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September 3, 2024

VIA ELECTRONIC DELIVERY
http://www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849)

Dear Administrator Brooks-LaSure:

Amgen Inc. (Amgen) appreciates the opportunity to submit comments on the Information Collection Request (ICR) Form for Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) ("Data Elements and DPN Process ICR") posted in the Federal Register on July 2, 2024.

Amgen is committed to using science and innovation to dramatically improve people's lives, improving access to drugs and biologics (collectively, "drugs," consistent with CMS's convention), and promoting high-quality care for patients. Amgen develops innovative medicines as well as biosimilar biological products. Thus, our interest is to ensure a robust market for, and improve patient access in the United States to, both innovative and biosimilar biological products.

Amgen remains deeply concerned that government price controls implemented under the guise of a fair "negotiation" under the Inflation Reduction Act of 2022 (IRA) are stymieing biopharmaceutical innovation at precisely the time when the world needs more new medicines to treat an aging population. Though we also continue to believe the IRA is unlawful, we submit these comments on certain aspects of the Data Elements and DPN Process ICR for initial

payment year (IPAY) 2027 as part of our ongoing commitment to patients and in an effort to bring to CMS's attention the myriad problems the IRA contains and creates.

Biopharmaceutical innovation is key to improving public health and people's lives. We encourage CMS to consider the impact on innovation as well as the impact on biosimilars development and patient access as it develops guidance for this and other IRA-related programs.

Amgen strongly supports the comments of the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Innovation Organization (BIO) on the Data Elements and DPN Process ICR.

I. CMS SHOULD LIMIT MANDATORY DISCLOSURES TO INFORMATION NECESSARY FOR PRICE SETTING AND REDUCE THE BURDEN ON MANUFACTURERS OF SELECTED DRUGS

We urge CMS to limit the burden of data production imposed on manufacturers of selected drugs. Under section 1193(a)(4) of the SSA, manufacturers must submit to CMS "information that the Secretary requires to carry out" price setting for a selected drug. Under section 1194(a)(2)(A) of the SSA, this information must be submitted less than 30 days after CMS identifies a product as a selected drug (that is, the period between February 1 and March 1).

Amgen's subsidiary Immunex Corporation ("Immunex") has first-hand experience with this process. Anticipating that the Immunex product Enbrel® (etanercept) would be selected for IPAY 2026, Immunex began work on data production in Spring 2023, and it was still a challenge to submit all data by the October 2, 2023, submission deadline. We estimate that at least 1,000-2,000 staff hours were required to assemble and submit the information. It would have been impossible to assemble these data within 30 days.

Furthermore, it is unclear to us how a significant portion of the information that was required to be submitted was of use to CMS in its price setting exercise. For example, CMS required manufacturers to report research and development (R&D) costs broken down into five categories. As we communicated to CMS in our comments on the IPAY 2026 ICR, our records did not break out costs in this way, so Immunex had to develop assumptions to satisfy the CMS reporting requirements. But for price setting purposes, CMS's final IPAY 2026 guidance stated that it would consider adjusting the initial offer price upward or downward based on whether the manufacturer has recouped its <u>total</u> R&D costs, which suggests the five categories were irrelevant. Nor did the guidance provide any explanation of how the cost information, broken into the categories CMS demanded, was used. CMS could limit the burden on manufacturers by simply requiring them to attest whether R&D costs had been recouped.

Another example is federal financial support. An objective indicator of federal financial support is a patent application containing a Government Interest Statement. Instead of simply relying on information that could be compiled based on a search of relevant patent applications (which is a significant burden in itself), CMS also required manufacturers to report tax credits or other types of funding that are insufficient to result in a Government Interest Statement. Amgen does not

believe it is typical or ordinary to track this information in in a way that would allow reasonably efficient collection and assessment and CMS gave no guidance about what diligence it expected manufacturers to perform. Imposing this kind of burden on manufacturers seems arbitrary and unnecessary, especially when it is unclear to what degree CMS is using, or should use, such information to set prices of selected drugs.

In addition, the HPMS module CMS utilizes to collect data adds to the high level of burden. CMS requires manufacturers to submit what can be thousands of fields of data and the HPMS module requires manufacturers to manually enter each data point. For example, the system does not allow for the upload of an Excel file that contain these data—which would largely streamline the submission.

We have provided only a few examples, but there are many more. We urge CMS to engage with manufacturers so there can be a better understanding of the types of information CMS "requires" for price setting and how manufacturers can provide this information as efficiently as possible and within a month after the selected drug publication date.

The Data Elements and DPN Process ICR for IPAY 2027 makes few meaningful changes to the manufacturer required data elements from IPAY 2026 and some of the changes would **increase** manufacturer burden, such as newly needing to provide net Medicare Part D data. Given the lack of meaningful changes, we are providing Amgen's comments on the IPAY 2026 ICR dated May 22, 2023 in their entirety as Appendix A.

II. ADDITIONAL AREAS OF COMMENT ON DATA ELEMENTS AND DPN PROCESS ICR FOR INITIAL PAYMENT YEAR (IPAY) 2027

- **CMS should not add a data submission requirement for Part D net price**. CMS was able to calculate a Part D net price for drugs selected for IPAY 2026 and should not increase manufacturer burden by requiring this new data element, which would impose new tracking and data aggregation requirements on manufacturers.
- **CMS should finalize the option for manufacturers to submit a dossier.** This option offers manufacturers more flexibility to submit information demonstrating the value of a selected drug to patients.
- **CMS should avoid imposing arbitrary character limits on submissions.** CMS's arbitrary character and citation limits negatively impact the ability of all data submitters, including patients, caregivers, and manufacturers, to provide the narrative explanations CMS seeks.
- **CMS should clarify how input from various respondents will be prioritized and how it will arbitrate disagreements between respondent types on key inputs** like therapeutic alternatives, course of care, outcomes, and "meaningful" improvement.
- **Manufacturers have extensive experience across multiple study designs, and input in this regard should not be limited to researchers.** In fact, different indications may require different study types and comparative effectiveness approaches, and manufacturers are uniquely qualified to provide guidance in this regard. CMS should specify how it will incorporate and quantify diverse inputs like specific populations, unmet need, etc.

- **CMS should clarify how newer vs older data will be assessed, and how it plans to address gaps** if comparative evidence is lacking for newer therapeutic alternatives or if comparators in trials are now obsolete. The choice of new therapeutic alternatives outside of the drug class should be transparent and supportable.

* * * * *

We appreciate CMS's consideration of these comments. Please do not hesitate to contact Yola Gawlik at (202) 320-1159 or ygawlik@amgen.com if you have any questions.

Sincerely,

Greg Portner
Senior Vice President
Global Government Affairs & Policy

Appendix A: Amgen's comments on the IPAY 2026 Information Collection Request (ICR) Form for Negotiation Data Elements under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) (CMS-10847, OMB 0938-NEW) dated May 22, 2023

Appendix A

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May 22, 2023

VIA ELECTRONIC DELIVERY

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 445-G
200 Independence Avenue, SW
Washington DC 20201

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

Dear Administrator Brooks-LaSure:

Amgen Inc. (Amgen) appreciates the opportunity to submit comments on the Information Collection Request (ICR) Form for Negotiation Data Elements under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) ("Data Elements ICR") posted on the Centers for Medicare & Medicaid Services (CMS) website on March 21, 2023.

Amgen is committed to using science and innovation to dramatically enhance people's lives, improving access to drugs and biologics (collectively, "drugs," consistent with CMS's convention), and promoting high-quality care for patients. Amgen develops innovator medicines and biosimilar biological products. Thus, our interest is to ensure a robust market for, and improve patient access in the United States to, both innovator and biosimilar biological products.

Amgen also supports the comments of the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Innovation Organization (BIO).

I. OVERARCHING CONCERNS

As an initial matter, Amgen remains extremely troubled that manufacturers will be compelled to participate in the Maximum Fair Price (MFP) program at all, including with respect to the Data Elements ICR that is the focus of this letter. The "negotiation" contemplated by the IRA is a negotiation in name only; it bears no resemblance to a traditional arms' length commercial

agreement. To the contrary, the IRA requires manufacturers to submit data in order to help CMS prepare for the "negotiation" and even dictates the format in which such data must be provided. This is all on pain of significant monetary penalties (CMPs) for failure to comply. Then, once CMS communicates an offer, manufacturers are restricted to making a counteroffer that is based only on certain factors listed in the statute. And all of this occurs against the threat of a crippling excise tax if the "negotiation" does not succeed. Any resulting "agreement" cannot be the result of a fair process and will in no way represent an agreed-upon mutual understanding between manufacturers and CMS.

