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On behalf of the

COALITION OF STATE RHEUMATOLOGY ORGANIZATIONS
and the
ALLIANCE OF SPECIALTY MEDICINE

before the

ENERGY AND COMMERCE COMMITTEE
HEALTH SUBCOMMITTEE

May 17, 2016

The Alliance of Specialty Medicine (the Alliance) is a coalition of national medical societies representing specialty physicians in the United States. This non-partisan group is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

The Coalition of State Rheumatology Organizations, or CSRO, is a group of state and regional professional rheumatology societies formed in order to advocate for excellence in rheumatologic disease care and to ensure access to the highest quality care for the management of rheumatologic and musculoskeletal diseases. Our coalition serves the practicing rheumatologist in charge of patient care for these illnesses. CSRO is a member of the Alliance.

Appropriate Medicare coverage of and reimbursement for treatment are critical for our patients, which is why we are very concerned about the Part B Drug Payment Model ("the model") proposed by CMS. I appreciate the opportunity to share the views of the many clinicians CSRO represents who see patients on a

daily basis. Specifically, my testimony will focus on the process and procedural concerns, as well as our substantive concerns including prescriber behavior, patient access, and sustainability.

THE MODEL

CMS proposes to modify the average sales price (ASP) add-on amount over the course of a two-phase demonstration. Under Phase I, CMS would create two study cohorts; one cohort would receive Part B drug payments under the current payment methodology (ASP+6 percent), whereas the other cohort would receive a reduced add-on payment (ASP+2.5 percent) plus a flat fee of $16.80. Under Phase II, CMS would create two additional study cohorts of the same but add value-based purchasing (VBP) tools currently employed by commercial health plans, pharmacy benefit managers, hospitals, and other entities that manage health benefits and drug utilization. CMS proposes that Phase I would begin in Summer 2016; Phase II would begin as soon as January 1, 2017. Specific to the VBP strategies, CMS proposes to allow 30 days for public comment and would provide a minimum of 45 days public notice before implementation.

As rheumatologists, we are on the frontlines treating actual patients with Part B drugs. We are keenly aware of the unsustainable rise in drug costs and the effects of those costs on our patients' ability to adhere to their treatment regimens. While we appreciate CMS's attention to the topic of drug costs, we feel that this proposal is misguided. As CMS acknowledges in the rule, the proposed approach "does not directly address the manufacturer's ASP, which is a more

significant driver of drug expenditures than the add-on payment amount for Part B drugs." Given that a slash to the ASP add-on is unlikely to actually lower costs for patients (and, as explained below, may increase it in some cases) and may jeopardize access, **we have requested that CMS withdraw the model and we urge the Committee to do the same**.

PROCESS CONCERNS

In early February 2016, CMS posted guidelines to contractors about the Medicare Part B Drug Payment Model, which proposed changes to the Average Sales Price (ASP) methodology for Part B drug reimbursement. This demonstration project would be mandatory for zip codes identified by CMS. The posting appeared to have happened erroneously, as the agency quickly removed the guidelines from its website. This posting and its subsequent hasty removal greatly worried us, as it indicated a major payment change was well underway, even though CMS had not engaged in any pre-rulemaking dialogue such as town halls or Requests for Information.

Rather than pause to address these concerns, CMS only seemed to accelerate its timeline for beginning this sweeping payment change. Within a month, CMS issued the proposed rule containing the model.

Executive Order 13563 (January 11, 2011) explains that, "*Before issuing a notice of proposed rulemaking, each agency, where feasible and appropriate, shall seek the views of those who are likely to be affected, including those who are likely to*

benefit from and those who are potentially subject to such rulemaking." Apart from the erroneous posting for contractors described above, **CMS did not engage affected stakeholders in an open, transparent manner to inform and improve the proposed regulation**.

CMS has employed pre-rulemaking engagement strategies in developing the requirements associated with new physician payment programs established under the Medicare Access and CHIP Reauthorization Act (MACRA). It is unclear why CMS refused to utilize that process for the Part B Drug Model, particularly in light of the tremendous impact it will have on providers and patients. We see CMS' process as a blatant overstep and abuse of its statutory authority.

PROCEDURAL CONCERNS

The Affordable Care Act authorizes the Innovation Center to test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care furnished to beneficiaries. However, the scope of the Model far exceeds any reasonable definition of a "test" and is so expansive as to constitute a program change.

