

Date: September 5, 2013

To: Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services

From: Thomas R. Barker
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Regarding: CMS-1601-P; Payment of Apligraf® As a Specified Covered Outpatient Drug
Under the Statutory Default in the Hospital Outpatient Prospective Payment
System

I. Overview

Our client Organogenesis Inc. has asked us to prepare this legal memorandum, which provides our analysis of the statutory authority of the Centers for Medicare & Medicaid Services (CMS) to package the payment of the skin substitute Apligraf® – a biological product meeting the statutory definition of a Specified Covered Outpatient Drug – as proposed in the CY 2014 Hospital Outpatient Prospective Payment System (HOPPS) Proposed Rule.¹ Organogenesis is the manufacturer of Apligraf®, a biological product used to heal skin ulcers, such as diabetic foot and venous leg ulcers, that are not healing after three to four weeks, despite treatment with conventional wound therapies.

It is our conclusion that, based on the clear and unambiguous language of the Social Security Act, CMS does not have the legal authority to package Apligraf® with an associated outpatient surgery in which the product is used, nor can Apligraf® be treated identically to, and placed in the same APC with, other biological or cell tissue based products used in an outpatient surgery. A central premise of both Medicare payment policy and administrative law is that CMS may not change a payment method for a drug or biological where that method is established by statute, even when CMS believes that it has a policy reason for that change.

¹ 78 Fed. Reg. 43,534, 43,571 (July 19, 2013).

Here, Congress has already established a statutory payment scheme for a specific category of drugs and biologicals, which includes Apligraf®. These “*specified covered outpatient drugs*” (SCODs) must be paid separately based upon a precise statutory scheme. In point of fact, Apligraf® has been paid separately under this scheme since the methodology became effective in 2006. Furthermore, the agency has adopted a “statutory default” under section 1833(t)(14)(A)(iii)(II) of the Social Security Act which authorizes payments to be equal to the payment rates established under the methodology described in sections 1842(o), 1847A, or 1847B of the Act (generally, average sales price, or ASP) when the average acquisition cost of a SCOD is not available. Indeed, in the very Proposed Rule to which this memorandum is directed, CMS confirmed this precise policy: SCODs are to be paid based on the statutory default under Section 1847A at ASP plus 6%.² Thus, CMS is required to pay Apligraf® — a single source biologic — at ASP plus 6%, and only sales of Apligraf® may be used to calculate the ASP payment.

Based on these collective arguments, we request that the agency not package Apligraf® in the Final Rule, and pay Apligraf® separately based on the Average Sales Price (ASP) methodology as required by statute.

II. Clinical Overview of Apligraf® and Background on Medicare Payment History

A. Clinical Overview of Apligraf®

Apligraf® is a unique, bioengineered, cell-based biological for the treatment of chronic, hard-to-heal venous leg ulcers and diabetic foot ulcers. Like human skin, it is made from living cells and it is composed of two layers, a dermis and an epidermis, comprised of healthy, functioning, responsive cells that stimulate the wound to heal. Apligraf® is the only active wound-healing product approved by the U.S. Food and Drug Administration (FDA) to treat both venous leg ulcers and diabetic ulcers.³ On May 22 1998, the FDA approved Apligraf® for marketing under its pre-market approval (PMA) process for “use with standard therapeutic compression for the treatment of non-infected partial and full-thickness skin ulcers due to venous insufficiency of greater than adequately responded to conventional ulcer therapy.”⁴ Multiple supplements have been added since the first approval, including an indication for treating diabetic foot ulcers.

Pursuant to FDA’s regulations, Organogenesis conducted significant and extensive clinical testing in order to demonstrate that Apligraf® is safe and effective for healing diabetic foot ulcers that are present for at least three weeks and venous leg ulcers that are present for at least one month. The Apligraf® diabetic foot ulcer pivotal study included more than 200 patients with diabetic foot ulcers of at least two to three weeks duration. This

² *Id.* at 43,607-09.

³ Other skin substitutes, most of which are not SCODs, are also paid separately under HOPPS, based on a longstanding CMS policy. *Id.* at 43,608.