Even assuming the IRA did not so coerce manufacturers, however, the data elements, including as addressed in the Data Elements ICR, present significant challenges and create inefficiencies. For instance, it will be impossible or infeasible for manufacturers to produce some of the information described the Data Elements ICR because manufactures would need to submit information that, though highly sensitive, is inappropriate and unnecessary for setting the MFP. Further, the data elements are requested in a manner that will generate unprecedented levels of burden for reporting to a government agency within an unrealistic timeline to appropriately address and verify in the format requested. This is particularly inappropriate given the excessive CMPs that can be imposed for failure to comply.[1] While we have tailored this letter to these and other concerns about the Data Elements ICR itself, in an attempt to engage in good faith with the opportunity to comment on the Data Elements ICR, we believe the entire process and law, of which the data elements are only a part, is fundamentally flawed.

CMS should publicly announce that the agency will take a flexible approach to data submission and enforcement, particularly in the early years of the program

In the Data Elements ICR, CMS has proposed incredibly detailed, burdensome, and, in many cases, confusing submission requirements for manufacturers. Furthermore, these requirements are supported by scant agency knowledge and experience, considering that this is the first year of the Maximum Fair Price (MFP) program and no comparable data collection has been carried out in the U.S. or, to our knowledge, anywhere in the world. Backing up these compelled disclosures are CMPs of $1 million per day.[2]

Moreover, many manufacturers may not be able to produce the information in the form and manner CMS has proposed. For example, in our comments below, Amgen has flagged several areas of concern, including research and development (R&D) costs specific to "[Food and Drug (FDA)]-approved indications" (Instructions to Section C), R&D costs for "failed or abandoned" products (Question 5), and product-specific federal financial support (Definitions for Section E).

In light of these issues, we recommend that CMS adopt a flexible approach to data collection, such as expressly allowing manufacturers to use reasonable assumptions and be open to communicating with manufacturers and working through submission challenges. We also urge the agency not to seek to impose CMPs where the manufacturer has submitted data to CMS in good faith. Publicly announcing these principles would help create a more cooperative environment.

[1] Social Security Act (SSA) §1197(b).
[2] *Id.*

The Data Elements ICR does not comply with the Paperwork Reduction Act (PRA)

Under regulations promulgated by the Office of Management and Budget (OMB), agency collection of information requests must demonstrate that the agency has taken:

> "every reasonable step to ensure that the proposed collection of information:
>
> > (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 Data Elements ICR fails to satisfy each of these three requirements.

With respect to 5 C.F.R. § 1320.5(d)(1)(i) and (ii), we urge CMS to scale back the mandatory data submission requirements so that the agency: a) collects only information that the Department of Health and Human Services and other federal agencies do not already possess and b) permits manufacturers to submit information maintained in the usual course of business, rather than creating new data solely for the purpose of the MFP program, particularly in cases where it is not clear why data maintained in the usual course of business would not satisfy the needs of CMS.

In our comments that follow, we identify specific data elements that CMS should eliminate or modify to mitigate the burden on manufacturers without limiting CMS's ability to administer the MFP program.

In the "duplication of efforts" section of the Supporting Statement of the Data Elements ICR, CMS appears to try to sidestep the requirements of 5 C.F.R. § 1320.5(d)(1)(i) and (ii) regarding both burden and duplication by stating:

> "Some manufacturer-specific data described in sections 1193(a)(4) and 1194(e)(1) of the [Social Security Act (the Act)] may already be collected by CMS from manufacturers. However, the Act requires that manufacturer-submitted data must be obtained from the Primary Manufacturer."[4]

This is not actually the case. In no place does the IRA state that CMS cannot rely on data that it already possesses in lieu of obtaining it from manufacturers. Given the Paperwork Reduction Act and other initiatives by Congress and the federal government to reduce unnecessary regulatory burden, CMS should not read into the IRA a limitation that does not exist.

Moreover, the mandatory disclosure provisions of the IRA cited by CMS are best read as authorizing CMS to obtain information that it does not have. Under section 1194(e)(1),

[3] 5 C.F.R. § 1320.5(d)(1)(i)-(iii).
[4] Data Elements ICR, Supporting Statement at 4.

manufacturers that are compelled to participate in the MFP program must submit in the following general categories:

- Research and development costs of the manufacturer for the drug and the extent to which the manufacturer has recouped research and development costs.
- Current unit costs of production and distribution of the drug.
- Prior Federal financial support for novel therapeutic discovery and development with respect to the drug.
- Data on pending and approved patent applications, exclusivities recognized by the [FDA], and applications and approvals under section 505(c) of the Federal Food, Drug, and Cosmetic Act or section 351(a) of the Public Health Service Act for the drug.
- Market data and revenue and sales volume data for the drug in the United States.

Other than the fourth category, these are all categories of information that the government does not possess. For example, manufacturers historically have reported limited information on cost inputs to the government. In contrast, manufacturers already report detailed pricing information to the federal government, such as information related to average sales price, average manufacturer price, and best price, which is presumably why section 1194(e)(1) does not expressly reference pricing data. In the Data Elements ICR, CMS characterizes this pricing information as "market data and revenue and sales volume data." Setting aside whether it is reasonable to interpret the phrase "market data and revenue and sales volume data" to include pricing data, it is not reasonable for CMS to take the position that the IRA requires that this information must be obtained from manufacturers as a mandatory submission under the MFP program, as to do so would be "duplicative of information otherwise available to the agency" and unnecessarily burdensome.

Furthermore, section 1194(e)(1)(D) merely requires "[d]ata on" patents, exclusivities, and FDA approvals, suggesting that Congress felt that manufacturers were in the best position to catalogue the relevant information for CMS.[5] However, there is no reason to believe that Congress intended for manufacturers to produce actual patent applications, FDA submissions, and approval letters, all of which are readily accessible to the government.

With respect to 5 C.F.R. § 1320.5(d)(1)(iii), the Data Elements ICR is incredibly broad and burdensome, with no apparent "practical utility" as to how CMS would use most of the information for price setting. For example, in the Data Elements ICR, CMS proposes to require manufacturers to provide an extensive list of confidential commercial information characterized as "market data and revenue and sales volume data,"[6] yet, in its March 15, 2023 guidance document (MFP Guidance), CMS struggles to explain how it will use this data, other than indicating that "if the average commercial net price is lower than the preliminary price, CMS may consider adjusting the preliminary price downward."[7]

[5] *Id.*§ 1194(e)(1)(D).
[6] Data Elements ICR § G.
[7] Medicare Drug Price Negotiation Program: Initial Memorandum, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026, and Solicitation of Comments, § 60.3.4 (March 15, 2023).

Another example is that CMS is proposing to require disclosure of a poorly defined category of information labeled "U.S. commercial average net unit price– best."[8] Manufacturers already expend significant resources to report "best price" under the Medicaid Drug Rebate Program and CMS provides no rationale as to why it needs manufacturers to calculate and report this additional best price.

CMS also provides no explanation as to why it would mandate disclosure of "quarterly total U.S. unit volume."[9] As the IRA is a Medicare-only price setting program, it is not obvious why CMS needs manufacturers to report non-Medicare unit volume. Even if one could guess at potential uses for such information, this is sensitive, potentially market-moving information that manufacturers should not be disclosing to CMS, or any third-party, without good reason.

Under 5 C.F.R. § 1320.5(d)(1)(iii), information collections must be limited to information that has "practical utility." CMS has not met this requirement with respect to the Data Elements ICR.

Finally, Congress did not give CMS carte blanche in the IRA. Under section 1193(a)(4)(B) of the SSA, CMS may require manufacturers to submit "information that the Secretary requires to carry out" the agency's price setting activities. In order for CMS to be authorized to mandate disclosure of information, CMS must articulate why the agency "requires" such information for the MFP program—or, in other words, why it has "practical utility." It has failed to do so in both the MFP Guidance and the Data Elements ICR, and thus, mandating the submission of this information is not only contrary to OMB regulations but also inconsistent with the IRA.

Other principles for all data elements

Data elements required to be submitted by manufacturers should reflect the following principles, in order to streamline and reduce the administrative burden placed on Primary Manufacturers:

- *Consistency with other agency reporting requirements*. Data elements such as non-federal average manufacturer price (non-FAMP) should be reported in a manner identical to how manufacturers are required to report to other government agencies in order to save time and labor costs on re-formatting for selected drug submissions given the short turnaround time requested.
- *Flexibility to supplement timely submissions*. CMS should provide manufacturers the option to supplement their submissions after the October 2, 2023 deadline if new data, documentation, or other substantive developments arise. Given the 30-day deadline established by the IRA and the massive amounts of data involved, manufacturers, as a practical matter, likely will be unable to provide all of the requested data. It would benefit both CMS and manufacturers for CMS to allow manufacturers to supplement their submissions, although we recognize that the IRA requires that manufacturers submit by October 2 some minimum amount of information in the five categories under section 1194(e)(1) of the SSA.
- *No word limits*. Throughout the ICR, CMS provides extremely limited space in the data fields via word and citation limits. Given the scope of these requests, and the lack of clarity in many of the terms applicable to the information to be collected, manufacturers may require additional space to adequately address these requests.

