**Biotechnology Innovation Organization**
1201 New York Avenue NW
Suite 1300
Washington, DC, 20005
202-962-9200

July 31, 2023

**Via Electronic Delivery**
The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-10847
7500 Security Boulevard
Baltimore, MD 21244-1850

**RE: Information Collection Request (ICR) for Negotiation Data Elements (CMS-10847)**

Dear Administrator Brooks-LaSure:

The Biotechnology Innovation Organization (BIO) appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) Information Collection Request for Negotiation Data Elements under the Inflation Reduction Act (IRA).

BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than thirty other nations. BIO's members develop medical products and technologies to treat patients afflicted with serious diseases, to delay the onset of these diseases, or to prevent them in the first place. In that way, our members' novel therapeutics, vaccines, and diagnostics yield not only improved health outcomes, but also reduced health care expenditures due to fewer physician office visits, hospitalizations, and surgical interventions.

For purposes of negotiation of the maximum fair price (MFP), the statute (SSA 1194 (e)) directs CMS to consider the following factors:

- Manufacturer-specific data (SSA 1194 (e)(1)): Research and development costs and the extent to which the manufacturer has recouped such costs; current unit costs of production and distribution; prior federal financial support for discovery and development; and data on pending and approved

patents and exclusivity; and market data and revenue and sales volume data.

- Evidence about alternative treatments (SSA 1194 (e)(2)): the extent to which the drug represents a therapeutic advance as compared to existing therapeutic alternatives and the costs of such alternative; FDA-approved prescribing information for the drug and the alternatives; comparative effectiveness of the drug and the alternatives, including effects on specific patient populations; the extent to which the drug and the alternatives address unmet medical need.

Most fundamentally, and as we have noted in previous comments to the Agency, we believe CMS should emphasize factors related to clinical benefit and unmet need in section 1194(e)(2)) and de-emphasize manufacturer specific data elements such as cost of production and research and development costs in section 1194(e)(1)).

Furthermore, we note our serious concerns with CMS's approach regarding the collection of data on the factors outlined in section 1194(e)(1). The proposed ICR form outlines 45 pages of data requirements – the majority of which are related to manufacturer-specific data. CMS is seeking an unwieldly amount of information for factors that have little – if any – relevance to the therapeutic value of a treatment to patients and under extremely limited timeframes. Of additional concern, in many areas – particularly regarding research and development costs – CMS is requesting information that is simply not collected in any standardized format today. In the interest of all stakeholders, we request that CMS refocus its data submission requirements on a more limited and focused set of information, with emphasis on publicly or already available information and the minimal factors necessary to determine a Medicare-only price. In addition, to address issues that we highlight below, we recommend that, in lieu of the proposed standardized definitions, CMS allow manufacturers to use reasonable assumptions (with accompanying justifications) regarding the information they submit on the manufacturer-specific data. If CMS continues to insist on its pre-planned process and continue with a lack of specificity and clarity in its definitions and data elements, we ask for the ability for manufacturers to use reasonable assumptions in filling out the form—particularly in light of the fact that despite reasonable and good-faith efforts, manufacturers would be subject to severe CMPs should they fill out the data elements form incorrectly. The form is already extremely difficult in terms of timeframe and personnel required to fill out, and without a lack of clarity, manufacturers are left spending valuable time trying to discern CMS's meaning on key issues.

Our more detailed comments follow.

**CMS must clarify how it will evaluate the evidence it receives from different stakeholders regarding the elements in section 1194(e)(2) and how such evidence will be considered in identifying therapeutic alternatives and setting the MFP**.

CMS should be transparent and provide sufficient detail regarding its framework for how each piece of evidence was used to inform the identification of therapeutic alternatives for a selected drug, the establishment of the preliminary price, as well as the initial offer and response to any counteroffer, including what evidence was most impactful in CMS's analysis and why. CMS should provide a strong justification that the identified therapeutic alternatives are appropriate and primarily driven by clinical guidelines and patient need.

