Alliance for Regenerative Medicine

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

June 7, 2024

Submitted via http://www.regulations.gov

Re: Medicare and Medicaid Program and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Changes

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 fiscal year ("FY") 2025 Hospital Inpatient Prospective Payment System (the "Proposed Rule").[1]

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 475 members across 25 countries, including emerging and established biotechnology companies, academic and medical research institutions, and patient organizations.

There Has Been a Rapid Pace of Advancement in The Field Of Cell And Gene Therapies, Leading To The Development Of Novel Treatments For Growing List Of Therapeutic Applications.

[1] 89 Fed. Reg. 35,934 (May 2, 2024).

As of April 2024, there were 2,762 engineered cell therapy and genetic medicine developers worldwide sponsoring 1,920 clinical trials across dozens of indications, including rare monogenetic diseases, oncology, cardiovascular, central nervous system, musculoskeletal, metabolic disorders, ophthalmological disorders, and more.[2]

For the past decade, treating hematologic malignancies has been and remains one of the main indications targeted by engineered cell therapies. Leading the charge are chimeric antigen receptor T-cell (CAR-T) therapies, which have engineered receptors that target cancer cells. Currently, six CAR-T cell therapies for blood cancers are approved in the United States (US). However, many more cell therapies for blood cancers, including non-CAR-T approaches, are in the clinical pipeline. Of the ten most explored indications in cell therapy, nine fall within the scope of blood cancer. Scientific advancement is driving these therapies to new heights for safety and effectiveness. A handful of the authorized therapies were approved as a last line of treatment, meaning a patient must endure several treatments before being eligible. Since 2022, the U.S. Food and Drug Administration (FDA) has approved some of these cell therapies for earlier lines of treatment based on robust safety and efficacy data. In early 2024, a Tumor-Infiltrating Lymphocytes (TIL) therapy used to treat metastatic melanoma became the first adoptive cell therapy for a solid tumor to be approved by the FDA. Another approval to treat solid tumors, an engineered T-cell receptor (TCR) therapy to treat advanced synovial sarcoma, a cancer found in soft tissue, could occur later this year. And this is just the beginning, the clinical pipeline for cell therapies demonstrates that treatments for solid tumors maintain a sizeable presence in early-stage trials, showing the potential for more therapies to reach the market in the years ahead.

Overall, the cell and gene therapy (CGT) pipeline most relevant to Medicare beneficiaries is set to extend beyond oncology care. It is a potentially unprecedented year for US approvals with thirteen more expected in 2024. These include therapies to treat steroid-refractory acute graft versus host disease and Hemophilia A and B. The current pipeline of CGTs is expected to result in 66 product-indication approvals (estimated range 54-74) by 2032. Where there are currently 16 product indication approvals and an average of five new approvals annually for the next four years, an estimated 41 conditions will be treated with cell and gene therapies by 2027.[3] The modality of treatments is set expand on the evolution of the sector as well. The expansions in number of indications and types of modalities are illustrated in the Appendix. There are over 225 Phase I clinical trials underway utilizing allogeneic biological sources to bring a therapy to market.

The proposals outlined in the Proposed Rule address forward thinking approaches that enhance Medicare beneficiaries' access to advanced therapies. To enhance

---

[2] *See* https://alliancerm.org/wp-content/uploads/2024/05/Sector-Snapshot-4.30.2024.pdf

[3] https://newdigs.tuftsmedicalcenter.org/payingforcures/defining-disruption/cell-and-gene-therapy-products-and-pipeline/cgt-pipeline-deep-dive/

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

- Strengthen the New Technology Add-On Payment (NTAP) program by revising eligibility criteria, extending the application submission cycle and aligning payment rates with the liabilities incurred by healthcare system
- Ensure rate setting methodologies align with adequate reimbursement for commercially available therapeutics and prevent unnecessary outlier payments
- Provide clarity and transparency by detailing the process to establish a reimbursement system that supports the anticipated pipeline of advanced therapeutics

Addressing Unique Considerations for New Technology Add-on Payments for Cell and Gene Therapies

The New Technology Add-on Payment (NTAP) program is intended to facilitate access to new therapies and technologies, and the NTAP statute requires that a new technology represent an advance in medical technology that significantly improves the diagnosis or treatment of Medicare beneficiaries to be eligible.[4] CGTs and regenerative medicine represent precisely the kind of innovation that Congress hoped to encourage by establishing the NTAP program.

