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CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8016
Attention: PO Box 8016

Re: Information Collection Request for Negotiation Data Elements under Section 11001 and 11002 of the Inflation Reduction Act (CMS-10847, OMB, 0938-NEW)

Dear Deputy Administrator Seshamani:

The Pharmaceutical Research and Manufacturers of America (PhRMA) is pleased to submit these comments in response to the Centers for Medicare & Medicaid Services' (CMS, the Agency) *Information Collection Request for Negotiation Data Elements under Section 11001 and 11002 of the Inflation Reduction Act* (ICR or the ICR), including the Federal Register Notice, Supporting Statement – Part A, and ICR Form (CMS-10847, OMB, 0938-NEW).[1] PhRMA represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier, and more productive lives. Since 2000, PhRMA member companies have invested more than $1.1 trillion in the search for new treatments and cures, including $102.3 billion in 2021 alone.

PhRMA's comments on the ICR focus on: (1) the scope, necessity, and utility of the proposed information request for proper performance of CMS' functions relating to the Drug Price Negotiation Program (the Program); (2) ways to enhance the quality, utility, and clarity of the information to be collected; and (3) the burden estimate. PhRMA is particularly concerned with the vast scope of information requested, the unnecessarily burdensome approach CMS has proposed in how it defines certain types of data, and the inadequate time for manufacturers to prepare responses to such requests. Some of the data sought by CMS in the ICR extends beyond what is needed for the Agency to implement the Program, and conflicts with the Paperwork Reduction Act's requirement to collect information in the "least burdensome" way possible.

[1] 88 Fed. Reg. 16,983. (March 21, 2023). Centers for Medicare and Medicaid Services (CMS), Information Collection Request for Negotiation Data Elements under Section 11001 and 11002 of the Inflation Reduction Act, Supporting Statement – Part A. Available at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10847; CMS. (March 21, 2023). Information Collection Request for Negotiation Data Elements under Section 11001 and 11002 of the Inflation Reduction Act, ICR Form. Available at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10847.

PhRMA urges CMS to limit the data that must be provided within the thirty-day response period to elements that are essential to the operation of the Program, as outlined in these comments; permit manufacturers to respond with references to publicly existing data sources, where appropriate; limit submission of information that is already accessible to CMS; and allow additional time for submissions of supplemental data required by CMS for the MFP decision-making process after the October 2 deadline.

In addition, the lack of clarity of some of the terms used in the draft ICR, and the lack of flexibility CMS provides in response fields, will hinder submission of relevant, timely data by manufacturers and external stakeholders. Below we recommend specific changes to address this concern.

PhRMA has expressed concerns related to negotiation factors and data elements in comments filed in response to the *Medicare Drug Price Negotiation Program: Initial Memorandum, Implementation of Sections 1191 – 1198 of the Social Security Act for the Initial Price Applicability Year 2026, and Solicitation of Comments* (Guidance, or the Guidance). While we will reference some of our stated policy positions in this letter, we will not reiterate the full breadth of those comments here. As such, we encourage CMS to consider these materials in tandem for the full scope of our concerns and have thus attached our previous comments to this submission as Appendix A.

As noted in our comments on the Guidance, we are concerned generally with the lack of transparency, openness, and opportunities for manufacturer and stakeholder engagement in the maximum fair price (MFP) process that CMS proposes. A single ICR will not provide for adequate input and dialogue in this process, and the ICR mechanism is not well-suited for soliciting the wide range of data and research elements CMS will need in MFP decision-making, particularly in light of the novel and complex types of data and evidence required, and the importance of ensuring adequate weight is given to factors related to comparative clinical effectiveness and unmet medical need, which require consideration of a wide range of outcomes, evidence sources, and stakeholder perspectives. We urge the Agency to consider additional, complementary mechanisms to seek input, engage key stakeholders, and make publicly available the non-proprietary information it receives during the MFP process.

As previously noted in our comments to the Agency we also have concerns that the Data Elements ICR suggests an intent on the part of the Agency to over-rely on factors related to manufacturer costs and the flawed concept of "recoupment" of R&D and potentially drive to a "cost-plus" approach to price-setting. For example, the disproportionate number of fields requiring manufacturer-specific data, as well as the excessive and detailed data requirements proposed by CMS for manufacturer-specific data, indicate a potential for CMS to set MFPs based on "cost-plus" calculations. CMS' approach to determining MFPs for selected drugs has significant implications for patient access and biopharmaceutical innovation, and it is critical that the Data Elements ICR is aligned with an approach to price setting that focuses on the clinical benefit that selected drugs offer to patients, caregivers and society. As noted in our prior comments on the initial Guidance issued by CMS on the Program, we urge CMS to address this by making suggested changes to the ICR as detailed in the following comments by scaling back excessive and unworkable demands for manufacturer-specific data and strengthening the ICR's section on comparative clinical effectiveness and unmet medical needs.

I. Requirements of the Paperwork Reduction Act (PRA)

The PRA was enacted in response to the "enormous growth of our federal bureaucracy" and "its seemingly insatiable appetite for data."[2] Regulations implementing the PRA of 1995 establish that in order to receive Office of Management and Budget (OMB) approval, agency collection of information requests must demonstrate that the agency has taken "every reasonable step to ensure that the proposed collection of information:

[2] *United States v. Ionia Mgmt. S.A.*, 498 F. Supp. 2d 477, 487 (D. Conn. 2007), *citing Dole v. United Steelworkers of America,* 494 U.S. 26, 32 (1990).

(i) Is the least burdensome necessary for the proper performance of the agency's functions to comply with legal requirements and achieve program objectives;

(ii) Is not duplicative of information otherwise accessible to the agency; and

(iii) Has practical utility. The agency shall also seek to minimize the cost to itself of collecting, processing, and using the information, but shall not do so by means of shifting disproportionate costs or burdens onto the public."[3]

The Inflation Reduction Act (IRA) requires CMS to consider certain factors – five specific elements for manufacturer-specific information and evidence about alternative treatments – as the basis for determining offers and counteroffers for a selected drug under the Program. The IRA also contemplates submission of non-Federal average manufacturer price (non-FAMP) data for a selected drug.

As noted above, CMS' proposed requirements for data submission – particularly related to manufacturer-specific data – are well in excess of what the Agency needs to implement the IRA's MFP provisions and fall well short of the PRA requirements.

II. Concerns with How the ICR Aligns with Requirements of the PRA

As a starting point, the data requested is not the "least burdensome necessary" for CMS to perform its functions in compliance with the IRA and achieve program objectives, as required by the regulations implementing the PRA of 1995.[4] While CMS must collect certain data under the IRA, CMS proposes to collect such data in an unduly burdensome manner that goes well beyond the requirements of the IRA by requesting an extensive array of proprietary and non-proprietary data as well as expanding and subdividing data categories laid out in the IRA. The information CMS requests is both vast in its scope and imprecise, such that it raises serious burden and compliance concerns for manufacturers. Many of the elements will be impossible for manufacturers to collect such as in cases where the original developer of a product no longer exists. Other elements will be impossible for manufacturers to complete with the level of precision outlined in the draft ICR given current business practices for recording and accessing information.

The enormous breadth and detail of the information request, the challenges with quantifying some of the data elements with any degree of certainty, and the departure of requested data from current business practices, will create an exceptionally high burden and make compliance exceptionally challenging if not impossible within the thirty days permitted for response, affecting the ultimate utility of the data in contravention of the PRA. Further, the lack of clarity on many fundamental issues related to submission of data on treatment alternatives will further undermine the practical utility of the requested data. PhRMA is also concerned with the burden created by the short deadline for manufacturers to submit the data required by the ICR (at most, 31 days between date of selection on September 1, 2023 and date of submission on October 2, 2023). As noted in our Guidance comments, PhRMA believes CMS has the ability under the IRA to permit data submission from both manufacturers and other stakeholders beyond October 2, 2023.[5]

The data requested, in many areas, duplicates information already accessible to CMS through other means, in contravention of the PRA statute[6] and regulations, creating additional unnecessary burden on manufacturers.[7] CMS can alleviate burden induced by the tight timeline by allowing manufacturers to authorize CMS to access information readily available through other sources.