Furthermore, CMS's review and assessment of the evidence should be patient-centered, with a particular focus on advancing health equity and reducing disparities. To that end, we strongly support CMS's confirmation that evidence that uses discriminatory approaches such as Quality Adjusted Life Years (QALYs) will not be considered. We also note that other measures that have been often promoted as alternatives to QALYs – such as the Equal Value of Life Years Gained (evLYG) – are similarly problematic as they limit the value of interventions that both extend life and improve the quality of life – and CMS should similarly reject evidence referencing or discussing evLYGs. CMS should consider and prioritize high quality, robust real-world evidence (RWE), evidence provided by clinicians with the necessary expertise, as well as evidence submitted by manufacturers – who have a vast depth and breadth of clinical and scientific expertise regarding their marketed therapies. CMS should also focus on patient-centered outcomes, such as a patient's quality of life, and the broader societal benefit conferred by a therapy. Further, providing higher relative MFPs to products that have advanced patient care and address unmet medical need will help maintain investment in assets and clinical programs that show scientific promise.

We recommend that CMS provide manufacturers with robust detail regarding its analysis of evidence throughout the negotiation process and provide manufacturers with opportunities for discussion and dialogue, including before CMS's initial offer in February 2024 and especially in its identification of therapeutic alternatives that will be used in setting the MFP. Additionally, CMS must provide selected companies with its analysis prior to their Fall 2023 meetings, as these companies can't be expected to go into that meeting without that information. It would also be helpful for CMS to communicate information related to the Fall 2023 meeting (e.g., timing, duration, attendees, etc.) as expeditiously as possible. CMS should also provide a line of sight into its assessment of the evidence for the broader stakeholder community, so as to ensure appropriate transparency and accountability not just to manufacturers but to Medicare beneficiaries and to providers and other key stakeholders.

In addition, we recommend that manufacturers should have the opportunity to review and verify third party data submissions. Manufacturers have a vast depth

and breadth of clinical and scientific expertise to draw upon for their therapies, more so than outside third parties who may make erroneous assertions in their data submissions. CMS should also confirm that third party submissions will also be done through this ICR process.

We recognize CMS's stated intent to "consider" the definition of "unmet need" in footnote #38, and are appreciative of the Agency's consideration of this important definition.[1] However, CMS should move from consideration of this to actually implementing it. In doing so, CMS should commit to the FDA's definition outlined in its "Guidance for Industry Expedited Programs for Serious Conditions – Drugs and Biologics.[2] Under the FDA guidance, "An unmet medical need is a condition whose treatment or diagnosis is not addressed adequately by available therapy. An unmet medical need includes an immediate need for a defined population (i.e., to treat a serious condition with no or limited treatment) or a longer-term need for society (e.g., to address the development of resistance to antibacterial drugs)." The FDA's definition consists of established concepts that underpin and inform drug development and are therefore more widely understood and adopted.

**CMS's focus on research and development recoupment is misguided and unworkable.**

Regarding research and development costs, a key issue that CMS must consider is that R&D recoupment for a specific therapy is a misnomer and not reflective of the way innovation occurs today. Companies invest in research and development for "programs" in a specific disease area, not simply discrete drugs or biologics. A program can have many investigational compounds or molecules at different stages of development each with multiple potential indications, and all which would factor into the research and development costs for an FDA-approved or licensed therapy. This can include thousands and sometimes millions of compounds that could be screened early in the research and development process, with an overall success rate of less than 12%. Additionally, assessing therapies by primarily using research and development costs devalues therapeutic performance and harms innovation and the development of new indications and therapies.

Further, it is fundamentally mistaken to approximate "value" using research and development costs and CMS's focus on "recoupment" of these costs reflects a fundamental misunderstanding of the biopharmaceutical sector and the effort to bring new therapies to patients. Not all companies conduct research and development in the same manner. Some smaller companies might undertake single-therapeutic, high-risk approaches to developing a compound, while many

[1] Revised Negotiation Data Elements ICR at 43.

[2] https://www.fda.gov/files/drugs/published/Expedited-Programs-for-Serious-Conditions-Drugs-and-Biologics.pdf

others, often bigger companies, conduct research using the framework of "programs," as noted above. These differences in the way research and development is conducted could disadvantage certain smaller companies in negotiation if manufacturer-specific data is too heavily relied upon for "value."

