PMC
PERSONALIZED
MEDICINE COALITION

January 17, 2018

Tamara Syrek Jensen, J.D.
Director, Coverage & Analysis Group
Centers for Medicare & Medicaid Services
Mailstop S3-02-01
7500 Security Blvd.
Baltimore, MD 21244

Sent electronically

RE: Proposed Medicare Coverage Decision Memorandum for Next Generation Sequencing (NGS) for Medicare Beneficiaries with Advanced Cancer (CAG-00450N)

Dear Ms. Syrek Jensen:

The Personalized Medicine Coalition (PMC), a multi-stakeholder group comprising more than 200 institutions across the health care spectrum, appreciates the opportunity to submit comments regarding the Centers for Medicare & Medicaid Services (CMS)' Proposed Medicare Coverage Decision Memorandum for Next Generation Sequencing (NGS) for Medicare Beneficiaries with Advanced Cancer.

Personalized medicine is an evolving field that uses diagnostic tools to identify specific biological markers, often genetic, to help determine which medical treatments and procedures will be best for each patient. By combining this information with an individual's medical history, circumstances, and values, personalized medicine allows doctors and patients to develop targeted prevention and treatment plans.

Personalized medicine is helping to shift the patient and provider experience away from trial-and-error and toward a more streamlined process for making clinical decisions, which will lead to improved patient outcomes, a reduction in unnecessary treatment costs, and better patient and provider satisfaction. As noted above, PMC's members are leading the way in personalized medicine and recommend that patients who may benefit from this approach undergo appropriate testing and tailored treatment as soon as possible during their clinical experiences.

In recent years, NGS technologies have played an essential role in advancing our understanding of altered genetic pathways involved in human cancer. PMC appreciates CMS' recognition that NGS is an important technology for identifying

cancer patients who may benefit from a specific treatment path, and we applaud CMS' work with the Food and Drug Administration (FDA) to accelerate coverage for the FoundationOne CDx (F1CDx) through the Parallel Review Process. We commend the agencies on their approval and preliminary coverage for the F1CDx. High quality, validated genomic profiling assays accelerate patient access to precision approaches to cancer diagnosis and treatment. PMC supports timely finalization of the National Coverage Determination (NCD) for the F1CDx and encourages CMS to continue allowing product developers to pursue Parallel Review as a voluntary process.

We sense growing enthusiasm for the diagnostic innovation upon which personalized medicine depends. In order to capitalize on this opportunity, stakeholders must work toward agreement on a framework that lays out clear paths to coverage and payment, which in turn will encourage the investment that the field requires. Those policies will accelerate the pace of advancement in both diagnostics and personalized medicine. We appreciate therefore CMS' interest in putting in place guidance that will shape an industry with great potential to improve patient care and make the health system more efficient.

We are concerned, however, that the scope of the proposed decision memo for this National Coverage Analysis (NCA) interferes with current established care pathways and removes the flexibility some test developers have to quickly bring NGS technologies to market outside of the Parallel Review Process. We believe that both allow patients and providers to benefit from personalized medicine technologies. Our comments pertain to how the proposed policy, as written in the decision memo, would affect coverage for clinical testing services already employed in patient care and those that will be developed in the future, as well as the potential burden patient, providers, and product developers will face under the proposed coverage with evidence development (CED) requirements. PMC respectfully asks that you consider the following comments as you finalize this proposed decision memo and we would be honored to serve as a resource to CMS as you contemplate the implementation of broader coverage policies for diagnostic laboratory tests using NGS.

Statement of Neutrality

Many of PMC's members will present their own responses to CMS and will actively advocate for those positions. PMC's comments are designed to provide feedback so that the general concept of personalized medicine can advance, and are not intended to impact adversely the ability of individual PMC members, alone or in combination, to pursue separate comments with respect to the proposed decision memo on NGS for Medicare beneficiaries with advanced cancer or related issues.

Criteria for National Coverage

Under Section A of the proposed decision memo, to be granted full coverage patients must have recurrent, metastatic, or advanced stage IV cancer; cannot have been previously tested using the same NGS test; and must have decided to seek further cancer treatment. This language does not address coverage for NGS testing in patients with cancer at earlier stages. However, use of NGS-based testing,

including liquid biopsies, in patients with earlier stage cancer may have an even greater impact on survival, outcomes, and quality of life. If CMS moves forward with finalizing the NCA for other diagnostic laboratory tests using NGS in addition to the F1CDx test, the agency should consider broadening the NCA to include coverage of testing performed in patients facing earlier stages of cancer and allow more than one test in an individual's lifetime to account for potential recurrence.

Section A of the proposed decision memo also describes the criteria for full coverage of a diagnostic laboratory test using NGS. PMC understands that the NCA will only extend full coverage to tests if they are FDA-approved companion in vitro diagnostics; are used in cancers with FDA-approved companion diagnostic indications; and provide FDA-approved reports of test results to the treating physicians specifying FDA-approved treatment options. We agree that tests meeting these criteria should receive full coverage but also acknowledge concerns raised by the American Medical Association and others in the medical community that the proposed national coverage criteria are restrictive and run counter to processes firmly established in medical practice.

