INFUSION PROVIDERS ALLIANCE

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September 9, 2024

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (CMS-1807-P)

The Infusion Providers Alliance (IPA) is pleased to provide comments regarding two issues in the physician fee schedule proposed rule: 1) direct supervision flexibility that was initially granted during the public health emergency (PHE) and has continued on an annual basis since then; and 2) the Centers for Medicare and Medicaid Services (CMS) proposed solution for the downcoding of certain complex biological therapies by Medicare Administrative Contractors (MACs).

Background on the Infusion Provider Alliance

The IPA is a leading voice for in-office and freestanding ambulatory infusion providers, with nearly 1,000 community-based, non-hospital sites across 42 states. Our members are committed to preserving the integrity of the provider-patient relationship in a manner that delivers exceptional care to patients and value to the health care system, typically saving Medicare more than 60 cents on the dollar per Part B drug infusion compared to hospital administration. Our facilities are major access points of care for patients with complex and chronic health conditions in communities, large and small. The IPA's mission is to serve as a thought leader and to educate on issues critical to safeguarding, supporting, and strengthening provider-directed, patient-focused access to infused medications. More information about IPA can be found on our website: www.infusionprovidersalliance.org.

Overview of IPA Comments

The IPA's comments focus on two issues:

1. CMS should (permanently) extend the virtual direct supervision to maintain increased access to quality care, allow for a nimble health care ecosystem in the face of future pandemics, and ensure patient adherence to vital therapies.

2. In an effort to align CMS and physician objectives, we propose updating Chapter 12, Section 30.5 of the IOM Medicare Claim Processing Manual to align with the AMA CPT Infusion Section Notes, incorporating a few targeted edits. The IPA believes the MACs have been acting in an arbitrary and inconsistent manner in categorizing drugs and ask that CMS apply a consistent policy for determining "complex" drugs not by disease but by the risk profile of the drugs and nurse

intensity to administer those products. This alignment will enhance patient safety, improve access to care, and support the financial health of the Medicare program.

Continuation of the Virtual Direct Supervision Flexibility Allows for Undisrupted and High-Quality Patient Care

After several years of utilizing the flexibility provided by the waiver to allow the use of two-way audio/visual communication to meet the "immediate availability" requirement of direct supervision, we believe CMS now has the evidence to support making this policy permanent. Data we have collected from our member companies and shared with CMS over the last several years continues to show that virtual direct supervision for infusions is a safe and effective practice that ensures that patients can receive their lifesaving therapies when they need them and without delay.

Many of the infusion patients that our members treat suffer from conditions such as Crohn's Disease, Multiple Sclerosis, and Rheumatoid Arthritis, thus leaving them with weakened immune systems that make them highly susceptible to infections. Studies have demonstrated that immunocompromised patients are at increased risk of acquiring a hospital-acquired infection (HAI) when treated in hospital settings,[1,2] therefore, these vulnerable patients are better served by safely receiving their infusions in freestanding infusion centers and physician offices. Maintaining flexibilities that promote easy accessibility to care at less risky sites, such as virtual direct supervision, is key to ensuring that our most vulnerable patients are not put at unnecessary risk for treatment.

Virtual direct supervision allows highly trained Registered Nurses (RNs) to safely provide services to patients while Nurse Practitioners (NP) offer virtual oversight for these encounters. This is beneficial for both patients and practitioners because when an NP becomes ill or has a family member become ill, virtual direct supervision can be conducted to ensure that the vulnerable patient is not exposed to the illness, such as COVID-19, and that the infusion can be delivered at the appropriate time according to the patient's administration schedule. Patient adherence to their medication schedule is key, as missed doses or delays due to practitioners being out sick which can disrupt their health system and result in flare-ups, increased disease progression, and even hospitalization.