Looking at research and development costs in the post-market setting can also be misleading because of ongoing costs that are difficult to quantify. For example, the FDA requires post-market safety monitoring for all marketed products; these costs are augmented if a manufacturer must utilize FDA-mandated risk evaluation and mitigation strategies (REMS), or other post-marketing commitments or requirements, which can be costly and take years to complete.

Additionally, through question 6 CMS is seemingly looking to calculate the recoupment of FDA-approved indications only, which would only be a US-based metric, by comparing them to global lifetime net revenues. This is an asymmetrical and inappropriate approach, and focusing only on FDA approved indications also fails to capture label-enhancing research, such as different dosing regimens, new routes of administration, new delivery devices or other label enhancements that improve the patient experience. This must be a U.S. based metric, and global lifetime net revenues must be omitted from this equation.

These concerns are heightened by the fact that approximately a quarter of the questions on the proposed data elements collection form are asking specifically about research and development costs. There is little utility in requiring research and development costs to be reported to in multiple different categories which do not align with the way data are collected and reported in the normal course of business. This in turn increases the burden on manufacturers, which is further exacerbated given the extreme time constraints. We believe CMS's approach is misguided and should be reconsidered, looking at potential alternatives such as reducing the number of metrics and making them more harmonious with the way that data is collected in the normal course of business. Further, for the manufacturer-submitted data elements, including information on research and development costs, CMS should allow manufacturers to use reasonable assumptions (with accompanying justifications) regarding the information they submit.

Since each manufacturer tracks and manages R&D spending differently another approach for CMS to consider would be to amend the ICR to align with the single global figure for R&D costs such as from Securities and Exchange Commission (SEC) Form 10K filings and a simple attestation of whether or not a company has recouped the cost of R&D. If a manufacturer has not yet recouped R&D costs CMS should provide a field for the manufacturer to explain why the costs were not recouped.

**CMS should streamline its data requirements, focus on existing data sources versus creating new metrics, and clarify definitions.**

There are many areas where CMS proposes to collect information that is not collected today – One example is net revenue "without patient assistance programs." It is unclear why CMS would be collecting data in this manner and the underlying implication of patient assistance programs on price. Moreover, it is unclear what CMS means by "patient assistance" as the Agency refers to it in several different contexts. CMS should eliminate all mentions of "patient assistance" from its questions and from the negotiation process.

In requesting certain metrics, CMS is asking for the creation of completely new pricing metrics that have not yet been defined, such as "commercial average net unit price." These metrics are unnecessary and will add to the reporting burden on manufacturers. Moreover, they will likely yield imprecise or inconsistent data across manufacturers' submissions given that these new, unestablished metrics are not well defined.

Moreover, there is a functional concern regarding the data requested of manufacturers in the ICR. There are some cases where manufacturers will not be able to comprehensively compile answers to some of the historical data points requested in the questionnaire (especially as it relates to research and development costs), as some products may have been discovered several decades ago long before CMS had required this level of information. This creates a difficulty in providing the data that CMS requests, as the march of time could have resulted in data loss as accounting systems changed, personnel with sufficient knowledge have since been long retired, or data may not be available in the corporate archives with the level of granularity required by CMS, to name a few key concerns.

In other areas, the definitions CMS proposes are unclear, which will make it difficult for manufacturers to comply with submission requirements. For instance, "Primary Manufacturers" have no insight into patents that are not theirs, making it both impractical and legally challenging. As well, the FDA does not release information on pending patents. For another example, regarding data on approved and pending patents, clarifications are required to better define the patents and pending patent applications that must be disclosed. More precision is required where CMS is asking for patents "relating" or "linked to" the selected drug, as it is unclear what CMS means – related or linked how? In this respect, we also note that "patent" and "patent application" are well-understood terms of art that don't require further definition in the CMS guidance. For example, the CMS guidance definition of a "pending patent application" specifies any patent application "for which a patent number has not been issued." This definition would plainly include applications that are not, in fact, pending because they have been abandoned. An "approved patent

application" presumably means a patent application that has received a notice of allowance, meaning that it is still a pending patent application (and not a "patent") that does not require a special definition. And a "patent" comes into existence not on the date a patent application is "approved," but on the date a patent is issued, and the official patent grant is transmitted. We recommend deleting the special definitions of "pending patent application," "approved patent application," and "expired patent," and to change the operative language as suggested in our proposed edits below.[3]