First, with very limited exceptions, **the Model will include all Part B drugs**. Second, CMS proposes to **mandate participation by all providers** who prescribe Part B drugs. The model can no longer be considered a "demonstration" when it is scaled nationwide (excluding Maryland) and will apply to all Part B medicines. Third, the length of the demo – five years – is an unusually long time period for a project that is intended to merely test a new

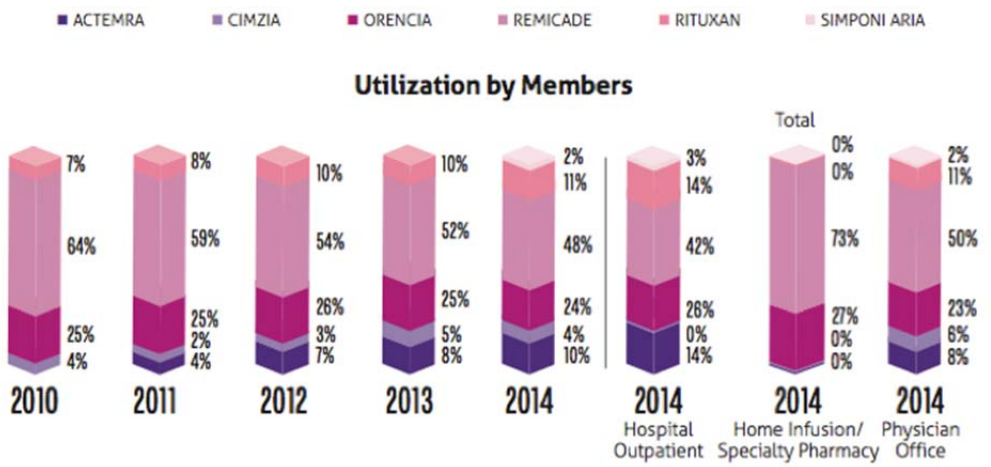
payment structure. Given that **Congress statutorily defined the ASP methodology and add-on in section 303 of the Medicare Modernization Act of 2003**, it is an inappropriate overreach of regulatory authority for CMS to force changes to this formula.

SUBSTANTIVE CONCERNS

Clinical decision-making is not influenced by the add-on percentage.

In the proposed rule, CMS notes that the "ASP methodology may encourage the use of more expensive drugs because the 6 percent add-on generates more revenue for more expensive drugs[.]" In other words, CMS implies that clinical decision-making by physicians is driven by the opportunity to maximize revenue. Yet, a recent report by Magellan studied utilization of rheumatoid arthritis medicines and found that physicians are not routinely prescribing the most expensive product. In fact, in 2014, in the physician's office, Remicade was used 50% of the time. Rituxan was prescribed only 11% of the time, despite the fact that "Rituxan ($20,205) and Orencia ($15,892) costs were higher than Remicade ($15,312)[.]"[1] The entire graph is included below:

[1] Magellan Rx Management, "Medical Pharmacy Trend Report" 2015 Sixth Edition.



In the proposed rule, CMS cites MedPAC data in support of its assertion that clinical decisions are driven by revenue generation. However, MedPAC noted that, "it is difficult to know the extent to which the percentage add-on to ASP is influencing drug prescribing patterns because few studies have looked at this issue."[2] At a minimum, there are conflicting data on this point and, as such, these data should not drive a Medicare program overhaul as expansive as this one.

Many rheumatology practices will be unable to absorb this reduction.

The current six percent add-on already results in practices without volume purchasing power being "underwater" on several products. A reduction from 6% to 2.5% plus a $16.80 flat fee will result in unsustainable cuts, especially considering that CMS did not incorporate the impact of sequestration in its calculations. Specifically, the current reimbursement level is actually ASP plus 4.4% and, **accounting for sequestration means the new rate will be ASP**

[2] MedPAC June 2015 report, Chapter 3: Part B drug payment policy issues. Available: http://www.medpac.gov/documents/reports/chapter-3-part-b-drug-payment-policy-issues-(june-2015-report).pdf?sfvrsn=0.

plus 0.86% with a flat fee. We gathered some illustrative data from CSRO member practices:

