Alliance for Regenerative Medicine

September 8, 2023

Chiquita Brooks-LaSure
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

Submitted via http://www.regulations.gov

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Issues; and Basic Health Program [CMS-1784-P]

Dear Administrator Brooks-LaSure:

The Alliance for Regenerative Medicine (ARM) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed payment updates to the calendar year 2024 Medicare Physician Fee Schedule (Proposed Rule).[1]

The Alliance for Regenerative Medicine (ARM) is the leading international advocacy organization championing the benefits of engineered cell therapies and genetic medicines for patients, healthcare systems, and society. As a community, ARM builds the future of medicine by convening the sector, facilitating influential exchanges on policies and practices, and advancing the narrative with data and analysis. We actively engage key stakeholders to enable the development of advanced therapies and to modernize healthcare systems so that patients benefit from durable, potentially curative treatments. As the global voice of the sector, we represent more than 400 members across 25 countries, including emerging and established biotechnology companies, academic and medical research institutions, and patient organizations.

As of year-end 2022, 1,308 regenerative medicine and advanced therapies developers worldwide are sponsoring 1,200 clinical trials across dozens of indications, including rare monogenetic diseases, oncology, cardiovascular, central nervous system, musculoskeletal,

[1] 88 Fed. Reg. 52,262 (August 7, 2023).

1015 18th Street NW, Suite 1102
Washington, DC 20036
www.alliancerm.org
info@alliancerm.org
@alliancerm
@Alliance for Regenerative Medicine

metabolic disorders, ophthalmological disorders, and more. As discussed in previous comment letters, a large subset of these clinical trials focuses on the power of cell and gene therapies. These therapies are the first in a wave of new and exciting advanced therapies and technologies that are the next frontier in the fight against some of humankind's most devastating diseases and disorders. ARM is currently tracking the outcomes of approximately 897 cell-based immuno-oncology (cell IO) trials which includes CAR T therapies. In addition, ARM tracks hundreds of other clinical trials exploring the power of the immune system, particularly focused on T cells. ARM believes that the new and promising technology of using the patient's own immune system to fight disease provides the possibility that future treatments for many types of cancer, at its many stages, could be durable and curative.

To date, the FDA has approved nine gene therapies – eight for rare genetic diseases, and six CAR-T cell therapies for various blood cancer indications. These innovative therapies address high unmet medical needs; they can be lifesaving; and many have the potential to reduce the need for burdensome and costly chronic care.

To promote appropriate access to cell and gene therapies and support the patients receiving these treatments, ARM urges CMS to adopt the following recommendations:

- Modify the drug discard rebate policy in recognition of the unique circumstances surrounding administration of cell and gene therapies.
- Finalize proposed coverage and payment policies for dental services inextricably linked to a CAR T-cell therapy and extend this coverage to all other immunotherapies with similar protocols and risks.
- Implement the proposed coverage and payment policies for Principal Illness Navigation services for patients living with cancer and other high-risk serious illnesses.

CMS Should Utilize the Unique Circumstances Authority to Exempt Cell and Gene Therapies from Drug Discard Rebate Requirements

Under the Unique Circumstances Authority, CMS Should Apply 100 Percent Applicable Percentage to Cell and Gene Therapies. There are numerous reasons why cell and gene therapies should be categorically exempt from the drug discard policy. First, these therapies are typically one-time durable therapy treatments representing a completely different treatment regimen than the currently listed top discarded drugs, which require frequent and regular delivery of the product to a beneficiary. The overwhelmingly one-time nature of these therapies requires that all potentially needed product be on hand and available for all procedures, consistent with clinical trial data and FDA-approved labeling. Second, the administration and manufacturing of these products is tailored to each patient and thus the volume of material packaged for administration is often individualized, as it is dependent upon many factors including but not limited to each patient's cell volume and weight. As such, these therapies follow a specific coding designation methodology, which describes cell therapy codes by the number of cells, a component of the overall material within the package as compared to IV administered drugs that are typically described as units of all the material within the vial or bag.