[8] Data Elements ICR § G.
[9] *Id.*

II. COMMENTS ON SPECIFIC DATA ELEMENTS

Section B. Non-FAMP Data Collection

Amgen 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).[10] The annual non-FAMP is calculated using data from the 12-month period that aligns with the federal fiscal year (October 1-September 30). For 2021, this would be the annual non-FAMP value reported to the VA by November 15, 2021, calculated using transactions from October 1, 2020 through September 20, 2021. As discussed above, this would be consistent with 5 C.F.R. § 1320.5(d)(1)(i) and(ii), which requires CMS to make every reasonable effort to ensure that information collected is "the least burdensome necessary for the performance of the agency's functions" and "[i]s not duplicative of information otherwise accessible to the agency."[11] We also ask that manufacturers have the ability to make timely restatements.

Amgen further requests that CMS clarify that the units for non-FAMP may be different from the units on the Part D Prescription Drug Event record, which uses National Council for Prescription Drug Program 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. Due to the burden on respondents, as well as the CMP implications and related exposure, CMS must perform any cross-walking necessary.

Section C. Research & Development Costs and Recoupment

General Comments

CMS should provide manufacturers the option to attest that R&D costs have been recouped

Providing data in response to CMS's proposed detailed definition of R&D costs, broken into six specific categories, would impose an immense burden on manufacturers. We are concerned that CMS is under the impression that manufacturers track and maintain R&D cost information at a level of detail that does not correspond with the ordinary course of business of manufacturers. An attempt at compliance would require Amgen to review prior expense records and retrospectively flag them by product and CMS R&D cost category. It may prove to be an impossible task to assemble and submit accurate information, but, even if did not, it would be immensely time consuming, expensive, and burdensome. It would be even more challenging for older products, such as those subject to the MFP program, and products acquired through merger or acquisition. That the challenges of assembling this data will vary according to products—not to mention across manufacturers—makes it extremely unlikely that CMS will ever receive data homogenous enough to allow for meaningful analysis (assuming that is what CMS intends to do).

Such burdensome requirements are not necessary for CMS to carry out the MFP program. In the MFP Guidance, CMS appears to be proposing to consider only the binary question of whether the manufacturer has recouped total R&D costs related to the product, stating that it will

[10] 38 U.S.C. §8126(h)(5).
[11] 5 C.F.R. §1320.5(d)(1)(i), (ii).

consider adjusting the initial offer price upward or downward based on whether the manufacturer has recouped its costs.[12]

To accomplish the same policy purpose while mitigating burden on manufacturers, CMS should give manufacturers the option to attest that they have recouped R&D costs.

CMS should not finalize its proposal to require reporting of R&D costs in six categories

If manufacturers are to report drug-specific costs, we ask that CMS permit total R&D costs, not broken down by category. Again, there is apparently no policy purpose behind the six categories, it would be burdensome to divide costs in this artificial way, and we believe that overall, it will result in confusion and less accurate reporting.[13]

For products acquired by a manufacturer, CMS should permit manufacturers to report as R&D costs acquisition costs attributable to R&D

In the Data Elements ICR, CMS instructs manufacturers to exclude acquisition costs.[14] This is an ill-conceived policy that CMS should reverse when it issues its final guidance document. Given that, in the MFP Guidance, CMS proposes to adjust the initial offer price upward or downward based on whether the manufacturer has recouped R&D costs, it appears that CMS believes that molecules developed in-house should be assigned greater value than products that have been acquired. This distinction makes no business sense. Manufacturers such as Amgen are constantly investing in their internal R&D as well as evaluating opportunities to "buy R&D" through external acquisitions. In either case, the value of the therapy is the same to patients, health care providers, and payers. The product may also be of greater benefit to patients in the hands of an acquiring company if the company has better capability to market and manufacture a reliable supply of the product. Furthermore, when developing reasonable allocation methodologies related to R&D costs, a manufacturer would never exclude acquisition costs because such an approach would understate, in some cases drastically, the manufacturer's investment.

Instructions for Section C

Manufacturers should be permitted to include costs for label-enabling research

If CMS moves forward with mandating disclosure of product-specific information and with requiring detailed categorization of R&D costs, we ask that CMS explicitly broaden the definition of R&D costs to include costs incurred for label-enabling research and for ongoing research.

The Data Elements ICR proposes that R&D costs include only costs "incurred by the Primary Manufacturer for all FDA-approved indications of a drug...."[15] Read narrowly, limiting R&D costs to those incurred for "FDA-approved indications" would fail to reflect the breadth of significant R&D investment that many manufacturers make in approved drug products. Manufacturers may

[12] MFP Guidance § 60.3.4.

[13] Amgen also would support the two alternative options proposed by PhRMA: 1) allowing manufacturers to allocate a percentage of total R&D to the selected drug based on a generally accepted standard and 2) allowing manufacturers to provide data in two broader categories: a) costs of R&D *before* initial FDA approval and b) 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.

[14] Data Elements ICR §C.

[15] *Id.*

routinely incur R&D costs concerning new routes of administration, dosing regimens, delivery devices, or other uses that improve patient experience or convenience. While this research may not result in a new FDA-approved indication, such new conditions of use are reflected in the drug labeling. We therefore urge CMS to explicitly permit manufacturers to submit R&D costs associated with all label-enabling New Drug Application (NDA) or Biologics License Application (BLA) supplements. We recommend that CMS permit manufacturers to submit such cost information in response to Question 6 ("All Other R&D Costs").

Perhaps more importantly given the CMPs associated with manufacturer-reported data elements, Amgen does not track R&D costs based on whether it specifically resulted in an "FDA-approved indication," and it would be infeasible or impossible to reconstruct this information, so we would likely be unable to provide the information in the form requested.

CMS should permit manufacturers to include costs for ongoing research

The Data Elements ICR also states that CMS intends to exclude from R&D costs the "costs associated with ongoing basic pre-clinical research, clinical trials, and pending approvals."[16] Ongoing research and clinical trials frequently result in new uses that meaningfully contribute to the value offered by a drug. Such research may later result in an approval—a category of cost included in the proposed R&D cost definition—yet CMS proposes to preclude a manufacturer from including ongoing costs simply if a drug happens to be selected for negotiation before completion of the research. We request that CMS permit manufacturers to include ongoing research when reporting R&D costs.

Question 5

CMS should not differentiate between successful and "failed or abandoned" products

As Amgen currently tracks R&D costs, all discovery and preclinical developmental costs are categorized the same (and, under framework of the Data Elements ICR, would be reported under Question1) and we do not differentiate between molecules that were later studied in clinical trials and "products with the same active moiety / active ingredient or mechanism of action as the selected drug that did not make it to clinical trials."[17] In fact, it is inappropriate at the pre-clinical stage to make distinctions between "products" because the end-result "product" may not be clear at this early stage because critical details including routes of administration and dosing regimens may be determined through clinical trials.

Question 6

CMS should clarify that it is appropriate for manufacturers to include royalty payments attributable to R&D costs in this category

In cases where rights to a product are split between multiple manufacturers, agreements between manufacturers may require royalty payments attributable to R&D costs. We believe such costs should be reported in response to Question 6, and we ask that CMS expressly clarify this.

[16] *Id.* § C, Instructions.
[17] *Id.* § C, Question 5.

Question 7

CMS should choose whether to consider R&D costs and revenue on a global or U.S. basis and be consistent

CMS has proposed to *include* in the total lifetime net revenue calculation the "global, total lifetime net revenue"[18] yet *exclude* from R&D costs any "costs associated with receiving foreign approvals."[19] This lack of symmetry in the assessment of revenues versus expenses inappropriately disadvantages manufacturers. It essentially penalizes manufacturers for international sales while failing to recognize a manufacturer's investment in research that supported the approvals that enabled such marketing. As a matter of consistency and as but one step toward fairness, CMS should adopt a uniform approach to inclusion (or exclusion) of international revenues and expenses.