[3] 5 C.F.R. § 1320.5(d)(1)(i)-(iii).
[4] 5 C.F.R. § 1320.5(d)(1)(i).
[5] Guidance comments at I.c.
[6] 44 U.S.C. § 3506(c)(3).
[7] 5 C.F.R. § 1320.5(d)(1)(ii).

PhRMA views the highly burdensome requests of the ICR as unnecessary and without practical utility for CMS to comply with the requirements of the IRA or operate the Program. We urge CMS to carefully reconsider the data elements requested and limit them to those that are essential to the Program operations and leverage information in a form in which it is already available and accessible to the Agency. In addition, the Agency should consider complementary mechanisms, like stakeholder meetings or solicitation of comments, which could be used to gather input in a more effective, efficient manner.

III. General Comments and Recommendations

CMS is only in its first year of implementation of the Program that Agency officials have acknowledged is "novel" and "complex"[8] with an extraordinarily short period for implementation.[9] Moreover, CMS' simultaneous issuance of the Guidance and the Data Elements ICR means that the ICR incorporates definitions and concepts (such as the Primary/Secondary Manufacturer construct) that CMS presented as proposals that could change in final guidance in response to comment. This makes commenting on the ICR that much more difficult for stakeholders, who in their ICR comments cannot be certain of CMS' final policies. Rather than unnecessarily complicating its first-year collection of information, we urge CMS to seek information in the most flexible manner possible and allow manufacturers to present information under the plain terms of the statute.

CMS should thus provide a format for data collection that facilitates flexibility, consistency, and compliance rather than unjustifiably exposing respondents to potential liability. To this end, there are several areas where PhRMA has suggested that CMS not take an overly aggressive interpretation of very vague statutory terms and require excess detail and granularity of data that will be of low utility to the Agency.

Our recommendations are described in more detail below.

Follow Least Burdensome Necessary Approach:

In compliance with the PRA, CMS should reduce the data elements proposed for collection to those essential to operation of the Program. For data that are essential, CMS should ensure that the reporting is consistent with the ways in which data are typically tracked and recorded by companies or reported to the government. PhRMA provides specific recommendations below to this effect. Please see Section II.b. of PhRMA's Guidance comments for additional suggestions for CMS to be consistent with how data is collected and reported.

CMS could further alleviate unnecessary burden by abandoning the ICR's demand for use of detailed methodologies that do not comport with how data are currently available to manufacturers, as well as by allowing manufacturers to authorize CMS to access information readily available through other sources.

CMS could also alleviate burden by requesting only one year of data be provided for some financial data elements such as various market data, revenue, and sales volume data. Please see our comments below in Section IV on "Market and Revenue Data" regarding the recommendation to collect less than 5 years of data.

Avoid Duplication of Information Available to the Agency:

Some of the data CMS is requesting is already accessible to the Agency from other sources. To avoid unnecessary duplication, CMS should permit manufacturers to provide references to publicly available sources (*e.g.*, the Food and Drug Administration's Drugs@FDA database, the Orange Book, and the Purple Book) or provide a box to check affirming that CMS may use other (including non-public) sources

[8] 87 Fed. Reg. 62433 (October 14, 2022)
[9] Castronuovo, C. (2023). Drug Price Negotiations Need 'Nimble' Approach, Official Says. Bloomberg Law. Available at: https://news.bloomberglaw.com/health-law-and-business/drug-price-negotiations-need-nimble-approach-official-says

of information in lieu of duplicating this information via the submission. We believe CMS has erroneously concluded that manufacturers must provide a full re-submission of already available data, even if the manufacturer were to agree that CMS' use of a specific source of data (including cases where CMS can obtain non-public data available to the Agency) constitutes the manufacturer's "submission" of such data.[10] Consistent with the PRA, however, CMS should provide greater flexibility, and find that a manufacturer agreeing that CMS may obtain data from an already-available source, or citing to a publicly available reference, is tantamount to an affirmative submission.

Ensure Practical Utility of Submission Requirements:

To ensure practical utility of the data for CMS, companies should be able to explain the data elements in a more unstructured way, as long as reasonable assumptions are documented and disclosed to the Agency. A less structured, more flexible approach, especially in the first few years of the program, will enable CMS to gain greater knowledge and better use of data points. This includes eliminating text limits and providing more flexibility for the submission of data CMS is seeking, for example on the evidence about alternative treatments, which is likely to be voluminous given the years on the market at time of selection. In its current approach CMS is shortchanging its ability to best understand the medicines selected for their Program by confining submission to a limited number of words and rigid data fields with very little utility, given the price-setting methodology outlined in the guidance. Eliminating character and word limits gives manufacturers the ability to better explain their data elements and therefore provides CMS a better understanding of what data has been submitted.

In addition, some manufacturer data will be most useful to the Agency, as well as less burdensome, if the fields are rolled up into a single question and single global response with an unlimited narrative field, such as for the fields dedicated to capturing the costs of research and development (R&D) for the selected drug. Eliminating character and word limits gives manufacturers the ability to better explain their data elements and therefore provides CMS a better understanding of what data have been submitted. As highlighted in our guidance comments and discussed further below, PhRMA does not believe that CMS should be capturing R&D cost data at a granular level and should instead amend the ICR to allow a single global response for R&D costs, similar to a Form 10-K for Securities and Exchange Commission (SEC) filing, and a single attestation (YES/NO) regarding the extent to which these costs have been "recouped." As noted in our guidance comments, we believe the standard of R&D "recoupment" is fundamentally misguided, unworkable, and difficult if not impossible to quantify with any degree of precision. Therefore, if a manufacturer of a selected drug estimates that R&D costs have not been "recouped," or even if they estimate costs have been "recouped", they should be able to provide more explanation of this to CMS, including narrative on manufacturer's level of certainty and thoughts on the "extent to which" costs have ben recouped. In our detailed comments we outline a flexible approach the Agency could allow for manufacturers to explain their selection.

Related to the practical utility concerns discussed above, it is critical that CMS establish submission requirements that are workable based on the reality of corporate and legal structures in the industry. As PhRMA explained in detail in our Guidance comments, "Primary Manufacturers" may not have a right to access "Secondary Manufacturer" information and thus, the proposed Primary/Secondary Manufacturer policy contemplated in the Guidance and in this ICR should not and cannot be adopted. We are concerned that this ICR contains unreasonable assumptions related to a Primary Manufacturer's ability to access data requested from Secondary Manufacturers. Furthermore, given that this information is highly sensitive, if third parties share information about contracts they have with an impacted manufacturer, the manufacturer should be notified in order to have the ability to confirm or clarify the provided information.

[10] We believe CMS' erroneous conclusion is based upon statutory language stating that the Secretary should consider certain data with respect to the selected drug "as submitted by the manufacturer." SSA § 1194(e)(1).

CMS could improve the usefulness of the information it receives (and facilitate manufacturer compliance with data submission requirements) by exercising its discretion to permit submission of data after the October 2 deadline. In the ICR, CMS appears to recognize discretion to solicit information outside of specific statutory deadlines,[11] and we strongly encourage the Agency to recognize this discretion as it applies to manufacturer-specific data as well and provide explicit, complementary opportunities to submit information.