ARM encourages CMS to further refine the requirements of the NTAP program to enable it to continue to serve its objective of promoting access to innovative treatment modalities. Many of the current challenges with the NTAP program stem from practical problems related to the approval process such as frequency of NTAP applications and timelines or criteria applicable to their review. Further, while the NTAP program strives to incentivize early adoption of newly approved products, the program does not adequately cover the cost of eligible products, leaving hospitals with significant financial shortfalls. Table 1 (below) uses FY 2022 100% Research Identifiable Files to describe Medicare payment for CAR-T products with and without NTAP. The analysis includes data from two approved CAR-T products that received NTAP awards and assumes a product's wholesale acquisition cost (WAC) of $425,000 and patient care costs of $54,000. The analysis includes data from two approved CAR-T products that received NTAP awards and assumes a product WAC of $425,000 and patient care costs of $54,000.[5]

[4] Social Security Act § 1886(d)(5)(K)(vii).

[5] FY 2022 (October 1, 2021-September 30, 2022) 100% Inpatient Research Identifiable Files (RIFs)

Table 1. Evaluation of Medicare Payment for CAR-T therapy with and without NTAP

	Total Cases	**Average Medicare Payment**	**Hospital Loss (per case)**
With NTAP	242	$519,220	
Without NTAP	52	$410,191	($68,809)

ARM Supports the Agency's Proposal To Expand The Newness Period In Assessing An NTAP Applicant's Eligibility

In the FY 2024 IPPS rule, CMS finalized a policy change by which NTAP applicants must have received FDA approval or clearance by May 1 (rather than the prior deadline of July 1) of the year prior to the beginning of the fiscal year that the NTAP application was to be considered. In the FY 2025 Proposed Rule, CMS seeks to change the April 1 cutoff for determining whether a technology would be within its 2- to 3-year newness period when considering eligibility for NTAP. The Agency proposes that, in assessing whether to continue the NTAP for a technology first approved for NTAP in FY 2025 or a subsequent year, CMS would extend NTAP designations for an additional fiscal year when the three-year anniversary date of the product's entry onto the U.S. market occurs on or after October 1 of that fiscal year. Similarly, CMS would use the start of the fiscal year (October 1) instead of April 1 to determine whether to approve NTAPs for that third fiscal year.

ARM supports CMS' proposal regarding the newness period as it helps to address concerns around eligibility timelines raised by ARM and other commentors in prior rulemaking cycles.

With the established application eligibility timeline in place, ARM recommends expanding the New Technology Add-on Payment (NTAP) newness period proposals to allow for each NTAP recipient to receive 3 fiscal years of NTAP designation, or, at a minimum, apply the proposed policy to existing products whose NTAP is set to expire in 2024.

Additional Solutions to Optimize the NTAP Application Process Include Conditional Approvals On a Quarterly Basis

However, additional solutions exist to optimize the NTAP program including the permission NTAP application submissions on a quarterly basis. Because the current NTAP application process occurs only once per year and the FDA's approval timelines are frequently subject to uncertainty, applicants may not be able to obtain an NTAP designation until well after the date that their product is approved. A quarterly process would better serve Congress' intent in establishing the NTAP program, namely, to promote timely access to innovative new therapies. Increasing the frequency of opportunities for manufacturers to submit NTAP applications to

once per quarter would alleviate the burden on CMS of reviewing a significant number of applications, in some cases over the course of two or more rulemaking cycles, while supporting access to innovative therapies by Medicare patients. This year, the FDA extended Prescription Drug User Fee Application ("PDUFA") dates for CGT products that have subsequently pushed out approval timelines for these therapies and made them ineligible for an NTAP award in FY25. In one circumstance, a developer's original PDUFA date was set for March 2024 placing their submission within the current eligibility timeline, however, once their date was moved to the end of June the developer than had to delay their NTAP submission. As a result, the developer retracted their NTAP application after the FDA delayed their PDUFA date, so their product will now not be eligible for an NTAP award until 10/1/25.[6] Allowing for multiple NTAP cycles mitigates barriers that are truly beyond a biotechnology company's control and directly impacts patient access to newly approved therapies.