⁴ FDA CDRH, *Summary of Safety and Effectiveness Data: Apligraf*, available at http://www.accessdata.fda.gov/cdrh_docs/pdf/P950032b.pdf.

pivotal study found clear evidence that nearly 50% of patients treated with Apligraf® experienced complete wound closure during the first eight weeks of treatment. In addition, the incidence of complete wound closure was higher for patients receiving Apligraf® during the first eight weeks as opposed to those patients in the control group that were treated with conventional measures. Similarly, the Apligraf® venous leg ulcer pivotal study included over 200 patients at multiple centers throughout the country with ulcers present at least one month. This pivotal study demonstrated significant wound closure during the first eight weeks of treatment and a greater incidence of complete wound closure for patients treated with Apligraf® as opposed to patients in the control group. The FDA reviewed this clinical data and approved Apligraf® specifically for the treatment of venous leg ulcers of greater than one month duration and diabetic foot ulcers of greater than three weeks duration.

B. Medicare Payment History of Apligraf® as a Biological

The Medicare payment history of Apligraf® demonstrates that Apligraf® has been recognized and paid as a biologic for more than 13 years and as a SCOD since the 2004 implementation of the Medicare Modernization Act of 2003. This background may help clarify for the agency the classification of Apligraf® in the hospital outpatient setting as a separately payable SCOD. In 2001 and 2002 Apligraf® was paid in the hospital outpatient setting as a biological under the pass through list.⁵ In February, 2001 CMS (then HCFA) issued a Program Memorandum (Transmittal B-01-07) that states “Apligraf® has met the statutory requirement as a biologic.”⁶ (See attachment 1). Following the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 Apligraf® has been paid in the hospital outpatient setting as a sole source biological at 88% of AWP in 2004 and 83% of AWP in 2005 under the specified covered outpatient drug provision.⁷ Apligraf® was included in the Government Accountability Office (GAO) survey in 2005 of acquisition costs for hospital outpatient drugs as a specified covered outpatient drug.⁸ Since 2006 Apligraf® has been payable as a SCOD biological under the ASP methodology. Since 2013 Apligraf® has been paid under the statutory default provisions of 1833(t)(14)(A)(iii)(II) of the Act at ASP plus 6%.

⁵ 65 Fed. Reg. 67,798, 67,837 (November 13, 2000). (See attachment 2).

⁶ Apligraf® meets the statutory definition of a biological. Under Section 1861(t)(1), the term “biological product” includes such biologicals “as are included (or approved for inclusion) in the United States Pharmacopoeia” and other compendia, or are approved by the pharmacy and drug therapeutics committee of the Medical staff of the hospital furnishing the biological for use in the hospital. Apligraf® was approved for inclusion in the United States Pharmacopoeia in 2000, and is therefore a biological.

⁷ 69 Fed. Reg. 819, 823 (January 6, 2004). The interim finale rule implementing the Medicare Modernization Act of 2003 lists Apligraf® as a “Sole Source Drug” in Table 1. The rule states in relevant part “The sole source category is defined in section 1833(t)(14)(F)(i) of the Act as a biological product (as defined under section 1861(t)(1) of the Act) or a single source drug (as defined in section 1927(k)(7)(A)(iv)) of the Act.” (See attachment 3.)

⁸ (GAO-05-581R) Medicare Hospital Outpatient Drug Prices, June 30, 2005. The GAO Report on specified covered outpatient drugs states “[GAO] obtained from our survey data the average and median purchase prices for each of the 53 SCOD drug categories.” Apligraf® is listed under number 38 in Table 1 of the GAO report detailing the categories of SCODs. (See attachment 4.)

When Apligraf® is administered to a Medicare beneficiary incident to a physician’s services, the payment methodology under Section 1847A is the ASP methodology. Thus, Apligraf® has consistently been separately payable as a biological in the Part B setting since 2005.

III. HOPPS Procedural Background

On July 19, 2013, CMS published in the Federal Register the Hospital Outpatient Prospective Payment System (HOPPS) Proposed Rule for calendar year 2014.⁹ In the Proposed Rule, CMS announced its intention to begin packaging certain skin substitutes with their associated surgeries, on the basis that “skin substitutes . . . function as supplies or devices that are used in surgical procedures and, therefore, should be packaged with the surgical procedure in which the products are used.”¹⁰ The agency proposes to revise its regulations at 42 C.F.R. § 419.2(b)(4) to include skin substitutes as an example of a packaged surgical supply. The proposed rule acknowledges that currently skin substitutes are separately paid in the OPSS as biologicals, pursuant to the ASP methodology, and are subject to the drug and biological packaging threshold. In the Proposed Rule, CMS compresses more than fifty different products with varying indications and modalities into a single, broad category of “skin substitutes.” The text of the Proposed Rule does not refer to Apligraf®. However, Apligraf® is listed in Addendum P for those codes to be packaged under this proposal and assigned to status indicator “N” for CY 2014.

