COALITION FOR ACCESSIBLE TREATMENTS

May 9, 2016

The Honorable Sylvia Mathews Burwell
Secretary of Health and Human Services
200 Independence Avenue SW
Washington DC 20201

Re: Comments on Centers for Medicare and Medicaid Services Part B Drug Payment Model

Dear Madame Secretary:

On behalf of the Coalition for Accessible Treatments (CAT), the undersigned organizations seek to provide comments on Centers for Medicare & Medicaid Services' (CMS) March 8, 2016 proposed rule that would implement a new Medicare Part B Payment Model. CAT is a coalition of more than 30 patient advocacy and provider organizations, representing millions of Americans living with chronic and rare diseases and conditions and the physicians who treat them.

Our goal is to break down the barriers that prevent American patients from accessing critical life-changing and life-saving treatments. Medicare beneficiaries with chronic and life-threatening health conditions often try multiple medications before finding the appropriate treatment for their complex conditions. These patients need immediate access to the right medication, which may change on a frequent basis depending on several variables being considered by the patient and his or her clinician.

Our individual organizations have varied perspectives on broader and overriding aspects of the proposed rule. That said, as a coalition, we would like to provide you with our perspective on aspects of the proposed rule that could most impact treatment affordability for our community.

We share the goal of CMS and the Center for Medicare & Medicaid Innovation (CMMI) of evaluating the impact of value-based purchasing tools have on Part B drugs to reduce system costs. Such reforms have the potential to reward value and eliminate unnecessary spending without adversely affecting patient access to vital medications in the outpatient and physician office settings. At the same time, we believe that measured, transparent implementation of such significant changes is essential to avoid interruptions in necessary care for patients in need of treatments associated with significant costs. We want to avoid a situation in which the implementation of this model forces Medicare beneficiaries with life-threatening or disabling conditions to navigate a changing landscape of provider options that could produce a lapse in their care.

Our organizations are particularly concerned about the potential access barriers that could follow in the case of a sizable shift and consolidation in practices offering infusions to Medicare beneficiaries. If patients are directed to Part D drugs as a result, that could pose huge challenges to patients who are stable on a Part B drug and may not respond well to drugs offered through Part D. Just as concerning, the out-of-pocket costs for patients accessing drugs through Part D are prohibitive. Many of these medications are placed by plans on specialty tiers that push patient costs to thousands of dollars a month, essentially making medically-necessary treatments out of reach for average insured beneficiary. For many patients, this leads to failure to adhere to a treatment plan, which can lead to worsening disease, increased rates of disability, and rising out-of-pocket and system costs.

Of course, for beneficiaries with cancer or autoimmune diseases, the infusion medications covered under Part B are often the only effective treatment option for patients. CMS must work to ensure that nothing in the proposed model would constrict the current flexibility to prescribe the breakthrough treatments that are available. Our Medicare patients and the providers who care for them already face significant complexities in their care and treatment options, and CMS must take every precaution to prevent the implementation of this model from limiting treatment options.

As CMS considers payment and delivery system reforms such as this proposed model, there is a critical need for patient stakeholder engagement throughout the process. We believe these types of initiatives should be initially implemented in a targeted, patient-centered and transparent way that accounts for the unique needs of individual Medicare beneficiaries. Without sufficient patient community input, implementation could adversely affect the care and treatment of Medicare patients with complex conditions, such as cancer, psoriasis, macular degeneration, hypertension, rheumatoid arthritis, Crohn's disease and ulcerative colitis, primary immunodeficiency diseases and others.

We appreciate the opportunity to offer our perspectives through these comments on access to treatment issues for the millions of patients that our groups represent. We stand ready to work with you and your colleagues to advance our shared goals of improving quality, ensuring access, and reducing costs. Should you have questions, or if we can be of assistance, please contact co-chair of CAT, Quardricos Driskell, and health policy manager with the National Psoriasis Foundation at gdriskell@psoriasis.org or at 503-546-5559.

Sincerely,

The AIDS Institute
Alliance for the Adoption of Innovations in Medicine
Alpha-1 Foundation
American Autoimmune Related Diseases Association
Arthritis Foundation

Colon Cancer Alliance
Crohn's and Colitis Foundation of America
Hemophilia Federation of America
Immune Deficiency Foundation
The Leukemia & Lymphoma Society
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of America
National Hemophilia Foundation
National Organization for Rare Diseases
National Psoriasis Foundation
Patient Services, Inc.
Scleroderma Foundation
Sjogren's Syndrome Foundation
Susan G. Komen