Current local coverage determinations are based on the clinical usefulness of proven biomarkers independent of test methodologies and the status of their regulatory approval for marketing and labeling. Clinicians rely on research findings to help them assess and understand a given patient's disease and to guide treatment decision-making. Thus, in practice, new clinical oncology data often prompts guideline revisions and spontaneous adoption prior to FDA-indicated approval to allow physicians to provide patients with the best care based on the most up-to-date findings. The NCA will supersede these existing local coverage determinations, which currently provide coverage for clinically valid and medically necessary testing services. In addition, the criteria requiring an NGS-based test to have FDA approval for companion diagnostic indications would limit the ability of providers to use NGS tests that are recommended in clinical guidelines.

Diagnostic tests performed in clinical laboratories are reviewed using well-accepted processes for determining the analytical and clinical validity of tests and are subject to ongoing review by accreditation bodies and through statute. They are often included in prevention, screening and treatment guidelines for specific conditions that are developed by professional societies, the Agency for Healthcare Research and Quality (AHRQ), and the United States Preventive Services Task Force (USPSTF). If the proposed scope of coverage is not modified, the NCA will lead to blanket non-coverage determinations for many of these tests and services moving forward, making it difficult for patients to access care that reflects the most up-to-date science. A representative cross-section of PMC's membership urges CMS to modify the criteria for full coverage to better reflect established patterns of reimbursement and adoption of diagnostic testing in clinical practice.

Requirements for Coverage with Evidence Development (CED)

In 2013, PMC provided feedback to CMS on the agency's revision of CED guidance. At that time, PMC called on CMS to maintain the use of CED only in circumstances where it would expand access for Medicare beneficiaries. PMC was concerned that the 2013 guideline revision signaled CMS' intent to utilize CED more regularly for new technologies and services and that CED could be applied in a manner

that impedes access to care by restricting the ability of providers to make decisions in the best interest of individual patients.

The Coalition's comments to CMS on CED also recognized that experience was gained from prior CED efforts. We observed that collaboration among stakeholders during the early stages of defining CED study designs, research protocols, and coverage decision-making was essential to successful implementation of CED. PMC's contention that broad participation throughout the CED process was particularly important in relation to personalized medicine, where science and clinical practice rapidly evolve and external expertise on appropriate research questions and study designs would be necessary.

Section B of the decision memo details the criteria for diagnostic NGS-based laboratory tests that would be considered for coverage under CED. CED is proposed when NGS tests for advanced cancer are FDA-cleared or -approved but no companion diagnostic indications currently exist. These tests must be registered in the National Institutes of Health (NIH) Genetic Testing Registry, and patients and furnishing laboratories must participate in a prospective consecutive registry, answering questions designed to compare patient outcomes, patient clinical characteristics, and initial clinical validation of the tests.

CED is also proposed for NGS tests that are not FDA-cleared or –approved, but coverage would be limited to participants in National Cancer Institute (NCI) clinical trials. We understand that these tests would be required to be registered in the NIH Genetic Testing Registry; be part of a trial in the NCI Clinical Trial Network; adhere to CED standards of integrity; have a written analysis plan; and address the same questions in the criteria for FDA-cleared or -approved tests designed to compare patient outcomes, patient clinical characteristics, and initial clinical validation of the tests.

In keeping with PMC's earlier comments to CMS in 2013 on its CED guidance, we believe the proposed CED criteria detailed for NGS diagnostic laboratory tests in advanced cancer are too restrictive, exclude alternative methods for data collection, burden study participants, and limit patient access. We doubt this was CMS' intention and we call on you to convene patients, providers, product developers, laboratories and other stakeholders to develop consensus on solutions to major issues impacting the larger community. We specifically recommend discussion of the need for flexibility in meeting CED requirements through the use of alternative data sources, the level of evidence sufficient for successful completion of CED and transitioning to full coverage, and how CMS plans to treat a gap in coverage for tests that were reimbursed prior to the NCA but will subsequently be denied coverage until a CED study is approved and underway.

Recommendations and Conclusion

In summary, PMC recognizes and appreciates CMS' work with the FDA to reduce the time between FDA approval and Medicare coverage of the F1CDx through the voluntary Parallel Review Program. We urge you to finalize the NCD for this test, but strongly urge revision of the decision memo as it pertains to other tests using NGS technology for cancer if they are to be included in the final NCD. When revising the decision memo, we respectfully ask that CMS:

1. Prioritize testing using NGS technologies that aid in clinical care across numerous cancer types and stages by continuing to allow tests that do not meet the criteria in Section A to receive coverage.

2. Modify the scope of coverage proposed in the decision memo to minimize the effect it will have on reimbursement for clinical testing services already employed in the care of patients with early and advanced stage cancer, as well as tests that will be developed in the future.

3. Convene patients, providers, product developers, laboratories and other stakeholders to develop consensus on solutions to major issues with the proposed CED requirements.

Thank you for considering our comments. PMC welcomes the opportunity to serve as a resource for you in continuing to shape this policy so that it more effectively achieves the goal we share with CMS of delivering appropriate, efficient, and accessible health care to patients. If you have any questions about the content of this letter, please contact me at 202-589-1769 or cbens@personalizedmedicinecoalition.org.

Sincerely yours,

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