In the rule CMS proposes that “skin substitute products [] be unconditionally” packaged. However, the proposed rule does acknowledge that these skin substitute products would continue to be paid under the statutory requirements for “pass-through status” for new skin substitutes that meet the pass-through criteria. As discussed in more detail below in Section V., the proposed rule fails to acknowledge that certain skin substitutes, including Apligraf®, meet the statutory definition of a SCOD and must continue to be paid under that statutory scheme.

As explained below, Apligraf®’s unique status as a SCOD and therapeutic make it inappropriate for packaging as both a statutory and policy matter.

IV. The Statute and CMS Precedent Prohibit Packaging Apligraf®

A. The Social Security Act Requires a Unique Payment Methodology for SCODs like Apligraf®

⁹ *Supra*, n. 1.

¹⁰ *Id.* at 43,572.

Congress has “minutely detailed the reimbursement rates” for most drugs and biologicals.¹¹ In the case of SCODs, section 1833(t)(14)(A)(iii) of the Social Security Act specifies one such reimbursement rate. Under that statute, CMS is required to pay separately drugs and biologicals that meet the statutory definition of a SCOD under a specific statutory payment scheme. As set out below in detail, under the agency’s own determination and practice, Apligraf® meets this statutory definition and has been separately payable as a SCOD since 2004. Therefore, absent a change in the statute, CMS is precluded from altering this “minutely detailed” payment methodology for Apligraf® by means of regulation.

Section 1833(t)(14)(B) of the Social Security Act defines a SCOD as a drug or biological (or radiopharmaceutical) used in hospital outpatient departments, and for which CMS has established a separate ambulatory payment classification (APC) group. In addition to these criteria, the statute narrows the scope of a SCOD to include only those drugs or biologicals paid for on a pass-through basis on or before December 31, 2002. CMS has recognized Apligraf® as a SCOD since 2004.¹² Apligraf® was first separately payable under APC 1305 in 2000.¹³ Additionally, Apligraf® received its first pass-through payment on January 1, 2001, prior to the statutory deadline. Importantly, as discussed in detail in Section V., most other skin substitutes are not SCODs, as they did not begin receiving pass-through payments until after January 1, 2003.¹⁴

The CMS proposal to package payment for Apligraf® with other products based on hospital claims is exactly the opposite of what Congress sought to establish with the SCOD special payment status. Congress revised the hospital outpatient payment for certain drugs and biologics as part of the MMA, due to concerns over payment for these drugs and biologicals under the HOPPS APCs based on claims data.¹⁵ To remedy concerns about hospital underpayment, Congress established a clear statutory formula that was intended to capture the average acquisition costs associated with each individual qualifying product. The Act thus establishes that in all years subsequent to 2005, the payment rate for SCODs “shall be equal . . . to the average acquisition cost for the drug for that year . . . as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D)” (emphasis supplied). Section 1833(t)(14)(A)(iii). Under subparagraph (D), the Act also specifically requires that the Secretary’s cost survey must “generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug”

¹¹ Hays v. Sebelius, 589 F.3d 1279, 1286 (D.C. Cir. 2009) (quoting Hays v. Leavitt, 583 F. Supp. 62, 71 (D.D.C. 2008)).

¹² 69 Fed. Reg. 819, 823 (January 6, 2004).

¹³ 65 Fed. Reg. 67,798, 67,837 (November 13, 2000).

¹⁴ Based on our review, the only other skin substitute that meets the definition of a SCOD is Dermagraft®. See 65 Fed. Reg. 67,798, 67,837 (November 13, 2000) (setting payment rate for Apligraf® at \$1,157.81). See also 66 Fed. Reg. 59,856, 60,051 (November 30, 2001) (setting payment rate for Dermagraft® at \$577.60).

