January 13, 2023

Filed electronically via email to *MedCACpresentations@cms.hhs.gov.*

Medicare Evidence Development & Coverage Advisory Committee (MEDCAC)
Centers for Medicare & Medicaid Services (CMS)
Central Building
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Virtual Meeting of the Medicare Evidence Development and Coverage Advisory Committee; Written Comments for February 13 and February 14, 2023 Virtual Meetings

The Pharmaceutical Care Management Association (PCMA) appreciates the opportunity to provide written comments to the Centers for Medicare & Medicaid Services (CMS) regarding its upcoming public workshop on coverage with evidence development (CED) convened by the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC).[1]

PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans and operate specialty pharmacies for more than 266 million Americans with health coverage through Fortune 500 companies, health insurers, labor unions, Medicare, Medicaid, the Federal Employees Health Benefits Program, and through the exchanges established by the Affordable Care Act. Our members work closely with plans and issuers to secure lower costs for prescription drugs and achieve better health outcomes.

PCMA applauds CMS for evaluating the CED criteria to "*assure that CED studies are evaluated with consistent, feasible, transparent and methodologically rigorous criteria and advise CMS on whether the criteria are appropriate to ensure that CED-approved studies will produce reliable evidence that CMS can rely on to help determine whether a particular item or service is reasonable and necessary*."[2] We believe that CMS's efforts to update the requirements for clinical studies used under CED is timely and an important step to improving the clinical data available to the agency in clinical decision-making.

Given our membership, PCMA has focused its comments on the use of CED for prescription drugs but acknowledges that CMS is examining the criteria for use in all future CEDs – not just for CED-approved studies for prescription drugs. We recommend that MEDCAC consider each of the comment sections prior to finalizing their recommendations and policies. Our written

[1] 87 FR 74632 (December 6, 2022)
[2] MEDCAC Meeting - Analysis of Coverage with Evidence Development (CED) Criteria (02/13/2023) (cms.gov)

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comments focus on the statutory standard, existing mechanisms for coverage, and impact of CED across the Medicare and Medicaid programs.

I. CMS is Responsible for Determining Reasonable and Necessary Standards for the Medicare Population.

Under section 1862(a)(1)(A) of the Social Security Act, the Medicare program may cover products that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Per that requirement, CMS is charged with deciding which medical items and services are reasonable and necessary, or otherwise covered, for Medicare beneficiaries.[3] Under this authority, CMS may issue either National Coverage Determinations (NCDs) based on the reasonable and necessary standard for items and services covered under Parts A and B of the Medicare program. For NCDs, CMS considers the available clinical data for the Medicare population based on statutory requirements for reasonable and necessary (R&N) determinations. CMS may also provide coverage only in the context of an NCD with clinical study under CED if the agency believes that additional clinical evidence is needed to determine if a product is R&N for the Medicare population.

When discussing the use of NCDs with CED for prescription drugs, some stakeholders have asserted that CMS is encroaching on the authority of the Food and Drug Administration (FDA). However, the FDA's role is to ensure that products are safe for the public at large – not to ensure that those products are R&N for the Medicare population, which is a responsibility held by CMS. This is a key distinction in the roles of the two agencies. The vast majority of clinical trials do not focus on the Medicare population due to their clinical complexity and age. Therefore, an NCD with CED allows CMS to continue to study the effectiveness of the product for Medicare beneficiaries. This approach is not unlike the pharmacy and therapeutics (P&T) committee process used by PBMs to develop formulary structures where clinical experts evaluate the evidence to develop coverage criteria. Given these factors, PCMA believes that CMS should continue to review prescription drugs, especially those with limited clinical evidence in a Medicare population, to determine if they are R&N for Medicare beneficiaries.

***PCMA Recommendation*: CMS should continue to review prescription drugs, especially those with limited clinical evidence in a Medicare population, to determine if they are reasonable and necessary for Medicare beneficiaries.**

[3] See CMS MedCAC charter available at https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/Downloads/medcaccharter.pdf.

II. CED is an Important Tool to Study the Efficacy of an Item or Service in the Medicare Population When it is Lacking Clinical Evidence.

As stated earlier, many of the clinical trials developed by prescription drug manufacturers do not focus on the Medicare population, which provides CMS with limited data for clinical decision-making. Additionally, it is expected that the number of drugs and technologies that are approved through accelerated approval and Breakthrough Device Program pathways will only increase in the coming years.[4] Although fewer in number, the rate of increase for Breakthrough Therapy designations is similarly increasing.[5] PCMA believes that these pathways serve an important role but is concerned about the limited data that is available to support clinical decision-making for both CMS and PBMs especially for products approved on a surrogate end point. This is particularly true considering recent studies revealing unrepresentative clinical trial designs based on race and age, raising questions regarding the generalizability of results and health equity.