From a legal perspective, though the NTAP statute requires a public meeting be held "before publication of a notice of proposed rulemaking regarding" a technology's eligibility for NTAP,[7] the statute does not prohibit CMS from considering an NTAP application prior to such a meeting. In fact, it is permissible for the Agency to grant NTAP approvals quarterly on a conditional basis. Where necessary, the Agency could then withdraw such approvals if the result of the public meeting process is unsatisfactory. With this process, CMS could also continue to hold a single meeting to consider the substantial clinical improvement criteria, if it occurs prior to the publication of a notice of proposed rulemaking. Further, ARM notes that a quarterly approach would more closely mirror the process for applying for transitional pass-through status under the Outpatient Prospective Payment System, which would further reinforce the goal of according CGTs similar treatment regardless of whether they are offered in an inpatient or outpatient context.

CMS Should Consider Utilizing Formal FDA Designations such as Regenerative Medicine Advanced Therapy and Breakthrough Therapy Designations to Satisfy NTAP Criteria

CMS might consider how CGTs are often a perfect fit for the "newness" and "substantial clinical improvement" criteria in any event. The same goals for which CMS seeks to achieve those criteria can be evaluated in other ways, such as by considering those criteria to be satisfied with therapies that have achieved the Regenerative Medicine Advanced Therapy ("RMAT") or "Breakthrough Therapy" ("BT") designation from the FDA. As CMS notes in the Proposed Rule, the purpose of the "substantial clinical improvement" criterion is to ensure that the therapy "substantially improves, relative to services or technologies previously available, the diagnosis or treatment of Medicare beneficiaries."[8] "Newness," similarly, is not

[6] https://www.cms.gov/files/document/fy-2025-ntap-tracking-forms-applicants.pdf
[7] Social Security Act § 1886(d)(5)(K)(viii)(III).
[8] 89 Fed. Reg. at 36,023.

just a chronological inquiry but, more specifically, is intended to determine whether a therapy is "substantially similar to one or more existing technologies."[9] Moreover, given the incremental nature of technological advancement, the ability for CMS to determine when a product meets a "newness" standard is not clear. ARM believes the proliferation of novel therapies are critical for the advancement of clinical practice and modernizing health systems, thus, we look forward to collaborating with the Agency in enhancing the care journey for patients.

By way of their definition, RMAT and BT designations are intended to extend beyond the considerations for traditional pharmaceutical products. The RMAT designation focuses on whether the applicant can demonstrate that a CGT "has the potential to address *unmet medical needs* for" the condition it is intended to treat.[10] The Breakthrough Therapy designation likewise is reserved for therapies "for which preliminary clinical evidence indicates that the product may demonstrate *substantial improvement over available therapies* on one or more clinically significant endpoints."[11]

ARM notes that the Proposed Rule addresses FDA designations to some extent, stating that CMS "do[es] not rely on FDA criteria in our evaluation of substantial clinical improvement" because CMS views FDA as an entity that primarily evaluates "the standard of safety and effectiveness" rather than "a demonstration of substantial clinical improvement (SCI) in the Medicare population."[12] The Agency specifies that SCI evaluation is based on "the totality of the circumstances" when determining whether a new medical service or technology significantly advances the diagnosis or treatment of Medicare beneficiaries compared to previously available options. CGTs, given their substantial improvement over existing technologies, should meet these criteria by way of FDA approval alone. However, as noted above, the RMAT and Breakthrough Therapy designations consider more than the typical safety and effectiveness standard, and in fact are specifically geared to whether the therapy offers more innovative options for treatment than those currently available.

It is also notable that CMS already exempts certain categories of therapies from the newness and substantial clinical improvement criteria – namely products designated as Qualified Infectious Disease Products (QIDP) or approved under the Limited Population Pathway for Antibacterial and Antifungal Drugs pathway – which are determined solely by their FDA designations. CMS does so upon the basis that the drug-resistant infections those therapies are intended to treat have a "serious impact on Medicare beneficiaries" and tend to drive additional hospital stays.[13] CGTs, in many cases, provide solutions to otherwise intractable and serious problems as noted, for example, by CMS in describing its rationale for increasing

[9] 89 Fed. Reg. at 36,022.
[10] *See* Expedited Programs for Regenerative Medicine Therapies for Serious Conditions – Guidance for Industry, FDA, February 2019, *available at*: https://www.fda.gov/media/120267/download (emphasis added).
[11] *Id*. (emphasis added).
[12] 89 Fed. Reg. at 36,024.
[13] 89 Fed. Reg. at 36,138.