Section D: Current Unit Costs of Production and Distribution

Instructions for Section D

Sales and marketing costs should be included as costs of distribution

Under the Data Elements ICR, CMS proposes to exclude "marketing costs" from the definition of "current unit costs of production and distribution of the selected drug."[20] We believe this apparent bias against sales and marketing is misplaced. After FDA approves a product, patients may not see the benefit of it unless manufacturers expend resources to educate health care providers (through disease state education, and information regarding the safety and efficacy of the product itself, and patient support services) and to negotiate with payers for access to the product. These functions are critical to create awareness of the disease and the product's efficacy so that the product reaches appropriate patients. Excluding marketing costs creates an inaccurate picture of the full costs of production and distribution related to a product.

Manufacturers should report liquid injectable units based on weight rather than volume

Amgen assesses production costs per unit for liquid injectable drugs using micrograms or milligrams, which reflects the ingredient weight. We believe this is also the industry standard.

In the Data Elements ICR, CMS is proposing that manufacturers report costs using liquid volume, referencing the National Council for Prescription Drug Programs (NCPDP) Billing Unit Standards.[21] As suggested by the title, the NCPCP standards were developed for billing purposes and, in fact, providers typically bill payers for injectables using milliliter-based units. But they do not reflect current industry practices for tracking costs per unit. Accordingly, CMS should switch to weight-based reporting when it finalizes its reporting guidance.

[18] *Id.* § C, Question 7.
[19] *Id.* § C, Instructions.
[20] *Id.* § D, Instructions,
[21] *Id.*

CMS should permit manufacturers to determine the most appropriate 12-month period for reporting costs

CMS proposes that manufacturers report average unit costs during the 12-month period ending May 31, 2023.[22] Manufacturers are unlikely to track information in this way, instead typically using a calendar or fiscal year approach. There seems to be little or no benefit to CMS prescribing such an unusual reporting period, given the burden it would impose on manufacturers. Therefore, CMS should allow manufacturers to determine their own period based on current business practices.

Manufacturers should have flexibility to align allocation between production and distribution with existing business practices

Certain aspects of CMS's definitions of "costs of production" and "costs of distribution" are inconsistent with Amgen's existing business practices. For example, Amgen treats packaging, packaging materials and labeling as costs of production, but these costs are defined as costs of distribution under the Data Elements ICR.[23] Given that whether a cost is categorized as a production or distribution cost has no bearing on CMS's price setting activities, and to mitigate unnecessary burden, CMS should permit manufacturers to characterize production and distribution costs consistent with usual business practices.

Section E: Prior Federal Financial Support

General Comments

Disclosure should be limited to Government Interest Statements

We encourage CMS to limit the data disclosure requirements for prior federal financial support 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.

CMS should establish a defined look back period

We encourage CMS to narrow the relevant time period for this request to federal financial support received within the last 10 years of the BLA/NDA approval. As currently written, the time period starts at the beginning of the research and development program,[24] which for some drugs, will have occurred more than 30 years ago, and in some instances by a predecessor company that no longer exists. This would seemingly require companies to try to track down financial and tax records for several decades and perhaps well before this type of data was routinely kept in electronic form. It is unclear whether companies could meet this request without limiting the time frame.

[22] *Id.*
[23] *Id.*
[24] *Id.* § E, Definitions.

Definitions for Section E

CMS should not require manufacturers to provide the "federal financial support" data on a product-specific basis

Under the Data Elements ICR, CMS proposes to define "federal financial support for novel therapeutic discovery and development" to include tax credits, direct financial support, grants or contracts, and any other funds provided by the federal government that support discovery, research, and development "related to the selected drug."[25] We urge CMS to reconsider this request, and instead require disclosure only of Government Interest Statements, because companies do not typically track financial or tax credits on a product-by-product basis. In fact, there is not any meaningful way to calculate such product-specific taxes or credits given that the amount of taxes or credits potentially associated with one product is highly interdependent on what happens with other products and aspects of the business.

Section F: Patents, Exclusivities, and Approvals

Definitions for Section F

CMS should limit disclosure to patents directed to the active ingredient

We encourage CMS to limit the data disclosure requirements to only those patents and patent applications with a specific claim directed to the active ingredient of the selected drug, rather than more generic patents that, for example, cover a specific manufacturing process, a process for purifying a drug substance, or a process of formulating a drug substance that could be used to manufacture a number of different pharmaceutical products.

CMS should clarify the definitions and instructions for Section F to promote clarity and accuracy

We have the following recommendations for the definitions under Section F:

- The definitions section states that exclusivity refers to certain delays and prohibitions on the approval of competitor drugs "that attach upon approval of a drug."[26] CMS instead should refer to exclusivity attaching upon "approval of an NDA/BLA or approval or submission of a supplement to such application." Some types of regulatory exclusivity, including orphan exclusivity and new clinical investigation exclusivity, may attach upon FDA approval of a supplement after initial approval of a drug. In addition, pediatric exclusivity may attach after submission of a supplement reporting results of pediatric testing.
- According to the definitions section, the phrase "active and pending FDA applications and approvals"[27] would include "all applications for approval" under specified federal statutes. We recommend that CMS clarify that the phrase "applications and approvals" includes "all applications or supplements." Inclusion of supplements is appropriate and appears to be consistent CMS's intention. Omission of the word "supplements" may cause unnecessary confusion.

[25] *Id.* § E, Definitions, Question 10.
[26] *Id.* § E, Definitions.
[27] *Id.*

- With respect to the definition of applications and approvals, we also suggest that CMS state that manufacturers need only list potential label-enabling supplements and approvals. We request that CMS explicitly exclude manufacturing or other chemistry, manufacturing, and controls supplements. A manufacturer may submit numerous manufacturing-related supplements over the life of a drug. Providing a detailed listing would be burdensome to manufacturers while offering little-to-no value to CMS during the price negotiation process.

Instructions for Section F

The period for reporting FDA exclusivities and approvals should explicitly include dates of supplements

The instructions provide that for Questions 13 through 16, the time period for reporting "ends on the date the most recent NDA/BLA was approved for the selected drug."[28] We recommend amending the instruction so that the reporting period ends on the date that "the most recent NDA/BLA *or supplement* was approved for the selected drug." Adding the reference to a "supplement" would more clearly capture situations where orphan exclusivity, pediatric exclusivity, and new clinical investigation exclusivity are earned based on submission of a post-marketing supplement.

Question 13

Manufacturers should not be required to upload patent applications

In the table under Question 13, CMS appears to be proposing to require that manufacturers upload patent applications. We question what purpose a patent application might serve in CMS's price setting process. That said, to the extent there is relevant information contained in a patent application, CMS should obtain it directly from the Patent and Trademark Office (PTO). Requiring manufacturers to upload patent applications would be unnecessarily burdensome for manufacturers because older applications may not be available in electronic format, especially considering the 30-day turnaround time to submit data. The government already has access to patent applications through the PTO. CMS therefore should obtain patent applications from PTO to the extent they are necessary to the MFP program.

Question 15

CMS should acknowledge uncertainties regarding expiration of regulatory exclusivity

Question 15 asks that manufacturers list each type of applicable regulatory exclusivity and the corresponding "Exclusivity Expiration Date."[29] Not every licensure of a biological product is considered a "first licensure" that qualifies for its own 12-year exclusivity period. Whereas FDA's Orange Book and Purple Book provide authoritative information on the date of expiration of many types of regulatory exclusivity, FDA does not routinely proactively publish in the Purple Book (or otherwise) determinations about Reference Product Exclusivity for Biological Products or the date of expiration. We recommend that CMS acknowledge that in some cases there may be some

[28] *Id.* § E, Instructions.
[29] *Id.* § E, Question 15.

uncertainty as to whether a particular product has received 12-year Reference Product Exclusivity and ask manufacturers to provide their best judgment as to the expiration date of such exclusivity.

Question 16

The "submission number" column should be deleted

Question 16 prompts manufacturers to include a "submission number"—in addition to an "application number"—for all active and pending applications and approvals.[30] It appears that "submission number" intends to refer to the numbers used internally by manufacturers to track their submissions in serial order. We believe that this number would have no meaning to CMS. We ask that CMS remove this field from Question 16.

Section G: Market Data, Revenue, and Sales Volume Data

Questions 21 (340B Ceiling Price), 27 (Federal Supply Schedule), and 29 (Big Four)

We ask CMS to clarify which units should be included

For each of these three questions, it is not clear whether manufacturers should report: 1) all units subject to the ceiling price under the program, whether they are sold for the ceiling price or a lower, sub-ceiling price or 2) only units actually sold at the ceiling price. CMS should clarify the information it is seeking so that all manufacturers will provide consistent information.

