December 21, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Re: Medicare Program; International Pricing Index Model for Medicare Part B Drugs [CMS-5528-ANPRM]

The Alliance for Regenerative Medicine (ARM) appreciates the opportunity to comment on the Center for Medicare & Medicaid Services' (CMS) recently published advance notice of proposed rulemaking (ANPRM) entitled: Medicare Program; International Pricing Index Model for Medicare Part B Drugs.

ARM recognizes that regenerative medicines that make it to market will fulfill their promise only if patients can obtain timely access to them. We appreciate that the Administration put forward the ANPRM with concerns around healthcare system sustainability in mind, and we agree that our members have a responsibility to help address those concerns. Specifically, we firmly believe that regenerative medicines are a key part of the foundation of a sustainable healthcare system because they often aim to address the underlying cause of disease, not just its symptoms. This can result in significant health benefits over the long-term for patients and commensurate healthcare benefits and cost offsets for the system. In this way, many regenerative medicines represent a paradigm shift in how we, as a society, treat disease, a reality that is especially true in the case of one-time administered, potentially curative therapies. With this in mind, ARM offers comments on the ANPRM that we believe maximize the ability of regenerative medicines to contribute to the sustainability of the Medicare program.

ARM believes the proposed model would introduce significant reforms that will alter pricing, reimbursement, and distribution of drugs covered under the Medicare Part B benefit. The model combines several approaches including: international price benchmarking; intermediary management; and changes to Average Sales Price (ASP) reimbursement. When combined, these approaches could have a significant, adverse impact on the market. As we noted, ARM shares CMS' goal to increase Medicare efficiency by aligning value with reimbursement for Part B drugs. However, we are concerned that, as currently drafted, the proposals included in the ANPRM will fall short of that goal. Accordingly, our comments focus on discrete concerns with the three major components included in the proposal and on ARM-developed approaches that we believe will better drive the Administration's goal of balancing beneficiary access to high-value care, program sustainability over the short- and long-term, and continuing to incentivize medical innovation.

The order of issues discussed in this comment letter reflects the order in which the ANPRM presents them. ARM has organized our letter this way for ease of reference for the Department, but notes that we put particular emphasis on our recommendations related to alternative mechanisms to successfully achieve the Administration's broader goals, especially the need for and role of value-based payments for novel regenerative medicines.

ARM is an international multi-stakeholder advocacy organization that promotes legislative, regulatory, and reimbursement initiatives necessary to facilitate access to life-giving advances in regenerative medicine worldwide. ARM comprises more than 300 leading life sciences companies, research institutions, investors, and patient groups that represent the regenerative medicine and advanced therapies community. ARM takes the lead on the sector's most pressing and significant issues, fostering research, development, investment, and commercialization of transformational treatments and cures for patients worldwide.

The regenerative medicine and advanced therapies sectors are the next frontiers in the fight against some of humankind's most devastating diseases and disorders. As of October 2018, ARM estimates there are 892 regenerative medicine and advanced therapies developers worldwide sponsoring 1003 clinical trials across dozens of indications, including oncology, cardiovascular, central nervous system, musculoskeletal, metabolic disorders, ophthalmological disorders, and more.

Allowing private-sector vendors to negotiate prices for drugs covered under Medicare Part B (similar to the Competitive Acquisition Program (CAP))

ARM appreciates and looks forward to working with CMS to potentially implement a new and improved CAP that would introduce competition to improve quality of care for beneficiaries while reducing both Medicare expenditures and a beneficiary's out of pocket spending. These principles lay at the foundation of the clinical development of ARM's member companies who are developing new and innovative therapies that treat a wide range of diseases and patient populations.

ARM, however, urges the Agency to prioritize maintaining appropriate beneficiary access to therapy over cost reduction. To do this, ARM believes that a CAP model should not be applicable to all drugs and biologicals covered and reimbursed by Medicare Part B. This priority was shared by Congress in the CAP's authorizing statute that explicitly gave the Secretary the authority to exclude therapies from the CAP that are "likely to have an adverse impact on access" to such therapy.