*Patents, Exclusivities, and Approvals*

*For the purposes of describing patents, exclusivities, and approvals to be collected for use in the Negotiation Program for the selected drug, as described in section 1194€(1) of the Act and section 50.1 of this memorandum, CMS intends to adopt the definitions described in this subsection.*

- *CMS considers patents relevant to this data to include:*
    - *all patent applications pending in the USPTO, international patent applications filed under the Patent Cooperation Treaty that designate the United States, and all U.S. patents, that are owned by, licensed to, or controlled ~~pending and approved patent applications, including expired and non-expired approved patents, submitted, sponsored, licensed, and/or acquired~~ by the Primary Manufacturer ~~relating to the~~, and that claim the selected drug, a constituent part of the selected drug, or an approved method of using the selected drug as of September 1, 2023;*
    - *U.S. patents ~~linked to~~ that claim the selected drug, a constituent part of the selected drug, or an approved method of using the selected drug where the Primary Manufacturer is not listed as the assignee/applicant but with respect to which the manufacturer has enforcement rights (for example, for a joint venture product); and any patent that is with respect to the selected drug included in a list published under section 351(k)(9) of the Public Health Service Act or section §505(j)(7) of the Federal Food, Drug, and Cosmetic Act, ~~patent applications, pending and approved~~, for which a claim of patent infringement could reasonably be, or has been, asserted against a person engaged in the unlicensed manufacture, use, or sale of the selected drug ~~in any form~~.*

[3] Note that the nomenclature of "Primary Manufacturer" is retained in the edits we suggest but we note our comments later in this section that raise concerns with the "Primary Manufacturer" and "Secondary Manufacturer" construct.

With just thirty days to work across the entirety of the manufacturer to prepare data for submission to CMS, this is a burdensome timeline to ensure a complete and comprehensive response to the numerous questions in the form, especially when there are artificial constraints on manufacturers on what they can submit, hamstringing them even further. Both CMS and the manufacturers would benefit from a streamlining of the form and reducing the number of questions asked, especially for those that are duplicative of data that CMS already have or publicly available information. For items such as price reporting templates, it would behoove CMS to use what they already have on hand and not create new ones for the purpose of this submission form.

**Manufacturers should be able to supplement their timely submissions if new data arises (or other good cause).**

Inevitably, there will be situations where information relevant to the negotiation arises after the submission deadline has passed. Such late-breaking developments will often be completely unforeseeable at the time of submission but highly relevant to the setting of the MFP. The potential scenarios are virtually limitless: For example, new therapeutic alternatives may come to market; production costs may shift due to ingredient shortages or supply chain issues; or new comparative effectiveness studies may become available.

The thirty-day data submission period is already an onerous requirement for manufacturers, especially with the number of questions and data that they must answer and submit. It is therefore highly possible that additional, relevant data will become available after this short timeline to submit. This ICR on Negotiation Data Elements does not outline any way in which manufacturers would be able to submit additional information after the deadline.

CMS should not blind itself to highly pertinent new information, simply because the submission deadline has passed. In the initial negotiation guidance, the Agency proposed to limit the presentation of such information to the negotiation meetings during the period after the rejection of a counteroffer. Because such information can equally inform an initial offer, the Agency should more generally permit the manufacturer the option to supplement its timely submission wherever there is good cause to do so, including when new information relevant to the negotiation process becomes available after the submission deadline.

CMS should establish a procedure that would allow manufacturers (and other stakeholders) the option to submit pertinent new information even after the deadline should the need arise. The current uncertainty for manufacturers on their

ability to submit pertinent supplemental information in advance of potential negotiation meetings is another way in which the "negotiation" process has proven to be anything but fair and predictable.

