NHIA
National Home Infusion Association
Providing solutions for the infusion therapy community

June 15, 2015

The Honorable John Boehner
Speaker
Office of the Speaker
H-232 US Capitol
Washington, DC 20515

The Honorable Nancy Pelosi
Democratic Leader
Office of the Democratic Leader
H-204 US Capitol
Washington, DC 20515

Dear Speaker Boehner and Leader Pelosi:

The National Home Infusion Association (NHIA), representing the nation's providers of infusion therapy in home and alternate-site settings, is writing in opposition to H.R. 2570. This legislation would create a 3-year demonstration program to test the use of value based insurance design methodologies under Medicare Advantage plans. NHIA does not take a position on the creation of a demonstration program, but to pay for this 3-year demonstration the legislation includes a provision that would change the payment structure for infusion drugs under the Part B durable medical equipment (DME) benefit to an Average Sales Price (ASP) payment methodology. The legislation also includes a prohibition on competitive bidding of the Part B DMEPOS infusion drugs.

Currently, home infusion providers are able to provide these drugs to beneficiaries only because the drug reimbursement is sufficient to cover the costs of the professional services, which are necessary for patients to receive these therapies in their homes. These professional services are currently not separately paid for, but have been captured by the drug reimbursement, thus making the drug therapies available to beneficiaries for several decades. Without reimbursement from Medicare for the services component of home infusion, the payment change for these drugs as set out in HR 2570 will make it very difficult, if not impossible, for home infusion providers to provide these drugs and the necessary services to Medicare beneficiaries. Beneficiaries without access to home infusion would most likely need to receive their care in more expensive institutional settings.

NHIA does support the prohibition on competitive bidding of Part B DMEPOS drugs and appreciates that this provision was added to the legislation. However, it must be noted that while this provision may prevent the drug reimbursement under DMEPOS from being driven even lower, the issue of a service payment for home infusion professional services remains paramount to the industry and the industry cannot support an ASP pricing methodology without home infusion services being reflected in the payment methodology.

The home infusion industry has been proposing a solution to this problem **since 2006**, which is currently reflected in the Medicare Home Infusion Site of Care Act, HR 605. It is unconscionable that this change in drug payment be used to pay for legislation that does not affect the home infusion industry at all when the industry itself has been proposing a solution to this problem for almost a decade. If HR 2570 is passed in its current form, it would further fracture the already broken and illogical Medicare home infusion coverage structure.

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NHIA is aware that the provisions included in HR 2570 are carrying out the recommendations of a recent OIG follow up report on home infusion drug payments. We are greatly concerned with the methodology that the OIG used in its original and follow-up reports. The OIG's reports' recommendations do an injustice to a full and productive dialogue regarding Medicare's coverage of home infusion.

Specifically, both reports simply promote the "savings" that would result if Medicare reimbursed DME infusion drugs at the current ASP rates, instead of at the statutorily-mandated methodology of 95% of the average wholesale price as of October 1, 2003. The reports' recommendations are seriously flawed and may trigger policies that would result in Medicare beneficiaries having no choice but to obtain infusion drugs in hospitals, skilled nursing facilities or hospital outpatient facilities. Receiving infusions in these sites of care would be at a far greater cost to the Medicare program and at a significant impact to quality of life for this chronic patient population who require these drug therapies.

These two OIG analyses are, by design, very narrow. They are far too narrow to be the basis for new policy in this area. The analyses are **only** focused on the drug pricing methodology for Part B drugs, and do not reflect any attempt to assess the impact of a drastic reduction in drug reimbursement on an accredited Part B supplier's ability to provide all of the essential components of care for these extremely ill and vulnerable patients. Professional services (which include specialized pharmacy and nursing services) are critical to the safe and effective provision of these drugs and are not explicitly covered under the DME benefit. Simply recommending a significant payment reduction for the drugs, without a corresponding assessment on the overall clinical care provided to the patient, is extremely reckless.

