March 15, 2019

Tamara Syrek Jensen
Director, Coverage and Analysis Group
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Proposed Decision Memo for the National Coverage Analysis (NCA) for Chimeric Antigen Receptor (CAR) T-cell Therapy for Cancers (CAG-00451N)

Dear Ms. Syrek Jensen,

On behalf of the National Marrow Donor Program® (NMDP)/Be The Match®, we thank you for the opportunity to provide our comments on the Centers for Medicare and Medicaid Services' (CMS) Proposed Decision Memo for Chimeric Antigen Receptor (CAR) T-cell Therapy for Cancers.

For the thousands of Americans diagnosed every year with life-threatening blood cancers like leukemia and lymphoma, a cure exists. NMDP manages the largest and most diverse marrow registry in the world through a competitively-bid contract with the Health Resources and Services Administration (HRSA). Each year, the Congress appropriates funds to operate this federal program, which is designated by the Congress as the C.W. Bill Young Cell Transplantation Program (Program). Since the mid-1980s, Congress has reauthorized the Program with virtually unanimous support. Through a public-private partnership, we not only manage a registry of 19 million U.S. volunteers and more than 249,000 cord blood units available for donation, but we also ensure that patients have access to cellular therapies that are potentially curative. Our goal is to ensure that every patient gets the cell therapy that they need when they need it.

In our comments submitted jointly with the American Society for Transplantation and Cellular Therapy (ASTCT), formerly the American Society for Blood and Marrow Transplantation (ASBMT), and the American Society of Hematology (ASH), we strongly opposed a National Coverage Determination (NCD) as we believe that it will cause significant and ongoing barriers to providing current and future CAR T-cell therapies. Patients falling within the indications for current CAR-T therapies represent an especially compelling case for individual, patient-directed decisions within the patient-physician relationship. CAR T-cell therapy is groundbreaking. The currently approved products exist in a class of their own: they are personalized therapies for a group of patients that have no other potentially curative options. Patients that otherwise might have died now have the hope of being cured of their cancer. Because of the nature of this therapy, both in its innovative approach to fighting cancer for patients who otherwise would have no alternatives and the rapidly evolving understanding of the most appropriate timing of therapy, NMDP believes that an NCD is premature to implement at this time until further data and studies are done in this rapidly changing field of medicine.

However, if CMS decides to issue an NCD, NMDP strongly urges CMS to eliminate the coverage with evidence development (CED) study requirement and instead implement an NCD

with a registry reporting requirement. We believe the Center for International Blood and Marrow Transplantation Research (CIBMTR) is best-positioned to serve as the CMS approved data-collection registry.

Please consider the following comments that outline our suggestions on how to improve this proposed decision memo to limit any negative impacts on patient access and innovation should CMS decide to proceed. There are also many aspects of this policy that require further clarification that must be provided before this policy is finalized in order to minimize any disruptions to patient care.

Current Patient Access to Coverage

We are concerned that changes in how CMS is covering CAR T-cell therapy could negatively impact Medicare beneficiaries who are currently in the process of being treated with CAR-T, whether already infused or just starting the lymphodepleted regimen and/or awaiting receipt of the manufactured product for infusion. The decision in the final memo should make accommodations to not exclude coverage for those patients whose cells were collected before the effective date.

CMS should cover FDA-approved CAR T-cell therapies for labeled indications

The draft decision memo proposes to cover CAR T-cell therapies that are delivered in a way that meets the label requirements of the two currently FDA approved therapies. Because cell therapy is a fast-growing field with many types of new and emerging therapies in the pipeline for approval, we suggest that the requirements for coverage should be for medically accepted, FDA approved, cellular therapies for on-label uses (rather than explicitly for relapsed and refractory cancer), and compendia-supported uses for off-label usage. This provides the most flexibility for emerging therapies while reducing the need to re-open this decision each time a new CAR T-cell therapy or a new indication is approved by the FDA.