Provide Transparency for Manufacturers of Selected Drugs:

CMS could still improve the process by sharing with the selected drug manufacturer nonproprietary evidence submitted on alternative treatments by third parties. Individuals or entities submitting information should be required to indicate whether evidence submitted is proprietary or non-proprietary. Any non-proprietary data, particularly data submitted under Section 1194(e)(2) or data that specifically identifies a manufacturer should be shared with the selected drug manufacturer. Relatedly – and in addition to our broader comments on the Guidance on the importance of CMS making publicly available the non-proprietary data it receives under 1194(e)(2) – the system should provide an upload function for respondents submitting evidence about alternative treatments to upload information, studies, and related documents and in doing so, automatically share such studies with the selected drug manufacturer.

Protect Confidentiality of Proprietary Data:

CMS acknowledges that much of the information to be submitted by selected drug manufacturers will constitute proprietary information and that such information "shall only be used by CMS or disclosed to and used by the Comptroller General of the United States for purposes of negotiation."[12] To facilitate the identification of proprietary information, CMS should allow for checkboxes or other means for manufacturers to easily designate submitted information as proprietary. In addition, CMS should develop and solicit comments on a robust confidentiality and data security protocol for protecting manufacturer proprietary information. Please see Section I.d. of PhRMA's Guidance comments for additional recommendations and comments on CMS protecting proprietary information.

Do Not Penalize Responses Provided in Good Faith

The IRA may impose substantial Civil Monetary Penalties (CMPs)[13] and excise taxes[14] when a manufacturer does not submit certain information or submits "false information." In light of the types of challenges described above related to manufacturer submission of data from a wide range of sources, some of which will be very difficult to calculate, as well as the need to rely on reasonable assumptions, CMS should publicly affirm that when manufacturers respond in good faith, with reasonable assumptions identified, they are not subject to these penalties. As discussed in more detail throughout these comments, the ICR could exacerbate the risk of potential liability by requiring manufacturers to submit vast amounts of data in a format that does not accord with typical business practices, including by requiring Primary Manufacturers to obtain data from Secondary Manufacturers that they may not have access to, through unclear definitions, and by requiring completeness and accuracy but then imposing arbitrary word limits. Manufacturers may need to reconfigure financial systems, develop assumptions that are inconsistent with other federal programs (e.g., SEC , and break down data in a new and highly prescriptive way to delineate data in the manner CMS requests, and for the sole purpose of the price-setting process. CMS should therefore create safe harbor-like standards that afford manufacturers prospective assurances that they can, using best efforts and in good faith, submit the novel information

[11] See Supporting statement at 2, stating: "This ICR Form serves as one of multiple ways that CMS intends to collect data per Section 1194(e)(2)."
[12] Supporting statement at p.6.
[13] SSA § 1197(b) and (c).
[14] IRC 5000D(b)(4).

CMS is requesting without the threat of extreme penalties. We also refer CMS to, and incorporate here, PhRMA's extensive discussion on these issues in Section VI of our Guidance comments.

IV. Manufacturer Data

This section of our comments delineates examples of PhRMA's areas of concern based on the vastness of information requested. These comments endeavor to ensure that the data required are essential to the operation of the Program and align with the PRA.

Non-FAMP Data Collection

CMS requests that manufacturers submit the non-FAMP for selected drugs, following specifications set forth in the ICR. For IPAY 2026, manufacturers are instructed to complete a table about the non-FAMP, using the reported National Drug Code (NDC)-11s and quarterly non-FAMP and total package unit volume to compute the average non-FAMP for calendar year 2021.

As set forth in our Guidance comments, PhRMA recommends that CMS use the annual non-FAMP already reported by manufacturers to the U.S. Department of Veterans Affairs (VA) as defined in 38 U.S.C. § 8126(h)(5). For 2021, this data would be the annual non-FAMP value reported to the VA by November 15, 2021. Such use of already available sources would accord with the PRA, which prohibits "any federal agency from adopting regulations which impose paperwork requirements on the public unless the information is not available to the Agency from another source within the Federal Government,"[15] and which requires each agency to "manage information resources to…reduce information collection burdens on the public."[16] PhRMA also recommends that manufacturers have the ability to make timely restatements to CMS in the event that the manufacturer restates non-FAMP values.

PhRMA further requests that CMS clarify that the units for non-FAMP may be different than the units on the Part D Prescription Drug Event (PDE) record, which uses National Council for Prescription Drug Program (NCPDP) defined values. CMS should recommend that manufacturers report the unit measure for non-FAMP in the explanatory field for Section B. More specifically, for all pricing metrics, the unit the manufacturer reports should match the unit used in the original metric. CMS should not transfer the burden nor rely on manufacturers to accurately crosswalk reporting of unit values between the two standards in Definitions for Section G, for unit type and unit of measure (CMS Medicaid units and the NCPDP billing unit standard). Due to the burden on respondents, as well as the CMP implications and related exposure, CMS must perform any cross-walking necessary. We request that CMS refer to our detailed comments on the Guidance related to non-FAMP in evaluating the ICR Data Elements.

As CMS recognizes in its supporting statement, "non-FAMP data is proprietary information"[17] and, as such, a Primary Manufacturer does not have access to Secondary Manufacturer non-FAMP data. As noted in our Guidance comments, CMS previously concluded that including sales of a Secondary Manufacturer within a Primary Manufacturer's AMP calculation "would be problematic from an administrative accounting and anti-trust perspective."[18]

R&D Costs and Recoupment

The IRA provides for manufacturer submission of R&D costs of the manufacturer for the drug and the extent to which the manufacturer has recouped those costs. We urge CMS to refer to Section II.b. of PhRMA comments where we raise concerns around the general validity of CMS's approach to capturing "R&D recoupment," and to modify the ICR to recognize both the inherent problems with the concept and

[15] *Dole v. United Steelworkers of America,* 494 U.S. 26, 32-33 (1990).
[16] 44 U.S.C. § 3506(b)(1)(A).
[17] Supporting statement at p.6.
[18] PhRMA Initial Guidance Comment Letter at 14; 72 Fed. Reg. at 39200 (Jul. 17, 2007).

the challenges of quantifying it with any degree of certainty. The ICR requests a far broader and more detailed array of data than necessary, some of which appear grounded in erroneous assumptions about manufacturers' ability to gather such data, which significantly increases the difficulty and burden of complying with this requirement. Specifically, CMS seeks dollar amounts for R&D, as well as explanations of how costs were calculated, where applicable, related to six categories: (1) basic pre-clinical research for all approved indications of the selected drug; (2) post-IND costs for all approved indications of the selected drug; (3) costs of all completed, Food and Drug Administration (FDA)-required Phase IV studies for the selected drug; (4) costs of all post-marketing trials for the selected drug; (5) costs of failed or abandoned products related to the selected drug; and (6) costs of other R&D for the selected drug not accounted for in the preceding questions. Cost data and explanations are also requested related to global, total lifetime manufacturer net revenue for the selected drug, as a way to assess recoupment of R&D costs for a selected drug. CMS describes a breakdown of costs into what they believe to be mutually exclusive categories.

PhRMA is concerned about the breadth of the information requested, the specificity and novelty of CMS' six-part subdivision of R&D costs, the compressed period for gathering and submitting such atypical information, and the assumptions that the R&D costs can be broken down in the specific terms sought related to the labeled indications for a selected drug. This specificity is particularly challenging for manufacturers with regard to the costs of preclinical research. CMS' reporting methodology is not consistent with how manufacturers track cost information, thus raising concerns for companies seeking to comply under a very tight deadline, particularly in the first year of the program. CMS' reporting methodology is not clear as there could be overlap in how costs are allocated, for example allocation of indirect expenses could apply to multiple categories. Manufacturers also may not have documentation and retention policies that would allow them to reconstruct all the R&D costs of products that have been on the market for seven or eleven years, and which were under development for many years before approval, at the level of specificity that CMS is requesting. CMS' interpretation of forms of a drug extending to all active moieties and active ingredients only compounds this complexity. Practical concerns related to these proposals are set forth in detail in Section II.b. of our comments in response to the Guidance, and we incorporate those comments by reference here as well.