As such, ARM urges CMS to exclude regenerative medicine (RM) therapies from the IPI model. CMS stated that it is considering excluding (1) drugs that are identified by the US Food and Drug Administration (FDA) to be in short supply, and (2) drugs paid under miscellaneous or "not otherwise classified" (NOC) codes. We encourage CMS to also consider excluding RM therapies as they are intended to treat serious or life threatening conditions that are recognized as areas of significant unmet medical need. In other words, where the standard of care is inherently limited, ineffective, or unavailable for many or most patients.

It is important to note that RM therapies are considerably different than traditional Part B drugs. Regenerative medicine therapies, including cell, gene, and tissue engineering therapies (advanced therapies), represent some of the most innovative approaches to potentially curative medical treatment and could address many of the most burdensome, difficult to treat, and costly diseases including rare pediatric diseases in the United States. Many of these treatments are expected to deliver a profound

and durable therapeutic benefit following a one-time treatment and/or by providing a long-term durable effect. RM therapies have a substantial impact on patients in terms of clinical outcomes, quality of life, and in economic terms (e.g. cost of both clinical and non-clinical care, quality of life for the patient and family members that may need to provide home care, and overall cost burden).

The potential for dramatic clinical benefit, as well as the potential ensuing direct and indirect cost offsets, is why these innovations are changing medical care. ARM believes that the field of regenerative medicine has the potential to heal people and bend the health cost curve toward lower long-term costs and higher quality outcomes. Accordingly, CMS should encourage the development and commercialization of these types of therapies by excluding them from the proposed model rather than advance policies that may have unintended effects for these vulnerable patient populations.

ARM would like to work with CMMI on the development of alternative approaches that would be voluntary for all stakeholders. A voluntary model increases the likelihood of success because participants will be highly engaged, supportive of the demonstration concept, and motivated to help CMMI achieve its goals.

ARM believes the soundest approach to testing a vendor/CAP-like approach would be to do so within CMS existing CAP authority, while making key operational improvements to address flaws in the original implementation of the program and encourage vendor and physician participation. We believe CMS has sufficient flexibility to achieve its goal within the Part B competitive acquisition program's statute; however, if CMS chooses to go beyond the statute and utilize its authority under the CMMI, we urge the agency to first establish in regulations key safeguards — including that models be voluntary, small scale, and limited in length.

The IPI model is unprecedented in both scale and scope and would significantly impact payment and access for beneficiaries in the rest of the Medicare Part B program. The mandatory nature of the model would force beneficiaries into the experiment, eliminating their ability to choose a provider not subject to the model. The proposed model would also put vendors with no clinical or medical expertise between patients and their providers. This is particularly risky for vulnerable Medicare patients with conditions who require complex treatment regimens.

Phasing down Medicare payment amounts for certain Part B drugs to more closely align with international prices

As an initial matter, we are concerned that that the approach would not significantly lower drug prices in Medicare Part B spending. We believe that the model makes a number of presumptions about pricing behaviors in both domestic and international markets that are untested. Information about international markets is still incomplete. For instance, it is unclear if the prices set under a single-payer system can or should be compared to prices set under a multi-payer system.

Notably, many Part B medicines available in the United States are unavailable in countries that have been proposed for inclusion in the IPI proposal. There are also significant launch delays of new Part B drugs as compared with United States launches. To illustrate, since 2011 (compared with US statistics) 50 percent of all Part B drugs available in the United States are available in Canada. New Part B drugs are made available an average of 17 months later in Canada than in the United States. Other proposed IPI-referenced countries have similar results. For example, France has 59 percent of US Part B availability

with 17-month average delays for new Part B drugs, Greece has 2 percent of US Part B availability with 26-month average delays for new Part B drugs, and Japan has 39 percent of US Part B availability with 23-month average delays for new Part B drugs.[1]

Further, the administration has repeatedly acknowledged that foreign price controls have damaged medical innovation. Instead of fighting these price controls, we are concerned that the proposed IPI adopts them. There is evidence that patients in other international countries do not have access to state-of-the-art medical innovation and accordingly is not a model CMS should emulate. Economists have estimated that had European-style price controls been adopted in the U.S. from 1986-2004, 117 fewer new medicines would have been produced for worldwide use.[2]

Further, cutting prices can lead to a decreasing number of research and development (R&D) projects being undertaken. The United States is responsible for the development of more biopharmaceuticals than all other countries combined.[3] ARM is concerned that international price controls would hurt patients and will suppress competition and innovation, by reducing the value of pharmaceutical projects and by curtailing the resources available to carry them out. This could also impact the number and characteristics of drugs that will be launched in the market in the future. A 50 percent drop in drug prices could lead to a 14-24 percent drop in the number of drugs in the development pipeline.[4] We urge CMS to carefully consider the effects of reducing Medicare payment amounts for certain Part B drugs and the effect it would have on the ability of manufactures to innovate in our country.