NTAP amounts for CGTs that treat sickle cell disease(SCD): such treatments address a condition that "has historically had limited treatment options" and tended to drive hospitalizations and, subsequently, Medicare spending. These same concerns animate and align with the clinical solutions addressed by medicines approved by way of the RMAT and Breakthrough Therapy designation processes.

ARM Supports CMS' Proposal to No Longer Consider A "Hold" Status On An FDA Marketing Application To Be "Inactive" For Purposes Of Eligibility For NTAP And Expands Additional Opportunities for Efficiency.

As noted above, the timelines associated with the NTAP program can lead to delays and difficulties when misaligned with FDA regulatory timelines for marketing authorization approval. As the Agency highlights in the Proposed Rule (and ARM agrees), applications can be considered to be on hold by the FDA during the normal process of completing requests for additional information from the FDA, and this should not result in a delay with respect to NTAP.

ARM further observes that CMS could provide manufacturers with additional elasticity by retaining the requirement to provide evidence of an approved FDA marketing application as part of the NTAP process, but de-coupling the timing of that evidence from submission of the NTAP application. Specifically, the Agency could require manufacturers to attest that they are in the process of obtaining a timely market authorization as part of the NTAP application and then requiring submission of evidence that the marketing authorization request is complete and active within 60 days following submission (based on criteria to be specified by CMS via notice-and-comment rulemaking) of an NTAP application. For example, a manufacturer who has begun their FDA marketing application could apply for NTAP in the typical October timeframe and subsequently submit evidence of their completed FDA marketing application by early December in time for the NTAP Town Hall. Because the FDA marketing authorization requirement is not compelled by statute, CMS may make this change via the notice-and-comment rulemaking process.

The Proposal to Increase the Maximum NTAP Payment For Gene Therapies Treating Sickle Cell Disease (SCD) From 65% To 75% Of Product Costs Support A Concept Applicable To Most Advanced Therapies

Offering durable, life-changing therapy for sickle cell disease is indeed a significant accomplishment of gene therapy and ARM applauds CMS' recognition that this life-changing innovation must be coupled with a policy framework that increases access for Medicare beneficiaries. CMS also rightly notes that, in addition to improving the lives of patients, investing in therapies that reduce the need for chronic care and, especially, costly hospitalizations for SCD patients has the potential for significant long-term savings for the Medicare program.[14]

[14] 89 Fed. Reg. at 36,138.

ARM encourages CMS to apply the same supportive posture to the broader scope of advanced therapies that share characteristics with gene therapies used to treat sickle cell disease, including not only the significant up-front costs to the hospitals providing the therapies but also significant reduction in chronic care needs and costs to the Medicare program on an ongoing basis. Indications for other treatments in the CGT pipeline poised to impact Medicare beneficiaries include, but are not limited to, Parkinson's disease, systemic lupus nephritis and Type I diabetes.

As the Proposed Rule acknowledges, a hospital should not be required to sustain a potential financial loss after providing access to a life-changing treatment, but reductions in chronic care costs generally accrue not to providers but rather to the payer responsible for a beneficiary (in this case, the Medicare program itself). Lifetime costs for several sickle cell disease patients are upwards of $4-6 million.[15] The NTAP program is one pathway by which CMS can and should bridge that gap by providing adequate support for the hospitals that incur the up-front cost of purchasing and administering life-saving gene therapies. Table 2 describes the potential losses with the 75% NTAP from inpatient SCD gene therapy without taking into account any outlier payments if triggered.