CMS uses disparate standards at different places in the ICR, potentially leading to miscalculations of R&D costs and recoupment. Specifically, the ICR limits calculation of R&D costs to "FDA-approved indications," but then seeks data on "global lifetime revenue." This incongruence will not only yield inaccurate estimates but is unduly burdensome with regard to how manufacturers actually track R&D expenditures. PhRMA previously raised the concern in our comments that companies do not consider drug development costs related to specific market applications only. In fact, companies regularly utilize global clinical trials to facilitate the goal of simultaneous market access in as many countries as feasible when considering their product development and launch strategies. In addition, the global lifetime revenue of a drug will necessarily include revenues from markets outside the U.S. Bifurcating the requests for development costs vs. recoupment revenues in a U.S. market-based approach for costs but a global approach for recoupment creates additional complexity and unnecessarily increases the compliance risks for manufacturers without providing a clear benefit for CMS' ability to determine the MFP offer.

The ICR, as drafted goes beyond the plain language of the IRA. The IRA states only that a manufacturer should submit information on: "research and development costs of the manufacturer for the drug and the extent to which the manufacturer has recouped research and development costs."[19] In accordance with this statutory direction, CMS should focus only on whether a company has recouped the cost of R&D. CMS' requested level of detail is unnecessary and the categories are not helpful for CMS to determine whether R&D has been "recouped" under 1194(e)(1). Not only does the submission of such data in granular categories create undue burden on manufacturers, but it is also unclear in the ICR why the R&D

[19] SSA § 1194(e)(1)(A).

data must be broken out in the format specified. Each company tracks and manages R&D spending differently, and CMS' rigid outline of costs does not account for such variability.

To address these inconsistencies and reduce manufacturer burden, PhRMA recommends that CMS amend the ICR to allow a single global response for all the manufacturer's R&D costs across all development programs, similar to a Form 10K for Securities and Exchange Commission (SEC) filing, and a single attestation (YES/NO) for recoupment. If a respondent stipulates "YES" that they have recouped research costs, then CMS need not gather any additional information. If a manufacturer checks "NO," then the manufacturer should be allowed the flexibility to provide an explanation, free of word limits, as to how the costs weren't recouped through one or more of the following approaches. These could include allowing manufacturers to allocate a percentage of total R&D to the selected drug based on a generally accepted standard (e.g., 20% of total R&D spending to the selected drug based on historical actual or budget) and a free text box to explain how that calculation was derived. Another approach, based on data availability, would allow manufacturers to provide data in two broader categories: (1) costs of R&D *before* initial FDA approval (an aggregate way to gather all basic/preclinical and clinical development), and (2) costs of R&D *after* FDA approval, which would include Phase IV costs, allowing for reasonable assumptions and allocations of spending for the selected drug. Other approaches provided by the manufacturer and including reasonable assumptions and methodologies should also be acceptable for CMS.

As the ICR stands currently, manufacturers are very likely to exceed the full 500 hours CMS projects for completion of the entire ICR on this section alone. PhRMA urges CMS to amend the ICR to the single global response and associated free text field for explanation as recommended above to ensure a workable and "least burdensome" approach.

Current Unit Costs of Production and Distribution

The ICR sets forth a methodology for calculating and reporting current unit costs of production and distribution for each NDC-9 included in the selected drug, as well as any NDC-9 of the drug marketed by a Secondary Manufacturer. PhRMA is concerned with the broad, overly burdensome request in a manner that extends beyond the terms of the IRA. In addition, the ICR contemplates manufacturer submission of data that may not be available to them, such as data residing with third-party suppliers and others in the supply chain. We incorporate our Guidance comments from Section II.c. for additional concerns on this Section.

CMS should revise the ICR to provide discretion to manufacturers to describe production and distribution costs that they are able to report and offer a narrative explanation, without word limits, for how the costs were computed and to flag other considerations that may impact production and distribution, rather than specifying a detailed methodology that may not mirror how these costs are recorded and tracked by different manufacturers. Breaking down current costs of production and distribution by drug is difficult and such data is not typically recorded at the NDC-9 level. Production costs are not typically allocated based on a per-product basis and, from an accounting perspective, are not tracked at the NDC level.

Prior Federal Financial Support

CMS requests prior Federal financial support for novel therapeutic discovery and development related to the selected drug. This includes support from when initial research began or when the drug was acquired by the manufacturer, until the date of the most recent NDA/BLA approval for the selected drug. CMS seeks financial support dollar amounts and supporting explanations related to tax credits (General, R&D); Orphan Drug Act and other specific tax credits; Direct Federal Financial Support of Development; NIH Grants; Department of Defense (DOD) Congressionally Directed Medical Research (CDMR) Funding; Defense Advanced Research Projects Agency (DARPA) Funding; and other federal financial support not

included elsewhere. CMS also seeks details on agreements between the manufacturer and the federal government, such as licensing or purchasing agreements.

PhRMA strongly recommends that consideration be limited to funding that resulted in a patent application containing a Government Interest Statement and/or research where a patent assignee was a U.S. government agency for an invention directly related to the development of the selected drug (*e.g.*, excluding basic science, research tools, or similar general concepts). To comply with the PRA, CMS should obtain this information through other, already-available sources, rather than procuring it entirely from manufacturers. In addition, the federal financial support chart should request only one field with the total federal financial support figure, along with an explanation. The burden and difficulty of obtaining data in the specific manner CMS requests in these fields significantly outweighs the utility of this data for the Program.

We are concerned that CMS strays far beyond the statute for this data element. Our recommendation, of one total figure directly related to the selected drug, is more in line with the statute. The IRA only requires one line-item for reporting prior support and states that the manufacturer should submit "prior Federal financial support for novel therapeutic discovery and development with respect to the drug."[20] Moreover, if CMS is to limit R&D manufacturer costs to FDA-approved indications for the selected drug, CMS similarly should be consistent and consider only the federal financial support directly relevant to such labeled indications. To that end, general tax credits that are not product-specific should not be considered.

Further, CMS should clarify that prior federal financial support that must be reported is only for the period starting from when the manufacturer acquired the drug, even if this methodology may result in reporting of no prior federal financial support during the period for products associated with patent applications that included a Government Interest Statement.

In relation to CMS' requests relating to agreements between the manufacturer and the federal government, such as licensing or purchasing agreements, manufacturers may not continue to have access to these documents, depending on document retention policies. Even if this information is available, divulging it may represent a breach of contract or confidentiality within parties.

Patents, Exclusivities, Applications, and Approvals:

The ICR requests data on "pending and approved patent applications," exclusivities recognized by the FDA, and applications and approvals pursuant to Section 505(c) of the Federal Food, Drug, and Cosmetic Act (FDCA) or Section 351(a) of the Public Health Services Act (PHSA).

PhRMA urges CMS to procure information on "approved patent applications" from the FDA's Orange Book and Purple Book listings and information about approved applications under the FDCA and PHSA from Drugs@FDA. Doing so will better align with the PRA's requirement for the Agency to refrain from seeking information that is duplicative of data already accessible to the Agency. As set forth in our preceding general recommendations, manufacturers should be permitted to check a box stating that CMS may use these publicly available resources in lieu of manufacturer submission of duplicative data. Companies should be permitted to similarly reference these sources, as needed, in responses rather than duplicating the information.