Additionally, there is an ongoing healthcare workforce shortage, including nurse practitioners. A study conducted by the global consulting firm Mercer projected that the United States would face a shortage of 29,400 nurse practitioners by 2025.[3] Physician offices and freestanding infusion centers compete with better-resourced hospitals for the same health care workforce. As large hospital systems can often offer bigger bonuses and more flexible hours, physician offices and infusion centers' sites of care are disproportionately impacted by these shortages. Therefore, the ability for these sites of care to use virtual direct supervision will help mitigate the impact of the shortage of NPs by allowing for more flexibility and the ability to still see more patients despite not being physically present. Notwithstanding this important flexibility, it is important to note that freestanding infusion centers utilize this flexibility only as needed;

[1] .Siegel JD, Rhinehart E, Jackson M, Chiarello L, Health Care Infection Control Practices Advisory Committee. 2007. 2007 Guideline for isolation precautions: preventing transmission of infectious agents in health care settings. Am J Infect Control 35 (10 Suppl 2):S65–S164.

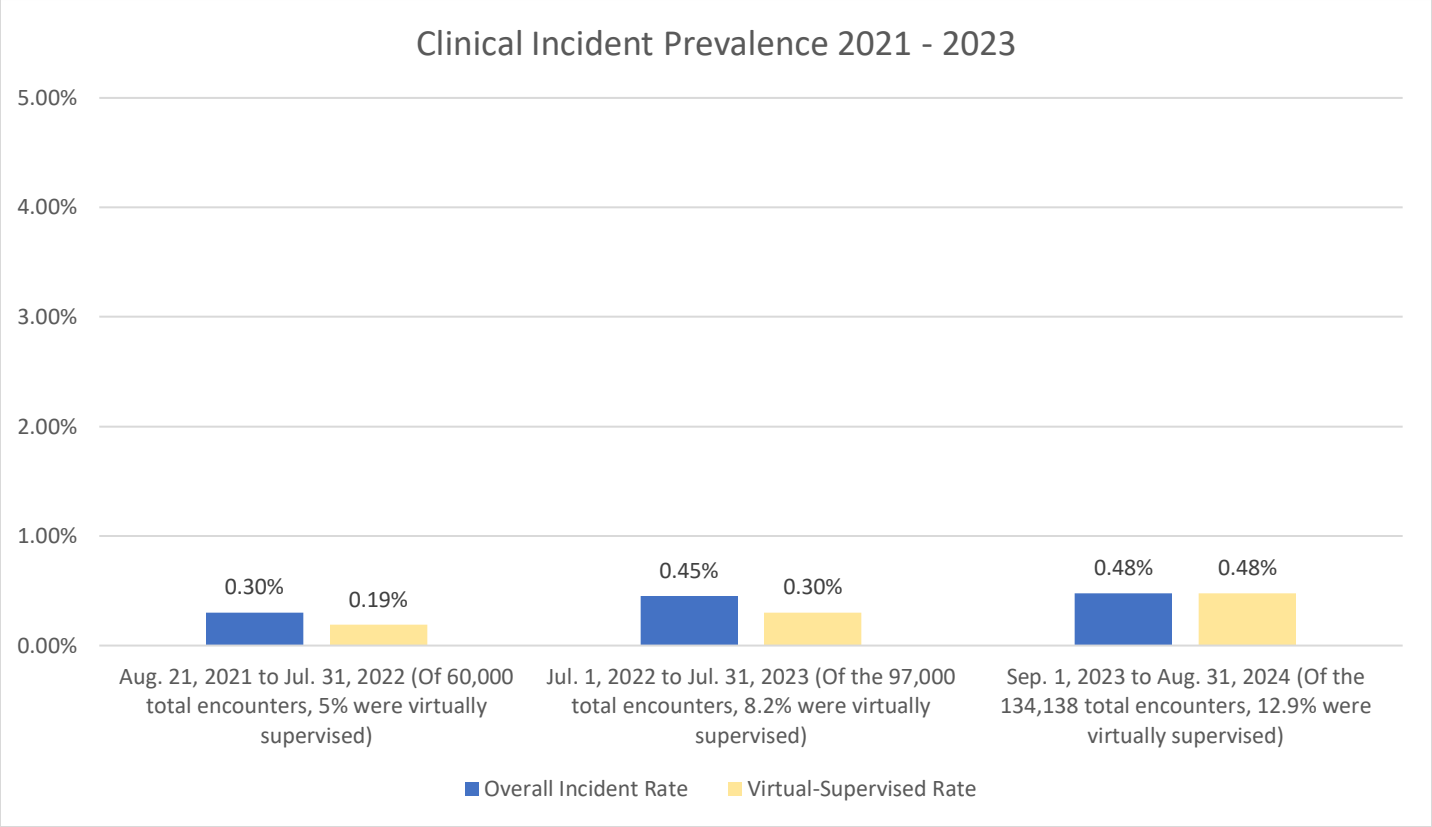
[2] Horan TC, Andrus M, Dudeck MA. 2008. CDC/NHSN surveillance definition of health care-associated infection and criteria for specific types of infections in the acute care setting. Am J Infect Control 36:309–332.

