March 17, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Tamar Syrek Jensen
Director
Evidence and Analysis Group
Center for Clinical Standards and Quality
Centers for Medicare and Medicaid Services
7500 Security Boulevard
S3-02-01
Baltimore, MD 21244

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

Dear Administrator Verma and Ms. Jensen,

On behalf of the Cancer Support Community (CSC), we appreciate the opportunity to provide comments on the proposed decision memo for chimeric antigen receptor (CAR) T-cell therapy for cancers. CSC is the largest provider of social and emotional support services for people impacted by cancer, and the largest nonprofit employer of psychosocial oncology professionals in the United States. As such, CSC has a unique understanding of the cancer patient experience. Overall, we deliver more than $50 million in free, personalized services each year to individuals and families affected by cancer nationwide and internationally. We are grateful to CMS for recognizing the importance of CAR T-cell therapies in the lives of cancer patients. We also welcome the opportunity to provide these comments and raise inquiries regarding the potential impact on patients of the National Coverage Analysis (NCA).

The Centers for Medicare and Medicaid Services (CMS) has proposed to cover autologous treatment with T-cells expressing at least one chimeric antigen receptor (CAR) through coverage with evidence development (CED) when prescribed by the treating oncologist, performed in a hospital, and a host of requirements are met. Our comments below reflect our commitment to advocacy to help ensure that patients have access to affordable, high-quality, comprehensive cancer care that reflects a shared decision making process between the patient, their support network, and their oncology care team. We believe this NCA must incorporate flexibility in order to prioritize patients and ensure access to timely, appropriate treatments.

Background

CAR T-cell therapies are one way to use the body's natural defenses to fight cancer. Thus far, two CAR T-cell therapies have been approved by the U.S. Food and Drug Administration (FDA) for patients living with certain kinds of acute lymphoblastic leukemia (ALL) and large B-cell

lymphomas. Patients treated with CAR T-cell therapies typically have cancers that have relapsed, recurred, or progressed following other treatments. Patients undergoing CAR T-cell treatment are often extremely ill and may have no other options for treatment. Side effects up to and including nervous system side effects and cytokine release syndrome can be serious. We have great interest in the future of these innovative therapies, including the treatment of solid tumors and first-line therapies and ask that coverage policies do not impede patient access to future cellular therapies.

Cancer Type(s) and Stage(s)

The NCA states that the patient must have relapsed or refractory cancer and not currently been experiencing any comorbidity that would otherwise preclude patient benefit. This includes relapsed or refractory large B-cell lymphoma or relapsed or refractory B-cell precursor acute lymphoblastic leukemia. Based on current FDA indications, contraindications, and the inclusion and exclusion criteria of published articles, these comorbidities include: primary central nervous system lymphoma, Burkitt lymphoma, HIV/AIDS, active Hepatitis B or C, active uncontrolled infection, any autoimmune disease currently requiring immune suppression, and active grade 2 to 4 graft-versus-host disease.

Based on the NCA, it is unclear how CMS will address future CAR T-cell treatments for patients with other disease states and stages. CSC supports a decision that would not preclude access to the appropriate CAR T-cell therapies for current or future cancer patients. Further, how will CMS determine whether a patient has a relevant comorbidity? Will health care providers maintain autonomy within the context of a shared decision making relationship with their patient to determine if CAR T-cell therapy is the most appropriate treatment? How will exclusion based on comorbidities be determined and tracked?

Finally, repeat treatment when a patient receives more than one therapeutic dose of a specific CAR T-cell product using the same biological in the same patient is covered only when a new primary cancer diagnosis is made by the treating oncologist and the patient conditions are met. We support coverage for additional doses as covered by FDA labels or Medicare-approved compendia.

Treatment Setting

CMS states that "CAR T-cell therapy falls under the benefit categories set for in SSA § 1861(b) "inpatient hospital services" and § 1861(s)(2)(B) "hospital services." This may not be an exhaustive list of all applicable Medicare benefit categories for this item of service."