¹⁵ Pub. L. No. 108-173 § 621, 117 Stat. 2066, 2307- 11 (Dec. 8, 2003). The House Ways and Means Committee report on the earlier version of the bill explains that the new payment methodology for SCODs was being enacted in response to a lack of uniformity in reimbursing outpatient drugs. According to the report, the problem was that “[h]ospital charges were not designed to specifically capture the resource costs for specific items.” H.R. Rep. No. 108-178 at 227.

(emphasis supplied). Since its CY 2006 HOPPS Final Rule, CMS has set average acquisition cost based on data reported under the ASP methodology pursuant to section 1847A.¹⁶

The statute is thus clear and unambiguous: where a drug or biological qualifies as a SCOD, its payment “shall” be based on the average acquisition cost for the drug — not based on the average acquisition cost of the larger APC to which the drug is assigned and not based on the cost of other drugs. Thus, CMS cannot package together multiple skin substitutes with Apligraf®, as doing so would not reflect the average acquisition cost of Apligraf® — as required by statute — but would instead reflect the average cost of whatever items are used with the associated procedure. Moreover, the Act emphasizes Congress’s drug-specific focus again in subparagraph (D), expressly requiring that the Secretary’s cost survey determine the average hospital acquisition cost for each SCOD. Had Congress intended the Secretary’s survey to determine average acquisition cost for each APC, Congress could easily have done so.¹⁷ Instead, Congress emphasized, in two different places in the statute, that the cost and reimbursement calculations for SCODs must be drug-specific.¹⁸

B. CMS’s “Statutory Default” Methodology Sets Apligraf® Payment at ASP Plus 6%.

The statutory payment for Apligraf® is a two step analysis. As we have shown above, the first step is that Apligraf® meets the statutory definition of a SCOD. The second step is which statutory payment methodology for a SCOD the agency elects to assign. Initially, the agency determined payment for SCODs based on a determination of “the average acquisition cost of the drug for that year.”¹⁹

In the 2013 Final HOPPS rule, CMS made a significant determination to alter the statutory payment methodology of SCODs. While the impact of the payment rate was only minimal, the determination by the agency is significant for the calculation of the Apligraf® payment amount. In that final rule, the agency implemented for the first time the statutory requirements of section 1833(t)(14)(A)(iii)(II) of the Act to require an alternative methodology for determining payment rates for SCODs. This provision states that if hospital

¹⁶ 77 Fed. Reg. 68,210, 68,389 (Nov. 15, 2012).

¹⁷ Indeed, the legislative history of (MMA) lends further support to the Congressional intent that SCODs be reimbursed separately. According to the Conference Report, “[i]t is the intent of the conference that products eligible payment under the hospital outpatient department section include all products paid by Medicare on a pass-through list as a drug or biologic prior to December 31, 2002.” 149 CONG. REC. 22, 30,373 (2003). The current CMS proposal to package SCODs would achieve the exact opposite result, by favoring certain drugs over others, even where some drugs are more appropriate for certain patients.

¹⁸ It is a fundamental tenet of statutory construction that Congress knows how to say what it means. See, e.g., Meghrig v. KFC Western, Inc., 516 U.S. 479, 485 (1996) (“Congress . . . demonstrated in CERCLA that it knew how to provide for the recovery of cleanup costs, and . . . the language used to define the remedies under RCRA does not provide that remedy”); National Bank v. New York, 347 U.S. 373, 378 (1954) (finding “no indication that Congress intended to make this phase of national banking subject to local restrictions, as it has done by express language in several other instances”).

¹⁹ *See* 70 Fed. Reg. at 68,516, 68,642 (Nov. 10, 2005) (describing choice to use average acquisition cost methodology).

acquisition cost data are not available, payment shall be equal (subject to any adjustment for overhead costs) to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act. As previously explained, pursuant to sections 1842(o) and 1847A of the Act, Part B drugs are paid at ASP plus 6 % when furnished in physicians' offices.

