lower add-on payment (4 percent) and less expensive ones (e.g., biosimilars) a larger add-on payment.
3. Cap Medicare beneficiary out-of-pocket coinsurance at the hospital outpatient cap ($1,484), since patients should never be penalized when obtaining care in a more efficient, lower cost setting such as our clinics.
4. Encourage the approval and market adoption of biosimilars.

The IPA is undertaking an educational campaign with members on committees of jurisdiction this summer and is also in dialogue with the Biden Administration and MedPAC on these ideas. We hope these thoughtful and reasonable reforms can be adopted in lieu of more radical approaches that could threaten patient access and drive more care to the higher cost hospital setting.



[6] IPA Letter to MACs

[7] IPA Principles for Rx Reform