The NCA states that the treatment must be administered in a hospital that has: 1) a Cellular Therapy Program consisting of an integrated medical team that includes a Clinical Program Director, a Quality Manager, and at least one physician experienced in cellular therapy, and demonstrates that protocols, procedures, quality management, and clinical outcomes are consistent from regular interaction among all team members; 2) a designated care area that protects that patient from transmission of infectious agents and allows for appropriate patient isolation as necessary for evaluation and treatment; and 3) written guidelines when administering CAR T-cell therapy for patient communication, monitoring, and transfer to an intensive care unit.

While we recognize that current standard of care largely translates to CAR T-cell therapy administration in hospital settings, CSC wants to ensure that no barriers to safe and appropriate therapies will be in place for patients who may be treated in inpatient or outpatient settings in the future. Further, how does CMS intend to monitor compliance with these standards?

Patient Experience

CSC supports the collection of data that are meaningful to patients. We believe that it is incumbent upon the FDA, industry, academic institutions, members of the health care team, patient advocacy organizations, and other stakeholders to consistently collect robust patient feedback and patient experience data at all points along the care continuum. We agree with the Institute of Medicine (2008) that it is not possible to provide high quality cancer care without assessing psychosocial health needs (Institute of Medicine, 2008). An update to the definition of "patient experience data" in the Food and Drug Administration Reauthorization Act (FDARA) of 2017 reflects the importance of measuring the patient experience as it now incorporates not only the physical but also the psychosocial impacts of a disease or condition or related therapy or clinical investigation. As the comprehensive care conversation evolves and becomes more inclusive of the patient, it is no longer acceptable limit patient assessments to disease symptoms, treatment side effects and physical functioning.

Ideally, the data gathered will contribute to the literature based regarding the full range of experiences facing cancer patients. From the perspective of psychosocial health, these data would ideally help us provide leading edge interventions. Such interventions have been proven to improve health outcomes and survival rates including improved functional status and immune biomarkers (Andersen et al., 2007), reduced emotional distress, anxiety, depression, and health related quality of life (Faller et al., 2013), and reduced recurrence and death (Andersen et al., 2008).

While we generally support the collection of data that are meaningful to patients, we also strongly encourage CMS to consider ways to ensure that the use of CED does not impede patient access to CAR T-cell therapy. For example, can we be assured that there will be a registry prepared to collect these data on May 17, 2019? If these data are not collected in their entirety at each collection checkpoint, how might this impact patients? Will there be a bridge period for patients who are undergoing CAR T-cell therapy close to May 17, 2019?

We also support the selection of a single tool with which to collect patient reported outcomes data. As written, there would be an option between Patient Reported Outcomes Measurement Information System (PROMIS) and Patient-Reported Outcomes version of the Common Terminology Criteria for Adverse Events (PRO-CTCAE). The content and intent of these tools are very different and will produce datasets and information that will not allow for scientific comparison and will dilute the strength of data across the registry. Further, both of these tools are comprehensive, dynamic, and designed for customization. How will decisions regarding appropriate items, forms, and administration? The NCA does not address what will occur if patients do not wish to participate in CED and share their data. Will they still have an opportunity to receive coverage? If so, this would violate patient self-determination and CSC strongly urges CMS to reconsider the barrier this would create for patients in need of treatment.

Finally, as noted above, this NCA would apply only to relapsed or refractory disease, which would prevent future data collection with patients with different types and stages of disease who will be treated with CAR T-cell therapies.

In closing, we appreciate the opportunity to provide comments on this NCA. We encourage CMS to incorporate flexibility into the CED process to ensure that the goals outlined in the NCA are being met, while also being sensitive to the potential impact on patients. We strongly oppose barriers in access to timely treatment for cancer patients in need of CAR T-cell therapies. We look forward to working with CMS to ensure appropriate access to care for cancer patients. If we can serve as a resource, please do not hesitate to reach out to me at efranklin@cancersupportcommunity.org or 202.650.5369.

Sincerely,

Elizabeth Franklin, LGSW, ACSW
Executive Director, Cancer Policy Institute
Cancer Support Community Headquarters

References

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Faller H, Schuler M, Richard M, Heckl U, Weis J, and Kuffner R. (2013). Effects of psycho-oncologic interventions on emotional distress and quality of life in adult patients with cancer: systematic review and meta- analysis. *Journal of Clinical Oncology,* 31, 782-793.

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