For example, the OIG study is focused largely on a single drug—milrinone lactate—and states that subjecting the drug to the ASP payment methodology would have saved as much as $166 million from Q2 2013 to Q3 2014. This analysis falls far short of providing the full picture of what is involved to ensure patient safety and therapy success in the alternate-site setting for a drug with an extremely narrow therapeutic index.

Milrinone lactate is a type of inotropic medication that is indicated for patients suffering from end-stage heart failure.[1] These patients are either candidates for heart transplants, with inotropic therapy provided to sustain cardiac function and tissue perfusion until transplant occurs, or inotropic therapy is provided to maintain the highest quality of life possible in the final phase of their terminal condition. In both cases, care of these patients in the home setting requires a high degree of expertise, with intensive clinical monitoring needed to ensure patient safety. Inotropic therapy is life-sustaining.

Home infusion nurses and pharmacists prepare patients and their caregivers with comprehensive education regarding maintenance and use of the infusion pump that delivers the medication, as well as 24/7 access to clinical assistance should the need arise. Frequent clinical contact is essential to ensure optimal response to therapy, and to communicate changes in the patient's condition with the prescribing physician so that any needed adjustments to the patients overall medication regimen can be made. The goal in all cases is to maintain care of these end-stage heart failure patients at home, reducing or even eliminating emergency room visits and/or hospitalization whenever possible. Home infusion for patients receiving inotropic medication has been a great success story for our nation's health care system. It has reduced long stay hospitalizations, saved

[1] Hunt SA, Abraham WT, Chin MH, Feldman AM, Francis GS, Ganiats TG, Jessup M, Konstam MA, Mancini DM, Michl K, Oates JA, Rahko PS, Silver MA, Stevenson LW, Yancy CW. 2009 Focused update incorporated into the ACC/AHA 2005 guidelines for the diagnosis and management of heart failure in adults: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *Circulation.* 2009;119:e391– e479.

significant dollars for the Medicare program, and allowed patients the opportunity to receive life maintaining care in their own homes.

By its own admission in both the 2013 and follow-up reports, **the OIG "did not examine any infusion-related services (either covered or uncovered) that may have been provided to beneficiaries who received DME infusion drugs."** For this reason alone, we strongly believe the recommendations included in these reports should not be acted upon. However, there is a clear path towards sensible, cost-effective coverage of home infusion drugs—and that is for Congress to enact the Medicare Home Infusion Site of Care Act, HR 605.

As we continue to work toward a Medicare program that reflects the current needs of older and disabled Americans, it is important that we take an inclusive or holistic approach to home infusion policy issues and resolutions. Long ago, NHIA, along with numerous health policy professionals, identified the need for a comprehensive home infusion benefit to ensure that drug pricing methodologies are adequate and appropriate. We stand ready to work with you to find a realistic solution to ensure home infusion is a viable care option for seniors.

Please consider removing the ASP pricing provision from HR 2570 and instead take action to enact the Medicare Home Infusion Site of Care Act. This legislation will resolve the Part B drug payment issue and also fix the fragmented Medicare coverage of home infusion.

Should you have questions for NHIA, please feel free to call me directly at (703) 838-2678, or contact our Vice President of Legislative Affairs, Kendall Van Pool, at (703) 838-2664. Thank you for considering our concerns on this pressing issue.

Sincerely,

Russell T. Bodoff
NHIA President & Chief Executive Officer

cc: Majority Leader Kevin McCarthy
Majority Whip Steve Scalise
Democratic Whip Steny Hoyer
Chairman Paul Ryan, Ways and Means
Ranking Member Sander Levin, Ways and Means
Subcommittee Chairman Kevin Brady, Ways and Means Subcommittee on Health
Subcommittee Ranking Member Jim McDermott, Ways and Means Subcommittee on Health
Representative Diane Black
Representative Eliot Engel
Representative Pat Tiberi
Members of the US House of Representatives