[3] Mercer. "Mercer projects a deficit of over 100,000 healthcare workers in the US by 2028, worsening health disparities and impacting patient care," August, 29, 2024. https://www.mercer.com/en-us/about/newsroom/future-of-the-us-healthcare-industry-labor-market-projections-by-2028/

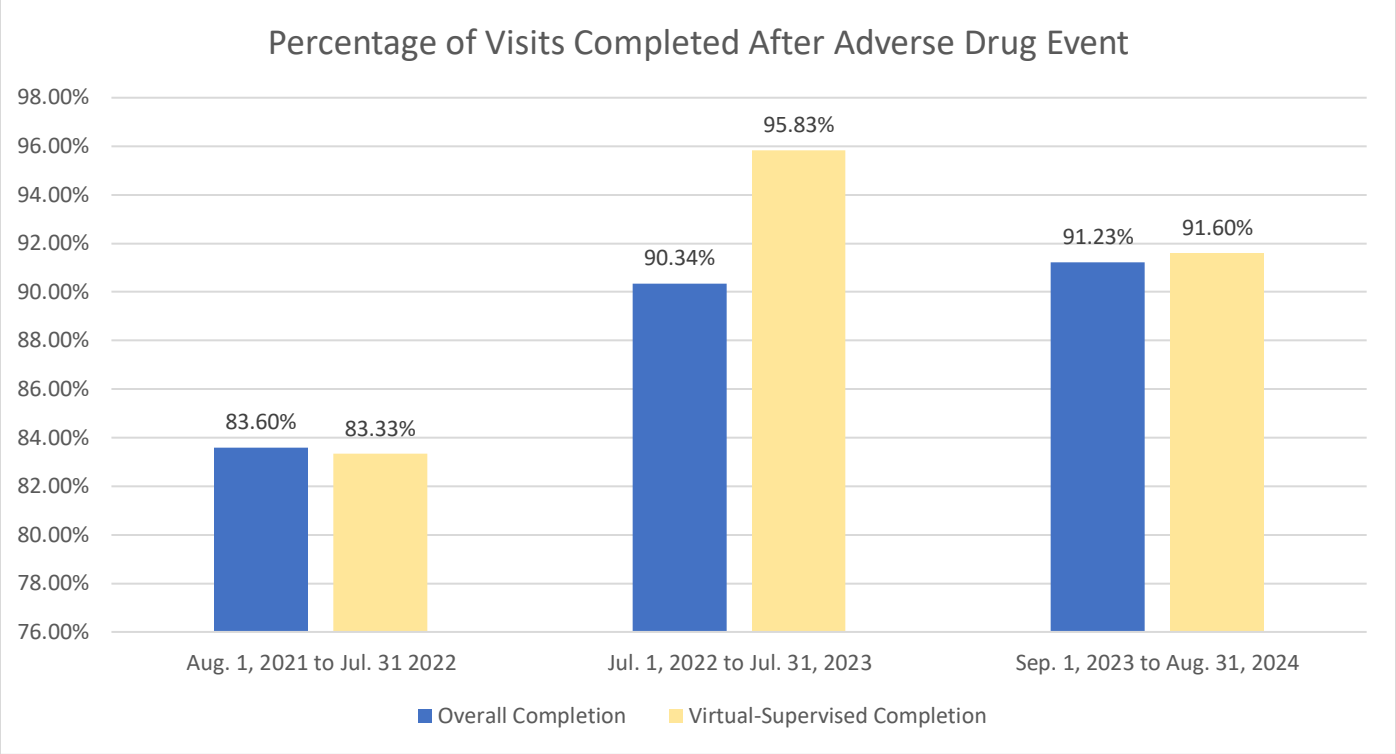
their business models are not built around virtual supervision. The vast majority of cases continue to be monitored in person by nurse practitioners.

