April 14th 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Meena Seshamani, M.D., Ph.D.,
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Re: Medicare Drug Prescription Pricing Negotiation Program

Dear Ms. Brooks-LaSure and Dr. Seshamani,

In service of the neuromuscular disease (NMD) patient community, the Muscular Dystrophy Association (MDA) thanks the Center for Medicare and Medicaid Services (CMS) for the guidance released on March 15th 2023, about the Medicare Prescription Drug Negotiation Program (The Program) as required by the *Inflation Reduction Act of 2022* (IRA).

MDA is the nation's leading nonprofit organization dedicated to empowering the lives of individuals living with neuromuscular diseases through innovations in science and innovations in care. MDA fulfills its mission by funding biomedical research, providing access to expert clinical care and support through its national MDA Care Center Network, and championing public policies and programs that benefit those we serve. Since its inception, MDA has invested more than $1 billion in research grants to accelerate treatments and cures for neuromuscular disorders, making MDA the largest source of neuromuscular disease research funding in the U.S. outside of the federal government.

Background:

The Maximum Fair Price (MFP) provisions of the IRA provide the CMS with the authority to negotiate with drug companies for certain medications reducing drug prices for Medicare beneficiaries. CMS's guidance recognizes that the MFP provisions of the law also include provisions to protect patients and support patient centered action. CMS has the opportunity to continue advancing this crucial goal throughout the implementation of The Program.

Given the relatively few rare diseases that have an FDA approved treatment, continued research and innovation will remain vital. Therefore, as CMS continues to implement this provision of the IRA, we ask that you continue to further consider the unique perspective brought and challenges

faced by those with rare neuromuscular diseases. To best support these communities, we offer the following recommendations:

Patient Access:

MDA emphasizes the need for beneficiary protections in access to care while CMS undertakes the new drug price negotiation process. We are optimistic that the provisions of the IRA which require products within the Medicare Part D, and eventually Part B, plans to be included in negotiations have the potential to reduce out-of-pocket expenses for Medicare beneficiaries. However, with these negotiations come various concerns relating to patient access. We encourage CMS to protect beneficiary access to eligible drugs to ensure that there are as few barriers to access to them as possible. This protection should include both negotiated drugs, and ensuring unintended deleterious effects toward access to non-negotiated drugs do not occur.

This oversight should include monitoring changes to formularies and utilizing the highest practicable specialty tier to reduce out-of-pocket costs. Additionally, we would ask that CMS eliminate denials or delays of treatment for the rare neuromuscular disease community. Eliminating these denials is particularly important for those with rare neuromuscular diseases as many of these conditions are progressive. If there is a delay in appropriate care due to utilization management, a patient's disease state could irreversibly progress further. Those with rare diseases and their healthcare providers are best positioned to decide on the best course of treatment. This combined with CMS's determination that the drugs under covered by The Program have been priced fairly should mean that utilization management tools such as step therapy or prior authorization can and should be limited or eliminated by CMS for these products.

Orphan Drug Exemption:

MDA appreciates that the IRA includes a limited exemption for orphan drugs that only treat one rare disease from drug price negotiation. However, we are concerned CMS's current interpretation of this rare disease exemption, which makes products eligible for negotiation if they have been designated for two or more orphan diseases, even if the drug is not actually FDA approved to treat the second orphan disease, will disincentivize drug companies from conducting even the basic research necessary to develop a drug for additional rare diseases. We have already potentially seen this disincentive in real time. Two companies, Eli Lilly[1] and Alnylam[2], have, if nothing else, both cited concerns with the IRA's consideration of the orphan drug exemption as cause for halting their development. While the IRA may not be the sole reason for their

[1] Gelman, Updated: Eli Lilly blames Biden's IRA for cancer drug discontinuation as the new pharma playbook takes shape. Endpoints News, Nov. 2022. https://endpts.com/eli-lilly-rolls-snake-eyes-as-it-axes-two-early-stage-drugs-including-a-40m-cancer-therapy-from-fosun/

[2] Liu, As Amvuttra makes inroads in ATTR, Alnylam scraps heart disease trial interim analysis, rethinks another rare disorder plan. Fierce Pharma Oct. 2022. https://www.fiercepharma.com/pharma/amvuttra-makes-inroads-attr-alnylam-scraps-heart-disease-trial-interim-analysis-rethinks

hesitation, it is, at a minimum, noteworthy. We urge CMS to clarify that obtaining additional designations for a small molecule or biologic will not make a drug negotiation eligible until the drug has been approved by FDA to treat a second disease or condition.