Changing Medicare's payment formula for Part B drugs

ARM is concerned that the proposed model assumes that substantial savings would be achieved through reforms to Part B that presume that the ASP system drives inappropriate spending among clinically similar drugs. Notably, many of the RM therapies in development are for diseases with no current treatment options. Studies have demonstrated that there is no meaningful correlation between drug payment and utilization, challenging the theory that physicians favor drugs with high add-on payments.[5]

The elimination of buy and bill for certain drugs, coupled with reimbursement changes and the provider's role in collecting patient cost sharing, may create "winners" and "losers" by provider specialty (and within specialties) and could affect provider prescribing incentives and finances. According to Avalere, more than 60% of the drug payment reductions from the proposed IPI Model would occur for drugs administered by oncologists, rheumatologists, and ophthalmologists. If the IPI index was constructed to include the 27 drugs highlighted by the administration for potential inclusion in the model, then 20 of those drugs would see a price reduction averaging 42%, and the other 7 would receive no price reduction. Price reductions would range from 0% to 82% for the 27 drugs.[6]

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[1] IVQIA Institute, Pharma 2018

[2] Joseph Golec and John Vernon. Government Price Controls on Drugs Will Reduce Innovation and Cost Lives http://www.aei.org/press/government-price-controls-on-drugs-will-reduce-innovation-and-cost-lives/

[3] Milken Institute; https://www.bio.org/toolkit/infographics/biotechnology-ecosystem-numbers

[4] Civan Abdulkadir & Maloney Michael T., 2009. "The Effect of Price on Pharmaceutical R&D," The B.E. Journal of Economic Analysis & Policy, De Gruyter, vol. 9(1), pages 1-24, April.

[5] Xcenda. Medicare Physician-Administered Drugs: Do Providers Choose Treatment Based on Payment Amount? http://partbaccess.org/wp-content/uploads/2017/06/Xcenda_Provider-Utilization_2018-09-10_XD.pdf.

[6] Avalere. Post-Election, Part B Drug Reform is Likely to Advance. https://avalere.com/insights/post-election-part-b-drug-reform-is-likely-to-advance.

These effects will be relevant to providers both in and out of the model. We believe that the proposal could have the unintended effect of counterbalancing prices for drugs and biologicals not purchased and furnished as part of the model.

ARM-supported opportunities to drive value

Recognizing the Administration's concerns around balancing patient access with the sustainability of the Medicare program, ARM offers several recommendations to strengthen our health care system through patient-centered reforms that support innovation and value transformation. As noted above, we are concerned that the IPI model is not aligned with those goals. As such, we hope to work with CMS to pursue payment and delivery models that will achieve innovation and drive value.

One of the answers to rising health care costs, the ailments of an increasingly elderly population, and many incurable diseases can be found in regenerative medicine. Regenerative medicine therapies promise significant clinical efficacy over time, but in the absence of broad thinking about delivery and reimbursement their value may not be fully realized. Among the critical obstacles are:

- Concerns about the ability of current payment mechanisms to recognize the high but long-term value of a potentially curative treatment;
- The limited availability of reliable and accepted mechanisms to routinely track outcome and cost performance in conjunction with such models; and
- A payment and regulatory system designed for FFS payment systems that could complicate efforts by regenerative medicine companies working with payers and providers.

Overcoming these obstacles will require implementing payment models that take into account the long-term value offered by these curative therapies and those that provide significant disease-free intervals in order to mitigate the high up-front budget impact associated with these novel therapies and risks associated with long-term clinical uncertainty. Thus, given the promise of these therapies we would urge the Administration to consider pilot programs and regulatory changes that foster and facilitate timely access to these novel treatments across public and commercial payers alike.