These trends underscore the importance of CMS developing robust criteria to ensure the evidence generated from CED-approved studies is reliable. The use of CED is an import tool for the Medicare population and taking steps to strengthen the clinical evidence developed through CED-approved studies will further support the clinical decision-making by CMS by *adding* to the clinical evidence-base. As stated numerous times, this is particularly true for prescription drugs which may not have clinical trial data that includes the Medicare population or may be approved based on a surrogate end point. In that spirit, PCMA believes that the following criteria outlined for discussion with the MEDCAC are essential to ensuring that CEDs generate additional peer-reviewed clinical evidence with clinically meaningful primary outcomes that could support decision-making by CMS.[6]

- **Point #4**: The rationale for the study is supported by scientific evidence and study results are expected to fill the specified knowledge gap and provide evidence of net benefit.
- **Point #5:** Sponsors/investigators establish an evidentiary threshold for the primary outcome(s) so as to demonstrate clinically meaningful differences with sufficient precision.
- **Point #6:** The primary outcome(s) for the study are clinically meaningful and important to patients. A surrogate outcome that reliably predicts these outcomes may be appropriate for some questions.

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[4] See https://www.medtechdive.com/news/fda-breakthrough-device-designations-q2-2022/629056/#:~:text=The%20agency%20authorized%2015%20breakthrough,full%2Dyear%20total%20for%202021 and Somnath Pal, "Recent Trends in Approvals of Novel Drugs." U.S. Pharmacist. (October 15, 2021). Available at https://www.uspharmacist.com/article/recent-trends-in-approvals-of-novel-drugs.
[5] Somnath Pal, "Recent Trends in Approvals of Novel Drugs." U.S. Pharmacist. (October 15, 2021). Available at https://www.uspharmacist.com/article/recent-trends-in-approvals-of-novel-drugs.
[6] MEDCAC Meeting - Analysis of Coverage with Evidence Development (CED) Criteria (02/13/2023) (cms.gov)

- **Point #8:** The study population reflects the demographic and clinical diversity among the Medicare beneficiaries who are the intended users of the intervention. This includes attention to the intended users' racial and ethnic backgrounds, gender, and socio-economic status, at a minimum.
- **Point #12**:
    - The study design is selected to generate valid evidence safely and efficiently for decision-making by CMS. If a contemporaneous comparison group is not included, this choice must be justified.
    - The sponsors/investigators minimize the impact of confounding and biases on inferences with rigorous design and appropriate statistical techniques.
- **Point #15**: The study is submitted for peer review with the goal of publication using a reporting guideline appropriate for the study design and structured to enable replication.

PCMA Recommendation: PCMA supports reworking the methodology and processes used to access the impact of innovative and novel technologies on Medicare beneficiaries. We recommend that this assessment go beyond clinical safety and efficacy and address important factors such as advanced age, multiple comorbidities, and social determinants of health.

III. Guidance the Implications for Coverage Outside of Medicare Parts A and B Should be Considered Best Practice.

While the process for establishing an NCD is specific to services provided under Parts A and B, an NCD can also have implications for coverage in other parts of the Medicare and Medicaid programs. This was most recently demonstrated with the NCD for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (Alzheimer's NCD). In this case, while CMS's NCD was specific to Parts A and B, CMS provided explicit guidance on what the coverage decision meant for coverage outside of Parts A and B including the implications for dual eligibles, the Medicaid program, and Part D.[7] This approach was extremely helpful to stakeholders and should be considered a best practice for future NCDs. This is particularly true for prescription drugs, which depending on the product and the site of care, could be covered under Parts B or D. Since NCDs with CEDs are considered absolute coverage guidance in the Medicare program, as an industry we appreciate all the coverage details provided by CMS, especially the clarity specific to Part D coverage. We encourage CMS to continue to address coverage requirements explicitly in tandem with continued clinical data collection parameters.

PCMA Recommendation: CMS should leverage the CED process to collect data and evaluate clinical effectiveness and safety for the Medicare population. In addition, CMS should consider providing guidance on the relevance of the NCD with regard to coverage

[7] Medicare Coverage Policy for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease | CMS

outside of Medicare Parts A and B at the time of an NCD decision, if prescription drugs are involved.

IV. Conclusion

PCMA appreciates MEDCAC's efforts to assess and improve the CED study design used under the Medicare program. As the pace of innovation continues to accelerate and potentially transformative therapies enter the market based on increasingly limited data, it will be more important than ever for CMS to have a standardized and evidence-based approach towards evaluating these new technologies. We would like to reiterate that while it is the FDA's role to ensure that products are safe for the public, it is CMS's role to ensure that those products are reasonable and necessary for a Medicare population. The vast majority of clinical trials do not focus on the Medicare population and CED allows CMS to continue to study the effectiveness of the product for Medicare beneficiaries.

We look forward to how PCMA may support these efforts. If you need any additional information, please reach out to me at tdube@pcmanet.org.

Sincerely,

Tim Dube

Tim Dube
Vice President, Regulatory Affairs