Update on Home and Alternate Site Infusion Therapy

Key Thoughts and Insights Coming Out of the 2025 NICA Conference

Last week, **the Bourne Partners team attended the 2025 National Infusion Center Association (NICA) Annual Conference** in Miami, Florida to meet with executives and private equity investors in the home and alternate site infusion therapy space. We view home and alternate site infusion therapy as one of the most attractive verticals in healthcare services today with growth driven by therapeutic innovation, the shift towards lower-cost, non-hospital settings of care, and patient preferences. Also, the home and alternate site infusion therapy space continues to be highly fragmented. So, we see an opportunity for meaningful economies of scale to be gained through mergers and acquisitions and through the adoption of modern information technology.

However, **there are also headwinds and uncertainties.** At the NICA conference we heard discussions about the potential re-emergence of white-bagging mandates by health plans and an uncertain outlook for drug pricing under the *Inflation Reduction Act*. Based on our conversations, we believe that home and alternate site infusion therapy providers derive most of their profitability from the margin on the drugs that they administer -- making much less on pharmacy services or nursing care. Accordingly, any changes to drug reimbursement are something to monitor. More recently, the Trump administration also issued an executive order to implement a "Most Favored Nations" policy for drug pricing, which could have effects as well. *For more discussion on the home and alternate site infusion therapy space, refer to our deep-dive industry report:* ***Infusion Therapy Market Report*** *(August 7, 2024).*

1) Opportunities and Threats to Home and Alternate Site Infusion Reimbursement

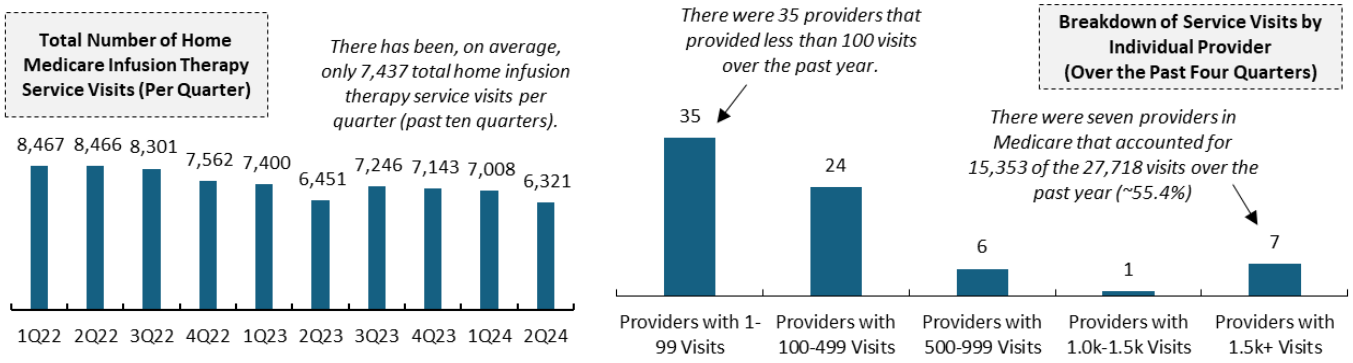
At the NICA Conference, we were able to have a number of conversations with industry experts on the opportunities and threats to home and alternate site infusion therapy reimbursement. In our view, the primary opportunity for reimbursement upside for providers (of home infusion services, in particular) is a potential "fix" to the Medicare Part B reimbursement methodology. By contrast, the primary threats to reimbursement that came up at the Conference were white-bagging, the uncertainties associated with the ongoing rollout of the *Inflation Reduction Act (IRA) of 2022*, and the more recent *Most Favored Nations (MFN)* executive order by President Trump in May 2025.

1a) Opportunity to Fix Medicare Part B for Home Infusion Providers

At NICA, **we had a chance to meet with representatives from the National Home Infusion Association (NHIA)**, an industry group of home infusion providers. By far, **the primary legislative focus of the NHIA is finding a "fix" to the flawed Medicare Part B reimbursement methodology** for home infusion providers. Currently, the reimbursement for home infusion therapy under Medicare Part B makes it uneconomic to provide these services. As evidence of this, only ~5.2k Medicare beneficiaries are able to access their home infusion benefit annually -- out of 30M+ total traditional Medicare beneficiaries. This is clearly a gross underutilization of home infusion among the Medicare population -- vs the 3.2M patients (outside of Medicare) who are able to access home infusion annually. We see "fixing" Medicare Part B as a huge opportunity for home infusion therapy providers as it would likely result in a significant, industry-wide 10%+ lift to annual patient volumes.