Question 33

CMS should strike the column "Manufacturer Average Net Unit Price to Part D Plan Sponsors-Without Patient Assistance Programs"

The HHS Office of the Inspector General (OIG) has made clear that manufacturers may not offer copay assistance to Part D enrollees,[31] and manufacturers do not currently provide such assistance to Medicare beneficiaries. Accordingly, there is no need for this column under Question 33.

Questions 37 and 38

CMS should delete these questions because they are redundant to Question 19

In Question 37, CMS requests data on unit type and volume by quarter for five years by National Drug Code. In Question 19, CMS asks for the same information, plus Wholesale Acquisition Cost. CMS should delete Questions 37 and 38, so manufacturers are not required to provide the same information twice.

[30] *Id.* § E, Question 16.

[31] See, e.g., OIG Special Advisory Bulletin: Pharmaceutical Manufacturer Copayment Coupons (September 2014).

Section H: Evidence About Alternative Treatments

Instructions for Questions 40 through 43

CMS should clarify that it will consider quality of life data

Consistent with the prohibition against certain uses of Quality of Life Years (QALYs) under section 1194(e)(2) of the Act, CMS instructs submitters not to "include as 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." [32] However, it is important that CMS clarify that submitters may submit, and CMS will consider, evidence regarding the impact of a therapy on quality of life, provided that it does not treat 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.

Question 40

CMS should seek input on the selection of therapeutic alternatives

In this question, CMS requests information regarding prescribing information with respect to therapeutic alternatives of a selected drug,[33] but it is unclear how CMS will identify therapeutic alternatives and to what extent manufacturers and other stakeholders will be permitted to comment on them. 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, as well as any resources (e.g., clinical guidelines) it relied upon to identify the therapeutic alternative, on which it seeks information in response to Question 40 and communicate this information at the same time it announces the products selected for the MFP program. We also request that CMS seek input with respect to whether it has selected the appropriate therapeutic alternatives, either through Question 40 or otherwise.

The word limit is insufficient

As discussed above, there should be no word or character limits for any of the explanatory fields in this information collection, particularly in early years of the MFP program as CMS learns the types and quantity of information that is helpful to administration of the program. If CMS decides to finalize a word limit, we request that CMS increase the 1,000 word limit to 5,000 for Question 40 given the breadth of information available for selected drugs that have been studied for several years and have several indications.

Question 41

CMS should clarify that submitters are not required to submit information regarding all indications

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.[34] We request that instructions be updated to confirm that data for every

[32] Data Elements ICR § H, Instructions.
[33] *Id.* § H, Question 40.
[34] *Id.* § H, Question 41.

indication for the selected drug is not required. This will allow manufacturers to focus the available word count on the priority indications where the selected drug is most commonly used.

The word and citation limits are insufficient

If CMS decides to finalize a word limit, we request that CMS increase the 3,000 word limit to 10,000 for Question 41 given the breadth of information available for selected drugs that have been studied for several years and have several indications. Likewise, CMS should increase the citation limit from 50 to 200.

Question 42

The word and citation limits are insufficient

If CMS decides to finalize a word limit, we request that CMS increase the 3,000 word limit to 10,000 and increase the citation limit from 50 to 200.

Question 43

The word and citation limits are insufficient

If CMS decides to finalize a word limit, we request that CMS increase the 1,000 word limit to 5,000 and increase the citation limit from 50 to 200.

* * * * *

We appreciate your consideration of our comments on the Information Collection Request (ICR) Form for Negotiation Data Elements under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) ("Data Elements ICR"). Please contact Giana Mandel by telephone at (571)-228-6637 or by e-mail at gmandel@amgen.com if you have any questions about our comments.

Regards,

Greg Portner

Senior Vice President

Global Government Affairs and Policy

BY ELECTRONIC SUBMISSION VIA REGULATIONS.GOV
September 3, 2024
William N. Parham, III
Director
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Centers for Medicare and Medicaid Services
Attention: CMS-10849
Room C4–26–05
7500 Security Boulevard Baltimore, Maryland 21244–1850

RE: Information Collection Request (ICR) Form for Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849, OMB 0938-1452)

Dear Mr. Parham:

AstraZeneca is a global, science-led biopharmaceutical company that focuses on the discovery, development and commercialization of prescription medicines, primarily for the treatment of diseases in three therapy areas – Oncology, Cardiovascular, Renal & Metabolism (CVRM) and Respiratory & Immunology. We are also working to solve the challenges for rare disease patients through our subsidiary Alexion. AstraZeneca operates in over 100 countries and its innovative medicines are used by millions of patients worldwide.

AstraZeneca is an innovative company that supports value-based care and evidence-based decisions. While AstraZeneca remains troubled about the impact the Inflation Reduction Act could have on the development of future medicines and patient access to the latest cures, we are committed to complying with the law and appreciate the opportunity to submit comments in response to the above captioned Information Collection Request (ICR) setting forth the proposed information submission requirements for selected drugs in the Medicare Drug Price Negotiation Program (Negotiation Program) to the Centers for Medicare & Medicaid Services (CMS) for initial price applicability year (IPAY) 2027.

Executive Summary and Our Global Perspective

- **Burden Reduction.** The Paperwork Reduction Act (PRA) is principally focused on reducing the administrative burden that the Federal government imposes on private businesses and citizens. Some aspects of the ICR, such as reporting requirements on manufacturers for

certain pricing metrics like net price, seem duplicative of the information that CMS already has access to. Requiring manufacturers to submit redundant information runs counter-purposes to the PRA.

- **Streamlined Data Entry**. CMS could enhance the efficiency of its data collection by automating the input of routine information, including patent numbers and additional details pertaining to the selected drug. This automation would alleviate the burden on manufacturers of responding to the ICR. Additionally, CMS should maintain word-based limits as opposed to transitioning to character-based limits for submissions, as word limits offer a more user-friendly and intuitive approach to keeping track of submission length.
- **Reinstatement of the Executive Summary**. The current version of the ICR has notably omitted the Executive Summary section from Section I. AstraZeneca advocates for the reintroduction of the Executive Summary section. The inclusion of this section is crucial as it allows manufacturers to present a clear and concise overview of the information regarding the value of their selected drugs. Moreover, the Executive Summary aids CMS in efficiently sifting through extensive and intricate data to evaluate the clinical significance of the selected drug under consideration.
- **Outreach to External Stakeholders**. AstraZeneca values the inclusion of specific inquiries directed at non-manufacturer stakeholders like caregivers, patients, providers, and researchers. We are confident that incorporating their unique insights will enhance the understanding of the clinical benefits and patient impact of selected drugs. Nonetheless, AstraZeneca suggests that CMS engage more proactively with these non-manufacturer groups and we are further concerned with the administrative burden placed on patients to complete the ICR form. To this end, we encourage CMS to increase the ICR comment period for patients and caregivers to submit data on Section I to at least 60 days to ensure adequate feedback is received. Additionally, it is important to clarify the significance of their contributions and how they can shape the negotiation process. Given that providing information to CMS requires a considerable amount of administrative effort, these parties should comprehend the influence their input has on the broader process so they can make an informed decision whether to undertake the burden of doing so. We therefore ask that CMS publicly release information on how many individuals and organizations respond to the ICR for IPAY 2027, and how such participation impacted the negotiation process.
- **Definition of Therapeutic Alternative.** We are concerned the revised definition of Therapeutic Alternative in the ICR could lead CMS to selecting therapeutic alternatives that are not clinically appropriate. AstraZeneca urges CMS to maintain the policy it finalized for IPAY 2026, under which CMS selects the "most clinically comparable" therapeutic alternatives.
- **FOIA Exemptions.** AstraZeneca strongly supports CMS's inclusion of new sections to identify information exempt from disclosure under the Freedom of Information Act (FOIA) through discrete data fields. Much of the data reported in the ICR is highly sensitive and protected from disclosure by statute. Providing manufacturers with a space to specifically identify exempt material facilitates CMS compliance with those requirements.

Below we discuss our comments in more detail.

I. CMS should minimize redundant data submission when CMS already has access to the relevant information.

The ICR, as it stands, requires manufacturers to submit detailed pricing information already reported to the government. This includes data points such as Medicaid Best Price (Question 19), the Federal Supply Schedule (FSS) price (Question 21), and the Big Four Price (Question 22), among other information. However, these pricing metrics are readily within the government's reach by request from the various agencies that collect and maintain the information. For instance, CMS itself maintains data on Medicaid Best Price, which manufacturers report through the Medicaid Drug Program (MDP) system on a quarterly basis. Moreover, the FSS and Big Four prices are readily available to CMS through inter-agency communication with the Department of Veterans Affairs.