Essentially, the flexibility of infusion centers and physician offices to use virtual direct supervision will maintain patient therapy adherence, reduce overall medical costs due to potential therapy administration delays, and allow the provider setting to utilize its well-trained staff effectively.

The below graph includes updated data collected from IPA membership, which utilized the virtual direct supervision flexibility. The data below demonstrates that clinical incidence prevalence has remained low over the last few years, below 0.48% overall, despite an increase in the number of patient treatments. The prevalence of clinical incidents during encounters that are virtually supervised continues to be on par with the overall incidence rate of clinical incidents, thus suggesting that infusions administered using virtual supervision are no riskier than infusions administered using direct supervision.



Another point we wish to underscore is the percentage of visits completed after an adverse drug event (ADE) during a virtually supervised encounter remains comparable, if not slightly better than the overall encounter rate for the second year in a row. This means that more patients were able to complete infusions after an ADE for virtually supervised encounters than directly supervised encounters. This data demonstrates that the highly trained nurses and NPs that conduct virtual direct supervision can handle these ADEs and therefore there is no degradation of clinical outcomes when it is utilized. The over 90% completion rate after an ADE for both directly and virtually supervised patients goes directly to adherence and patient satisfaction, and strongly supports virtual supervision being a safe adjunct to ambulatory infusion care.



While the vast majority of drug administrations remain directly supervised, there is an upward trend of virtual supervision from 5 percent virtually supervised in 8/21-7/22 to 8.2% for 7/22-8/23 to 12.9% in the 9/23-8/24 time period. As such, abrupt termination could result in patient access issues. The data shown here, as well as the experience of our members and their patients over the last several years, confirms that patient safety is not threatened by the incorporation of virtual direct supervision into clinical practice. While direct supervision remains the primary form of infusion administration, virtual direct supervision can be just as effective in settings with properly and extensively trained clinicians who have the requisite knowledge and experience.

Addressing MAC Downcoding of Certain Complex Biologic Infused Drugs

Recommendation

The IPA thanks CMS for acknowledging the issues related to the downcoding of certain non-chemotherapy complex biologic drugs in the CY 2024 Medicare PFS proposed rule and proposing a potential solution in CY 2025 Medicare PFS proposed rule. The IPA believes the MACs have been acting in an arbitrary and inconsistent manner in categorizing drugs and asks that CMS apply a consistent policy for determining "complex" drugs not by disease but by the risk profile of the drugs and nurse intensity to administer those products. As you know, CMS proposes modifications to its Medicare Claims Processing Manual, Chapter 12, section 30.5, to include language currently consistent with CPT code definitions for the complex non-chemotherapy infusion code series stating that the administration of infusion for particular kinds of drugs and biologics can be considered complex and may be appropriately reported using the chemotherapy administration CPT codes 96401-96549. CMS believes that this would allow the MACs to consider staff training, monitoring and expertise needed to infuse these complex drugs, as well as special considerations for preparation, dosage, or disposal for these infusion drugs.

We appreciate CMS' thoughtful and proactive approach to addressing these coding challenges while acknowledging the complexities of administering these drugs, regardless of the disease they treat. While the IPA is supportive of the proposed updates to the Manual described in the proposed rule, we remain concerned that the MACs may continue to find ways to work around these updated definitions and continue to arbitrarily, inappropriately, and inconsistently reimburse providers for complex biologic infusions. We urge CMS to avoid the potential use of loopholes by the MACs by aligning Chapter 12, Section 30.5 of the IOM Medicare Claim Processing Manual with the AMA CPT Infusion Section Notes, incorporating a few targeted edits, which are outlined below. This alignment will enhance patient safety, improve access to care, and support the financial health of the Medicare program.

