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Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
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RE: Orphan Drug Exclusion from the "Line Extension" Rebate

Dear Mr. Coster:

We are writing to encourage the Centers for Medicare and Medicaid Services (CMS) to r evise its proposed rule on Medicaid "line extension" rebates,[1] and exclude orphan drugs from the scope of this policy. This discretionary decision would greatly encourage the development of ne w treatments for rare diseases, while maintaining the intent and appropriate scope of the line exte nsion rebate. As CMS promulgates its final rule, the agency clearly has the discretionary authori ty to reinstate the orphan drug exclusion as a reasonable agency interpretation of the clear congre ssional intent underlying the provision.[2]

As you know, section 2501(d) of the Affordable Care Act[3] authorizes an additional Medi caid rebate to be imposed on line extension products. Congress intended this provision to preven t manufacturers from resetting their Average Manufacturer's Price (AMP) to avoid the statutory i nflation-based rebate described in section 1927(c)(2) of the Social Security Act by making a "sli ght alteration" to an existing product, such as creating an extended-release formulation.[4] The pro vision defines the term "line extension" as "a new formulation of the drug, such as an extended r elease formulation."

The legislative history of the provision establishes that Congress was targeting a very nar row subset of drugs and enacted it to ensure that a new formulation that is simply a "slight alterat ion" or "minor change" made by a single manufacturer to an existing covered outpatient drug is s till subjected to a form of the inflation penalty rebate under the Medicaid Drug Rebate Program.[5]

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[1] Medicaid Program; Covered Outpatient Drugs, 77 Fed. Reg. 5318, 5340 (Feb. 2, 2012).

[2] See, e.g., K Mart Corp. v. Cartier, Inc., 486 U.S. 281, 291 (1988) (courts should look "to the particular statutory la nguage at issue, as well as the language and design of the statute as a whole" in order to ascertain statute's "plain me aning").

[3] Patient Protection and Affordable Care Act ("ACA") § 2501(d), Pub. L. No. 111-148, 124 Stat. 119, 309.

[4] Congressional Budget Office, Budget Options Volume 1: Health Care 143 (2008).

[5] Id. See also Senate Committee On Finance, Chairman's Mark, America's Healthy Future Act of 2009 54-55 (relea sed Sept. 16, 2009); H.R. Rep. 111-299, pt. 1, at 635 (2009); S. Rep. 111-89, at 92 (2009) (restating the CBO policy objective and intended scope). The President also included this policy applying an "additional rebate to new drug for mulations" in his budget request for fiscal year ("FY") 2010. See Office Of Mgmt. & Budget, Exec. Office of the Pr esident, A New Era Of Responsibility: Renewing America's Promise 28, 127 (2009).

It is well understood that Congress acted to prevent such manufacturers from circumventing the intent and operation of the Medicaid Drug Rebate Program.

It is just as well established that treatments against rare diseases were never an intended t arget of the line extension policy. Congress explicitly exempted orphan drugs from this provisio n under the Affordable Care Act; however, this exemption was repealed as part of a broader resta tement of the provision in question under the Health Care and Education Reconciliation Act.[6] Th e repeal of the orphan drug exemption was unintended and wholly collateral to Congress' reversi on in the reconciliation bill to earlier House language, which was adopted in order to limit the sc ope of the policy to oral solid dosage form drugs.[7]

We strongly encourage you to restore the exemption in the final rule in order to ensure th at Medicaid beneficiaries suffering from rare diseases retain access to life-saving therapeutic cho ices. The current CMS interpretation creates an economic barrier that is contrary to stimulating o rphan drug development, which is in critical need of additional therapies for many devastating or phan diseases. Abiding by Congress' original intent to exclude orphan drugs, and target extende d-release and similar drug products, would greatly improve the prospects for new cures and treat ments for rare diseases, which together they affect nearly 30 million - or almost 1 in 10 - Americ ans. In the face of significant economic barriers to innovation, only a few hundred of the nearly 7,000 rare diseases currently have FDA-approved therapies.

Because rare diseases affect such small patient populations, a significant share of the inno vation in orphan drugs is upon the basis of previously approved drugs.[8] For example, both the Fo od and Drug Administration (FDA) and National Institutes of Health (NIH) are pursuing a drug r epurposing initiative intended to facilitate development or improvement of treatments for rare dis eases that lack an FDA-approved treatments as well as improvements to existing rare disease ther apies.[9] Yet the 2012 proposed rule would even apply the line extension rebate to orphan drugs w here the manufacturer of the FDA-approved, 'line extension' orphan drug is different from, and h as no commercial relationship with, the manufacturer of the original drug. This is clearly an unin tended consequence, and unjustifiable,

Moreover, in sharp contrast to the "slight alterations" or "minor changes" targeted by Co ngress in the line extension rebate, FDA approves orphan drugs that are the same drug for the sa me disease as a previously approved drug only upon a finding of clinical superiority to the earlier drug. For example, FDA has determined under its orphan drug policies that extended release cy steamine bitartrate capsules and extended release hydrocortisone tablets to be the "same" drug as the previously approved immediate release versions, and consequently subject to the standard of

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[6] Health Care and Education Reconciliation Act ("HCERA") of 2010 §1206, Pub. L. No. 111-152, 124 Stat. 1029, 1 056-1057.

[7] See HCERA § 1206.

[8] A. Kesselheim et al. "The roles of academia, rare diseases, and repurposing in the development of the most transfor mative drugs." Health Aff (Millwood). 2015 Feb;34(2):286-93. ("Nine of the twenty-six (35 percent) [drugs approv ed by the Food and Drug Administration between 1984 and 2009 that were judged by expert physicians to be transfo rmative] were repurposed from products developed for other indications, and ten (38 percent) were developed for rar e diseases before much broader applicability was found.")

[9] NIH, National Center for Advancing Translational Sciences (NCATS), "Repurposing Drugs", Last updated: 04-13- 2015; L. Neergaard, Rare Diseases: A Huge Push for More Drugs, Huffington Post (Apr. 26, 2011).

clinical superiority. Yet the 2012 proposed rule would even apply the line extension rebate to th ese orphan drugs.

We are deeply concerned with the Agency's proposed rule, which expressly includes orp han designated and approved drugs in the scope of the line extension rebate. By proposing a poli cy that is inconsistent with congressional intent and the clinical significance of many orphan dru gs, the regulation would inadvertently but detrimentally affect the development of significant ne w medicines for millions of American patients with life threatening and debilitating rare diseases , including thousands of Medicaid beneficiaries nationwide. For this reason, consistent with con gressional intent, we ask that CMS use its discretionary authority to expressly exempt orphan dru gs from the line extension rebate.

We appreciate your attention to this matter of importance to Americans with unmet medi cal needs, and look forward to your response.

Sincerely,

Jeff Larimore, President, Cystinosis Research Network

Kym Kilbourne, Vice President of Patient Advocacy, Global Genes

Paul Melmeyer, Associate Director of Public Policy, National Organization for Rare Disorders (NORD)

Jay Greissing, Director, U.S. Government Relations and Public Policy, Shire