Table 2. SCD Gene Therapy Reimbursement with Proposed Increase to NTAP Rate

SCD Gene Therapy (avg list price of marketed products)	**MS-DRG 016/017 FY 25 Proposed Base Reimbursement**	**FY 25 Proposed Fixed Loss Threshold**	**Proposed 75% NTAP (based on avg list price of marketed products)**	**Potential Loss Per Case (not including outlier payments)**
$2,650,000	$43,059	$49,237	$1,987,500	$656,322

In the Proposed Rule, CMS also invites comment on whether the increased NTAP for SCD therapies should be available only where an applicant meets "additional criteria, such as attesting to offering and/or participating in outcome-based pricing arrangements with purchasers […] or otherwise engaging in behaviors that promote access to these therapies at lower cost."[16] In the SCD context, the types of outcomes-based contracting arrangements CMS describes are encouraged to take place under the auspices of the Center for Medicare and Medicaid Innovation's (CMMI) CGT Access Model. Although ARM supports the goals of the CGT Access Model and agrees that outcomes-based arrangements can be appropriate in certain situations, ARM does not support a mandate that increased payments under NTAP are essentially tied to participation in the CMMI Model. ARM notes that the CMMI model is still under development and as such, many details including current and

[15] https://alliancerm.org/wp-content/uploads/2024/01/SOTI-2024-1-8-2024.pdf
[16] 89 Fed. Reg. at 36,139.

future manufacturer participation and plans for Medicaid beneficiary access following the conclusion of the demonstration period.

As an alternative, CMS could broaden eligibility criteria for the increased NTAP amounts to therapies obtaining the RMAT or Breakthrough Therapy designations. As explained above, these designations have been in place for several years, are well-understood by manufacturers, and focus on whether a therapy meets an unmet medical need or are substantially more effective than existing therapies.

With A Robust Pipeline of Cell and Gene Therapies, Thoughtful Considerations Regarding The Composition Diagnosis Related Groups Are Essential To Ensure Access

Maintain the Relative Weight Calculation for MS-DRG 018

ARM supports CMS' efforts to maintain a stable relative weight for MS-DRG 018, which is important for accurate reimbursement, promoting innovation, and ensuring timely access for Medicare beneficiaries to innovative cell therapies and genetic medicines.

ARM also supports CMS' proposed changes to the Relative Weight Calculation for MS-DRG 018, including CMS' proposed methodological changes intended to account for the effect of certain clinical trial cases on the calculation of the national average standardized cost per case. Known to be well within the Agency's knowledge base, claims for clinical trial cases do not always include the drug charges associated with a particular course of treatment and, as a result, do not capture the true cost of care incurred by providers. Additionally, stability and predictability with respect to the weighting of MS-DRG 018 is critical to ensuring continued timely access for Medicare beneficiaries.

However, as noted in our prior comments on the FY 2024 IPPS Rule, ARM continues to be concerned about CMS' use of the proxy of standardized drug charges of less than $373,000 to identify claims to be excluded. Although it is true that hospital coding for clinical trial cases may be improving over time, it also continues to be the case that a small but significant number of claims are not properly coded and have the effect of reducing the average cost for MS-DRG-018 in a way that does not accurately reflect the cost to the provider. To maintain accuracy, we seek transparency regarding the proportion of cases with drug charges below $373K that do not have a clinical trial or EA code. Publication of this information allows stakeholders to determine how inclusion of those cases affect MS-DRG 018 base payments.

Use of Outlier Payments Should Be Reserved for Unexpected Scenarios on Limited Basis

Outlier payments are made to hospitals on top of base reimbursement rates for cases that have extraordinarily high costs above the fixed-loss threshold. While CMS considers several factors in calculating outlier payments, including operating

and capital costs, outlier payments do not and are not intended to make a hospital whole for their outstanding inpatient care costs on a regular basis. Although outlier payments may be available to individual hospitals in the case that the cost of treating a particular case is unusually high, ARM encourages CMS, and hospitals, not to rely on the availability of outlier payments as the sole strategy to address the financial costs to hospitals for acquiring therapies that are administered under MS-DRG 018. First, outlier payments generally fall short of making a hospital whole for the cost of acquiring a treatment, let alone the patient care costs. Second, in the experience of our members, outlier payments are triggered disproportionately in the case of MS-DRG 018 – this stresses the importance of a stable relative weight collection for MS-DRG 018 that leads to a payment commensurate with the cost of providing the therapy in most instances. However, we recognize that outlier payments are vital to hospitals under the current system. As such, we are concerned with CMS' proposal to increase the fixed-loss threshold for FY 2025 to $49,237.