In that 2013 final rule, CMS established the "statutory default" methodology for determining payment rates for SCODs.²⁰ Under this "statutory default" CMS reverted to the alternative methodology under section 1833(t)(14)(A)(iii)(II), which authorizes payments to be equal to the payment rates established under the methodology described in sections 1842(o), 1847A, or 1847B. CMS concluded that this "statutory default" resulted in a payment rate of ASP+6 for SCODs in CY 2013.²¹ In the CY 2014 Proposed Rule, CMS again proposes to apply this statutory default payment methodology of ASP plus 6 % to "all separately payable drugs and biologicals, which include SCODs."²²

The adoption of the statutory default under HOPPS further supports the conclusion that Apligraf® cannot be packaged and must be paid based on its own ASP. CMS explained the rationale for implementing the statutory default language was that "we believe that establishing the payment rates based on the statutory default of ASP plus 6% is appropriate as it yields increased predictability in payment for separately payable drugs and biologicals under the OPSS."²³ Moreover, the agency stated the policy was also necessary in order to harmonize payment for drugs and biologics in the hospital outpatient and physician office setting.²⁴ In the physician office setting, under section 1847A(c)(6)(D), to qualify as a "single source drug or biological," a product must either be a "biological" or a "drug which is not a multiple source drug and which is produced and distributed under a new drug application." As previously mentioned, Apligraf® meets the statutory definition under the Social Security Act of a biological, having been approved for inclusion in the United States Pharmacopeia in 2000.²⁵ Because Apligraf® is a biological, it meets the statutory definition of a single source drug.

Under section 1847A(b)(4) — one of the statutory provisions covered by the "statutory default" — payment for single source drugs must be based on the lesser of ASP or wholesale acquisition cost for that drug. In contrast, for multiple source drugs, ASP is determined on the basis of the volume-weighted average of the sales of all drugs "including

²⁰ 77 Fed. Reg. 68, 210, 68,386 (Nov. 15, 2012).

²¹ *Id.*

²² 78 Fed. Reg. 43,534, 43,608 (July 19, 2013).

²³ *Id.*

²⁴ 77 Fed. Reg. 68,210, 68,386 (November 15, 2012).

²⁵ *See supra* n. 8. Under section 1861(t)(1) of the Act, the term "biological product" includes such biologicals "as are include (or approved for inclusion) in the United States Pharmacopeia" and other compendia, or are approved by the pharmacy and drug therapeutics committee of the Medical staff of the hospital furnishing the biological for use in the hospital."

within the same multiple source drug billing and payment code.”²⁶ Apligraf® has been consistently paid under the ASP methodology based on its own reported sales data since CY 2006. Because of the statutory default in section 1833(t)(14)(A)(iii)(II), under which CMS has properly paid for Apligraf® in prior years, CMS must continue to pay Apligraf® at ASP plus 6%.

C. SCODs Are Different Than Other Drugs and Biologicals

The statutory definition for SCOD expressly limits the scope of its application to a narrowly defined class of products. In addition to establishing the three statutory requirements discussed above, Congress explicitly excluded a wide range of products. In particular, the statute states “Such term does not include— a drug or biological for which payment is first made on or after January 1, 2003, under paragraph (6).”²⁷ Therefore, the vast majority of outpatient drugs and biologicals paid under the HOPPS system since 2003 do not, and will not, qualify for special payment status as a SCOD. Apligraf®, however, is not among those vast majority of outpatient drugs and biologicals.

CMS explicitly acknowledges this difference in rulemakings over the years, and refers to it again in the Proposed Rule. As a matter of policy, the agency has decided to treat all separately payable drugs and biologicals as SCODs, but it is only required to do so for products that meet the statutory language. On this point the agency notes in the Proposed Rule “it has been our longstanding policy to apply the same treatment to all separately payable drugs and biologicals, which include SCODs, and drugs and biologicals that are not SCODs.”²⁸ The agency reinforces this point by further stating that “although we do not distinguish SCODs in this discussion, we note that we are required to apply section 1833(t)(14)(A)(iii)(II) of the Act to SCODs, but we also are applying this provision to other separately payable drugs and biologicals, consistent with our history of using the same payment methodology for all separately payable drugs and biological.”²⁹

Therefore, although CMS may exercise policy discretion to propose to expand the special payment status of SCODs to a broader class of drugs and biologicals, it may not do what it has done here: narrow the class of SCODs from those drugs or biologicals which meet the statutory definition of that term.

* * *

In sum, the proposal to package Apligraf® would be contrary to both the statutory plain language and to Congressional intent. Apligraf® is a SCOD pursuant to the Act, and under CMS’ Proposed Rule must be reimbursed based on the “statutory default” methodology of ASP plus 6%. Absent legislative changes to section 1833(t)(14), CMS

²⁶ Social Security Act § 1847A(b)(3).