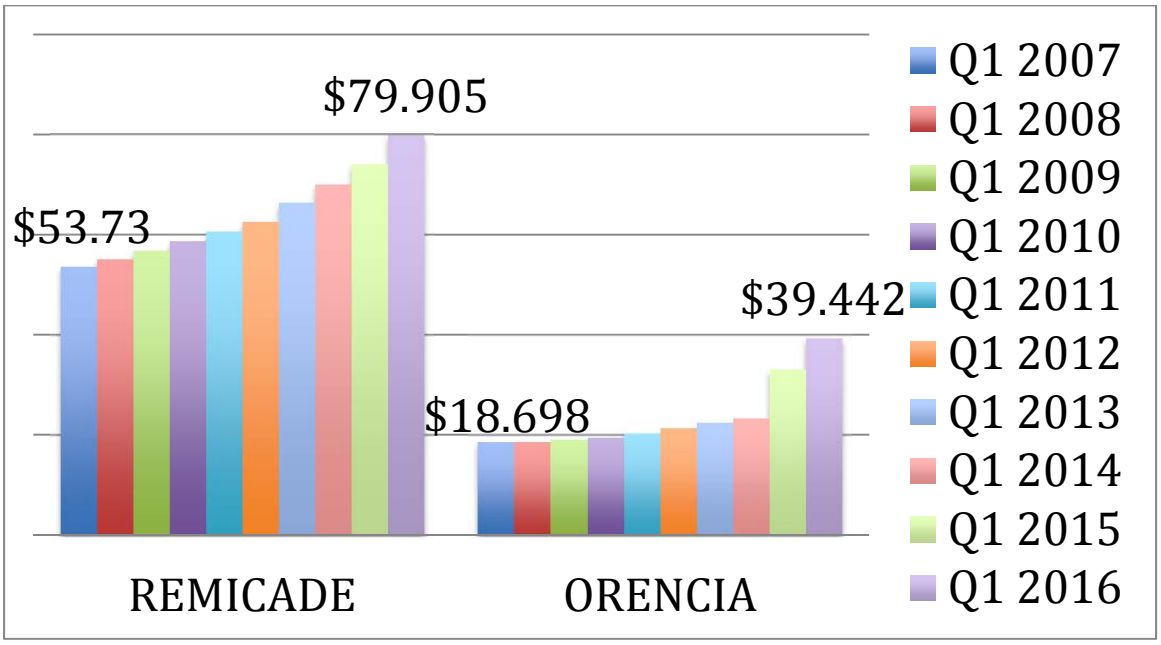
Practice Location	Practice Size	Drug	Purchase Price	Reimbursement Level (reflecting sequestration)	Differential	% +/-
Bethlehem, PA	2	Rituxan	$7,328.12	$7,567.10	$238.98	3.26%
Fremont, CA	2	Prolia	$904.41	$914.47	$10.06	1.11%
West Chester, PA	2	Benlysta	$3,715.20	$3,752.84	$37.64	1.01%
New Orleans, LA	4	Actemra	$2,408.96	$2,395.61	$-13.34	-0.55%
Riverview, FL	1	Euflexxa	$148.00	$146.71	$-1.29	-0.87

We hope that this data can help illustrate a few things. First, rheumatology practices are not getting wealthy off Part B drug purchases and, in fact, some practices are underwater on certain products. Second, there is no one factor that predicts whether a practice will be able to purchase at ASP. It depends on the volume of the purchase, the size of the practice, the ability to negotiate a rebate, and other factors. We have extended an offer to CMS to gather additional data from practices, should the agency wish to delve into these financial details, and

we extend that same offer to the Committee.

Additionally, the two-quarter delay in ASP uniquely affects small and rural practices, and this would only be exacerbated by a reimbursement reduction. The ASP at which a practice is reimbursed is two quarters behind the current prices. Given the fast and sharp increases in prices each and every quarter, this often puts a practice underwater for the medicines it is purchasing, even if it is able to purchase at ASP.

With regard to sustainability for the Medicare program, a far greater concern than the add-on percentage is the underlying ASP, and the steep, fast price increases that these medicines show each quarter. We included here a graph showing price increases for two representative rheumatology products from the first quarter of 2007 through the first quarter of 2016:



As noted above, these are only two representative products, but this trend is true across all Part B rheumatologic medicines. These ASP increases are unsustainable for both the Medicare program and its beneficiaries. However, the model does nothing to actually address the underlying prices.

Patients will lose access to office-based infusions.

Because the Model will include nearly all Part B drugs, rheumatologists may be forced to switch patients to alternative drug therapies, even if those patients are stable on their current medicines. This may be the case when the treating physician can no longer offer infusions, but there is no nearby hospital-based infusion center that the patient can travel to. Switching stable patients for non-clinical reasons violates the most basic teachings of rheumatology as it can result in loss of control over the disease – control that may not be regained even if the patient is switched back to the original product. This places patients at unnecessary risk and increases healthcare costs due to the potential for adverse reactions and loss of effectiveness.

As noted above, physicians may be forced to send patients to the closest hospital outpatient department to receive the needed medications. CSRO surveyed its members to better ascertain the behavioral response to the CMS proposal, and 73.08% of respondents said that infusible Part B biologic options would no longer be available for Medicare patients in their offices. 44.87% of respondents noted that they would refer to hospitals or external infusion centers

to continue therapy.