The current CPT Section notes read:

Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration
Chemotherapy administration codes 96401-96549 apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as certain monoclonal antibody agents, and other biologic response modifiers. The highly complex infusion of chemotherapy or other drug or biologic agents requires physician or other qualified health care professional work and/or clinical staff monitoring well beyond that of therapeutic drug agents (96360-96379) because the incidence of severe adverse patient reactions are typically greater. These services can be provided by any physician or other qualified health care professional. Chemotherapy and other highly complex Biologic Agent services are typically highly complex and require supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intraservice supervision of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage, or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of the nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician or other qualified health care professional about these issues.

Our recommended edits to the CPT Section notes:

Highly Complex Drug or Highly Complex Biologic Agent Administration
Highly Complex Drug or Highly Complex Biologic Agent Administration codes 96401-96549 apply to parenteral administration **of Highly Complex Drug or Highly Complex Biologic Agent Administration**. The highly complex infusion of drugs or biologic agents requires physician or other qualified health care professional work and/or clinical staff monitoring well beyond that of therapeutic drug agents (96360-96379) because the incidence of severe adverse patient reactions are typically greater. These services can be provided by any physician or other qualified health care professional. **Highly complex drug or highly complex biologic agent administration** services are typically highly complex and require direct supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intraservice supervision of staff. Typically, such **highly complex drug or highly complex biologic agent administration** require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage, or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of the nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician or other qualified health care professional about these issues.

We believe the update guidelines will allow equal consideration to all drugs no matter the specialty or patient disease.
Additionally, the IPA supports CMS taking other actions such as:

- Establishing documentation requirements that will allow providers to illustrate the undeniably complex nature of certain non-chemotherapy biological therapy administration;
- Creating a Medicare Learning Network (MLN) article to educate practices on the updated criteria and documentation requirements, and require MACs to post this resource on their respective website;
- Prohibiting program safeguard contractors, including MACs, from initiating retroactive program integrity audits or recoupments for complex drug administration services for dates of service from August 12, 2022, until the effective date of the Manual revisions; and
- Conducting oversight on the MACs to ensure that their reimbursement practices are consistent and appropriate, and that complex drug administrations are not arbitrarily being downcoded despite the manual changes.

Patient Safety and Specific Complex Biological Drug Examples

CMS notes that CPT guidance for these agents includes the need for specialized staff monitoring due to risk of infusion reactions, as well as "frequent consults with a physician or other qualified healthcare professional."

Described below is a review of a few non-chemotherapy agents used in rheumatology as well as gastroenterology and dermatology, comparing their administration and need for complex monitoring to chemotherapeutic agents, which shows that the current definition of treating only cancer drugs as "complex" is inappropriate and arbitrary.

Saphnelo (anifrolamab-faia) is indicated for treatment of adults with moderate to severe Systemic Lupus Erythematosus (SLE) who are failing conservative therapy. It is given as an intravenous infusion every four weeks. Infusion is associated with a risk of hypersensitivity reactions, including anaphylaxis, of approximately 3 out of 100 patients. This is a serious and potential life-threatening event requiring prompt recognition and aggressive emergent management. This risk mandates the presence of professionally qualified and trained personnel for effective management. Additionally, Saphnelo increases risk of serious infections such as Herpes Zoster as well as other serious, potentially fatal infections. Saphnelo has many potential adverse effects similar with a chemotherapy agent, Rituxan (Rituxamab), which is commonly used in treatment of lymphoid malignancies as well rheumatological conditions. Rituxan carries an elevated risk of significant infusion reactions/anaphylaxis, also requiring the presence of trained and experienced personnel for management. Rituxan carries an increase for serious risks as well, including reactivation of latent Hepatitis B. Both agents need staff with special experience and training for the drug administration, as well as close patient monitoring for safe administration.

Tysabri (Natalizumab) is indicated for the treatment of selected patients with Multiple Sclerosis or Crohn's Disease. Due to its potential for serious and possible fatal complications, it is available only through participation in the Risk Evaluation and Mitigation Strategy (REMS) program which is a drug safety program that the U.S. Food and Drug Administration (FDA) requires for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks. Tysabri is administrated intravenously every four weeks. It carries a black box warning for increased risk of

Progressive Multifocal Leukoencephalopathy (PML), which is fundamentally untreatable and often fatal. The estimated increased risk of PML increases with multiple exposures to Tysabri and prior immunosuppressive therapy but may be as high as 6 per 1000 patients, which is significantly higher than the general population. Tysabri's risk of PML is shared by the monoclonal antibody Gyvaza (Obintuzamab) used in a variety of lymphoid malignancies.

