



July 24, 2019

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Grassley and Ranking Member Wyden:

On behalf of our member hospitals and health systems, we are fully committed to helping the Committee address the issue of high drug prices, which have reached astronomical levels. We agree with the Committee's goal of reducing the price of drugs, and applaud many of the steps outlined in the description of the Chairman's Mark of the Prescription Drug Pricing Reduction Act (PDPRA) of 2019. However, we have serious concerns regarding the provisions that reduce reimbursements to providers and hospitals that administer drugs.

The Medicare Part B payment mechanisms available to Congress to address drug pricing does not simply affect drug companies, but involve the physicians and hospitals that administer the drugs to patients. We have concerns specifically with Sections 107, 110 and 111 of the PDPRA. These provisions would implement payment reductions to hospitals and physicians, but do not address the high prices set by drug companies.

Our specific concerns follow.

Section 107, Medicare Part B Rebate by Manufacturers for Drugs or Biologicals with Prices Increasing Faster than Inflation

We appreciate the intent of the provision to contain out-of-control price increases in Part B drugs. We note in the description of the provision that the Health and Human Services Secretary would be prohibited from making Medicare payment available under Part B for a drug for which the manufacturer has not paid an assessed civil monetary penalty for non-payment of a required rebate. As payment for Part B drugs is made to the administering provider and not the manufacturer, this could leave providers without a

critical source of payment for drugs already purchased and needed for patient care. In addition, to the extent an affected drug is single source, it would leave providers without an option for an alternative product. We ask that you consider this concern as you move the legislation forward to avoid harm to patients and providers.

Section 110, Establishment of Maximum Add-on Payment for Drugs, Biologicals, and Biosimilars

Currently, Medicare pays providers for most Part B drugs, biologicals and biosimilars furnished in a hospital outpatient department, physician office and ambulatory surgical center at the average sales price (ASP) plus 6% and pays for new drugs during their first two quarters on the market at wholesale acquisition cost plus 3%.

This provision would establish \$1,000 as the maximum add-on amount that a provider can be paid for a separately payable drug, biological or biosimilar. The current payment system sets our members up as purchaser and administrator of drugs. Not every infused drug costs \$10 (a 60 cent fee to administer) or \$20,000 (\$1,200 paid to administer). The ASP plus 6% statutory formula was intended to serve as a buffer to help address the gap between the manufacturer-reported ASP rate and the average purchase price across providers, which varies due to factors such as prompt-pay discounts, wholesaler markups and sales tax. However, the 6% add-on was implemented for other reasons as well. Specifically, due to the two-quarter lag in the data used to set the ASP plus 6% payment rate, the percentage add-on also provides protection for hospitals and physicians when price increases occur and the payment rate has not yet caught up. This protection already has been eroded by the impact of the budget sequester on the current ASP add-on, making the effective add-on after sequester ASP plus 4.3%, according to the Centers for Medicare & Medicaid Services and the Medicare Payment Advisory Commission. Under the proposed provision, after also being subject to the sequester, it is unlikely that the add-on payment would be sufficient to cover the costs to a hospital.

In addition, the add-on to ASP also is intended to cover pharmacy overhead costs, such as drug storage and handling costs. Many of the drugs used in hospitals require special handling, storage and training. Retaining an adequate add-on to ASP is critical to ensuring continued access to drug therapies for beneficiaries receiving care in hospitals and in physician practices that utilize such drugs with high handling expenses. Simply removing the higher reimbursement creates an imbalance from what was intended under the ASP plus 6% system. Medicare outpatient margins are already at -16.6%¹, and this provision will further erode hospital outpatient margins and put access and quality of care at risk for the most vulnerable of Medicare beneficiaries.

¹ This is the simple average of OPPS hospitals' individual Medicare operating margins, based on 2017 Medicare cost report data.

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Section 111, Treatment of Drug Administration Services Furnished by an Off-Campus Outpatient Department of a Provider

This new provision would apply site-neutral payment cuts to drug administration services furnished in “grandfathered” off-campus provider-based departments, facilities that had been specifically exempt from these cuts in both the Bipartisan Budget Act of 2015 and as amended in the 21st Century Cures Act. This site-neutral payment reduction would be applied in a non-budget neutral manner, meaning that the site-neutral payment reduction would cut aggregate hospital payments. We oppose any expansion of site-neutral payment policy, including imposing a site-neutral payment policy for drug administration services under Medicare Part B.

We applaud your steps in the PDPRA to reduce drug prices, and we appreciate your consideration of our concerns. We look forward to working with you to address these issues and lowering the price of drugs.

Sincerely,

American Hospital Association
Federation of American Hospitals
Association of American Medical Colleges