As stated in Section II.e. in our Initial Guidance comments, CMS should consider only those patents and patent applications that are directly related to the selected drug. CMS could further align with the PRA and clarify the currently vague definition of relevant patent information, which could encompass collection of information with little utility for the Program such as information on patents and patent applications that have no bearing on the continued single-source status of a selected drug. Rather, CMS

[20] SSA § 1194(e)(1)(C).

should focus as noted in Questions 13 and 14 on patents that claim the drug substance, drug product, or method of using the drug. CMS should accordingly delete the reference to manufacturing processes in the text of Question 14. Furthermore, CMS should amend the ICR to reflect the comments made in Section I.d. of our Initial Guidance comments, relating to the confidentiality of pending patent and FDA applications, which typically contain information that is proprietary, highly sensitive, and would also not have utility to CMS for the purposes of the program as they may be rejected or voluntarily withdrawn. In addition, as noted in our prior comments, CMS should confirm that "abandoned" patent applications do not constitute "pending and approved patent applications."

Market Data, Revenue, and Sales Volume Data

Under the category of market data, revenue, and sales volume data, CMS seeks to collect an extensive set of pricing data, including federal price reporting metrics and commercial prices, as well as acquisition costs, gross revenue, net revenue, net revenue without patient assistance programs, and quarterly total U.S. unit volume.

This section of the ICR represents a serious overreach by the Agency related to its authority to request information from manufacturers necessary for operation of the Program over such a significant period of time. The data elements required under this section must be reported for each quarterly period in the most recent five years, presenting a substantial burden without any basis in statute. Additionally, as discussed earlier in this letter, this section of the ICR raises significant concerns related to "primary manufacturers" reporting these data on behalf of "secondary manufacturers" as this could violate contractual agreements.

Furthermore, the only pricing metric that the IRA indicates manufacturers must report to CMS under the Program is non-FAMP. CMS cannot use the general term of "market data, revenue, and sales volume" to obtain broad propriety pricing information for a selected drug in nearly all market segments. These data points are not necessary or essential to the operation of the Program, their inclusion in the Program could create a disincentive for manufacturers to offer discretionary discounts to other federal programs and payers, and CMS provided no rationale for collecting such data, in either the Initial Guidance or in the ICR. Moreover, the ICR would require manufacturers of selected drugs to calculate and report various new and confusingly-described pricing metrics – which would require that manufacturers develop reasonable assumptions to use in calculating these metrics and report their reasonable assumptions – which assumptions may be difficult to describe correctly given the word limits on manufacturer responses.

In relation to questions 21 – 24 of the ICR (340B Ceiling Price and 340B Prime Vendor Program Price), CMS already has access to the 340B Ceiling Price through existing price reporting under the Medicaid program. However, the 340B Ceiling Price and 340B Prime Vendor Program price both have no bearing on Medicare "negotiation" and, as such, should not be included in the data requested. The IRA refers only to submission of non-FAMP, not other price reporting metrics, and requiring manufacturers to report sub-ceiling 340B pricing information could create a significant disincentive for manufacturers to continue to offer sub-ceiling discounts. Additionally, HHS already has access to the 340B utilization volume through the HRSA Prime Vendor data, although again the 340B utilization volume is not a required statutory data element and does not have bearing on IRA negotiation.

As for questions 25 – 30, which request Medicaid Best Price, Federal Supply Schedule (FSS) Price, and the Big Four Price, CMS already has access to Medicaid Best Price through existing price reporting to the Agency under the Medicaid program, and FSS prices are publicly reported. However, Best Price, FSS Price, and the Big Four Price are not appropriate reference points for Medicare and therefore lack utility. As noted in PhRMA's Guidance comments, the Senate overwhelmingly rejected (by 99-1) amendments

that would have incorporated FSS and "Big Four" pricing into the IRA,[21] and these price metrics already reflect negotiation by the federal government. Please refer to Sections II.f. and III.a. of PhRMA's prior comments for additional explanations as to why Veterans' Affairs pricing (which uses "national formularies . . . of preferred drugs, steer[s] patients to lower-cost drugs, and buy[s] drugs in large volumes"[22]) is not representative of "market" pricing and is not an appropriate model for setting Medicare prices. Similarly, Best Price is a Medicaid, not a Medicare, metric. Congress has historically allowed Medicaid, a program for the lowest income and most vulnerable U.S. populations, to act as payer of last resort and receive prices that are far lower than other pricing. And again, the IRA statute refers solely to submission of manufacturer non-FAMP, not to these pricing metrics.

In questions 31 – 34, CMS has created new methodologies (*i.e.*, multiple variations of "U.S. commercial average net unit price" and "manufacturer average net unit price to Part D plan sponsors") on which manufacturers need to report within the 30-day time period, including explanations as to how certain terms are treated and allocated, as well as how certain classes of trade were handled. First, commercial pricing data is not necessary or essential to the operation of the Program and should not be a required data element. The IRA statute refers only to submission of non-FAMP, not commercial pricing metrics, and furthermore, patient assistance is not a price available to either commercial payers or federal programs. Second, development and validation of these types of methodologies within 30-days is an unreasonable request and, again, places undue compliance burdens on manufacturers seeking to compliantly respond to the ICR. The new metrics are not defined with specificity and the lack of clear definitions will likely result in inconsistencies,[23] and the requirement for manufacturers to provide data on these new metrics covering quarterly periods for five years creates a particularly excessive burden. CMS should withdraw these new metrics, and the corresponding fields in the ICR, in their entirety. To the extent CMS is not willing to do so it should, at a minimum, define patient assistance and exempt manufacturer charitable free drug programs. For U.S. commercial average net unit price, CMS should explicitly exclude FSS and the Big Four Price from this metric, as they are not commercial prices. For U.S. commercial average net unit price, CMS should explicitly exclude all prices that are not prices to commercial customers from this metric. In addition to the excluded price and volume information already listed for Medicare and Medicaid, minimally FSS prices, the Big Four Price and 340B Ceiling Price should also be specifically excluded.

CMS should focus this section on data that are market data, revenue, and sales volume data, such as gross and net revenue and sales volume. There is no legitimate reason for CMS to request the pricing data as part of this ICR and we incorporate Guidance comments in Section II.e. of our letter that touch on this element of data collection as well.

V. Evidence About Alternative Treatments

Primary manufacturers and interested third parties may submit information on the factors described under Section 1194(e)(2) of the SSA on the selected drug and available therapeutic alternative(s) under the "Evidence About Alternative Therapies" section of the ICR.

Although all questions in this portion are voluntary for both manufacturers and public data submitters, CMS is required by statute under Section 1194(e)(2) to consider evidence about alternative treatments "as available." Many experts and stakeholders have noted the important role that this information will play in

[21] 24 S. Amdt. 5210 to S. Amdt. 5194 to H.R 5376. Available at: https://www.senate.gov/legislative/LIS/roll_call_votes/vote1172/vote_117_2_00288.htm.
[22] Congressional Budget Office. (2021). A Comparison of Brand-Name Drug Prices Among Selected Federal Programs. Available at: https://www.cbo.gov/publication/57007.
[23] CMS should be well aware that other mandatory pricing metrics (such as Average Manufacturer Price, Best Price, and Average Sales Price) have involved nuances in definition that have taken many years to fully address. Creating completely new mandatory pricing metrics under such short timelines for consideration risks an ill-defined and ill-targeted metric.

the MFP process.[24] Manufacturers will also need to consider 1194(e)(2) factors when responding to a CMS "initial offer" via a counteroffer. Thus, while technically voluntary under statute, it is important for the Agency to recognize that, as a practical matter, many manufacturers and other stakeholders (including, potentially, manufacturers of therapeutic alternatives that may also indirectly be evaluated in comparison to the MFP-selected drug) will feel compelled to submit evidence and data under this section. In light of the important role these factors can and will play in the MFP process, we believe CMS should provide additional detail and clarity to facilitate timely submission of relevant information on these factors. In addition, the breadth and complexity of this information, and its importance to patients, caregivers and public health, reinforce the importance of CMS establishing supplementary mechanisms for gaining ongoing stakeholder input (for example, for patients, caregivers and physicians). CMS will not be able to gain a complete and accurate picture of factors such as relative clinical benefit and unmet need without a) properly and clearly defining these terms and b) engaging patients, physicians and other stakeholders on an ongoing basis.