Excluding the utilization of Quality-Adjusted Life-Years (QALYs) in the negotiation process:

MDA applauds the IRA's prohibition of CMS's use of QALYs in The Program. QALYs rely on an inherently ableist and utilitarian concept of quality of life and assumes outcomes for able-bodied patients in perfect health. Such ableist assumptions about what constitutes a "good" quality of life in determining treatment effectiveness for patients with disabilities fail to consider other factors such as emotional wellbeing, the personal wishes, and aspirations of the patient, the will to live, the personal beliefs of the patient among others. As such, we are grateful for CMS's adherence to the IRA in their implementation and their willingness to further underline their exclusion of these metrics in the proposed guidance. However, CMS's proposal may exclude other helpful metrics in their establishing the value of a drug which will be crucial in the negotiation process (see below). Therefore, we ask that CMS offer additional information for how CMS will consider its approach to gathering information as to the effectiveness of therapies.

Comparative effectiveness:

MDA supports CMS's considerations of differing methods to evaluate the value of a prescription drug for patients. Among the different methods for valuation we ask that CMS consider, as discussed above, the value of slowing or halting disease progression. Given the relatively few options available to treat many neuromuscular diseases it is important to note that many drugs in this space may not share the exact same indications or be used by the same patient populations. Similarly, some drugs in this space may be the only therapy in a specific class to treat a condition while also falling outside of orphan drug exclusions. We urge CMS to approach these considerations wholistically rather than myopically focusing on the lower cost drug. Doing so may disincentivize manufacturers from investing in further innovations in these disease areas.

MDA does not singularly support any one metric. Specifically for gene and cell-based therapies, one potentially applicable value assessment method is one such as those for "Single or Short-Term Transformative Therapies" (SSTs). SSTs "are defined as therapies that are delivered through a single intervention or a short-term course of treatment that demonstrate a significant potential for substantial and sustained health benefits extending throughout patients' lifetimes."[3] Regarding SSTs, it is important to note from the outset that, first, SSTs are mostly only used for gene therapies and cell-based therapies, and therefore are likely inapplicable to other classifications. Second, The Institute for Clinical and Economic Review (ICER) uses QALYs in

[3] Institute for Clinical and Economic Review, Value Assessment Methods Such as Those for "Single or Short-Term Transformative Therapies" (SSTs), Aug. 2019. https://icer.org/wp-content/uploads/2020/10/ICER_SST_ProposedAdaptations_080619-2.pdf

its consideration of SSTs. As noted above, MDA roundly rejects the use of QALYs and we would only support the use of a method such as SSTs if QALYs were removed from consideration. With this background, however, given the rarity of the conditions SSTs consider and particularly the expense of these medications, the metrics by which these medications are considered may prove useful to CMS's current considerations. As MDA noted ,[4] in recent comments to ICER there are areas in assessing the value of neuromuscular disease therapies that warrant better consideration methods.

Particularly, we rejected ICER's concerns about "added dimensions of value." One such value to highlight the value of hope. ICER initially highlighted the importance of choice with an eye toward a risk benefit analysis with choices between therapies. We, however, see the value of hope as the potential for a more healthy and happy life in the future than was previously expected. SSTs offer patients the possibility of substantially healthier lives many years into the future, and with this brings the hope of attending college, getting married, and other important life experiences. In addition, we raised other concerns with ICER's perspective on scientific spillover which relates somewhat to our comparative effectiveness discussion above and flexible cost-valuation thresholds (though we reject the use of QALYs), and patient-focused expectations (see below). All of these metrics could prove useful for CMS's future consideration for comparative effectiveness.

We further discourage CMS from relying on equal-value Life Years Gained (evLYGs) as an alternative metric to QALYs. While evLYGs avoid the most egregiously discriminatory aspects of QALYs, they are an imperfect measure that inherently devalues the health and wellbeing benefits an intervention may bring the beneficiary by disregarding quality-of-life improvements entirely.

