



AMERICAN SOCIETY OF HEMATOLOGY

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March 15, 2019

Tamara Syrek Jensen, JD
Director, Coverage and Analysis Group
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

SUBMITTED ELECTRONICALLY VIA CMS.GOV

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

Dear Ms. Syrek Jensen:

The American Society of Hematology is pleased to offer comments on the Proposed Decision Memo for Chimeric Antigen Receptor (CAR) T-cell Therapy for Cancers.

ASH represents over 17,000 clinicians and scientists worldwide, who are committed to the study and treatment of blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as non-malignant conditions such as sickle cell anemia, thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists are pioneers in demonstrating the potential of treating various hematologic diseases and continue to be innovators in the field of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy. ASH membership is comprised of basic, translational, and clinical scientists, as well as physicians providing care to patients in diverse settings including teaching and community hospitals, as well as private practice.

ASH's members are at the forefront of CAR T-cell therapy, conducting research and providing this lifesaving treatment to patients with lymphoma and leukemia. The Society is concerned that the proposed decision memo has the potential to further limit patient access to this therapy. With this in mind, ASH's comments focus on access to care, coverage, patient and registry requirements, and the patient reported outcome (PRO) tools.

Access to Care

It is ASH's understanding that, if the decision memo is finalized as is, institutions will be able to opt out of participating in the coverage with evidence development (CED) requirement, thereby, giving institutions a legal means by which to opt out of providing CAR T-cell therapy to Medicare patients, but to continue providing it to patients with commercial insurance. Since the two commercial products were approved by the FDA, ASH has routinely heard from members regarding the significant negative financial impact on institutions of providing CAR T-cell therapy to Medicare patients due to inadequate reimbursement. Although ASH has been working closely with the American Society for Transplantation and Cellular Therapy (ASTCT) and the Centers for Medicare and Medicaid Services (CMS) to help address this problem, it remains a significant concern, and it is for this reason that ASH believes institutions may choose to opt out of participating in the CED.

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Patients receiving CAR T-cell therapy have typically exhausted all other treatment options, including chemotherapy, radiation, and stem cell transplant. Successful treatment with CAR T-cell therapy improves quality of life and increases survival for these patients. ASH has strong concerns that, as written, the proposed decision memo will narrow the already limited access to this therapy. The Society recommends that CMS eliminate the CED requirement and instead implement a National Coverage Determination (NCD) with a registry reporting requirement which will allow the agency to collect additional data on this therapy while mitigating the access concerns raised by the current policy.

Coverage

CMS proposes to cover autologous treatment with T-cells expressing at least one chimeric antigen receptor (CAR) through CED when prescribed by the treating oncologist, performed in a hospital, and all of the outlined requirements are met. ASH recommends revising “autologous” to “FDA approved,” thereby removing the tie to cell source. Kymriah® and Yescarta®, the two approved CARs, are the first therapies of their kind to be approved; however, there are numerous CARs currently under development that employ a different method of action. Because ASH recognizes that CMS prefers not to reopen its NCDs on a regular basis, this recommended change will provide a pathway to coverage for therapies ASH expects to be approved in next five years.

Patient Requirements

The patient requirements as proposed by CMS require a patient to have “relapsed or refractory cancer.” ASH recommends CMS change this to cover patients with “FDA label indications.” Although the two currently approved FDA products are approved for individuals with relapsed and refractory cancers, current clinical trials are underway to employ these constructs earlier in the disease process.^{1,2} Furthermore, the decision memo already recognizes treatment according to “FDA indication.” Section 3.a reads, “Treatment is an FDA-approved biological, providing targeted therapy for a known antigen expressed in the patient’s cancer according to an FDA indication in a hospital.”

Registry Requirements

If CMS proceeds with the CED despite our concerns, ASH requests that the Center for International Blood and Marrow Transplant Research (CIBMTR) be listed in the final NCD as a qualified registry. CIBMTR already collaborates with both Kite/Gilead and Novartis to track long-term outcomes of patients treated with CAR T-cell therapy; consequently, institutions currently providing CAR T-cell therapy, already report data to CIBMTR. Based on this and CIBMTR’s additional experience in the hematopoietic cell transplantation (HCT) and cellular therapy space, they are an ideal candidate to be a qualified registry for the CED. ASH recommends that CIBMTR be listed as an approved registry on the effective date of the coverage policy, if possible.

Additionally, ASH requests that CMS clarify section 3.a.iii, which states that “The furnishing hospital shall address the CED questions on all registry patients by tracking the following clinical data elements at baseline, at treatment, and at follow-up 3 months, 6 months, 12 months, and 24 months after the treatment is administered.” If CMS intended for hospitals to collect and analyze the data, then ASH respectfully recommends that CMS reword this provision so that it is clear that the responsibility for the data collection and analysis is with the registry. Our members are very concerned that if centers can opt out of the data collection requirement, that hospitals will opt out of providing CAR-T therapy to Medicare beneficiaries. This would exacerbate the existing patient access problems. Once adequate data are collected, validating the real-world effectiveness of these treatments, this CED should quickly evolve into a standardized coverage policy that ensures that Medicare beneficiaries get timely and unfettered access to evidence-based treatments.

Furthermore, in order to collect robust, complete data, ASH asks that race and ethnicity be added to the requirements for data collection.

Patient Reported Outcomes

¹ ZUMA-7: A phase 3 randomized trial of axicabtagene ciloleucel (Axi-Cel) versus standard-of-care (SOC) therapy in patients with relapsed/refractory diffuse large B cell lymphoma (R/R DLBCL).

² Long-Term Follow-up of CD19 CAR Therapy in Acute Lymphoblastic Leukemia

For collecting and analyzing patient reported outcomes (PROs), ASH recommends that CMS work closely with CIBMTR to implement a system that is least burdensome for providers and patients. ASH members recognize the importance of collecting and analyzing PROs; however, they have also noted the additional burden this places on the provider and the added difficulty in this particular patient population, due to high rates of adverse events. Additionally, developing the necessary infrastructure and protocols, all of which have to be approved by Institutional Review Boards (IRBs) of all participating centers, to collect PROs, will take time. Therefore, ASH recommends that CMS allow for additional time for this process while allowing patients to enroll on CED studies to evaluate clinical outcomes.

Additional Concerns

ASH wants to ensure that patients who have already begun the process of CAR-T therapy prior to the final proposed decision memo will not have a delay in care, and that patients not be denied appropriate life-saving care while an acceptable data collection trial is undergoing CMS selection, IRB approval, and widespread national deployment. For example, CMS must clarify how coverage will or will not be applied to patients who already underwent leukapheresis but have not yet been infused. The agency should implement this policy in a manner consistent with providing coverage.

Thank you for the opportunity to provide comments on the Proposed Decision Memo for Chimeric Antigen Receptor (CAR) T-cell Therapy for Cancers. We welcome the opportunity to discuss these comments with you and your team. If you have any questions or require further clarification, please contact Leslie Brady, ASH Policy and Practice Manager at lbrady@hematology.org or 202-292-0264.

Sincerely,

A handwritten signature in cursive script that reads "Martha Liggett".

Martha Liggett, Esq.
Executive Director