As currently requested in the ICR, CMS does not provide adequate clarity or time for respondents to provide the information necessary for CMS to properly conduct and synthesize patient-centered clinical effectiveness research and costs of selected drugs and treatment alternatives. Further, submission of these data by manufacturers and public stakeholders could be particularly challenging due to the large volume of research that will have accumulated for medicines as a result of post-approval research across multiple forms and indications. The arbitrary word counts and citation limits, particularly the 1,000-word limit on questions 40 and 43, are concerning given the complexity of the issues presented and the primacy CMS proposes to give net price of therapeutic alternatives in its price setting. As such CMS should remove these limits to allow for biopharmaceutical manufacturers and the public to submit all the data necessary for CMS to consider. Furthermore, as many members of the public, including patients and clinicians, may not be able to collect the volume of data requested, CMS should allow Section H to be submitted throughout the price-setting process. As the time constraint will prove a challenge for manufacturers, it will be even more so for representatives from underserved or underprivileged communities that may not have the resources to compile these data together within the provided window. Our concerns regarding substantive and technical components of this section are set forth below.

Minimize Burden on Respondents

As currently proposed, respondents are asked to submit all information on all potential comparators across all indications within the 30-day deadline, with no bounds on the potential universe of products. PhRMA is very concerned about the open-ended nature of this question and the practical utility to CMS of such an open and undefined data set. If selected therapeutics alternative(s) are not identified in advance, more manufacturers of *potential* therapeutic alternatives likely will feel compelled to submit data on these factors, thereby increasing unnecessary burden of data submission for stakeholders. To minimize burden of submission and increase likelihood that the information submitted to CMS is relevant and useful, CMS should publicly identify the therapeutic alternative(s) as well as any resources (e.g., manufacturer feedback, clinical guidelines, advisory panels, etc.) it relied upon to identify the therapeutic alternative(s) when the drugs selected for negotiation are announced. As noted in Section III.c. of our Guidance comments, experts, including manufacturers and clinicians, should be the primary resources for determining therapeutic alternative(s).

Avoid Duplication of Information Available to CMS

Under Question 40, CMS requests prescribing information to which the Agency already has access; it is unnecessarily burdensome to collect these data again through this ICR. In particular, the first bullet under the subheading, "Question to Respond to for Question 40," requests information on prescribing

[24] Bright, J., Oehrlein, E. M., Vandigo, J., Perfetto, E. M. (2023). Patient Engagement Data: Missing Ingredients for CMS' Successful IRA Implementation. Health Affairs Forefront. Available at:

information that has been approved by the FDA for the selected drug and therapeutic alternative. This information is accessible already and is redundant to FDA prescribing information available from Drugs@FDA. CMS should remove this bullet or clarify that this information is already publicly available FDA prescribing information and will be procured by CMS.

Clarification of Evidence Standards

CMS is not permitted to rely on quality-adjusted life-years (QALYs) or similar measures as part of the MFP process, as noted by CMS in the initial Guidance on the Program. However, PhRMA is concerned that the manner in which CMS instructions submitters to limit submission of comparative effectiveness research that relies on QALYs or similar metrics in the instructions for Questions 40-41. CMS instructs the submitter against submission of "evidence comparative clinical effectiveness research that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill", a reference to the prohibition on reliance on QALYs and similar metrics found in the statute. This instruction ignores the fact that CMS is also prohibited from reliance on QALYs, and similar metrics of cost effectiveness analysis under Section 1182 of the SSA, which does not include that qualifier. Whether or not research treats extension of life benefits differently for certain population is not the only applicable standard, and CMS should revise its language accordingly.

Furthermore, this prompt is not an attestation and will not provide any additional information that will inform CMS' use of the data, as CMS should evaluate all data submissions to protect against use of the QALY or other discriminatory metrics, and therefore should be deleted. As noted in Section II.g. of our Guidance comments, CMS fails to sufficiently define "clearly separated" to allow stakeholders to understand what information is prohibited and considered discriminatory by CMS. CMS does not have the time and expertise to review the large quantities of data to be submitted through the ICR to separate out the information in the study that is relevant to the price-setting factors but does not implicate the use of QALYs or other discriminatory metrics. Instead of spending time judging if the information submitted to CMS meets this vague and unnecessary standard, CMS should require all data submissions to remove all QALY-based information. Furthermore, CMS should thoroughly review all evidence submitted through this section of the ICR to ensure that the MFP determination does not rely on the QALY or other metrics that treat the lives of vulnerable populations – including the elderly, disabled, or terminally ill – as of lesser or lower value.

To help ensure CMS receives appropriate data, PhRMA also urges CMS to provide general clarification on the evidence standards for submitted data (*e.g.*, guidance on whether studies must be U.S.-based, types of studies accepted, rigor, evidence hierarchy, etc.). While biopharmaceutical manufacturers should have the ability, without word or citation limits, to provide a wide range of evidence that they can justify as accurate and appropriate for CMS to consider in MFP decision-making, it is critical that CMS help reduce the burden on data submitters by helping them to tailor their submissions to prioritize evidence that meets Agency standards. Further, CMS should outline whether there are levels of evidence that must be met for data provided from external stakeholders. This is especially important for the collection of real-world evidence as it can come from many sources and vary widely in quality, so CMS must specify guardrails to ensure submission and evaluation of high-quality and rigorous evidence. These guardrails should exist to ensure that public data submitters follow similar standards (e.g., pre-specified protocols, transparency, and use of fit-for-purpose data). Examples of these guidelines can be found from established professional societies such as ISPE (International Society for Pharmacoepidemiology)[25] and ISPOR (The Professional

[25] Sobel, R. E., Girman, C. Ehrenstein, V., Nyberg, F., Soriano-Gabarró, M., Toh, D. (2020). ISPE's Position on Real-World Evidence (RWE). International Society for Pharmacoepidemiology. Available at: https://pharmacoepi.org/pub/?id=136DECF1-C559-BA4F-92C4-CF6E3ED16BB6

Society for Health Economics and Outcomes Research).[26]

Clarification of Terms

PhRMA requests clarification and definition of key themes and terminology included in the ICR. As the ICR is open to the public with various levels of pre-existing knowledge regarding CMS' price-setting process, PhRMA recommends that CMS provide definitions of the key terms used in Section H at the beginning of each question and in the instructions to help stakeholders understand what information CMS is seeking. Examples of areas of concern are set forth below:

- Personal Experience: CMS should change the terminology of "personal experience" under the subheading, "Instructions for Questions 40 through 43," to expand beyond that of taking or prescribing the medicine described in the outlined narrative. The Agency should also include and collect important voices from any interested patient, clinician, caregiver, or patient advocate. Thus, CMS should carefully word these definitions to be inclusive and explicitly encourage these individuals to submit information. As noted in the Patient-Centered Outcomes Research Institute's Equity and Inclusion Guiding Engagement Principles: "inclusion of diverse perspectives and groups in research partnerships goes beyond achieving categorical representation; it requires explicit invitations, clearly stated intentions, culturally appropriate actions, humility, and the deliberate creation of welcoming environments that foster a sense of belonging."[27] The current wording may exclude the viewpoints of key stakeholders, such as family members or caregivers who also have exposure and experience with the treatment that does not fall under the current specifications.