Third, the one time and lengthy administration process underscores and warrants the importance of having ample drug at time of administration to minimize physician and patient burden, avoid unnecessary complications related to redosing which is not always permissible, and prevent further disease progression that could result from delayed treatment. Physicians should not be forced to risk performing an incomplete and ineffective procedure because of a limitation on the amount of available product that could be the natural consequence of applying discarded drug policy to cell and gene therapies.

Finally, while many patients currently receive cell and gene therapies are in the inpatient setting, increasing provider familiarity has resulted in more administration of these therapies in less acute sites of care, which is better for patients and the healthcare system. The option of administration in less acute sites of care, including the hospital outpatient department and physician office, often reflects patient preference, involves less resource intensity in treatment, and typically provides more reimbursement certainty.[2] An exemption of the drug discard policy can help accelerate this trend.

For all these reasons, ARM strongly encourages the agency to consider the complex and personalized nature of these therapies as a unique circumstance that greatly differentiates them from most drugs reimbursed under Medicare Part B and exempt them from the drug discard policy.

CMS Should Finalize its Two Proposed Categorical Unique Circumstances and its Application Process Under the Drug Discard Policy

Section 90004 of the Infrastructure Investment and Jobs Act (Pub. L. 117–9, November 15, 2021) (Act) amended current law to require manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug.[3] The Act also permits CMS to increase the applicable percentage for certain drugs that have unique circumstances.[4] In response to stakeholder comments, CMS proposes a hybrid approach to determining when it is appropriate to increase the applicable percentage for a drug with unique circumstances.[5] First, CMS proposes two categorical unique circumstances along with proposed increased applicable percentages and, second, the Agency proposes an application process for manufacturers to request that CMS apply an increased applicable percentage to its unique circumstance.[6]

Low Volume Dose and Orphan Drugs

ARM recommends that CMS finalize its proposed increase applicable percentages for drugs with a ‘‘low volume dose,’’ which CMS considers to be a dose of a drug for which the volume

[2] Myers GD, Verneris MR, Goy A, et al. Perspectives on outpatient administration of CAR-T cell therapy in aggressive B-cell lymphoma and acute lymphoblastic leukemia. Journal for ImmunoTherapy of Cancer 2021.
[3] Social Security Act (SSA) §1847A(h).
[4] *Id*.
[5] 88 Fed. Reg. at 52,391.
[6] *Id*.

removed from the vial containing the labeled dose does not exceed 0.4 mL.[7] CMS determines that for doses this small, there is a unique circumstance because there is a labeled amount that is unused and discarded that is not available for administration. ARM appreciates this clarity and urges CMS to finalize this categorical unique circumstance along with the proposed increased applicable percentages. Additionally, ARM also recommends that CMS monitor novel low-volume dose therapies that are approved in coming years as they may require increases in the proposed applicable percentages.

Second, CMS proposes a categorical unique circumstance for orphan drugs that are furnished to fewer than 100 unique Medicare fee-for-service beneficiaries per calendar year and to increase the drug discard applicable percentage to 26 percent.[8] CMS states that it is creating this categorical exception with the higher discard percentage because the standard deviation from the mean discarded drug percentage for these drugs is 2.64 times greater than that of the larger group of refundable drugs.[9] ARM supports this proposal and requests that CMS specify the factors it relied on to reach the 100 unique Medicare fee for service beneficiaries cut off and the 26% discard percentage. By disclosing further details on its processes, CMS will provide manufacturers with the further transparency and predictability required to better understand the scope of this unique circumstance.

Application Process for Individual Drugs

ARM urges CMS to finalize its proposed application process for individual drugs.[10] Each application must be received by February 1 of the calendar year prior to the year the increased applicable percentage would apply. A manufacturer must submit the following information in its application: (1) must be a written request that a drug be considered for an increased applicable percentage based on its unique circumstances; (2) FDA- approved labeling for the drug; (3) justification for the consideration of an increased applicable percentage based on such unique circumstances; and (4) justification for the requested increase in the applicable percentage. Detailed transparency throughout the application process is critical for manufacturers. In finalizing any request, CMS should provide visibility into their decision-making processes including how CMS reached each decision on unique circumstances and allowed percentages of discarded drug, what data it relied on, and if CMS relied on other third-party resources.

