PERSONALIZED MEDICINE COALITION

June 10, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1808-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare and Medicaid Programs 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, etc (CMS-1808-P)

Dear Administrator Brooks-LaSure:

The Personalized Medicine Coalition (PMC), a multi-stakeholder group established 20 years ago and comprising more than 200 institutions from across the health care spectrum to promote the understanding and adoption of personalized medicine concepts, services, and products for the benefit of patients and the health care system, thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to submit comments on the *Medicare Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule for FY 2025*.[i] As you may recall, in our comment letter on CMS' *IPPS Proposed Rule for FY 2021*, PMC supported the establishment of a new Medicare Severity-Diagnosis Related Group (MS-DRG) for chimeric antigen receptor (CAR) T-cell therapies as a way to accelerate access to these potentially life-saving personalized treatments.[ii] We believe the thoughtful continuation of MS-DRG 018 as outlined in CMS' proposed rule for FY 2025 will yield significant benefits for patients, providers, and hospitals, and we applaud CMS for taking this approach. PMC remains concerned, however, that the documentation requirements and timeline changes CMS finalized for New Technology Add-On Payment (NTAP) applications in FY 2024 could reduce patient access to new and innovative medical technologies like CAR T-cell therapies. While PMC recognizes there are numerous important payment issues addressed in the *IPPS Proposed Rule for FY 2025*, our comments are limited to the impact of specific proposed policy changes on beneficiary access to CAR T-cell therapies and other transformative personalized medicine technologies forthcoming in cancer, rare, and other diseases.

PMC defines personalized medicine as an evolving field in which physicians use diagnostic tests to determine which medical treatments will work best for each patient or use medical interventions to alter molecular mechanisms that impact health. By combining data from diagnostic tests with an individual's medical history, circumstances, and values, health care providers can develop targeted treatment and prevention plans with their patients.

Personalized medicine is helping to shift the patient and provider experiences away from trial-and-error toward a more streamlined process for making clinical decisions, which will lead to improved patient outcomes, a reduction in unnecessary treatment costs, and better patient and provider satisfaction. PMC and its members are leading the way in personalized medicine and in developing evidence showing how patients and the health care system can benefit from appropriate testing and tailored treatment as soon as possible during their clinical experiences.

CAR T-cell therapy represents a significant advancement in personalized medicine. Some cancer patients with very poor prognoses have experienced life-improving and life-extending outcomes resulting from CAR T-cell therapy. The CAR T-cell therapies already on the market have had a profound impact on the lives of patients with certain forms of lymphoma, leukemia, and multiple myeloma. Dr. Carl June, the University of Pennsylvania immunologist who designed the first CAR T-cell treatment, has stated that "We can now conclude that CAR T-cells can actually cure patients" based on evidence that CAR T-cells are still active in patients a decade after treatment and the fact that at least two of the first-ever patients treated with CAR T-cell therapies remain free of cancer.[iii] With CAR T-cell therapies being tested in hundreds of clinical trials, results like these — as well as the promise of other cell and gene therapies, including the two gene therapies recently approved by the FDA to treat patients with sickle cell disease — provide hope for many patients with cancer and other hard-to-treat diseases.

Statement of Neutrality

Many of PMC's members will present their own responses to the *Medicare IPPS Proposed Rule for FY 2025* and will actively advocate for those positions. PMC's comments are designed to provide feedback so that the general concept of personalized medicine can advance, and are not intended to impact adversely the ability of individual PMC members, alone or in combination, to pursue separate comments with respect to the proposed rule.