ARM Supports Maintaining the Title of MS-DRG 018 as "Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies."

ARM supports CMS' decision not to revise the title of the Pre-MDC MS-DRG 018. As CMS notes in the Proposed Rule, this MS-DRG "is intended to include other immunotherapies and is not restricted to CAR T-cell and autologous gene and cell therapies." More generally, ARM observes that this category of therapies continues to evolve and it is important to retain flexibility as new therapies are approved. As noted above, at the same time, it is critical for CMS to provide transparency regarding how MS-DRG assignments are made.

As The Pipeline Diversifies, ARM Seeks To Avoid Distortion In Medicare Reimbursement Through The Bundled Payment System By Suggesting Approaches To Restructure DRGs To Accommodate The Variety Of Therapies Set To Come To Market

ARM continues to believe that a stable, sufficient relative weight for MS-DRG-018 is important to encourage innovation and reduce the risk of losses to providers. When assessing the addition of new therapies to MS-DRG 018, CMS must evaluate clinical similarity and resource intensity compared to therapies currently within MS-DRG-018. Therapies currently mapped to and reimbursed under MS-DRG 018 are highly personalized treatments with comparable resource-intensive manufacturing and treatment processes. Overall, we support increased transparency in how the Agency applies the clinical similarity, treatment complexity, and resource use criteria when assigning therapies to DRG 018.

The adequacy of MS-DRG-018 may be compromised if new therapies are added with significantly lower resource intensity than existing treatments. This unintended consequence would heighten existing barriers to access for Medicare beneficiaries, including the increasing costs incurred by providers in making these innovative therapies available. As more novel therapies reach commercialization,

we recognize that not all manufacturers will be technically eligible for or chose to apply for the NTAP program, however the Agency should maintain incentives in the MS-DRG system to support the future of medicine and Medicare beneficiary access. ARM is happy to be a resource to CMS in considering how to modernize the MS-DRG system to meet the unique needs of cell and gene therapies.

Proposed Request for Information on Hospital Reimbursement Adequacy for Cell and Gene Therapies

As mentioned, commercialization of the substantial pipeline of CGTs requires continued stability and predictability in the way that CGTs are assigned to MS-DRGs and the relative weight of the MS-DRGs to which they are assigned. ARM continues to advocate that the Agency be flexible in establishing reimbursement policies that result in accurate payment, promote innovation, and ensure timely access for Medicare beneficiaries. ARM believes that the current construct of MS-DRG 018 protects the stability of the relative weight and appreciates the Agency's historic statements that it will continue to evaluate "the creation and assignment of multiple MS–DRGs for cell and gene therapy cases: One to cover patient care costs, the other to cover product costs across therapeutic product categories." However, as more therapies come to market, ARM urges CMS to further detail the circumstances under which it will create additional MS-DRGs for cell and gene therapies. Clinical similarity, treatment complexity, resource use amongst other publicly available considerations should inform DRG assignment to ensure CMS understands that we are not advocating for a single CGT DRG. ARM believes that this information will provide transparency and predictability to manufacturers supporting their commercialization efforts in the inpatient site of care. In doing so, CMS will hopefully maintain the goal of ensuring a stable and accurate provider reimbursement and therefore, patient access to all novel therapies. ARM further recommends that the agency collect information from the public to inform the agency's decision-making process in this area.

Inquiries the Agency may consider in a request for information (RFI) might include: 1) What considerations the Agency should review in their assessment of additional MS-DRGs? 2) Are there concerns that the stability of relative weights post-NTAP do reflect the average cost of therapy? 3) Should CMS consider a gene therapy specific MS-DRG? 4) What information is needed to consider extending the NTAP time frame beyond 2-3 years?

To establish this public engagement opportunity, ARM encourages CMS to submit a notice of request for information to the Office of Management and Budget either independently of or as an addendum to a future proposed Inpatient Prospective Payment System rule to solicit or establish best practices in the development of a reimbursement framework that enhances access to the administration of CGTs. This solicitation of public comment, pursuant to 5 C.F.R. § 1320.3(h)(4), is generally exempt and thus would remain in accordance with the implementing regulations of the Paperwork Reduction Act of 1995.