Xolair (Omalizumab), used for asthma and urticaria treatment, has a risk of injection reactions, including possible anaphylaxis as well as eosinophilic conditions such as vasculitis, requiring close monitoring and follow-up. Xolair has a black box warning citing the potential for anaphylaxis, which has occurred beyond one year after beginning treatment, thus an ongoing concern with each injection. The black box warning recommends administering Xolair in a healthcare setting by trained medical staff who are prepared to manage anaphylaxis, which can be life-threatening. As a comparison to a related agent, Dupixent, it is associated with an increased risk of ocular complications requiring close follow-ups. This is similar to the potential adverse effects of the chemotherapeutic agent Elahere (mirvetuximab soravtansine), which carries a Black Box warning for Ocular toxicity.

We have also provided a side-by-side comparison of these drugs in Appendix Table 1.

Even this brief review shows that multiple drugs used as response modifiers in Rheumatology, Allergy/Asthma, Gastroenterology, and other specialties share many of the complex monitoring needs and potentially debilitating or even fatal adverse effects as drugs used for Chemotherapy. We are requesting that claim processing be uniform and not dependent on the specialty prescribing the medication or the type of disease being treated.

Financial Considerations

At the crux of the downcoding issue is the fact that these complex non-chemotherapy drugs are resource-intensive and the downcoding of many of these therapies by the MACs does not adequately recognize the resources needed to administer these drugs to patients. The administration of these complex biological drugs typically requires considerable nurse time, specialized training, as well as intense monitoring of patient acuity, history of reactions, frequency of adjustments to dosage or infusion rate, and/or post-administration monitoring. In addition to these resources, our facilities must cover the overhead costs associated with provider offices, such as competitive salaries and benefits for their healthcare workforce, competitive salaries and benefits for their back-office staff, rent, utilities, infusion supplies, etc. Resource-intensive characteristics should dictate whether or not a drug is considered "complex," not the diagnosis that the therapy is being used to treat. The MACs' decision to reclassify these products does not somehow erase the significant staff time, training and clinical diligence needed to safely administer these biologics to Medicare beneficiaries.

Osteoporosis is a prime example of a condition that can lead to severe outcomes, such as high mortality rates following a fall that causes a fracture. Additionally, vertebral fractures associated with osteoporosis can significantly impair a person's ability to perform activities of daily living. Prolia (denosumab), approved by the FDA in 2010 for treating osteoporosis in high-risk patients, has clinical evidence supporting its effectiveness in improving bone strength and reducing fractures. However, Prolia must be administered by a healthcare professional and cannot be self-administered at home. Prolia contains the same active ingredient as Xgeva which is utilized by Oncologist and carries a black box warning. The cost of Prolia to providers exceeds $1,000, and to ensure reimbursement, practice staff must be specially trained to verify benefits, manage inventory, code, and track accounts receivables. Without such