²⁷ *Id.* at § 1833(t)(14)(B)(ii)(I).

²⁸ 78 Fed. Reg. 43,534, 43,609 (July 19, 2013).

²⁹ *Id.*

simply lacks the statutory authority to implement the approach proposed in the Proposed Rule.

V. Apligraf® Cannot Be Packaged Because it Does Not Function as a “Supply” and is Therapeutically Different from Other Skin Substitutes

A. Apligraf® Does not Function As A Supply

As noted above, the fundamental flaw in the proposal for packaging of skin substitutes is the failure to address the requirements of payment as a SCOD for certain products including Apligraf®. The Proposed Rule only makes a general statement that “Currently skin substitutes are separately paid in the OPSS as if they are biologicals according to the ASP methodology.” CMS goes on in the Proposed Rule, and purports to rely on its general authority to package medical devices, medical and surgical supplies, and surgical dressings into the related procedure under 42 C.F.R. § 419.2(b)(4) in order to package all skin substitutes.³⁰ To the extent that one of those skin substitutes is Apligraf®, CMS may not adopt its proposal.

Quite simply, Apligraf® also does not meet the definition of medical and surgical supplies, as it functions instead as a therapeutic. Moreover, Apligraf® has different clinical indications and characteristics that differ from the other skin substitutes. We discuss both points below.

Neither the HOPPS statute nor the regulation contain any explicit definition of a “supply,” but in the original HOPPS rulemaking in 2000, CMS described “supplies” as “surgical dressings used during surgery or other treatments in the hospital outpatient setting that are also paid under the DMEPOS fee schedule.”³¹ Apligraf® is neither a surgical dressing nor has it ever been paid under the DMEPOS fee schedule. Rather, Apligraf® is a therapeutic modality, indicated for the treatment of non-infected partial and full-thickness skin ulcers. Unlike other SCODs that have been packaged by CMS as “supplies,” Apligraf® provides a therapeutic modality to the patient, and is thus much more similar to therapeutic radiopharmaceuticals, which have not been package by CMS. In other words, Apligraf® is not provided in “in support of” a separate and distinct procedure; rather, it is the application of Apligraf® itself that provides the direct therapeutic benefit to the wound.

The primary legal and policy basis for the proposal to package skin substitutes appears to be the agency’s analogy to implantable biologicals. With respect to this point the agency states that “We see no reason to distinguish skin substitutes from implantable biologicals for OPSS packaging purposes based on the clinical application of individual products.”³² Critically, again, the agency fails to acknowledge the distinction of SCODs. In the CY 2009 HOPPS Final Rule, CMS used a supply-based policy argument to support

³⁰ *Id.* at 43,571.

³¹ 65 Fed. Reg. 18,434, 18,444 (Apr. 7, 2000).

³² 78 Fed. Reg. 43,534, 43,572 (July 19, 2013).

packaging three implantable biologics with expiring pass-through status. While these products qualified for pass through payment, they did not qualify for special payment status as SCODs and thus, the statute did not mandate that they be paid separately.³³

Instead, Apligraf® provides real therapeutic benefits, playing an active role in the healing process by providing the wound with proteins and collagen, both key components in the healing process.

B. Unlike other Skin Substitutes Apligraf® Meets the Definition of a SCOD and Is a Therapeutic Treatment

This legal memorandum only focuses on the authority of the agency to package biologicals like Apligraf® that meet the definition of a SCOD and does not address other skin substitutes that the agency likely has authority to package on policy grounds. With respect to Apligraf®, we would note that it differs from other skin substitutes in both legal and clinical terms. Based on a review of the codes listed in Addendum P for codes to be packaged under this proposal and upon the review of publicly available data, it appears that only one other skin substitute meets the definition of a SCOD.³⁴

Additionally, in clinical terms, Apligraf® is different than the other products both based on FDA approved indications and its clinical use as a therapeutic wound healing biological. In the Proposed Rule, CMS refers to a December 18, 2012 report prepared for the Agency for Healthcare Research and Quality (AHRQ) on “Skin Substitutes for Treating Chronic Wounds.”³⁵ CMS points to the report as evidence and support for the proposition that skin substitutes function as supplies and are “not a substitute for a skin graft.”³⁶ However, in the same report, AHRQ specifically distinguishes Apligraf® and Dermagraft® from other skin substitutes, noting in part:

For these products [Apligraf® and Dermagraft], the term “treatment” is used in the indications for use with chronic wounds. Each of the PMA entries in Table 2 is actually a combination of living human cells and another component (bovine collagen in Apligraf® and polyglactin mesh in Dermagraft®). FDA considers these to be combination products (i.e., combinations of device and biological components into a single entity) and regulates them as medical devices. Besides providing a biologic wound covering, these products also contain human cells capable of producing human

³³ In the FY 2009 Final Rule, CMS packaged three implantable biologics (Neuragen Nerve Guide, NeuraWrap Nerve Protector, and Tissuemend.) 73 Fed. Reg. 68,502, 68,633 (November 18, 2008). All three of these products were first paid on a pass-through basis in FY 2008 and therefore do not qualify as SCODs. See 71 Fed. Reg. 67,960, 68,083 (November 24, 2006).

³⁴ See 65 Fed. Reg. 67,798, 67,837 (November 13, 2000) (setting payment rate for Apligraf at \$1,157.81). See also 66 Fed. Reg. 59,856, 60,051 (November 30, 2001) (setting payment rate for Dermagraft at \$577.60).

³⁵ AHRQ, “Skin Substitutes for Treating Chronic Wounds Technology Assessment Report,” *available at* http://www.ahrq.gov/research/findings/ta/skinsubs/HCPRO610_skinsubst-final.pdf (Dec. 18, 2012).

³⁶ 78 Fed. Reg. 43,534, 43,572 (July 19, 2013).

growth factors and cytokines that may stimulate angiogenesis, tissue expansion, and re-epithelialization.

The report goes on to state that “[Apligraf® and Dermagraft] have the potential to be interactive with the wound bed and assist in the wound healing process.” The report’s use of the term “treatment” should be contrasted with the report’s use of the word “management” to describe those skin substitutes products considered Class II devices and regulated under the 510(k) process. While a product for the “management” of wounds may be more accurately classified as a supply, products like Apligraf® indicated for the “treatment” of wounds are more accurately classified as therapeutics.

In short, it is both legally and clinically impermissible to group Apligraf® with other skin substitutes as if they were interchangeable. They are not. In the Proposed Rule, CMS describes skin substitutes as “various types of wound dressings” that “stimulate the host to regenerate lost tissue” and that “replace the wound with functional skin.”³⁷ With an uncharacteristic lack of precision, CMS dismisses the substantive distinctions among skin substitutes as their functioning merely “through various mechanisms of action.” But it is precisely the substantive differences in these “various mechanisms of action” that distinguish Apligraf® from other skin substitutes. Apligraf® does not function as a supply, cannot be classified as a supply given its special payment status as a SCOD, and thus cannot be paid as a supply.

VI. Principles of Statutory Construction and Administrative Law Prohibit CMS from Altering the Longstanding Treatment of Apligraf®

A. CMS Cannot Change by Regulation a Reimbursement Methodology Established by Statute.

In circumstances where the statute specifies a reimbursement methodology for a given item or service — as is the case with SCODs like Apligraf® — it is settled law that CMS lacks the legal authority to alter that methodology by regulation.

In *Hays v. Sebelius*, 589 F.3d 1279 (D.C. Cir. 2009), CMS contended that the relevant coverage provision of the Act was ambiguous, and that CMS was therefore entitled to deference in its interpretation of that provision. At issue was CMS’ contractors’ policy of establishing a reimbursement methodology for a multiple-source drug by using its coverage authority. Under that authority, CMS sought to reimburse the drug at the cost of its individual subcomponents. The Appeals Court rejected this contention, concluding that where the Act “unambiguously forecloses that determination [i.e., the Medicare contractor’s determination to reimburse for a particular drug only up to the price of its least costly alternative],” Medicare must “pay for covered items and services at a statutorily prescribed rate.”³⁸

³⁷ *Id.*

³⁸ *Hays v. Sebelius*, *supra* n. 11.