As background, most people that we talk to seem to agree that the Congressional intent of the *21st Century Cures Act of 2016* was to allow for home infusion services among Medicare beneficiaries. However, in a subsequent rulemaking, the *Centers for Medicare and Medicaid Services (CMS)* limited home infusion reimbursement to only those days when a nurse is physically present in the patient's home (rather than each day the drug is infused). Essentially, this "physical presence" requirement fails to reimburse for the clinical, pharmacy, and administrative costs associated with home infusion therapy that occurs outside of the home -- thereby, making home infusion uneconomical to provide. No other payer (e.g., commercial, Medicare Advantage, or Medicaid) imposes such a "physical presence" requirement. As a result, most home and alternate site infusion therapy providers do not take traditional Medicare referrals, and there are only 78 infusion providers participating in the Medicare Part B benefit (of which seven accounted for over half of the visits). Refer to Figure 1.

Figure 1: Very Limited Provider Participation in Medicare Part B Home Infusion Benefits



Source: U.S. Centers for Medicare and Medicaid Services (HIT Monitoring Report; February 2025) and Bourne Partners

Backed by the NHIA, **the *Preserving Patient Access to Home Infusion Act* has been re-proposed in March 2025 to clarify the Congressional intent around home infusion therapy** -- by explicitly removing the "physical presence" rule. This would result in Medicare reimbursement for home infusion including all services needed to administer and manage drugs safely and effectively at home (even on days when a skilled professional is not physically present). The legislation would also direct CMS to pay 50% of the nursing rate on days when home infusion is provided, even when a nurse is not present. Altogether, this should increase provider participation in the benefit, increase home infusion patient volumes, and save money for the U.S. healthcare system. Unfortunately, as of now, we do not have any visibility to a near-term path for this legislation to pass. So, this proposed bill may have to wait until 2026.

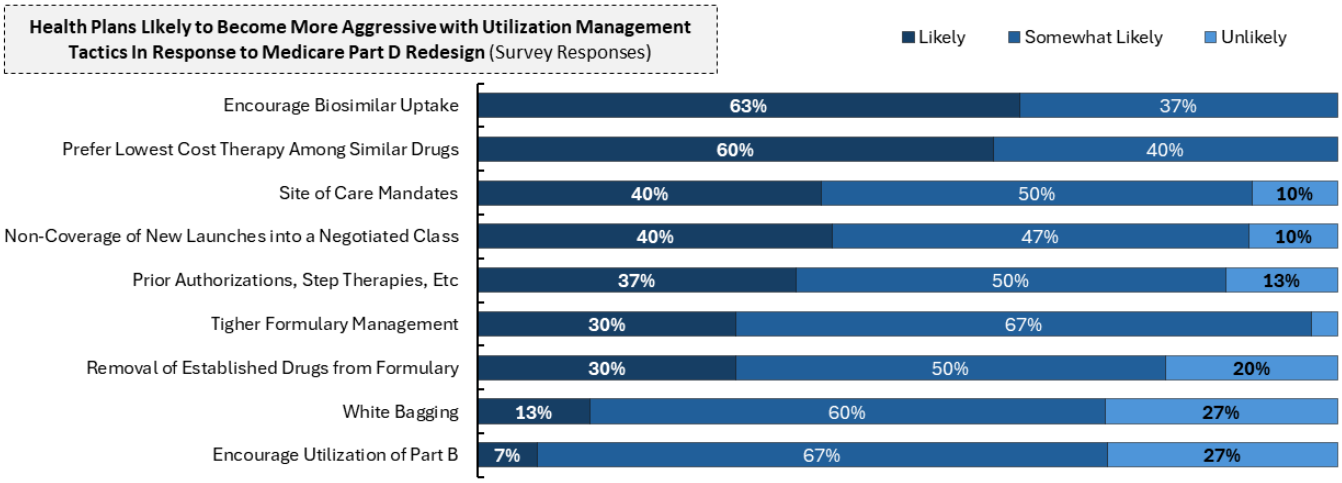
1b) The Re-Emergence of "White Bagging" Raises Eyebrows