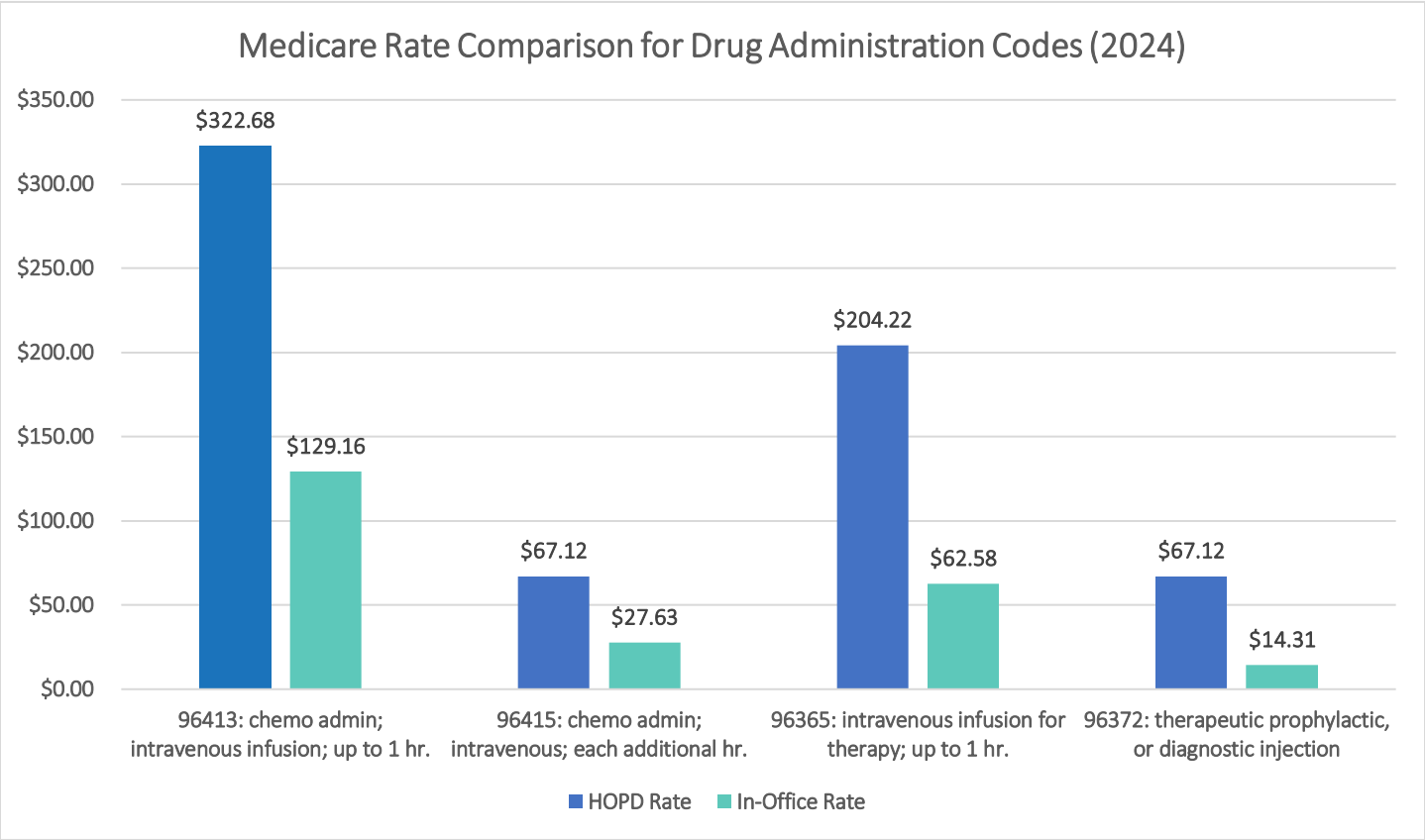
specialized staff, providers risk significant financial losses. It is estimated that the total cost for pre-injection, injection, and post-injection work is expected to be more than three times the reimbursement of therapeutic drug administration allowable, $14.31 national average in 2024. This reimbursement rate would render it financially unfeasible for private practices and freestanding infusion centers to continue providing this service. Consequently, eliminating the ability for patients to receive their Prolia injection at their preferred non-hospital setting would restrict patient access and impede physicians' ability to deliver high-quality care for osteoporosis. Prolia is one example of a complex drug, but others such as Orencia, Saphnelo, Xolair, and Simponi Aria could also be affected.

The cost of administering a highly complex drug in a physician's clinic remains consistent regardless of the specialty or disease being treated therefore the service reimbursement should also be consistent.

Access to Care and Cost to the Medicare Program Requires Proper Classification of Complex Drugs

Infusion providers are dedicated to delivering the highest quality care to their patients. In the United States, patients benefit from state-of-the-art medications that significantly mitigate the impact of diseases. However, a clinician's ability to provide this level of care should not be constrained by financial pressures that jeopardize the clinic's viability. Ensuring that healthcare practices remain financially sustainable is essential for maintaining the quality of care that physicians strive to offer. If disparities in reimbursement for complex drug administration are allowed, patient access to these essential treatments may be compromised.