ARM encourages CMS to work with manufacturers to advance value-based arrangements while simultaneously evaluating opportunities to modify existing regulations that impede innovation in the delivery of, and payment for, care. Specifically, ARM encourages CMS to use the full extent of its existing authority to experiment with novel payment models. ARM also emphasizes that HHS make this a budget priority, that the review and deployment of such demonstrations be expedited, and that a meeting is convened of stakeholders for an open dialogue on potential new payment approaches and specific guidance needed to enable them.

A broad discussion around various alternative payment model types is necessary because there is no "one size fits all" approach. The variety of technologies and approaches means that multiple options are needed, and in some cases will need to be combined. For example, CMS should explore combining value-based payment (payment tied to meaningful outcomes) with long-term financing approaches, including but not limited to payment over time, with payments spread out over a defined number of years**.** The benefits of the such a model "includes the potential to reward innovation and to better align costs with the time period over which benefits are delivered to the patient, thereby reducing up-front

budget impact to the payer or provider and reducing initial cost as a barrier to appropriate access for treatment-eligible patients."[7]

Such a long-term financing model could also be supported in alternative payment models like accountable care organizations (ACOs) that share risk across stakeholders. To date, neither traditional FFS payments nor alternative payment models account for one-time administered, potentially curative therapies. Rather than viewing payment reforms for regenerative medicine therapies and for health care providers as distinct, CMS could encourage developers of alternative payment models, through the CMMI, to engage on ways to maximize the value brought by new technologies. For example, this could include model frameworks and regulatory clarifications for sharing data related to the benefits and risks of new technologies for particular patients, or for incorporating drug and device shared accountability in ACOs and bundled payments. Other pricing models could also be considered that cannot be implemented today due to regulatory and legislative barriers—including but not limited to indication based pricing and/or capping a weight-based treatment cost as a fixed lifetime amount.

There is a need for this level of CMMI involvement to unleash the creative forces of the market around alternative payment models for novel regenerative medicines: currently, existing price reporting requirements and the limited safe harbors under federal fraud and abuse regulations hamper the ability of manufactures and payers (commercial and public) to engage in novel value-based payment. A demonstration program administered by CMMI, regardless of the statutory demonstration authority evoked, is a critical Department tool to bring the benefits of value-based payment to bear more quickly and across the entire Medicare program.

In particular, the Medicaid Best Price law (P.L. 101-508) may inadvertently limit the degree to which manufacturers can share risk under value-based arrangements. A number of articles have flagged the best-price rule as a potential obstacle to novel pricing arrangements; typically, it is invoked as a monolithic barrier against the idea of value-based arrangements. Similarly, value-based arrangements can distort the reporting of the average sales price for Medicare Part B reimbursements purposes.

We urge CMS to work with stakeholders to provide more flexibility to manufacturers and payers to engage in value-based arrangements for novel therapies, including waiving the traditional government price reporting requirements, but nevertheless requiring reporting that is consistent with requirements to assess the impact of the demonstration and promote program integrity and sustainability across all participating payer systems.

Conclusion

The pathway to advancing these remarkable therapies are full of potential challenges, including regulatory limitations. As such, we look forward to working with CMS to advance efforts that maximize patient access to medicines that can transform lives.

In light of the potential unintended consequences of this ANPRM, we urge the Department to work with us to halt implementation of the model and instead seek workable solutions that focus on patients and driving innovation. We appreciate your consideration of our viewpoints and look forward to working

[7] Ted Slocomb and Michael Werner, *New Payment And Financing Models For Curative Regenerative Medicines*, IN VIVO PHARMA INTELLIGENCE (July 24, 2017), https://invivo.pharmaintelligence.informa.com/IV005132/New-Payment-And-Financing-Models-For-Curative-Regenerative-Medicines.

with you. We also welcome the opportunity to meet with CMS and CMMI to discuss our suggested approaches for innovative, value-based payment models. Should you have any questions regarding this response, please contact Robert Falb at rfalb@alliancerm.org.

Sincerely,

Robert J. Falb
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