Permitting supplemental submissions is well warranted. Under the statute, manufacturers are given only one month from publication of the selected drug list to prepare a voluminous submission of complex information, including information regarding Non-Federal average manufacturer price (Non-FAMP); research and development costs; production and distribution costs; federal financial support for discovery and development; pending and approved patent applications, FDA exclusivities, NDAs or BLAs and approvals thereof, market data; and revenue and sales volume data. In some cases, requested data may also not exist in a format required by CMS, such that the manufacturer will need to painstakingly convert raw data from multiple sources into such a format. CMS should require less data to be submitted, and instead rely as much as possible on existing data sources. Currently, CMS is relying on new metrics that need to be reported, such as the US commercial average net unit price, and not data that manufacturers already have access to in the course of normal business.

Manufacturers will assuredly work with utmost diligence to comply with CMS's submission requirements. Still, they may need the flexibility of a supplement to their timely submission for legitimate reasons. Ultimately, more generally permitting the manufacturer to supplement its timely submission where there is good cause would help ensure that the MFP is set based on the best available information.

**Remove Limits on the Ability of Manufacturers to Respond**

We are concerned that CMS's approach in this data collection form may be too limiting in practice and will not allow for a robust submission of information - including any supplementary material – by manufacturers. In particular, we are concerned with the data fields outlined in the proposed questions, which have word counts ranging from 100 words to 3,000 words. Manufacturers should be able to submit as much information as possible that is necessary for them to make an argument that they believe will be comprehensive and not limited to artificial constraints. Further, CMS also caps the number of citations allowed for certain questions at 50 citations. It may very well be the case that manufacturers will have more than 50 citations of pertinent and essential information and we ask that CMS also remove this limit as well. Moreover, the data fields do not seem to contemplate submission of complementary, non-text information within the ICR, such as charts and tables.

Additionally, while we note that CMS has expanded word counts in some areas and specified the ability to add charts and diagrams to certain questions, these too are limited. The questions would benefit from a process where manufacturers are able to submit unlimited supplemental data, especially if CMS continues to insist upon word count limits.

We strongly recommend that CMS reconsider its approach and permit manufacturers to submit any information they determine relevant to the negotiation process (including information not related to the negotiation factors enumerated in the statute). CMS should consider all such information submitted by a manufacturer, not just the negotiation factors in sections 1194(e)(1) and 1194(e)(2). Removing these limits will allow for manufacturers to adequately respond and provide apposite supporting information that can help inform CMS's decision making.

**CMS underestimates the amount of time it will take for manufacturers to complete submission of the form.**

In the Supporting Statement attached to the ICR, CMS provides its estimate of the burden for collecting information for the 10 selected drugs for IPAY 2026. In Section A (with table 1) attached, CMS estimates the burden to be 500 hours per Primary Manufacturer per selected drug at a base estimate cost of $51,588.50 per manufacturer per drug. [4] We believe this estimate (and even the "high estimate CMS provides where it doubles these base numbers) are dramatic underestimates of the actual cost in time and money for each submitting manufacturer.

If selected for negotiation, this form will require manufacturers to pull different data elements from different sections of its organization for its response, as well as requesting data in some places that the manufacturer does not even have including, for example, "secondary manufacturers." Furthermore, the impact of this process and its results will have on each manufacturer means that more resources —including time and personnel—will be invested than CMS allocates for in its estimates. Moreover, the four roles or small teams that CMS outlines in its rationale for its estimate (the financial manager, cost estimator, business operations specialist, and the economist) will be just a small subset of the number of people required to submit the complete data package to CMS.

[4] Revised Negotiation Data Elements ICR Supplemental Statement at 11.

The negotiation and data submission process will be much more cumbersome for manufacturers than CMS currently estimates, and we ask CMS to reconsider these numbers.

**CMS should abandon its primary/secondary manufacturer construct.**

We are concerned with CMS's proposal to hold a Primary Manufacturer responsible for submitting applicable information concerning a Secondary Manufacturer. A Primary Manufacturer has no inherent legal authority to compel a Secondary Manufacturer to act or not act, including to share such information. It would be fundamentally unfair and legally problematic for CMS to threaten a Primary Manufacturer with significant civil monetary penalties (CMPs) for failure to do the impossible. We note that this same concern pervades the Initial Guidance, given the numerous contexts in which CMS proposes to hold a Primary Manufacturer responsible for the action or inaction of a Secondary Manufacturer.