Evaluation approaches exist that do not discriminate against those with disabilities while also capturing quality-of-life benefits. For example, one such method similar to QALYs are Health Years Total (HYT). HYT is a valuation method which modify QALYs by separating evaluations of life expectancy and quality of life improvement whereas QALYs consider these concepts as a single consideration. Additionally, HYTs do not consider utility values in its evaluation of life expectancy. However, HYTs do, unfortunately, still consider utility to values to discount quality of life improvement.[5] While not a perfect solution, HYTs do still represent an improvement compared to using QALYs. One method which eschews QALY's methodology altogether is The Efficiency Frontier (EF). EF takes into consideration condition-specific measures. EF benchmarks the price and benefit of the new therapy being considered against the value provided

[4] *See generally,* MDA Comments on ICER's SST Adaptations

[5] Gallegos, *Alternatives to QALY-Based Cost-Effectiveness Analysis for Determining the Value of Prescription Drugs and Other Health Interventions*, National Council on Disability, 7, Nov. 2022. https://ncd.gov/sites/default/files/NCD_Alternatives_to_the_QALY_508.pdf *See also,* Disability Rights Education & Defense Fund, *ICER Analysis Based on the QALY Violate Disability Nondiscrimination Law*, 27, Sep. 2021. https://dredf.org/wp-content/uploads/2021/09/ICER-Analyses-Based-on-the-QALY-Violate-Disability-Nondiscrimination-Law-9-17-2021.pdf [hereinafter referred to as DREDF]

by existing drugs to calculate cost per outcome unity which then informs the recommendation for the cost of the new drug.[6] In addition to these two methods there are methodologies such as Generalized Risk-Adjusted Cost-Effectiveness (GRACE) and Burden Augmented by Deadliness and Impact (BADI) among *many* others.[7] To reiterate, MDA does not recommend at this time any one non-discriminatory valuation technique over another, and only seeks to posit options outside of the use of QALYs for CMS's consideration.

Patient Input for Future Improvement:

The implementation of The Program will be a long and complex one and we are heartened that CMS has shown themselves to be open to feedback. We hope that this attitude will continue. We ask that CMS will monitor the program to ensure that it has the intended effects of increasing access to affordable medications, and again ensuring that lower out of pocket costs are, in fact, realized, and that barriers to access are minimized if not removed entirely.

To that end, we would suggest that CMS implement any of several metrics to continue listening to the voices of those with rare neuromuscular diseases. CMS should continue to utilize patient experience data to ensure effective services are delivered. To best utilize this data, CMS should make use of Requests for Information and listening sessions to ensure the collection of representative data. These processes should allow for as long a timeline as possible and should also streamline and simplify the process for submitting data and information to ensure stakeholders have adequate time to supply information. Similarly, granular summaries of the data and assumptions on which each negotiation was based should be made available to the public.

Finally, as is currently stated in the guidance by CMS the dispute resolution and compliance process under section 1145 of the IRA asks for evidence submitted by the manufacturers and holds that the negotiation and compliance processes will occur between manufacturers and CMS. We ask that CMS consider the voices of neuromuscular disease patients and other stakeholders should either be included in, or at a minimum made aware of, the metrics used in these negotiation and compliance processes. This will not only allow CMS to keep abreast of the voice of the neuromuscular disease community but will also allow the community to better understand the methods by which CMS makes its decisions both with regard to enforcing the requirements of The Program as well the factors they consider in the negotiation process. This information will allow the neuromuscular disease community to better communicate with CMS to improve the process going forward.

Conclusion:

MDA is committed to ensuring that individuals with rare neuromuscular diseases have access to FDA approved therapies to promote safe and healthy lives. We encourage CMS to heed the above feedback as they consider the implementation of The Program.

[6] *Id, at 9*. *See also,* DREDF *Supra* note 5 at *Id.*
[7] *Id* at 10-11. *See also,* DRDEF *Supra* note 5 at *Id.*

We appreciate this opportunity to provide comment on CMS's guidance. For questions regarding MDA or the above comments, please contact me at 336-409-4000 or jcartner@mdausa.org.

Sincerely,

Joel Cartner

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