The consequences of this arbitrary downcoding of complex biologics for certain sites of care occur at a systems level as well, as patient access can be threatened, and Medicare could face increased drug administration costs. Freestanding infusion centers and physician offices are reimbursed at significantly lower rates than hospitals. As the chart below demonstrates, hospitals get reimbursed at more than two times the rate that our sites of service receive, and on average we save Medicare more than 60 cents on the dollar when a drug is infused at one of our member companies rather than the hospital. However, allowing MACs to downcode these products and trigger devastating payments cuts means that it may no longer be economically feasible for these products to be provided in our cost-efficient setting. Our payments would be more than halved – from $129.16 (under code 96413) to $62.58 (under code 96365). This means many of these patients would be sent back to the hospital, where Medicare would pay $204.22 (under code 96365) instead of $129.16, the proper amount in our more efficient and convenient setting. Alternatively, and more concerning is that many patients will not be able to get care at all because hospitals lack the capacity to pick up this new volume or may be too far away from patients in the communities where they reside.



In summary, MAC downcoding of complex non-chemotherapy biologicals is arbitrary and should be based on the level of resource intensity, rather than the disease being treated, to ensure that the most financially efficient sites of care are able to continue administering the drugs.

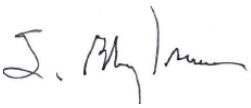
Conclusion

The IPA asks CMS to permanently extend the virtual direct supervision flexibility that has been used by practices since the PHE began in 2020 and has proved to be a safe and effective way to treat patients while supporting our health care workforce. In addition to the proposed Manual changes regarding coding reimbursement for certain non-cancer complex biologicals, which require intense levels of care that take up a lot of time and energy for practices, CMS should go further by aligning the Manual with the AMA CPT Infusion Section Notes and our suggested edits, which focuses on the resource-intensive nature of the therapy rather than the condition it treats.

We thank you for your time and consideration.

Sincerely,

Doug Ghertner
President
Infusion Providers Alliance



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Appendix Table 1							
Drug (Branded/NonBranded Name)	**Disease State**	**Diagnosis**	**Method of Administration**	**Infusion Risk**	**Reaction Rate**	**Overall Risk**	**Historical MAC Designation**
Saphnelo (Anifrolamab-faia)	Rheumatology	Systemic Lupus Erythematosus (SLE	Intravenous	High	2%	Increases risk of serious infections such as Herpes Zoster as well as other serious, potentially fatal infections	Non Complex
Rituxan (Rituxamab)	Oncology	Lymphoid malignancies	Intravenous	High	25%	Increased for serious risks as well, including reactivation of latent Hepatitis B.	Complex
Benlysta	Rheumatology	Systemic Lupus Erythematosus (SLE	Intravenous	High	3%	Increased risk for Serious Infections • Hypersensitivity Reactions, including Anaphylaxis • Depression and Suicidality • Malignancy	Complex

Tysabri (Natalizumab)	Neurology/GI	Multiple Sclerosis or Crohn's Disease	Intravenous	High	10%	Due to its potential for serious and possible fatal complications, it is available only through participation in the Risk Evaluation and Mitigation Strategy (REMS) program which is a drug safety program that the U.S. Food and Drug Administration (FDA) requires for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks. Tysabri is administrated intravenously every four weeks. It carries a black box warning for increased risk of Progressive Multifocal Leukoencephalopathy (PML), which is fundamentally untreatable and often fatal. The estimated	Non Complex

						increased risk of PML increases with multiple exposures to Tysabri and prior immunosuppressive therapy but may be as high as 6 per 1000 patients, which is significantly higher than the general population	
Gyvaza (Obintuzamab)	Oncology	Lymphoid malignancies	Intravenous	High	20%	REMS participation required and increased risk for PML	Complex
Xolair (Omalizumab)	Pulmonary	Asthma and Urticaria	Injection	High	3%	Anaphylaxis which can be life-threatening and Malignancy	Non Complex

Elahere (mirvetuximab soravtansine)	Oncology	Ovarian, fallopian tube, or primary peritoneal cancer	Intravenous	High	20%	Ocular toxicity	Complex