**More specification is needed on CMS's safeguards for confidential and sensitive information.**

BIO acknowledges CMS's stated commitment to confidentiality, but recommends that CMS establish more fulsome safeguards to ensure that the Agency is adequately protecting the confidentiality of all proprietary information submitted to CMS as part of the negotiation process. In addition, BIO opposes CMS's proposed imposition of overly broad confidentiality obligations on manufacturers.

BIO recommends the following minimum controls and safeguards to give full meaning to the confidentiality requirement:

> First, CMS should confirm that, in "implement[ing] a confidentiality policy that is consistent with existing requirements for protecting proprietary information,"[5] it will ensure protections comparable to, not only those under FOIA, but also those under government price reporting law and policy.
>
> We appreciate CMS's confirmation that the protections under FOIA, including the prohibition on disclosure of information designated as confidential without providing a pre-disclosure notification and an opportunity to raise objections to disclosure,[6] will apply to information to be submitted under the program.[7]

[5] Revised Guidance at 123.
[6] *See* 45 C.F.R. §§ 5.41, 5.42.
[7] Revised Guidance at 123.

We seek confirmation that the protections under government price reporting law and policy will also apply.

Second, CMS should implement robust storage and access controls and safeguards to protect the confidentiality of sensitive information. Confidentiality requirements are only as meaningful as the data privacy and security protections that are implemented to safeguard sensitive information against inadvertent or malicious[8] improper disclosure. Accordingly, CMS should implement robust systems and protocols, including by ensuring that all proprietary information stored in the Health Plan Management System (HPMS) and in electronic communications with the Agency is secure and accessible only to CMS staff and only where there is a legitimate programmatic need for access to such information.

In doing so, CMS should look to the safeguards it has already established under MDRP. Under MDRP, CMS has implemented a system with numerous privacy and security protections to safeguard sensitive product and pricing data submitted by manufacturers. For example, the online interface allows a manufacturer to view its pricing data, such as its Baseline Average Manufacturer Price (AMP) data, while disallowing states, which do not have a programmatic need to view such information, from doing likewise.[9] CMS should ensure that similar controls are in place with respect to HPMS, given CMS's intent to transition most information submissions to that system.

CMS should also specify how it will maintain the confidentiality of the subset of information that is required to be submitted via e-mail or Box. With respect to e-mail, CMS should explain, among other things, how it will enforce access security controls. In addition, we find it troublesome that CMS requests companies email data in the event that its HPMS submission system is delayed. More information is needed about this proposed backup plan, especially in the potential event that it becomes the primary submission method for manufacturers' highly sensitive data. It is important that CMS clarifies that information collected through email (in the event of the HPMS module not being completed in time) is similarly "privileged, private to the extent permitted by law, and protected from disclosure," and protected by FOIA [10] as CMS outlines that information submitted through HPMS will be. With regard to Box (a third-party commercial platform), BIO asks CMS to

[8] Malicious third-party cyber activities have increasingly targeted the federal government—in, part, because its databases are repositories of significant amounts of sensitive information. *Cf.* David E. Sanger, *Russian Hackers Broke into Federal Agencies, U.S. Officials Suspect*, N.Y. Times, https://www.nytimes.com/2020/12/13/us/politics/russian-hackers-us-government-treasury-commerce.html (last updated May 10, 2021).

[9] CMS, *Medicaid Drug Programs User Manual* 1 (Nov. 3, 2021).

[10] Initial Negotiation Data Elements ICR at 29.

specify how submitted information will be kept confidential, including as against misuse by Box personnel.

***

We thank you for the opportunity to register our thoughts and concerns on this topic and look forward to future discussions. Please do not hesitate to contact us with any questions at (202) 962-9200.

xxxxx

Crystal Kuntz

Senior Vice President,

Healthcare Policy and Research