The PRA was established to minimize the paperwork burden for individuals, businesses, and other entities by federal agencies. One of the key tenets of the PRA is to ensure that the government does not overburden private parties with information collection demands, especially when the government can obtain the information through alternative means. The PRA encourages agencies to share information and avoid duplicative efforts.

To align with the PRA's objectives and to reduce unnecessary administrative burdens, CMS should leverage existing data-sharing agreements and technologies to access pricing information from other federal agencies. By doing so, CMS can obtain necessary data without requiring manufacturers to resubmit it. In cases where CMS can access this information, it should pre-populate such information to indicate that it has access to the data, enabling manufacturers to correct the data (as CMS has done with other data elements, such as NDCs).

II. CMS can enhance the efficiency of data entry through automation or allowing alternative methods for submitting routine data.

By optimizing the process of data input, CMS can significantly enhance the efficiency and accuracy of data collection. This is particularly relevant when dealing with the complex and voluminous data involved in the Negotiation Program, including but not limited to patent numbers and detailed product information for selected drugs. Automating the entry of this information can lead to a substantial reduction in the reporting burden for manufacturers.

This automation can be achieved through various means, such as the integration of intelligent data capture solutions that recognize and extract relevant data from documents or direct integration with databases that store relevant information. CMS could also permit manufacturers to prepare excel forms and other documents that organize the required information into an easy-to-understand format. Over time, as CMS gains insights from reviewing numerous submissions, the agency can move towards standardizing these documents to create a more uniform and efficient review process.

Moreover, when it comes to the submission of data, CMS should consider maintaining word-based limits rather than transitioning to character-based limits. It can be difficult for individuals to estimate the length of submissions in characters, leading to potential confusion and errors. Manufacturers may find themselves spending excessive time editing and re-editing submissions to

meet character restrictions, which can be particularly cumbersome when dealing with technical or specialized content. Word-based limits are more intuitive, which can reduce the frustration associated with counting characters, especially when dealing with complex technical information.

We also note that character (rather than word) limits may be particularly disadvantageous in this context, given the need to reference products or other medical jargon that frequently have high-character count words, in that character limits may inadvertently encourage use of acronyms that CMS may be team is unfamiliar with, potentially causing confusion during the ICR review and the negotiation processes.

III. CMS should reinstate the Executive Summary under the Therapeutic Alternatives section.

The Executive Summary portion of the previous iteration of the ICR served to provide a succinct and accessible overview of the comprehensive data submitted by pharmaceutical manufacturers for selected drugs. AstraZeneca recommends that it be reinstated.

The benefits of including an Executive Summary are many. For manufacturers, it offers an opportunity to distill complex information into a digestible format, highlighting the most salient points of the clinical evidence and value story in their submission. This is especially beneficial when presenting data on prescription medications, where the details can be highly technical and voluminous, particularly for products with multiple on-label and off-label indications.

From the perspective of CMS, the Executive Summary acts as a navigational tool, allowing reviewers to quickly grasp the essence of the submission. This can streamline the decision-making process, as CMS can reference the summary to better understand the context and implications of the data presented.

In short, the Executive Summary can be seen as a bridge between the intricate scientific data provided by manufacturers and the evaluative tasks undertaken by CMS. Thus, the Executive Summary is not merely an optional addendum but a critical element of the ICR that facilitates better communication and understanding between drug manufacturers and CMS.

IV. CMS should reduce the administrative burden for patients to complete the ICR form by extending the comment period, and explain the impact that public (non-manufacturer) input will have on CMS's decision-making process.

The evaluation of a drug's clinical benefit is a multifaceted process that involves various stakeholders, each bringing a unique perspective to the table. AstraZeneca appreciates CMS's approach to soliciting feedback from a diverse group of stakeholders, including non-manufacturers like caregivers, patients, providers, advocacy groups, and researchers.

The inclusion of these perspectives ensures that the assessment of a drug's value can encompass the practical and experiential aspects of the drug's use. However, we are concerned that these groups will not be aware of the opportunity to submit comments without outreach by CMS, and even once they are, may not have sufficient time to complete the ICR form given the one-month timeline between the date that CMS will announce the selected drugs for IPAY 2027 (February 1st)

and the deadline to submit the ICR comments (March 1st). A 30-day comment period will be particularly burdensome for small and/or low-resourced patient groups, who lack full-time dedicated staff to devote all their resources to respond to CMS. We therefore ask that CMS increase the ICR comment period for patients and caregivers to submit data on Section I to at least 60 days.

We also note that manufacturers could assist with this outreach; however, as currently proposed, respondents will need to indicate they are "affiliated with the manufacturer" if the individual or organization has merely "been asked by the manufacturer to respond to this ICR or to advise the manufacturer of the Negotiation Program, regardless of compensation." We are concerned that this language may discourage interested organizations or individuals from submitting responses to the ICR without further clarification. To mitigate this risk, we recommend CMS revise this language to make clear that the receipt of factual information about the Negotiation Program, the ICR, and the relevance of submitting a response from a primary manufacturer will not render a respondent "affiliated with the manufacturer."

Lastly, AstraZeneca is concerned that CMS has not adequately explained how public input will affect the negotiation process, nor committed to increasing transparency around this participation. Stakeholders are being asked to contribute their perspectives and data, which involves a considerable investment of time and resources. The administrative burden associated with compiling and submitting this information is not trivial, and without a clear understanding of how their contributions will be utilized, stakeholders may be hesitant to engage in the process. It is crucial for CMS to articulate how the feedback from non-manufacturers will be integrated into the negotiation process to ensure that these stakeholders feel that their input is valued and that their efforts are not in vain. Further, CMS should, as part of its release of the explanation of MFPs, public release information on the level of public participation and how such feedback impacted the negotiation process.

The potential reluctance of non-manufacturer entities to participate due to the unclear impact of their submissions poses a risk to the integrity of the drug evaluation process. If these entities choose not to submit comments, the process may lose out on critical insights that could inform the negotiation and decision-making processes. This could ultimately undermine the very purpose of soliciting diverse viewpoints.

V. CMS should revert to its previous definition of Therapeutic Alternative that focuses on the most clinically comparable therapies.

In the ICR, CMS proposes unjustified changes in the definition of therapeutic alternative that could result in CMS selecting therapeutic alternatives that are not clinically appropriate. In the previous iteration of the ICR, CMS stated that it would identify therapeutic alternatives in the same class "before considering therapeutic alternatives in other drug classes." Further, under the previous ICR, CMS committed to focusing on "a subset of therapeutic alternatives that are *most* clinically comparable to the selected drug." CMS now proposes that it will always consider therapeutic alternatives in other drug classes, and has expanded its focused on therapeutic alternatives beyond those that are the "most clinically comparable."

As reflected in our comments on the Draft Guidance for IPAY 2027, AstraZeneca urges CMS to maintain the policy it finalized for IPAY 2026, under which CMS selects the "most clinically

comparable" therapeutic alternatives. We also redirect the agency to the five principles for the appropriate selection and assessment of therapeutic alternatives that would improve the appropriateness and transparency of CMS' process for selecting therapeutic alternatives, as set forth in our comments on the Draft Guidance.

VI. AstraZeneca strongly supports CMS's inclusion of new sections to identify information exempt from disclosure under FOIA through discrete data fields

In the ICR, CMS include new sections to identify information exempt from disclosure under the Freedom of Information Act (FOIA) through discrete data fields. AstraZeneca strongly supports this improvement to the ICR. As CMS is well aware, much of the data reported in the ICR is highly sensitive and protected from disclosure by statute. Providing manufacturers with a space to specifically identify exempt material facilitates CMS compliance with those requirements.

*****

AstraZeneca appreciates the opportunity to submit comments and looks forward to continuing to engage with CMS as it implements the Negotiation Program for IPAY 2027 and beyond. I can be reached at sarah.arbes@astrazeneca.com with any questions.

Sincerely,

Sarah C. Arbes

Head of Federal Affairs and Policy

BY ELECTRONIC SUBMISSION VIA REGULATIONS.GOV
September 3, 2024
William N. Parham, III
Director
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Centers for Medicare and Medicaid Services
Attention: CMS-10849
Room C4–26–05
7500 Security Boulevard Baltimore, Maryland 21244–1850

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By optimizing the process of data input, CMS can significantly enhance the efficiency and accuracy of data collection. This is particularly relevant when dealing with the complex and voluminous data involved in the Negotiation Program, including but not limited to patent numbers and detailed product information for selected drugs. Automating the entry of this information can lead to a substantial reduction in the reporting burden for manufacturers.