Several panel discussions at NICA highlighted a concern that "white bagging" may re-emerge as a threat to home and alternate site infusion therapy economics. Specifically, there were multiple references to a recent announcement that Aetna was mandating white-bagging for a portion of its membership. In our view, infusion therapy providers have largely been successful fighting back against the practice of white-bagging to-date. Also, in some states, provider groups have been able to lobby for state restrictions on the practice (due to concerns about patient safety). However, white bagging is still legal/allowed in Medicare and in many states. And it is feared by some that this new white-bagging policy by Aetna, if successful, could metastasize to other private health plans over time.

As background, white bagging is a cost-saving tactic used by health plans in which a lower-cost/higher-volume specialty pharmacy is used to dispense a specialty drug for a specific patient directly to that patient's healthcare

provider. (Brown bagging is when the medicine is dispensed to the individual, who then brings it to their provider.) This is distinct from the "buy-and-bill" model, in which a provider purchases a drug for later use. The health plan typically saves money with white bagging by being able to reimburse for a drug as a "pharmacy" benefit or as a Medicare Part D benefit -- versus as a "medical benefit" or a Medicare Part B benefit. White bagging has very negative financial implications for the provider who garners no margin on the drug. Also, several providers commented that refusing to see patients with white bagging mandates can have negative effects on referral relationships. Moreover, the practice of white bagging can lead to higher out-of-pocket costs for the patient because the patient often faces a separate deductible under his or her pharmacy benefit. This, in turn, has been seen to result in lower patient adherence. Finally, many providers argue that white bagging can lead to safety issues (e.g., improper transportation and handling of sensitive drugs by third parties), and they argue that white bagging limits the ability of a provider to make any same-day adjustments to an infusion treatment.

Figure 2: The IRA Medicare Part D Redesign May Lead to More Utilization Management by Health Plans



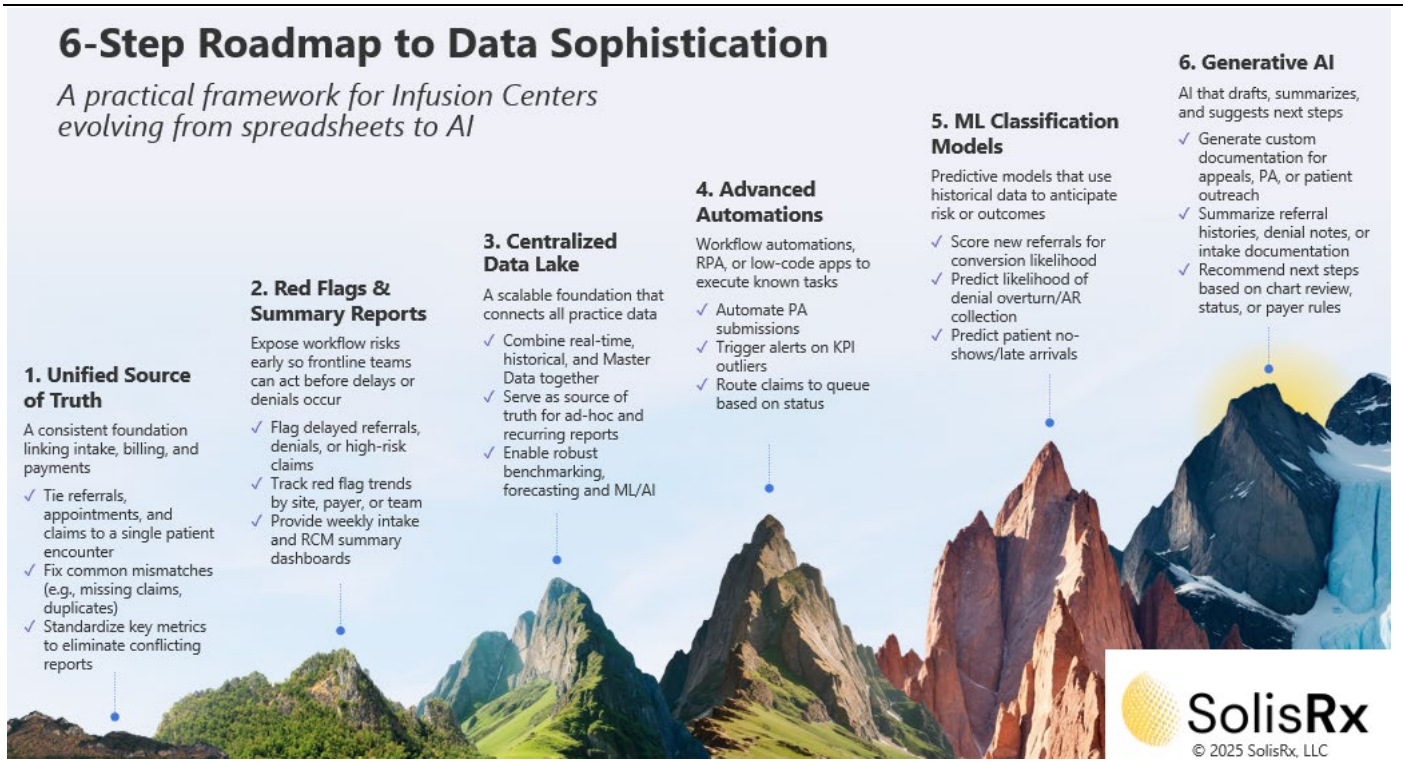
Source: Clarivate Payer Survey (September 2024) and Bourne Partners