Finally, ARM urges CMS to implement an appeals process for determining a unique circumstance and/or applicable percentages that provides manufacturers the opportunity to provide additional details to CMS to request and support reconsideration of these decisions. The appeals and dispute resolution processes must be timely and comprehensive in scope and should be done outside of rulemaking to expedite resolution and provide the manufacturer the opportunity to share confidential commercial information as part of the process.

[7] 88 Fed. Reg. at 52,392.
[8] *Id*. at 52,393.
[9] 88 Fed. Reg. at 52,393.
[10] *Id*.

CMS Should Finalize its Proposal to Reimburse for Dental Services Inextricably Linked to CAR T-Cell Therapy When Used in the Treatment of Cancer

CMS states that certain dental services are a clinical prerequisite to proceeding with the CAR T-cell therapy because without diagnosing and then treating any presenting infection of the mouth this could lead to systemic infection or sepsis, as well as other complications for the patient.[11] As such, CMS proposes to cover a dental or oral examination performed as part of a comprehensive workup in either the inpatient or outpatient setting prior to Medicare-covered CAR T-cell therapy.[12] ARM supports this initiative and urges CMS to finalize its proposal and then take this policy one step further. Specifically, ARM urges CMS to cover dental services for all other immunotherapies that have a similar lymphodepletion component to CAR-T cell therapies as the infection risks associated with any lymphodepletion mirror those of CAR-T cell treatments thereby warranting equal dental coverage.

Finally, CMS requests comments on whether dental services provided integral to the treatment of Sickle Cell Disease (SCD) and Hemophilia should also be covered. ARM agrees with CMS' noted commenters that periodic dental care reduces the risks of dental complications requiring haemostatic therapy (such as tooth extractions that may require clotting factor treatment) or oral surgeries requiring clotting factor replacement therapy. Additionally, ARM supports the conclusion that certain dental services are "inextricably linked" to other covered services used in the treatment of SCD, such as, but not limited to, hydroxyurea therapy. For these reasons, ARM believes that CMS should extend coverage for dental services to patients living with SCD or hemophilia for 2024 and finalize a process that provides for coverage of certain dental services for future cell and gene therapies.

CMS Should Finalize its Proposed Principal Illness Navigation Services CPT Codes

For 2024, CMS proposes two new CPT codes for Principal Illness Navigation (PIN) services performed by a certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist.[13] These individuals must be involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/ decompensation, functional decline, or death.[14] ARM agrees with CMS that the PIN services are appropriate for beneficiaries with serious high-risk diseases including cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.[15] ARM urges CMS to finalize this list of eligible diseases, however, we also urge CMS to develop clearer guidelines and definitions as what other diseases, such as sickle cell disease or hemophilia may also qualify as a "serious and high risk disease" such that other beneficiaries can benefit from these PIN services. Specifically, in

[11] 88 Fed. Reg. at 52,377.
[12] *Id*.
[13] 88 Fed. Reg. at 52,332.
[14] *Id*.
[15] *Id*.

finalizing these guidelines, CMS should ensure inclusion of conditions in which cell and gene therapies play a major role in treatment.

As stated above, providing a cell or gene therapy to a patient requires significant health education, coordination of care, and the facilitation of access to other community-based healthcare services. Coverage and payment for PIN services will support increased access to these innovative therapies, especially for patients who may face unresolved health related social needs and other barriers to care. Serious or high-risk patients are the most vulnerable Medicare patients and ARM supports CMS' efforts to reimburse providers for providing PIN services to these beneficiaries.

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. This trend is already evidenced by several approved and marketed first-generation regenerative medicine products that are demonstrating both clinical and cost reduction value. Accordingly, ensuring Medicare beneficiaries can benefit from cell and gene therapies could substantially reduce program expenditures by reducing hospital care, the need for physician, clinical and professional services, nursing, and home healthcare.

We thank CMS for its consideration of our comments. Please feel free to contact me at ecischke@alliancerm.org with questions.

Sincerely,

Erica Cischke, MPH
Vice President, Government Affairs
Alliance for Regenerative Medicine