- Therapeutic Impact on Specific Populations: Although CMS is directed in the IRA to consider comparative effectiveness of a drug and therapeutic alternatives, CMS goes further in Question 41 to state that the Agency will consider "therapeutic impact" on "specific populations." CMS should provide additional detail on what this entails or use and clearly define an alternative term.

- Safety Profile: In seeking information about the range of impacts of a selected drug and its therapeutic alternative(s) for the purpose of comparative effectiveness research, the ICR should substitute the current terminology "Safety Profile" with "Benefits and Risks" in Question 41 to ensure CMS is collecting information on the full range of information on each product. The current language is too narrow to capture the information we believe CMS is seeking through this question as basic safety profiles on comparators can be pulled from labels,

- Cost: "Cost" should be more clearly defined under Question 41 to include a consideration of a range of direct and indirect costs (such as the costs to caregivers, transportation costs, lost work time), and cost savings associated with appropriate use of a selected drug. Furthermore, to ensure an even comparison between the selected drug and any therapeutic alternatives, the cost considered should reflect the true net cost after rebates to Medicare including accounting for any significant discounts provided under the 340B Drug Pricing Program. In order to make sure CMS receives appropriate and comparable information from this question, CMS

[26] Berger ML, Sox H, Willke RJ, et al. (2017). Good Practices for Real-World Data Studies of Treatment and/or Comparative Effectiveness: Recommendations from the Joint ISPOR-ISPE Special Task Force on Real-World Evidence in Health Care Decision Making. Value in Health. 20(8):1003-1008.

[27] Patient-Centered Outcomes Research Institute's Advisory Panel on Patient Engagement. (2021). Equity and Inclusion Guiding Engagement Principles. PCORI. Available at: https://www.pcori.org/about/pcoris-advisory-panels/advisory-panel-patient-engagement/equity-and-inclusion-guiding-engagement-principles.

should also clarify what documentation or citations are required to support any provided cost figure(s).

- Unmet Medical Need: CMS' definition of "unmet medical need" in Question 43, which is defined as, "A drug or biologic that treats a disease or condition in cases where very limited or no other treatment options exist is considered to meet an unmet medical need[,]" is too narrow. As mentioned in Section III.f. of our Guidance comments, CMS should at a minimum expand this definition to meet the FDA's definition of unmet need.[28] However, CMS should also explicitly recognize other types of unmet needs including, but not limited to: 1) personalized medicines for certain subpopulations; 2) progress against rare and hard-to-treat illnesses; 3) treatments that improve patient adherence and quality of life; 4) need for additional treatments in a therapeutic area, such as a curative treatment; 5) treatments that improve the health of underserved and vulnerable communities who face health disparities; 6) treatments that benefit multiple common comorbidities at once; 7) populations and individuals failing to meet established treatment guideline goals from available therapies and; 8) the stepwise nature of progress in which significant gains for patients are achieved via advances that build on one another. To ensure CMS is able to fully assess whether or not a treatment addresses an "unmet" need, CMS should broaden and clarify its definition.

- Comparative Effectiveness: CMS should strive to accept all valid and rigorous methodologies that tell the value story. To do this, the Agency should clarify what is acceptable as appropriate comparative effectiveness including acceptance of indirect treatment comparisons (including non-head-to-head trials), and pre- or post-treatments comparisons.

- Therapeutic Alternatives: As noted in Section III.c. of our Guidance comments, experts, including manufacturers and clinicians, should be the primary resources for determining therapeutic alternative(s). The Agency should be clear that if data submitters choose to provide information on therapeutic alternative(s), the therapeutic alternative(s) should not only include drugs indicated for the same disease or condition as the selected drug, but also those that are similarly used in clinical practice.

- Therapeutic Impact: In question 41, "Therapeutic Impact and Comparative Effectiveness" the first bullet states "Please provide information on the therapeutic impact of the selected drug compared to existing therapeutic alternatives." As therapeutic impact can extend beyond comparative effectiveness, the Agency should confirm that they will accept information on therapeutic impact within healthcare system as well as comparative effectiveness.

Transparency for Manufacturers of Selected Drugs

CMS should provide transparency and visibility as to how it will conduct its review of the evidence and provide further guidance on whether this information obtained will be disclosed to manufacturers and other data submitters. Further, the Agency should publicly describe the process it will use to obtain information for clinical and subject matter experts through mechanisms other than the ICR, and how this information will be made available to the public and/or manufacturers participating in the MFP process. Upon review, CMS should make publicly available the non-proprietary data it gathers under Section (e)(2) on alternative treatments and should share information with the manufacturers of selected drugs and therapeutic alternatives as quickly as possible.

[28] FDA. (2014). Guidance for Industry Expedited Programs for Serious Conditions – Drugs and Biologics. Available at: https://www.fda.gov/files/drugs/published/Expedited-Programs-for-Serious-Conditions-Drugs-and-Biologics.pdf

Technical Improvements:

CMS currently provides a list of six categories of respondents (*e.g.*, representative of a manufacturer that does not manufacture the selected drug, representatives of a secondary manufacturer of the selected drug, etc.) under Question 39. CMS should make significant revisions to this list both to revise the descriptions of the stakeholders listed, and to list a broader range of stakeholders that will be interested in providing information. First, CMS should broaden the descriptions of the stakeholder categories it does identify. In particular, it should revise the description of health care providers and patients to extend beyond those with direct experience prescribing or taking a medicine and include those who otherwise have expertise or knowledge about the drug.

CMS also should expand the list of stakeholders to avoid creating the impression that submissions from some members of the public are not sought or valued by the Agency. This should include creating a category for "representatives of organizations representing patients, people with disabilities, family caregivers or consumers" that is separate from the "trade association" category. Further, in other documents related to the ICR (CMS' Guidance document and the Supporting Statement for the ICR itself), CMS identifies other categories of relevant stakeholders, and the Agency should ensure these, and other stakeholders are included on this list. For example, the ICR Supporting Statement lists "patients and consumers, Part D plan sponsors and Medicare Advantage organizations, Primary Manufacturers, manufacturers of therapeutic alternatives for a selected drug, hospitals and health care providers, wholesalers, pharmacies, researchers, and other members of the public" that "may provide additional insight into selected drugs and alternative treatments." CMS should ensure that the stakeholder list on Question 39 is at least as detailed and comprehensive as the list in the Supporting Statement.

Finally, CMS should also allow clinicians to indicate if they are a clinical expert in the field (e.g., specialist) and should make sure respondents can indicate if they are a caregiver, payor, or any other party with significant interest in the impact of the price setting process.

In the text containing the instructions for Questions 40 through 43, the sixth bullet, "When citing studies to support responses, briefly summarize the study context and relevant comparator or therapeutic alternative drug(s) studied, as applicable" is repeated as the eighth bullet. For clarity, CMS should remove one repeated bullet and once again explicitly state that this is optional as summarizing a study could be viewed as burdensome to patients, providers, and their representatives which could deter them from responding to the ICR.

The ICR "Questions to Respond to for Question 41" and "Questions to Respond to for Question 42" reflect the important role that comparative effectiveness data will play in the MFP decision-making process, and the very limited window of time that manufacturers will have to submit this data. In this context, it will be important for manufacturers to have more timely access to CMS' claims and prescription drug event files for conducting real-world analysis, particularly given that the Agency has indicated it may conduct their own real-word evidence analyses, and these may entail use of the same data sets. Under CMS' current policy on claims data access, it is not possible for manufacturers (or many other important stakeholders) to have ready access to CMS medical claims and prescription drug event files. Access to the CMS Research Identifiable data requires following the processes set forth by the Research Data Assistance Center (ResDAC). Requests to RedDAC require detailed descriptions of proposed analyses, can be rejected by ResDAC for any number of reasons, and the process for gaining data access is likely to exceed the time window afforded to a manufacturer (a month from notification to submission). As a result, CMS should either create a new mechanism for manufacturers to access CMS Research Identifiable data in order to conduct comparative effectiveness research or certify that they will not use mechanisms not available to manufacturers to access CMS Research Identifiable data. In addition, if CMS intends to conduct their own RWE studies, the process should be transparent and provide opportunities for manufacturers and other key stakeholders to review study designs and provide input.