1c) The Inflation Reduction Act (IRA) and Most Favored Nations (MFN)

We heard a lot of different perspectives at the NICA Conference on the Inflation Reduction Act (IRA). Our takeaway on the IRA is that it is not fully known at this point how it might impact home and alternate site infusion therapy providers. To date, the IRA Medicare price negotiations have not included infusion drugs. However, we expect that it is simply a matter of time before the Medicare pricing for many infusion drugs will be negatively affected. Most surveys that we have seen suggest that anything that happens to Medicare pricing will likely have a spillover effect on pricing in other payer categories. Also, it is important to consider that the pricing for one drug will likely impact the competitive dynamics of the *entire* category of drugs in which it resides. Finally, the IRA has redesigned Medicare Part D benefits such that health plans and pharma companies are now bearing more of the cost of their drugs. As a consequence, in order to protect their profit margins, we anticipate seeing more restrictive utilization management tactics by health plans over time -- such as volume limits, step therapies and prior authorizations, among other things. Pharma companies, in turn, may be more open to value-based reimbursement models as well. All of this could lead to incremental pressures on the drug spread that infusion providers are able to garner, and it may negatively impact patient access to home and alternate site infusion services. Refer to Figure 2 (above).

Like most of the presenters at NICA, **we are skeptical of the real-world workability of a Most Favored Nations (MFN) drug pricing policy.** On top of serious constitutional/legal questions, the Trump administration's executive order to implement MFN seems to rest on the assumption that pharma companies and foreign governments will voluntarily comply (against their interests) to the orders of the President. Having said that, the Trump administration could alternatively launch a demonstration program through the Centers for Medicare and Medicaid Innovation (CMMI) that includes many of the features of MFN. Although this would only impact Medicare, as with the IRA, it would certainly have derivative impacts on other payer categories. Also, a group of populist Republicans and left-leaning Democrats has recently introduced legislation that would codify MFN into law. Again, we think this is unlikely. However, we would not want to rule anything out. The ultimate impact of MFN is difficult to gauge. However, the consensus view at the NICA Conference seemed to be that, as with the IRA, MFN could pressure the drug spread that infusion providers are able to garner and negatively impact patient access to infusion services.