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In short, the Executive Summary can be seen as a bridge between the intricate scientific data provided by manufacturers and the evaluative tasks undertaken by CMS. Thus, the Executive Summary is not merely an optional addendum but a critical element of the ICR that facilitates better communication and understanding between drug manufacturers and CMS.

IV. CMS should reduce the administrative burden for patients to complete the ICR form by extending the comment period, and explain the impact that public (non-manufacturer) input will have on CMS's decision-making process.

The evaluation of a drug's clinical benefit is a multifaceted process that involves various stakeholders, each bringing a unique perspective to the table. AstraZeneca appreciates CMS's approach to soliciting feedback from a diverse group of stakeholders, including non-manufacturers like caregivers, patients, providers, advocacy groups, and researchers.

The inclusion of these perspectives ensures that the assessment of a drug's value can encompass the practical and experiential aspects of the drug's use. However, we are concerned that these groups will not be aware of the opportunity to submit comments without outreach by CMS, and even once they are, may not have sufficient time to complete the ICR form given the one-month timeline between the date that CMS will announce the selected drugs for IPAY 2027 (February 1st)

and the deadline to submit the ICR comments (March 1st). A 30-day comment period will be particularly burdensome for small and/or low-resourced patient groups, who lack full-time dedicated staff to devote all their resources to respond to CMS. We therefore ask that CMS increase the ICR comment period for patients and caregivers to submit data on Section I to at least 60 days.

We also note that manufacturers could assist with this outreach; however, as currently proposed, respondents will need to indicate they are "affiliated with the manufacturer" if the individual or organization has merely "been asked by the manufacturer to respond to this ICR or to advise the manufacturer of the Negotiation Program, regardless of compensation." We are concerned that this language may discourage interested organizations or individuals from submitting responses to the ICR without further clarification. To mitigate this risk, we recommend CMS revise this language to make clear that the receipt of factual information about the Negotiation Program, the ICR, and the relevance of submitting a response from a primary manufacturer will not render a respondent "affiliated with the manufacturer."

Lastly, AstraZeneca is concerned that CMS has not adequately explained how public input will affect the negotiation process, nor committed to increasing transparency around this participation. Stakeholders are being asked to contribute their perspectives and data, which involves a considerable investment of time and resources. The administrative burden associated with compiling and submitting this information is not trivial, and without a clear understanding of how their contributions will be utilized, stakeholders may be hesitant to engage in the process. It is crucial for CMS to articulate how the feedback from non-manufacturers will be integrated into the negotiation process to ensure that these stakeholders feel that their input is valued and that their efforts are not in vain. Further, CMS should, as part of its release of the explanation of MFPs, public release information on the level of public participation and how such feedback impacted the negotiation process.

The potential reluctance of non-manufacturer entities to participate due to the unclear impact of their submissions poses a risk to the integrity of the drug evaluation process. If these entities choose not to submit comments, the process may lose out on critical insights that could inform the negotiation and decision-making processes. This could ultimately undermine the very purpose of soliciting diverse viewpoints.

V. CMS should revert to its previous definition of Therapeutic Alternative that focuses on the most clinically comparable therapies.

In the ICR, CMS proposes unjustified changes in the definition of therapeutic alternative that could result in CMS selecting therapeutic alternatives that are not clinically appropriate. In the previous iteration of the ICR, CMS stated that it would identify therapeutic alternatives in the same class "before considering therapeutic alternatives in other drug classes." Further, under the previous ICR, CMS committed to focusing on "a subset of therapeutic alternatives that are *most* clinically comparable to the selected drug." CMS now proposes that it will always consider therapeutic alternatives in other drug classes, and has expanded its focused on therapeutic alternatives beyond those that are the "most clinically comparable."

As reflected in our comments on the Draft Guidance for IPAY 2027, AstraZeneca urges CMS to maintain the policy it finalized for IPAY 2026, under which CMS selects the "most clinically

comparable" therapeutic alternatives. We also redirect the agency to the five principles for the appropriate selection and assessment of therapeutic alternatives that would improve the appropriateness and transparency of CMS' process for selecting therapeutic alternatives, as set forth in our comments on the Draft Guidance.

VI. AstraZeneca strongly supports CMS's inclusion of new sections to identify information exempt from disclosure under FOIA through discrete data fields

In the ICR, CMS include new sections to identify information exempt from disclosure under the Freedom of Information Act (FOIA) through discrete data fields. AstraZeneca strongly supports this improvement to the ICR. As CMS is well aware, much of the data reported in the ICR is highly sensitive and protected from disclosure by statute. Providing manufacturers with a space to specifically identify exempt material facilitates CMS compliance with those requirements.

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AstraZeneca appreciates the opportunity to submit comments and looks forward to continuing to engage with CMS as it implements the Negotiation Program for IPAY 2027 and beyond. I can be reached at sarah.arbes@astrazeneca.com with any questions.

Sincerely,

Sarah C. Arbes

Head of Federal Affairs and Policy

Bristol Myers Squibb™

VIA ELECTRONIC DELIVERY

September 3, 2024

Meena Seshamani, M.D., Ph.D.
CMS Deputy Administrator, Director of the Center for Medicare
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR)

Bristol Myers Squibb (BMS) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) *Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) ("Negotiation Data Elements ICR")*.[1]

At BMS, we are inspired by a single vision—transforming patients' lives through science. Our talented employees come to work every day dedicated to the mission of discovering, developing, and delivering innovative medicines that help patients prevail over serious diseases. We combine the agility of a biotech with the reach and resources of an established pharmaceutical company to create a global leading biopharma company. In oncology, hematology, immunology, cardiovascular disease, and neuroscience—with one of the most diverse and promising pipelines in the industry—we focus on innovations that drive meaningful change.

BMS supports Medicare policies that promote beneficiary access to new and effective medical treatments and help ensure Medicare patients benefit from the innovation that defines the U.S. health care system. We do not support the so-called Medicare "negotiation" policies contained in the *Inflation Reduction Act (IRA)*. We are extremely concerned by the impact that these policies will have on clinical research in addition to current and future innovation for patients.[2]

The IRA will have vast ramifications for patients, providers, manufacturers, and other stakeholders across the country. BMS is concerned that CMS' implementation of the IRA could have sweeping negative repercussions with respect to

[1] CMS, "Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002" (July 2, 2024), *available at* https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849.

[2] For these reasons, BMS has filed a federal lawsuit asking a court to declare the IRA unconstitutional. BMS believes that, in the absence of full repeal of the IRA's drug pricing provisions, significant clarity and reforms are necessary in several critical areas. Although our comments are designed to help CMS in these areas as it implements the process that Congress established in the IRA, nothing we say in this comment letter should be construed as suggesting that CMS can cure the constitutional flaws in the statute that Congress wrote. The IRA takes BMS' property without just compensation and compels manufacturers to express "agreement" that there is a "negotiation," and that the resulting government-mandated price is the "maximum fair price" ("MFP"). But as we have noted in our litigation, there are no true negotiations or agreements involved, and the price is not fair.

Medicare beneficiary access to needed medicines, and, indeed, for all patients. It is vital for CMS to give meaningful consideration of and response to stakeholder feedback on its proposals, particularly as the Agency updates its approach for Initial Price Applicability Year (IPAY) 2027.

BMS appreciates the opportunity to provide the following comments on the Negotiation Data Elements ICR. We intend our input to help CMS improve transparency and clarity of IRA implementation. Our recommendations reflect and are driven by our deep expertise in pharmaceutical innovation, delivery and supply chain, and access, as well as our experience with the IRA to date,[3] and we offer them to help mitigate against the negative consequences the ICR would have on innovation and, most importantly, patients.

We thank CMS for seeking to incorporate lessons learned on the Negotiation Factors and process from IPAY 2026. Just as CMS has learned from the IPAY 2026 process, so too have stakeholders, including manufacturers—and it is critical for CMS to apply those learnings to IPAY 2027 and make meaningful, positive changes. In general, an ICR is not an adequate mechanism for providing public input and dialogue on the important process of establishing the wide range of data and metrics that CMS will use in MFP-decision making. We continue to note, however, that the current process is not sufficient to address (to the extent possible under the IRA) the full value of a selected medicine. For factors that are not tied to the value a selected medicine offers to patients, caregivers, providers, and the Medicare program, we strongly urge CMS to only collect essential information for setting the MFP and to do so in the most effective and accurate way possible. And importantly, we continue to ask the Agency for the maximum level of flexibility and transparency in implementing this process, especially in the early IPAYs. BMS also strongly supports CMS' efforts to directly and actively solicit focused input from patients, beneficiaries, caregivers, and consumer and patient organizations, but CMS must make significant improvements in order for the process to be more meaningful, comprehensive, transparent, deliberative, and relevant to understanding a medicine's value.