Considerations for CMS in Finalizing Proposed Rule

CAR T-Cell Therapies Under MS-DRG 018

PMC appreciates that CMS' *IPPS Proposed Rule for FY 2025* takes a similar overall approach to policies adopted for MS-DRG 018 in previous years, when policies have supported greater patient access to CAR T-cell therapy. The FY 2025 proposed rule sustains a base payment rate that is the highest of the MS-DRGs now in place, demonstrating the agency's commitment to maintaining access to CAR T-cell therapies. The rule also continues differential reimbursement based on whether the treatment was provided as part of a clinical trial or an expanded access use case where hospitals do not incur a drug cost, and we request CMS monitor the impact on rate-setting from relying solely on coding to identify these cases and no longer using the low-cost threshold. Overall, we believe the FY 2025 proposal is largely responsive to PMC's previous requests for a permanent reimbursement solution for CAR T-cell therapy that is formulated in a manner reflecting the true expenses associated with patient care.[iv]

We remain concerned, however, about the long-term viability of MS-DRG 018 as more novel products enter the market. As CMS has noted, MS-DRG 018 currently has assigned a wide variety of technologies with varying resource intensities. If CMS were to assign new, higher volume, lower cost therapies to

MS-DRG 018, it could potentially distort the relative weight of the MS-DRG and under-reimburse CAR T-cell therapies. We appreciate and share the agency's ongoing interest in developing a sustainable mechanism to accommodate the expanding portfolio of transformative therapies for which providers will need adequate reimbursement. Since CMS' FY 2022 policy that expanded MS-DRG 018 to include certain other immunotherapies, we have cautioned that the inclusion of additional procedure codes associated with other therapies could lead to reductions in the base rate for MS-DRG 018 over time and lead to under-reimbursement for CAR T-cell therapies.[v] We again encourage CMS to clarify its methodology for the inclusion of new procedure codes within MS-DRG 018. We also ask CMS to maintain the stability of the MS-DRG for CAR T-cell therapies by continuing to assess the appropriateness of therapies that may be assigned to MS-DRG 018. Specifically, CMS should ensure similarity of clinical use, treatment complexity, and resource utilization of a therapy for potential assignment to MS-DRG 018 to demonstrate alignment with therapies currently assigned to the MS-DRG, including CAR T-cell therapies. Maintaining the integrity of MS-DRG 018 will ensure that the cost and resource needs of potential new additions to MS-DRG 018 do not harm access to current therapies.

New Technology Add-on Payment (NTAP) Applications

New Technology Add-on Payment (NTAP)s encourage hospitals to adopt breakthrough technologies by helping them recover some of the increased costs associated with offering innovative treatments to patients. In our comments to CMS on previous IPPS proposed rules, PMC has asked CMS to grant NTAP status to CAR T-cell therapies and consider how new CAR T-cell therapies in the research and development pipeline differ from the CAR T-cell treatments now available, with differences relating to the uniqueness of patient populations, disease areas treated, specific antigen targets, and other differences in the therapies themselves. NTAP status provides another way CMS can remove a potential barrier to CAR-T cell therapy access when considering these differences. While there are currently no CAR T-cell therapies with NTAP applications, we understand that several applications for NTAP status included in the FY 2025 proposed rule related to personalized medicine include new gene therapies to treat sickle cell disease and transfusion-dependent beta-thalassemia and a cell-based immunotherapy for adult patients with unresectable or metastatic melanoma. We encourage CMS to assign NTAP status for new treatments and technologies supporting personalized medicine that meet the required criteria, including the applications under consideration for AMTAGVI™ (lifileucel), CASGEVY™ [exagamglogene autotemcel (exa-cel)], and LYFGENIA™ [lovotibeglogene autotemcel (lovo-cel)]. Doing so will remove a potential barrier to accessing innovative treatments and tools advancing this approach to care.

In addition, PMC supports CMS' proposal to increase the maximum NTAP payment percentage for certain gene therapies treating sickle cell disease to 75 percent. We share CMS' concerns that the potential for hospitals to incur a significant financial loss due to insufficient new technology add-on payment could prevent hospitals from offering gene therapies for sickle cell disease to patients. This same concern, however, applies more broadly to all cell and gene therapies. There are over 700 cell and gene therapies in development,[vi] and these therapies present tremendous opportunities for patients who have historically had limited treatment options available to them. Similar to gene therapies for sickle cell disease, cell and gene therapies are often indicated for conditions that disproportionately affect patients with unmet medical needs and patients from underserved communities. By making long-lasting changes to the genetic make-up of patients' cells, cell and gene therapies can reverse the root causes of certain cancers and rare diseases with just one or a few treatments. These therapies often represent wholly new treatments for which there are no comparable, historical claims data under the IPPS. NTAP is needed

to encourage hospitals to offer them to patients. Therefore, we also encourage CMS to extend eligibility for this higher NTAP payment to all novel cell and gene therapies.