Figure 3: Providers Should Consider Technology Enablement in an Iterative Manner



Source: SolisRx Presentation at the 2025 NICA Conference and Bourne Partners

2) Technology Enablement as a Driver of Scale and Valuation

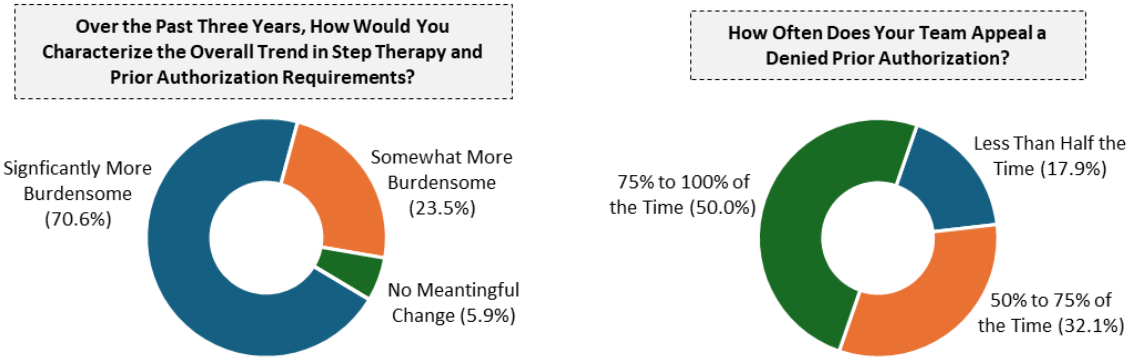
Outside of healthcare policy and reimbursement, **there was significant focus at the NICA Conference on opportunities for providers to adopt and use information technology** (including artificial intelligence). We believe that this is very important for infusion providers who are potentially looking to sell their businesses. Investors want to see home and alternate site infusion therapy providers with a clearly defined information technology roadmap. In our view, the lack of an information technology strategy raises red-flags about a provider's commitment to mid/long-term operating efficiency. Also, information technology adoption can have direct financial implications for a provider over time as well. Studies consistently show that technology enablement can accelerate patient referrals/transitions, reduce payment denials, improve patient engagement, and increase labor efficiencies, among other things. All of this shows up in revenues and EBITDA and facilitates economies of scale, something that investors want to see as a

business grows. Finally, we find that investors are often willing to 'adjust' for (add-back) one time information technology expenses when valuing a provider on a multiple of EBITDA.

2a) Developing a Roadmap to Generative Artificial Intelligence (AI)

It was difficult to have a conversation at the NICA Conference without the topic of artificial intelligence (AI) coming up. However, there are significant underlying basic elements that need to first be in place. This includes creating consistent data across intake, billing, and payments. We had a chance to meet with the management of **SolisRx**, which provided a very insightful presentation on what an information technology roadmap should look like. Key to information technology adoption is to focus on what drives efficiencies early for an infusion provider. Many providers, for instance, can see significant impact just by improving workflow visibility and flagging issues like delayed referrals or high-risk claims. Once this is established, providers can consider developing a centralized data lake to then inform automation, machine learning, and, ultimately, generative AI. Refer to Figure 3 (prior page).

Figure 4: Feedback from NICA Conference Participants (1) (Participant Survey)



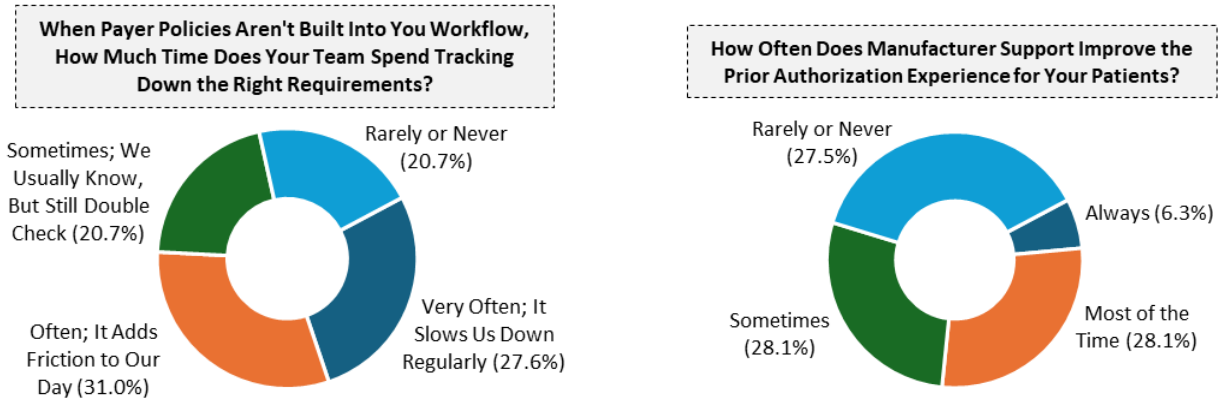
Source: SemaCare Presentation at the 2025 NICA Conference and Bourne Partners