Hays placed particular emphasis on the importance of CMS respecting the Act’s “mandatory reimbursement formulas,” which, in the case of the multiple-source drug at issue in *Hays*, provided that “the amount of payment . . . is 106% of the average sales price, as determined under the statutory formula”³⁹ (emphasis in original). As explained above, SCODs, too, are subject to a mandatory reimbursement formula under the Act, which provides that the “amount of payment . . . shall be equal . . . to the average acquisition cost for the drug . . .” Section 1833(t)(14)(A)(iii) (emphasis supplied).⁴⁰ *Hays* confirms in no uncertain terms that such mandatory reimbursement formulas must be respected by CMS and implemented as written. “We think it quite unlikely that Congress, having minutely detailed the reimbursement rates for covered items and services, intended that the Secretary could ignore these formulas whenever she determined. . . .”⁴¹

Finally, the Appeals Court in *Hays* emphasized that while “Congress could have written the Medicare Act to authorize” the policy that CMS proposed, “this is not the statute Congress wrote.”⁴² There is no dispute that if Congress wished to authorize the packaging of Apligraf® as proposed by CMS in the Proposed Rule, Congress could do so. However, where Congress has established a statutory scheme that singles out SCODs like Apligraf® for distinct treatment, *Hays* reiterates that CMS is precluded from changing by regulation what Congress has required by statute.

B. The Agency Has a Long Standing Policy of Paying Apligraf® Separately as a Biological

There is no discussion in the Proposed Rule of excluding from payment any biological products that meets the definition of a SCOD and payment under the statutory default at ASP plus 6%.⁴³ As a general principle of administrative law, once an agency “has given its regulation a definitive interpretation, and later significantly revises that interpretation, the agency has in effect amended its rule, something it may not do without notice and comment.” *Alaska Professional Hunters Ass’n, Inc. v. FAA*, 177 F.3d 1030, 1034 (D.C. Cir. 1997).

Here, CMS, in 2013, definitively interpreted its regulation as requiring payment for SCODs at the statutory default rate, and it has, since 2001, definitively interpreted payment

³⁹ *Id.* at 1,282.

⁴⁰ *Id.* Indeed, CMS concedes that it is statutorily required to reimburse SCODs at AAC. *See* 78 Fed. Reg. at 43,608, *supra* n. 2.

⁴¹ *Hays*, 589 F.3d at 1282.

⁴² *Id.* at 1282-83.

⁴³ In past rulemakings, the agency has packaged diagnostic radiopharmaceuticals that meet the definition of a SCOD. We do not address the issue of diagnostic radiopharmaceuticals as those products are not therapeutics and are ineligible for payment under the statutory default based on ASP plus 6. Section 303(c) of the Medicare Modernization Act of 2003 (MMA) revises the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Section 303(h) of the MMA excludes payment for radiopharmaceuticals under the ASP methodology and provides for continuation of the payment methodology under Part B prior to the MMA.

for Apligraf® separately as a biological. And although the 2014 Proposed Rule contains a recommendation to bundle skin substitutes, it does not solicit public comment on a policy that would exclude from the statutory default biological products that meet the definition of a SCOD, nor does it explicitly propose to cease treating Apligraf® as a biological.

Accordingly, we believe that a court could conclude that the public has not been given the effective notice required under the Administrative Procedure Act that the agency is effectively undoing, for at least one SCOD, the policy that it adopted last year and, indeed, re-iterated in this year's Proposed rule. Even more significantly: if CMS adopts its proposed policy as applied to Apligraf®, it will have reversed its longstanding policy of paying for Apligraf® separately as a biological since 2006, without the requisite notice to the public. This is not permissible under the *Alaska Hunters* doctrine.

VII. Conclusion

It is our conclusion that the existing statute is clear and unambiguous: Apligraf® must continue to be paid under the HOPPS payment system as a SCOD, at ASP + 6%. Apligraf® is a SCOD, and the statute, as interpreted by CMS, requires that SCODs be paid at the statutory default of ASP plus 6%. Unlike the other skin substitutes with which Apligraf® would be packaged, Apligraf® is a therapeutic treatment; it is not a supply. Therefore, CMS' rationale for packaging skin substitutes does not apply to Apligraf®. Finally, because the Congress has specified a "minutely detailed" reimbursement rate for SCODs, and because CMS has adopted a longstanding interpretation of the application of that statute, the agency may not alter it, neither under basic principles of statutory construction nor administrative law.

We would be pleased to answer any additional questions that you have regarding our legal analysis.