Chloe Barnes
Advisory Council
on Rare Diseases

April 13th, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Oregon's proposal contained in its 1115(a) Demonstration Waiver to be given "authority to allow the exclusion of accelerated-approval drugs that have not been shown to be clinically effective"

Dear Administrator Brooks-LaSure,

The Minnesota Rare Disease Advisory Council appreciates the opportunity to offer comments to the Centers for Medicare & Medicaid Services regarding the state of Oregon's proposal contained in its 1115(a) Demonstration Waiver to be given "authority to allow the exclusion of accelerated approval drugs that have not been shown to be clinically effective."[i] Membership on the Minnesota Rare Disease Advisory Council includes patient advocates, hospital administration leadership, researchers and clinicians, public health professionals, industry, and payers who all have expertise in rare disease management and care. We believe that this proposal will significantly impede access to medically necessary treatments for rare disease patients who are enrolled in Oregon's Medicaid program and exacerbate inequities that already exist for the rare disease community related to the availability of treatments. **We strongly urge CMS to reject the proposal to exclude Accelerated Approval Drugs contained in Oregon's 1115(a) Demonstration Waiver.**

There are unique characteristics of the rare disease community

The FDA defines a rare disease as a condition that affects fewer than 200,000 people in the US. There may be as many as 7,000 rare diseases and the total number of Americans living with a rare disease is estimated at between 25-30 million or roughly 8-10% of the population.[ii] Despite this, rare diseases have historically been overlooked and neglected for pharmaceutical development, giving rise to the term "orphan disease."[iii] Currently, less than 9% of rare disease patient populations have an FDA-approved drug despite many of these diseases being medically complex and life-threatening.[iv] Thus, the rare disease community is one with significant unmet therapeutic needs.

There is a necessity for alternative approval pathways that match the characteristics of the rare disease community because ***what is common sense when approaching common diseases is not common sense for addressing rare diseases***

In 1983, Congress passed the Orphan Drug Act, a seminal bill that recognized that the unique characteristics of the rare disease community called for unique approaches to drug development. Before its passage, only 38 products had been FDA-approved to treat rare diseases. While the Orphan Drug Act was effective in creating incentives for drug development, pathways were needed to address requirements for clinical trial design that was not well-suited to the unique characteristics of the rare disease community. Requiring measures of direct clinical benefit before FDA approval of a treatment is a salient example. Small patient populations with extended disease progression and life-threatening outcomes characterize many rare diseases, most of which have no treatment. The accelerated approval pathway is well-suited to address these challenges through its utilization of surrogate endpoints. Identifying a surrogate endpoint, whose function is to predict a clinical outcome, allows for measurement before the onset of irreversible effects and enables treatments to get to patient communities in a much shorter timeframe. When the direct clinical benefit is living vs dying, as is the case for a significant portion of rare diseases, the necessity of a surrogate endpoint is clear.

Alternative pathways are not inferior pathways

While accelerated approval allows flexibility in the metrics used to meet the unique challenges of drug development for certain patient populations, it does not, in any way, lower the standard for determining the safety and efficacy of treatments. We find the wording of Oregon's waiver proposal troubling in that it appears to ignore both the necessity of surrogate endpoints for some patient populations as well as to dismiss the standard set by the accelerated pathway which clearly states that an approved surrogate endpoint must be "**reasonably likely** to predict clinical benefit." The state of Oregon's argument for exclusion ignores the fact that, in the FDA's judgment, clinical benefit is likely and that surrogate endpoints have strong predictive value, often confirmed by post-approval studies. The Council affirms the necessity of post-market approval requirements already built into the accelerated approval process and supports their consistent implementation. But allowing a state to pick and choose which regulatory pathways they will and will not uphold sets a dangerous precedent that **undermines the FDA's statutory authority in determining the effectiveness and safety of treatments by the process they judge to be most appropriate.**

Oregon's proposal lacks a defined and transparent process

The FDA's approval processes are comprehensive and have been established through decades of engagement with stakeholders. With increasing frequency, the FDA systematically incorporates direct patient feedback into its deliberations using PFDDs (Patient-Focused Drug Development meetings) and Voice of the Patient reports to develop patient-centered outcomes. **The Council is concerned with the lack of an articulated process in Oregon's waiver describing how they would conclude that a drug "has not been shown to be clinically effective."**

Even should Oregon conclude that a drug has been shown to be clinically effective in agreement with the FDA, the delay of life-saving medications until a duplicative process has been completed will likely cause immeasurable harm to the very patients for whom the accelerated pathway was designed to expedite treatments to in the first place.

Excluding accelerated approval treatments is an ineffective cost control measure

Medicaid is the largest health insurer in the United States and many state Medicaid programs are understandably seeking effective cost control measures to reduce state healthcare spending; however, **drugs approved through the accelerated approval pathway do not drive the cost of Medicaid spending**. A report published by the Partnership to Fight Chronic Disease found that spending on drugs approved through the accelerated approval pathway accounted for less than one percent of annual Medicaid spending between 2007 and 2018.[v]

Limiting access to life-saving treatments for patient populations with unmet medical needs contributes to disparities

The Minnesota Rare Disease Advisory Council is comprised of physicians and hospital systems that are nationally recognized experts in caring for patients with rare diseases. Patients travel to Minnesota from across the country to receive care from our physicians, some of whom depend on medications that have been brought to market by the accelerated approval pathway. For example, the only effective treatment for progressive, life-threatening Pompe disease is enzyme replacement therapy (ERT). Without intervention, the most severe form of Pompe disease is fatal. **The Council fears that patients under the care of our physicians and organizations will lose access to life-saving medications should state Medicaid programs be allowed to exclude treatments that utilize the accelerated approval pathway.** The Council respectfully asks the Center for Medicare and Medicaid Services to honor the progress that has been made in drug development and research for the rare disease community and reject the state of Oregon's proposal to limit access to drugs based on their FDA-approval designation.

Sincerely,

Erica Barnes, on behalf of the MN Rare Disease Advisory Council

Council Administrator

Demo0050@umn.edu

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[i] *Oregon Health Plan 1115 Demonstration Waiver – Application for Renewal 2022-2027 Project Numbers 11-W-00160/10 & 21-W-00013/10*

[ii] U.S. Department of Health and Human Services. (2021, January 26). Faqs about rare diseases. Genetic and Rare Diseases Information Center. Retrieved April 8, 2022, from https://rarediseases.info.nih.gov/diseases/pages/31/faqs-about-rare-diseases

[iii] Aronson J. K. (2006). Rare diseases and orphan drugs. British journal of clinical pharmacology, 61(3), 243–245. https://doi.org/10.1111/j.1365-2125.2006.02617

[iv] Government Accountability Office (October 2021). Rare Diseases. Although Limited, Available Evidence Suggests Medical and Other Costs Can Be Substantial. (GAO Publication No. 22-104235). Washington, D.C.: U.S. Government Printing Office.

[v] Thorpe, Kenneth, and Holtz-Eakin Douglas. 2021. Quantifying Impact of Accelerated Approval Drugs on Medicaid Spending. Partnership to Fight Chronic Disease. Retrieved April 8, 2022, from https://www.fightchronicdisease.org/sites/default/files/FINAL%20Quantifying%20Impact%20-%20White%20Paper%20v6.pdf