With the basic elements in place, **one use case for AI is prior authorizations.** The challenges of prior authorizations came up in conversation after conversation at the NICA Conference. Dealing with prior authorizations is a highly labor-intensive activity that seems to be a clear-cut use case for AI, and we had the chance to meet with a number of vendors at NICA focused on automating prior authorizations, including **Lamar Health**, **SemaCare**, **Tennr**, and **WeInfuse**, among many others. Infusion therapy providers, in particular, need to be careful with prior authorizations because of the high-cost and complex nature of many of the therapies that they are administering. This can require days of documentation reviews and analysis by both the provider and the payer. And this can lead to delayed revenues and slower turnaround times. By many accounts, health plans are getting more aggressive demanding prior authorizations in response to their own financial pressures. Health plans are also themselves adopting AI to expedite prior authorization documentation (and, cynically, denials). In many cases, providers tell us that they often do not have the labor or time to appeal denied claims. Refer to Figure 4.

In our view, **core to the challenge of managing prior authorizations is the "human" element.** There is often a huge disparity between "published" payer coverage policies and the "real-world" interactions with health plans. This results in tremendous inconsistency in prior authorization behavior across health plans, drugs, and geographies. We see an opportunity for AI to be used to organize much of this chaos, creating labor efficiencies and helping to manage patient expectations with respect to if/when an infusion therapy will be covered. Complementing AI, NICA discussions also emphasized the importance of training programs for staff and collaborating with pharma

manufacturers. For many complex drugs, infusion providers are a gateway to "market access" for pharma companies so pharma companies have a direct incentive to support infusion providers with respect to addressing the challenges of prior authorizations. Collaborations with health plans can be further useful. In many cases, we heard stories of providers being able to engage with payers using benchmarking data to argue for changes to prior authorization actions. (This is another example of where having an information technology infrastructure can be helpful.) Payers do not want provider network abrasion, and providers can engage with payer staff associated with network relations as a resource. Finally, employers sometimes mandate that certain drugs are treated differently (than general payer policies). In these cases, we heard of several examples of providers working with payers to craft prior authorizations to deal with employer mandates as well. Refer to Figure 5.

Figure 5: Feedback from NICA Conference Participants (2) (Participant Survey)



Source: SemaCare Presentation at the 2025 NICA Conference and Bourne Partners

2b) Other Use Cases for Information Technology Enablement

Outside of prior authorizations, **a variety of other use cases for information technology came up at the NICA Conference**, including for the patient referral process. In our view, a key driver of valuation for a home and alternate site infusion therapy provider is the strength and diversity of its referral sources. Key to securing referrals, in turn, is being able to make "life easy" for referring hospitals and/or physicians. Referral sources want to know that an infusion provider can be trusted to have resources available, often on demand, particularly when the phone rings from a hospital case manager with an immediate patient need related to a discharge. Yet, we commonly hear that upwards of 50% of referrals ultimately do not convert to patients due to slow turnarounds that sometimes cause patients to seek care elsewhere. This is often due to inefficient pre-visit patient intake processing related to eligibility checks, benefit investigations, clinical reviews, and prior authorizations as well as poor patient communications. We hear that almost half of patients require some sort of manual intervention to close the loop, such as a phone call to the patient's health plan. And most payment denials are due to issues at the front end of the revenue cycle related to supporting documentation collection.

Also, **several NICA panel discussions pointed out uses for information technology to facilitate home and alternate site infusion providers with contract negotiations with health plans.** During payer contracting, it is critical for a provider to differentiate itself from other providers. This requires the ability to regularly track, document, and report patient outcomes as well as the ability to coordinate with third-parties. We expect the ability to stand out from the crowd will become increasingly commercially relevant over time as we anticipate seeing more and more value-based reimbursement arrangements, including the use of utilization management tactics by payers.

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