PMC appreciates CMS' efforts to facilitate patient access to new cell and gene therapies under both the Medicare program, through the FY 25 IPPS, and under the Medicaid program, such as through the CMS Innovation Center's recently announced Cell and Gene Therapy Access Model. We remain concerned, however, that certain changes proposed to the Medicaid Drug Rebate Program are misaligned with CMS' broader efforts to support clinical adoption of cell and gene therapies, including a proposal that would broaden the definition of rebate-eligible "covered outpatient drugs" to include cell and gene therapies administered in an inpatient setting.[vii] Expanding manufacturers' rebate liabilities under the Medicaid drug rebate program to include innovative cell and gene therapies could disincentivize investment in this promising space and discourage the adoption of value-based agreements facilitating patient access to these novel cell and gene therapies, including those that would be eligible for NTAP under Medicare.[viii] Therefore, we continue to urge CMS to withdraw its proposed rule for *Misclassification of Drugs, Program Administration and Program Integrity Updates Under the Medicaid Drug Rebate Program*.

NTAP Timeline and Documentation Requirements

Since providers rely on NTAPs to be able to provide access to new and innovative treatments and technologies, the timeline and documentation changes for NTAP that CMS finalized in FY 2024 could have significant implications for the availability and duration of add-on payments, reduce the number of technologies eligible for three full years of NTAP status, and thus impede patient access to innovative treatments. PMC continues to urge CMS to reconsider these timeline and documentation changes.

Currently, NTAP status lasts three years if the three-year anniversary date of Food and Drug Administration (FDA) approval is in the second half of the fiscal year (i.e., after April 1); otherwise, the duration is only two years. In FY 2024, CMS moved the FDA approval deadline for NTAP eligibility up by two months, from July 1 to May 1, effectively reducing the number of technologies eligible for three full years of NTAP status. We appreciate that in response to concerns shared by stakeholders, CMS is proposing an improvement in FY 2025 that would allow for NTAP eligibility if the three-year anniversary of the newness date falls after October 1, broadening the window in which products are deemed to still be in their newness period. Although this will make it more likely that a product will receive NTAP for three years, it still does not ensure that most products will receive three years of NTAP payment. To maximize patient access to future CAR T-cell therapies and other important technologies advancing personalized medicine, we urge CMS to go further by allowing all NTAP products to receive three years of NTAP status.

Shifting the deadline for FDA approval from July 1 to May 1 has also resulted in more products having to be on the market longer before NTAP payments begin, reducing the timeliness of reimbursement adequacy. Under the current timeline for NTAP, there is roughly a one-year lag between the initial October deadline for an NTAP application and the initiation of the add-on payment. For example, a product launching on May 2 would not receive an NTAP until October of the following year, creating reimbursement uncertainty for providers over an extended period with potential negative effects on the product's uptake.[ix] In our FY 24 comments on this change, PMC encouraged CMS to maintain its previous timeline,[x] and we recommended that CMS increase the number of NTAP submission periods to align more closely with FDA marketing authorization to ensure that a lack of associated NTAP is not a

barrier to patient access when newly approved innovative technologies receive FDA approval.

In addition, CMS finalized changes in FY 2024 that require an NTAP applicant to have a "complete and active" FDA market authorization request at the time the NTAP application is submitted. Because this "complete and active" criterion was not defined elsewhere in statute, PMC's FY 2024 comments encouraged CMS to be flexible in applying this new criterion in order to accommodate drugs, devices, and diagnostics eligible for NTAP across different application types and regulatory approval pathways at FDA where approval timelines and processes may differ, such as through rolling review, accelerated approval, or the real-time oncology review (RTOR) program. In FY 2025, CMS is proposing to allow applications in a hold status at the time of NTAP application submission to be eligible for NTAP, starting with the FY 2026 cycle. While this flexibility is an improvement, it applies mainly to devices and does not fully address challenges with CMS' new requirements for a "complete and active" FDA market authorization request. We encourage CMS to further clarify this language to ensure the gamut of personalized medicine treatments and technologies remain eligible for NTAP and reach patients who need them, without creating further delays in the availability of NTAP status.