Question 42, which asks about comparative effectiveness on specific populations, should include text boxes to allow respondents to identify key benefits and risks of the selected drug and therapeutic alternatives on specific populations.

As noted above, CMS should remove the word limits for responses in the entire ICR. These arbitrary limits may force data submitters to cherry pick data instead of providing a balanced view on the totality of evidence. The word and citation limits are especially concerning in Section H for the questions related to therapeutic alternatives because the ICR provides a very limited number of questions and data fields while seeking information that encompasses multiple treatment options, multiple indications, and large volumes of evidence on a wide range of clinical and patient-centered outcomes that have accumulated through years of post-approval research.

Based on the large volume and variety of data that may be available on the questions in Section H, CMS should provide additional fields for submission of data on specific indications and outcomes throughout the section. The Agency should also include an open text box at the end of Section H to allow for the submitter to include other information that was not captured in the previous questions but that is still important for CMS consideration. In addition, CMS should accept attachments and other sources of data to support the narrative provided. These could include, but are not limited to, tables, statements, and other sources of information that may not be able to be provided within a citation. Any such materials should be shared with the selected manufacturer as soon as possible.

VI. Certification of Submission

The ICR requires all respondents to certify that the information submitted is "complete and accurate."[29] Respondents must also agree to notify CMS in a timely manner upon becoming aware "that any of the information submitted in this form has changed[.]"[30] According to the terms of this certification, any misrepresentations may give rise to liability, including under the False Claims Act.

We first note that nothing in the statute requires a certification as proposed by CMS. This contrasts with other provisions in the Social Security Act, which specifically require such certifications. For example, section 1124(c)(3)(A) requires the Secretary to promulgate regulations for disclosure of ownership and other information that ensure that "the facility certifies, as a condition of participation and payment under [Medicare and Medicaid], that the information reported by the facility . . . is, to the best of the facility's knowledge, accurate and current."

CMS should modify the certification to delete the requirement to certify to "completeness," unless the Agency provides further guidance on the definition of "complete." As discussed previously, given the age, history, and preexisting retention policies, manufacturers may not be able to access all relevant records and thus may not be able to certify "completeness." Therefore, without additional guidance on what data and information qualify as "complete," particularly within the "Evidence About Alternative Treatments" portion of the ICR, stakeholders are beholden to a vague standard of certification on an open data set that may lead to legal risks. Furthermore, given the existing word limits, submitters may not be able to submit complete answers to some of the questions. Stakeholders should instead certify only that their submitted information is accurate.

CMS should remove the requirement of timely notification of changed information to avoid unintended noncompliance of the certification and unnecessary burden. The scientific field continues to evolve with new publications and disclosures. As a result, this term of the certification, with no specification of the applicability of a time limit, adds an ongoing burden for all submitters that CMS suggests could lead to legal liabilities and consequences.

[29] CMS, ICR Form at 42-43.
[30] *Ibid.*

PhRMA is further concerned that, as drafted, the certification statement may prevent manufacturers from submitting evidence that relies on disclosed assumptions or estimates where necessary, due to the timeline of data collection and issues with data collection previously discussed in this letter.

PhRMA urges CMS to remove the liability clause in the certification. Instead, CMS should mirror the Average Sales Price Data (Addendum B) certification, which requires only that the information was submitted "in good faith" and reflects the submitter's best "knowledge and belief."[31]

Additionally, PhRMA is concerned that the certification requirement could create an unnecessary barrier for data submission by many external stakeholders that is not imposed in other CMS decision-making contexts such as coverage determinations or provider fee schedule changes. In particular, CMS should not require patient groups or patients and caregivers, responding in their individual capacity, to sign any certification whatsoever. In addition, CMS should monitor submissions of evidence under (e)(2) to determine the extent to which certification may create a barrier for some stakeholders.

VII. Burden Estimates and Information Collection Burden

CMS has invited comment on both the burden estimates and the use of automated collection techniques or other forms of information technology to minimize the information collection burden. CMS' calculations provide an estimate that each manufacturer will likely spend 500 hours at a cost of $51,588.50 to respond to the data request. This is a severe underestimate for reasons that include the following:

- CMS proposes to collect a vast amount of data, in a new program, under an aggressive timeline, with potentially extreme penalties associated with the collection. Companies are thus likely to assign full or partial FTEs to the price submission requirements and hire consultants and/or law firms to advise on submissions and corresponding assumptions.

- CMS has requested data in a manner that is unfamiliar and unclear to manufacturers, such as CMS splitting one statutory R&D category into seven sub-categories, requiring many hours from manufacturers to collect, allocate, and report data with very little clear benefit. CMS should account for the extreme burden and cost of this approach. The R&D category alone will likely absorb more than the total 500 hours CMS estimates for the ICR.

- There is also the additional burden to collect and search for historical data, such as historical R&D data, that could be non-existent or maintained within older internal systems that are difficult to access.

- The manner in which CMS requests the information is not how manufacturers collect these data. As a result, collecting data – such as at an NDC-9 level – or converting units between alternate standards – will be highly burdensome and will vastly increase the monetary and time burdens required by manufacturers to comply.

- While PhRMA urges CMS to abandon its primary/secondary manufacturer policy, if CMS finalizes the policy, it will only exacerbate and increase the Primary Manufacturer's burden.

- Collecting the CER factor information and evidence about alternative treatments will be a significant burden, both for the manufacturer of the selected drug and other stakeholders, as this research is not currently collected or submitted to CMS.

[31] CMS. (rev'd 2018). Average Sales Price Data Certification Form (Addendum B). Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/downloads/aspdata_addendumb.pdf

CMS also states that manufacturers have experience providing information similar to the negotiation factors set forth in Sections 1193(a)(4)(A) and 1194(e) based on manufacturer submission of data to other entities, such as: the Securities and Exchange Commission (SEC); CMS as a result of the Medicaid National Drug Rebate Agreement; and States through negotiations for supplemental rebates. PhRMA, however, is not aware of any entity (public or private) that collects data at the excruciating level of detail CMS proposes in its ICR. States, the SEC, and private entities allow companies to report data in broader terms (such as overall R&D on a company-wide basis) and to offer reasonable assumptions. They also do not present the same level of risk, given the significant CMPs and excise taxes potentially at issue.

Further, CMS should have calculated some level of burden for collection and submission of information on comparative effectiveness, cost, and unmet need under Section 1194(e)(2). For reasons described above, many manufacturers of selected drugs, as well as other stakeholders including manufacturers of potential therapeutic alternatives, likely will feel compelled to submit information under (e)(2) due to the nature of the MFP process. The Agency is remiss in not giving any consideration to information collection burden under this section in its estimate.

VIII. Conclusion

PhRMA appreciates the opportunity to submit comments in response to the *Information Collection Request for Negotiation Data Elements under Section 11001 and 11002 of the Inflation Reduction Act.* We urge CMS to limit the data that must be provided to elements essential to operation of the Program; leverage data already available to them as much as possible; and provide additional time for supplemental data submission. Please contact James Stansel at jstansel@phrma.org and/or Jennifer Bryant at jbryant@phrma.org if there is additional information we can provide or if you have any questions about our comments.

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