2023 HOME AND ALTERNATE SITE INFUSION CONTRACTING RECOMMENDATIONS FOR PAYORS

National Home Infusion Association

Introduction

The National Home Infusion Association (NHIA) has developed the following recommendations for commercial, Medicaid, and Medicare Advantage payors to reduce administrative burden and remove barriers to accessing certain infusion services. By removing barriers to outpatient infusion services, payors can reduce the total cost of care by avoiding hospital stays and emergency room visits, limiting hospital outpatient department use, and preventing admission to long-term care facilities[1].

These recommendations were initially presented at NHIA's first annual **Home and Specialty Infusion Payor Summit** where payor representatives with responsibilities for benefit structure, network decisions, value-based programing, and specialty pharmacy policy were invited to attend and discuss ways to improve access and efficiencies associated with home and alternate site infusion services. The meeting's objectives were to provide education, discuss industry trends, and present recommendations aimed at helping plans to better leverage infusion services to lower the total cost of care. The content was provided by NHIA staff, as well as representatives from NHIA Board of Directors provider organizations.

Throughout the summit, payor representatives were encouraged to ask questions, offer feedback, and make suggestions for how home and alternate site infusion providers could demonstrate value for plans. Every effort was made to incorporate feedback from summit participants into these recommendations. Finally, the 2023 recommendations include proposed metrics to promote data collection by providers as a means of assessing the success and impacts of these proposed policy changes.

Questions or comments related to these recommendations may be sent to Bill Noyes, Senior Vice President, Reimbursement Policy at bill.noyes@nhia.org.

[1] Note: These recommendations can also apply to the federal government, however the gaps in coverage for traditional Medicare beneficiaries are so significant that initial steps to establish basic coverage need to be taken before applying the concepts in this document.

Recommendation	Rationale	Proposed Metrics
1. Establish distinct specialty networks for infused and HCP-administered drugs. Payors should distinguish infused and health care provider (HCP)-administered products from self-injected medications within the specialty category and maintain a separate network of local, qualified, full-service pharmacies to provide infused and HCP-administered medications.	• Infusion pharmacies take responsibility for ensuring all necessary supplies and equipment are provided to accomplish administration for infused and HCP-administered medications. • Utilizing locally based, full-service infusion providers can reduce delays in treatment and waste resulting from critical supply errors that are difficult for a remote/mail-order pharmacy to resolve. • Most locally based infusion providers offer patients the option of treatment at home or in a suite and can recommend the best option based on the drug characteristics, as well as the individual patient situation and preferences.	• Adherence to therapy (Ratio of doses prescribed to doses administered) • Waste (Ratio of doses administered to doses dispensed) • Patient satisfaction with provider services and site of care.[2]
2. Require the coordinated provision of infusion supplies, equipment, and services. Payors should ensure the coordinated provision by the pharmacy of all necessary supplies and equipment (e.g., sterile water for injection, sterile needles and syringes, catheter maintenance supplies, administration sets, pumps) and services required to administer infused medications. Additionally, sterile compounded medications must be prepared under conditions compliant with United States Pharmacopeia standards and provided to the patient in the most appropriate final form based on the method of administration. (Note: preparation of FDA-approved drugs per approved labeling is not considered compounding.[3]) Payors should utilize the established, comprehensive S codes[4] for contracting home and alternate site infusion services, which incorporates all components of the service. Payors should not adopt Medicare G codes for home infusion services as these are incomplete, apply to a very small number of pump-administered home infusion drugs, and do not currently incorporate coverage for all components of service.	• Infused medications often require sterile compounding or aseptic preparation just prior to administration. Improper preparation can result in denatured/ inactivated biologics. Providing the correct, necessary supplies ensures successful administration and prevents delays in treatment and waste. • Compounding and preparation of medications that will be stored for future use must occur in the pharmacy under ISO 5 conditions to prevent contamination and errors. • Placing the burden on patients to acquire essential supplies such as sterile water for injection can increase waste, cause delays in treatment, and/or result in harm from the use of dangerous, unapproved products available for sale on the internet. • Medicare's poorly structured home infusion services benefit is negatively effecting patient access to the home site of care.[5]	• Waste (Ratio of doses administered to doses dispensed) • Patient satisfaction with provider services.

[2] Recommend utilization of NHIF Validated Patient Satisfaction Survey Tool
[3] General Chapter <797> *Pharmaceutical Compounding – Sterile Preparations in USP-NF* 2023. Section 1.4 Preparation per Approved Labeling
[4] NHIA National Coding Standard for Home Infusion Claims
[5] CMS HIT Monitoring Report (January 2022)