Low-Volume, High-Cost Rare Disease Treatments

In our FY 2023 and FY 2024 comment letters, PMC applauded the agency for including a request for information in its FY 2023 proposed rule calling attention to the special challenges of reimbursement adequacy often faced by low-volume, high-cost rare disease treatments when delivered in the hospital inpatient setting with MS-DRG reimbursement rates based on averages.[xi] We were hopeful that CMS' request for information was an initial step toward addressing these challenges but it has been two years since CMS' request for information and the agency has yet to propose a solution in rulemaking. In 2023, 61 percent of new personalized medicines approved by the FDA were to treat rare diseases.[xii] The increasing number of personalized medicine approvals for rare diseases makes this a growing imperative for our community. We believe it is important for stakeholders to provide feedback to CMS on potential solutions for improving reimbursement adequacy under the MS-DRG system. We continue to urge CMS to propose in rulemaking as soon as possible a meaningful solution for adequately reimbursing and reducing payment disparities for innovative rare disease treatments that can be critical to patients with few or no alternative treatment options.

Health Equity and Social Determinants of Health (SDOH)

PMC commends CMS' commitment in the FY 2025 proposed rule to advancing health equity-related measures and to expanding the collection, reporting, and analysis of standardized health equity data, such as data on SDOH, as part of the *CMS Framework for Health Equity 2022-2032*.[xiii] In 2024, PMC published recommendations for improving the collection and use of inclusive health data in research informing personalized medicine that were developed in collaboration with leaders from communities historically underrepresented in biomedical research.[xiv] One priority recommendation included modifying and improving systems to capture and share data on SDOH in electronic health records (EHRs). We appreciate CMS' willingness to solicit feedback in this proposed rule on how it can further foster the documentation and reporting of the diagnosis codes describing social and economic circumstances to improve the reliability and validity of data supporting efforts to advance health equity. We also appreciate CMS' proposal to change the severity level designation for the SDOH diagnosis codes describing inadequate housing and housing instability from non-complication or comorbidity (NonCC) to

complication or comorbidity (CC) in FY 2025. Strengthening SDOH information collected by providers such as hospitals and physicians who typically have in-person encounters with patients for inclusion in EHRs can ensure that the unique circumstances of participants from underrepresented communities are accounted for. As the agency considers opportunities for advancing health equity in future rulemaking, CMS should prioritize the perspectives of patients and providers from diverse backgrounds and underserved communities to facilitate a greater understanding of how CMS can ultimately support robust and equitable patient access to CAR T-cell therapies and other transformative personalized medicine treatments or technologies.

Conclusion

Thank you for your commitment to ensuring that beneficiaries have access to transformative therapies. We look forward to working with you and your colleagues at CMS to protect patient access to CAR T-cell therapy and continue fostering innovation in this and related therapeutic areas for patients with unmet needs. If you have any questions about the content of this letter, please contact me at 202-499-0986 or cbens@personalizedmedicinecoalition.org, or David Davenport, PMC's Manager of Public and Science Policy, at ddavenport@personalizedmedicinecoalition.org or 804-291-8572.

Sincerely,

Cynthia A. Bens
Senior Vice President, Public Policy

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[i] Centers for Medicare & Medicaid Services. *Medicare and Medicaid Programs 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 Policy Changes (CMS-1808-P).* May 2, 2024. https://www.federalregister.gov/d/2024-07567. (Accessed May 28, 2024.)

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https://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/PMC_Comments_CAR-T_MSDRG_IPPS_FY_2022.pdf. (Accessed May 28, 2024.)

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