Hospital referrals will create financial challenges for patients who cannot afford the higher cost-sharing – for the exact same treatment. In Part B, most beneficiaries have wraparound coverage, so while the patients may not bear the increased financial costs directly, traveling to the hospital outpatient department is inconvenient and can be challenging for patients with rheumatoid arthritis, depending on the distance to the nearest hospital-based infusion center. It also runs counter to the goals of the model, as the cost to the Medicare program will be significantly higher when patients must receive therapy in the outpatient department instead of the physician's office. Oddly, CMS states in the preamble of the proposed rule that growth in drug spending has largely been driven by spending on separately paid drugs in the hospital outpatient setting, which more than doubled between 2007 and 2015, from $3 billion to $8 billion, respectively.

The following graph illustrates the varying cost of medicines, depending on the setting, and supports the fact that the physician's office is the cheapest setting to infuse rheumatologic medicines.

Brand Name	Cost per Unit			Cost per Claim		
	Hospital Outpatient	Home Infusion/ Specialty Pharmacy	Physician Office	Hospital Outpatient	Home Infusion/ Specialty Pharmacy	Physician Office
Botox	$5.89	$5.57	$5.54	$910	$1,101	$776
Gammagard Liquid	$42.83	$50.31	$46.81	$2,833	$4,569	$3,909
Gamunex-C/Gammaked	$47.29	$42.80	$41.42	$3,859	$3,836	$2,441
Herceptin	$93.87		$80.61	$3,754		$2,800
Neulasta	$2,392	$4,691	$3,501	$2,392	$4,691	$3,501
Orencia	$28.97	$28.89	$27.32	$2,147	$2,889	$2,109
Remicade	$82.40	$84.51	$74.66	$3,948	$4,486	$3,438
Soliris	$209.85		$189.44	$19,387		$16,671
Xgeva/Prolia	$17.69	$18.71	$14.57	$1,817	$1,283	$1,139
Yervoy	$181.62		$127.62	$39,377		$32,183

Finally, not all patients have hospitals nearby that offer infusions. We have found that most of the hospitals still offering infusion centers are 340B hospitals. Non-340B hospitals have mostly closed down their infusion centers due to a lack of profitability. Since 340B hospitals are not present in every area of the country, this may force beneficiaries to travel long distances to receive treatment, should their physician be unable to continue infusing them.

Value-based purchasing cannot be one-size-fits-all and will require significant stakeholder input through pre-rulemaking engagement.

With regard to some of the value-based purchasing ideas proposed by CMS for Phase 2, we offer the following feedback.

- A cost-sharing reduction (or even elimination) for beneficiaries would relieve a lot of the financial pressure our patients feel when they enter Medicare. In the private insurance market, patients can often use coupons to offset the large coinsurances they are responsible for. When they enter Medicare Part D, this is no longer an option as the program prohibits such assistance. For Medicare Part B, however, beneficiaries often have supplemental insurance that covers some or all of the twenty percent coinsurance for their medicines. Thus, it is unclear what a reduction in cost-sharing for Part B medicines would accomplish other than allow supplemental insurers to pay less. This would do nothing to actually reduce costs for beneficiaries. A more effective proposal would look at

Medicare drug coverage in its entirety and explore lifting the ban on cost-sharing assistance for Part D medicines.

- The reference pricing concept did not have enough detail in the proposed rule to meaningfully comment on. Rheumatologic Part B medicines may be good candidates for reference pricing, since the ASPs are mostly clustered together. However, the challenge will be setting a reasonable reference price, figuring out how to make the manufacturer bear the risk in a purchasing system that currently puts the purchaser at risk, and, finally, figuring out how biosimilars will fit into such a reference pricing structure in a way that does not automatically drive all patients onto the biosimilar, even in cases when that is not clinically appropriate. We are concerned that CMS has not thought through any of these aspects.
- Indication-based pricing is a concept that is difficult to envision in rheumatology because there is no population-level data indicating what biologics work better than others for patients with rheumatoid arthritis. Indeed, there are robust rheumatology registries that have not yet yielded such data, likely because autoimmune disease may not lend itself to these types of studies. Additionally, it is unlikely that manufacturers would commit funds for head-to-head studies that may prove their product is inferior to another.

CONCLUSION

The Alliance and CSRO appreciate CMS's concern about high drug prices and

would like to work with the Congress and the Administration to find solutions. However, we must oppose the Part B Drug Payment Model as it suffers from serious procedural and substantive flaws that we believe render it unworkable – and it does nothing to actually address drug prices. As such, we have requested that CMS withdraw the model and we urge the Committee to do the same.

In closing, the Alliance and CSRO thank the Committee for its attention to this critical topic and for the opportunity to provide the views of practicing specialists on the Part B model.