Differences In Medicare Reimbursement Methodology for the Inpatient Versus Outpatient Setting Can Sometimes Result in Uncertainty

It is important to recognize that, in the case of the types of therapies assigned to MS-DRG 018, the possibility for outpatient administration continues to increase. Understandably, payment rates can have a significant impact on innovation, including investment in new CGTs. ARM believes that patient site of administration for CGTs, to the extent possible, should be dictated by clinical discretion rather than the applicable payment methodology. For that reason, ARM urges CMS to study the possibility of divergence of payment rates for inpatient and outpatient therapies over time. Indeed, in other contexts CMS has generally hewed to a principle of site neutrality – that same principle should inform CMS' approach to CGTs, and CMS should take care that, as more CGTs are offered in an outpatient setting, therapies that are administered in an inpatient setting are not systematically disadvantaged with respect to payments over time.

Conclusion

The field of regenerative medicine has the potential to provide meaningful and life-changing health benefits to Medicare beneficiaries while also bending the health care cost curve downwards. This trend is already evidenced by several approved and marketed first-generation regenerative medicine products that are demonstrating both clinical and fiscal benefits. Accordingly, advanced therapies substantially reduce overall healthcare expenses by reducing hospital care, the need for ongoing physician, clinical and professional services, nursing, and home healthcare. To maintain this momentum, it is imperative that CMS policies recognize the durable value that regenerative medicines provide and encourage their further adoption through stability, transparency and predictability.

ARM thanks CMS for its proposals and looks forward to working with the Agency to establish policies that promote appropriate access to regenerative medicine therapies in both the near- and long-term. We would welcome the opportunity to meet with Agency staff to discuss our recommendations and provide any additional clarification or data. Please direct all correspondence to Monet Stanford at mstanford@alliancerm.org.

Sincerely,

Erica Cischke, MPH

Vice President, Government Relations

Appendix – Assessment of Anticipated Cell and Gene Therapies

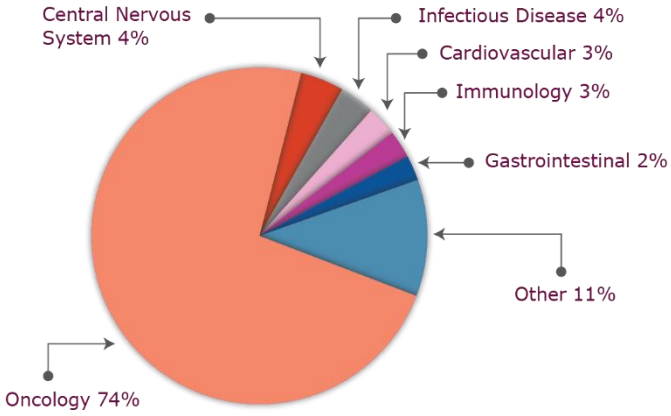
Commonly explored cell therapy indications (Q4 2023)

Indication	# Of Trials
Diffuse large B-cell lymphoma	161
Various solid tumors	157
Non-Hodgkin lymphoma	145
Acute Lymphocytic leukemia	126
Follicular lymphoma	120
B-cell non-Hodgkin lymphoma	104
Multiple myeloma	103
Acute myelocytic leukemia	103
Primary mediastinal B-cell lymphoma	90
B-cell acute lymphocytic leukemia	85

2024 Cell Therapy Landscape for Ongoing Trials

Therapy	Indication	Original lines of treatment authorized	Revised lines of treatment authorized
Abecma (Bristol Myers-Squibb & 2seventybio)	Multiple myeloma	5th line treatment (2021)	Decision date for 3rd line treatment pending
Carvykti (Legend Biotech & Janseen)	Multiple myeloma	5th line treatment (2022)	April 5, 2024, decision date for 2nd line use authorization
Breyanzi (Bristol Myers-Squibb)	Large B-cell lymphoma	3rd line treatment (2021)	2nd line treatment (2022)
Yescarta (Kite, A Gilead Company)	Large B-cell lymphoma	3rd line treatment (2017)	2nd line treatment (2022)

Clinical focus



Cell type used