Recommendation	Rationale	Proposed Metrics
3. Address the lack of coverage for resolving catheter occlusions. For patients actively receiving home or suite-based infusion services, payors should provide coverage of catheter de-clotting drug, supplies, and services without prior authorization and with no out-of-pocket cost to the patient. Applicable Codes: De-clot kit: S5517 Infusion Nursing: 99601, 99602 Alteplase recombinant (Cathflo) 1 mg: J2997	• Infusion providers can resolve catheter occlusions without sending patients to the emergency room, but the drug, supplies, and services are often not included in payor contracts, require prior authorization for nursing resulting in delays, or require the patient to pay out of pocket for the service. The patient co-pay responsibility results in patients opting to use the emergency room instead of allowing the infusion provider to intervene. • Incentivizing the timely resolution of occlusions by infusion providers prevents therapy delays, having to replace the catheter, reduces emergency room visits, and reduces burden on hospital staff.	• Incidence of catheter occlusions • % of occlusions resolved by home infusion provider • % of occlusions resulting in emergency room use • % of occlusions resulting in catheter replacement
4. Incentivize qualified infusion providers to place peripherally inserted central catheters (PICCs). Include coverage within home infusion contracts for placement of peripherally inserted central catheters in the home or infusion suite. Applicable Codes: S5522 for the insertion (includes nursing) S5520 for the PICC Kit (PICC and supplies)	• Infusion providers can facilitate PICC insertions to shorten hospital stays/ facilitate discharge or avoid the hospital setting entirely when a specialist orders infusion therapy after an outpatient office visit. • Incentivizing infusion providers to offer these services reduces burden on hospital outpatient departments. • Most home infusion contracts lack fair and adequate coverage for PICC insertion kits and services.	• PICC insertions performed successfully • Hospitalizations avoided • Hospital outpatient department (HOPD) use avoided
5. Add codes for use of ambulatory infusion suites (AIS) to home infusion contracts. Most home infusion providers offer services in pharmacy-owned ambulatory infusion suites (AIS). Payors should add coverage for AIS use for infusions, catheter insertions, and other services which maximizes nursing resources and avoids sending patients to the HOPD, however not all home infusion contracts include the codes allowing providers to use this site of care. Applicable Codes: SS Modifier and specific site of care to be utilized on claims (example: 49 – independent clinic)	• AIS's add capacity to the health care system for administration of specialty biologics and generate savings for the payor compared to the HOPD. • The safety of home infusion is well established.[6] Allowing the same clinicians who facilitate home infusion to perform administrations in the suite pursuant to a physician order does not present a safety risk and is within the nursing scope of practice.	• Patient satisfaction with provider services and site of care.

[6] Polinski JM, Kowal MK, Gagnon M, Brennan TA, Shrank WH. Home infusion: Safe, clinically effective, patient preferred, and cost saving. Healthc (Amst). 2017 Mar;5(1-2):68-80. doi: 10.1016/j.hjdsi.2016.04.004. Epub 2016 Apr 29. PMID: 28668202.

Recommendation	Rationale	Proposed Metrics
6. Allow home infusion providers to provide nursing for managed Medicaid patients, especially pediatrics. Allow accredited home infusion providers to provide nursing for managed Medicaid patients and do not require them to be home health certified. This will greatly increase the safety and availability of home infusion services for this patient population. Applicable Codes: Infusion Nursing: 99601, 99602	• There is a shortage of certified home health agencies (CHHAs) that will accept nursing responsibility for patients with managed Medicaid plans, which limits access to safe home infusion services for this population. • Managed Medicaid plans often require the infusion nursing provider to be home health certified to bill Medicare/Medicaid, even though the provider will not be billing either. • Lack of access to home infusion services increases the use of hospital outpatient departments and skilled facility use.	• % Not taken for care. (Ratio of patients not taken for care due to payor requirements for certification to the total number referred with managed Medicaid.) • Patient satisfaction with provider services and site of care.
7. Remove multiple therapy discounts for complex patients. Over the past decade, the acuity and mean age of patients requiring infusion therapies has increased. Many patients have multiple comorbidities and/or are utilizing multiple infusion therapies concurrently. The current practice of discounting per diem payments for the second and third therapy creates a disincentive for providers to accept complex patients. Payors should continue to use the secondary (SH) and tertiary (SJ) modifiers to avoid duplication of service denials, but remove discounted rates for second and third therapies. Examples of patients with multiple therapies: • Multiple anti-infective therapies • Parenteral nutrition and anti-infectives • Parenteral nutrition and hydration • Parenteral nutrition and pain management Applicable Codes: SH and SJ modifiers	• The higher demands on pharmacist and nurse clinical time, supply cost increases, and limitations on nursing authorization make high-acuity patients on multiple therapies challenging to serve[7]. • Complex patients may be diverted to skilled nursing facilities even when they prefer to be at home and have the appropriate level of caregiver support. • There are few, if any, true efficiencies associated with a second or third infusion therapy. Each therapy requires separate clinical assessment and monitoring, compounding, separate administration supplies and equipment, and adds to delivery costs.	• Patient satisfaction with provider services and site of care.

[7] Haines D, Garst R, Sullivan C, and Charron J. A multi-center time study of home infusion pharmacist professional services. Infusion Journal.2022;1(1):1-9

Recommendation	Rationale	Proposed Metrics
8. Coordinate and/or combine prior authorization procedures for home infusion drug and services to avoid delays in treatment due to having to wait for separate authorizations. Institute a rule that if the home infused drug is authorized then the applicable services and supplies necessary to manage the beneficiary's infusion therapy are also considered authorized. Second, allow for pharmacy benefit authorizations to be requested/obtained by the home infusion provider instead of the physician. Third, remove prior authorization requirements for high value, low-cost infusion therapies/services, (e.g. anti-infectives, hydration) and resolving catheter occlusions (see #3).	• Home infusion coverage is sometimes split between the pharmacy and medical benefit, requiring separate authorizations from 2 different departments, which is an administrative burden and delays treatment. • Timely authorization for the drug, services, and supplies is critical to avoiding delays in discharge from institutional settings and/or results in patients continuing to receive care in outpatient facility settings. • Example: The drug is authorized by the pharmacy benefit, but care cannot be initiated until the nursing services are authorized by the medical benefit.	• Timeliness of authorizations. (Time between requests and decisions.) • Prior authorization success rate. (Ratio of prior authorizations granted to prior authorizations requested.)

NHIA is a trade association that represents companies that provide medically necessary infusion therapies to patients with acute and chronic health conditions, as well as companies that manufacture and supply infusion related products and services.

Learn more

Payors: To learn more about NHIA's Home and Specialty Infusion Payor Summit and recommendations and/or request to be involved, please visit nhia.org/payors.

Infusion providers and industry suppliers: To learn more about the benefits of NHIA membership, please visit nhia.org/membership.

View 2024 Payor Summit Recommendations.