For example, in this memo, CMS proposes to cover therapies for patients with relapsed or refractory cancer, but there could be an approved therapy that is labeled for cancers in first remission, which the current proposal would not address. Furthermore, the draft decision memo specifies coverage for autologous treatment only. Allogeneic products are currently in development and CMS should not limit coverage by indication or disease stage, rather by FDA-approval status. As such, NMDP recommends removing the language in the decision memo specifying “autologous” and “relapsed or refractory cancer” and instead indicate coverage for labeled indications for FDA-approved CAR T-cell therapies. This will give the NCD the flexibility necessary to adapt to a rapidly changing field without the need for repeated NCDs.

Registry and CED Requirement Considerations

Since CAR T-cell therapy is already closely monitored through FDA-required post-marketing safety studies by the manufacturers, NMDP believes that issuing a CED for this therapy creates a barrier for patients and presents an additional burden to treatment centers. Currently, the insufficient Medicare inpatient reimbursement is creating challenges for treatment centers as they determine whether they can withstand the significant financial losses associated with delivering CAR T-cell therapy to Medicare beneficiaries. We understand CMS’ desire to closely track this type of therapy as it represents a novel way of treating hematological malignancies, and long-term effects are currently unknown. However, we believe that questions about long-term outcomes will be adequately answered with data that is currently being collected by

CIBMTR. We would urge CMS to rely on the data currently collected on outcomes for patients receiving these therapies, rather than implementing a CED study that would create duplicative efforts by providers but would not generate different data than is already being tracked. NMDP believes that CIBMTR is well equipped to be listed as the approved registry in the final NCD and doing so will reduce administrative burden on hospitals and providers.

CIBMTR has the existing infrastructure, experience, and proven track record in data collection for CAR T-cell therapies. It has decades of experience collecting clinical outcomes data and, more recently, has collected PRO data on select patient populations. CIBMTR is currently serving as the data registry for the post-marketing safety studies being conducted by manufacturers of the existing FDA-approved CAR T-cell therapies, Kymriah® and Yescarta®. These studies require 15 years of follow-up after product administration to assess long-term safety. These data, with identification of patients covered by Medicare, could be made available to CMS on a regular basis without increasing the data reporting burden of centers.

CIBMTR currently administers five studies under the CMS's CED mechanism for myelodysplastic syndrome, myelofibrosis, multiple myeloma and two sickle cell disease studies. Consequently, CIBMTR has experience over nearly a decade developing, administering and reporting on studies that meet CED requirements using its infrastructure and analytic capabilities. Additionally, CAR T-cell therapy is generally being provided by FACT-approved hematopoietic cell transplant (HCT) programs, which are required by law to report data on allogeneic HCT to CIBMTR, and are therefore familiar with its processes.

If CMS does finalize the decision to use the CED mechanism for CAR T-cell therapy at the end of the NCA process, we are concerned that the additional administrative requirements, including additional patient consent requirements, will place a burden on treatment centers and could result in some centers opting-out of providing this important therapy to patients.

Collecting Patient Reported Outcomes (PRO) data

We are concerned that a mandatory requirement for collection of PRO data for patients treated in the outpatient setting will be a barrier for both patients and centers. We strongly believe that Medicare beneficiaries who wish to be excluded from reporting PRO information should not be excluded from receiving treatment for their disease. We also support CIBMTR's contention that participation in PRO studies be voluntary to ensure the scientific validity of those studies, which require committed and motivated participants. If patients feel coerced to participate, they may not supply accurate or complete data.

If PRO are required in the final NCD, the NMDP also recommends that CMS utilize CIBMTR as the organization to collect these data. However, we recommend that CMS allows additional time for development of PRO data collection processes, as these are not part of routine data collection or the post-marketing safety studies. Although CIBMTR has experience in collecting PRO data, development of a protocol will take significant time, including time for appropriate Institutional Review Board oversight at all participating centers.

Conclusion

NMDP appreciates the opportunity to provide comments on the proposed decision memo and looks forward to continued collaboration with CMS on the best ways to ensure access to CAR T-cell therapies for Medicare beneficiaries. We welcome the opportunity for discussion with the Agency on these important issues that impact patient access to life-saving care. If you have any

questions, please free to contact me with any questions at blindber@nmdp.org or (763) 406-8566 or Susan Leppke, Director, Health and Public Policy at sleppke@nmdp.org or (763) 406-8522.

Sincerely,

Brian L. Lindberg, JD
Chief Policy Officer