Key comments include:

- **Scope and Burden of Information:** BMS remains concerned with both the scope and burden of information CMS will require as part of the ICR submission. For example, manufacturers will have exceedingly short timeframes for completing and submitting the data submission—which could require multiple individuals compiling complex data sources and then submitting in a form acceptable to CMS for submission. This process can be even more burdensome than CMS had outlined. Even for the appropriate data elements that manufacturers can provide, the breadth of information coupled with the strict timelines will make the burden exceptionally high. And without clear instructions and guidance from CMS on how to answer intricate questions, manufacturers may make reasonable assumptions with their submissions, but risk making such assumptions that are not consistent with how other manufacturers may interpret their obligation, thus creating an inequity in how CMS views this information to establish an MFP. There may also be information to which manufacturers do not reasonably have access or cannot provide with reasonable efforts, further driving inequities across data submissions and subsequent evaluations. And many of the requested data, such as government price reporting information, are already available to CMS, while others are publicly available, creating additional and unnecessary burden on manufacturers.

[3] In general, we refer CMS to BMS' comments in response to: the "Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027" Draft Guidance, released on May 3, 2024 (hereinafter referred to as the "IPAY 2027 comments"); and the "Information Collection Request (ICR) Form for Negotiation Data Elements under Sections 11001 and 11002 of the Inflation Reduction Act (IRA)" ICR, released on March 21, 2023 (hereinafter referred to as the "IPAY 2026 Negotiation Data Elements ICR comments").

- **Inappropriateness of Methodology:** Importantly, CMS' requested costs do not accurately portray the cost of innovation or reflect the cost of getting a selected drug to patients—and oftentimes, drug development and delivery are significantly more costly than what CMS' requested costs portray. For example, no other health technology assessment (HTA) process in the world includes supply side factors (*e.g.*, R&D costs, public funding) to determine the value of a product and/or to inform price considerations. BMS strongly urges CMS to place a lesser emphasis on factors such as R&D recoupment and more emphasis on the selected drug's therapeutic and clinical attributes, which is the true measure of innovation. The manufacturer-specific data elements are also not reflective of the realities of supplying product to the market, as channel complexities, access, and additional costs are not accounted for in the submission. To the extent possible, we urge CMS to account for these measures by providing an opportunity to submit a more complete view of the drug development and delivery process; and if CMS cannot commit to these updates, then BMS urges CMS to considerably de-emphasize the magnitude of adjustment based on manufacturer-specific data. BMS also asserts that only information germane to establishing an MFP for the Medicare market should be included in the manufacturer's submission (*i.e.*, commercial and/or non-Medicare government pricing information should not form the basis of a Medicare price). And practically speaking, only information that is currently available via standard price reporting conventions should be included in the manufacturer's submission. The IRA statute only refers to the submission of a manufacturer's non-FAMP, and not the other pricing metrics in the current ICR, and BMS urges CMS to remove these extraneous reporting requirements. We also ask CMS to only finalize submission requirements that are essential for operationalizing the MFP process and do so in the least burdensome way possible.
- **Evidence About Alternative Treatments:** While we have been encouraged that CMS appears receptive to a broad and holistic view of value and are pleased that CMS will allow for manufacturer dossier submissions (Question 36), we remain deeply concerned with the significantly limited opportunity proposed for manufacturers to share evidence about alternative treatments. It is extremely difficult for manufacturers to respond with constrained limits and provide comprehensive evidence on un-specified therapeutic alternatives across multiple indications. The burden associated with this is tremendous, and the Agency could alleviate some of this burden by creating scoping discussions to improve efficiency for both manufacturers and CMS. As we have encouraged CMS to do in our comment letters, the Agency should consider an appropriate forum and method for different stakeholders to provide input, and we urge the Agency to provide transparency and explicit rationale for decision making. Moreover, BMS recommends the Agency adopt a structured and transparent consultation process where relevant stakeholders are permitted to provide input in a format most suited to their expertise.

General Instructions

- Transparency, Clarity, and Burden: While we appreciate that each drug and patient population is unique, BMS believes that the lack of methodology and transparency in how the data elements will be weighted is a significant limiting factor that does not allow manufacturers to adequately prepare for the MFP process. If CMS does not create a meaningful process for how to establish an "Initial Offer" based upon the information submitted by manufacturers and other stakeholders, then manufacturers—as well as other stakeholders—are at an extreme disadvantage to provide a meaningful submission. We urge CMS to provide a more complete and transparent methodology to improve the data elements process. This should include a more formulaic approach to how CMS weighed each factor to give manufacturers more transparency and predictability in the process and for the future. And while we appreciate that CMS has provided some instructions and definitions related to the data submission, we continue to reiterate that CMS has not considered every necessary detail of that submission, including but not limited to factors such as cost of capital and lifetime net revenues. While BMS supports manufacturer flexibility in responding to the ICR, we are concerned that without clear instructions and

guidance from CMS on how to answer intricate questions, manufacturers may make reasonable assumptions with their submissions that are not consistent with how other manufacturers may interpret their obligation, thus creating an inequity in how CMS views this information to establish an MFP across negotiated products. There may also be information to which manufacturers do not reasonably have access or cannot provide with reasonable efforts, further driving inequities across data submissions and subsequent evaluations. And many of the requested data, such as government price reporting information, are already available to CMS, while others are publicly available, creating additional and unnecessary burden on manufacturers. Finally, the ICR represents a significant financial and operational burden for manufacturers, yet CMS' burden estimate is not even on the correct order of magnitude for manufacturers—and likely the Agency as well—to complete the ICR submission. We urge CMS to reconsider the burden estimate to be more in line with the significant workload that this process demands. To do this, CMS could consider engaging manufacturers who have gone through the process to confidentially discuss their experiences and seek to leverage lessons learned to reduce burden in the future.

- Confidentiality of Submitted Information: We applaud CMS for taking meaningful steps to ensure confidential commercial information submitted by manufacturers during the MFP process is protected from disclosure (*i.e.*, adding Question 28 to the ICR form). We note that CMS is taking a similar approach to the process certain states use in price transparency reporting, in which the manufacturer proactively designates which data are confidential and proprietary, and therefore not subject to public disclosure. We believe it is imperative that CMS ensure adequate safeguards to protect manufacturers' trade secret, proprietary, and other confidential commercial information from disclosure, including the opportunity for manufacturers to receive notice of potential disclosure and the opportunity to object to such disclosure.
- Instructions for Reporting Monetary Amounts: CMS states that when calculating monetary values, manufacturers should assume at most an 8.1 percent annual cost of capital.[4] We believe that the Agency inadequately considers a manufacturer's capital costs, and the cap on that cost appears to be arbitrary and uninformed. This approach further penalizes manufacturers as CMS does not seem to allow for any adjustments in future interest or inflation rate changes. In fact, in the "Research and Development in the Pharmaceutical Industry" report, in which CMS cites as supporting rationale, the Congressional Budget Office (CBO) notes that R&D costs "have increased by about *8.5 percent* per year over roughly the past decade."[5] In addition, when adjusted for inflation, pharmaceutical industry spend on R&D has increased over 10 times since the 1980s.[6] Further, we note that the 8.1% cost of capital adjustment was kept flat between the IPAY 2026 and 2027 ICRs. Adjusting for inflation in the cost of capital is not just crucial but also necessary—as inflation signifies the decrease in purchasing power of currency which translates to a loss in the real value. It affects both the cost of equity and the cost of debt, and higher inflation usually leads to higher interest rates. In other words, with rising inflation, the cost of R&D also increases, but the lack of adjustment in cost-of-capital does not account for that dynamic. Therefore, we strongly urge CMS to apply flexibility in its approach and remove the cap on the cost of capital or, at a minimum, allow manufacturers to adjust that cap appropriately based on interest and inflation rate levels in any given year. It is also unclear if CMS will apply the inflation adjustment on its own, as well as what level of inflation will be used. We seek clarification from the Agency on this topic. Also, we wish to clarify if CMS' monetary reporting instructions apply to Evidence About Alternative Treatments. Peer-reviewed studies, which are CMS' preferred form of submissions, may not have costs reported in the way the Agency is requesting, and we recommend CMS clarify that the monetary reporting guidance does not apply to peer-reviewed literature.

[4] CMS, Negotiation Data Elements ICR, p. 5.
[5] Congressional Budget Office (CBO), "Research and Development in the Pharmaceutical Industry" (April 2021), p. 16 (emphasis added), *available at* https://www.cbo.gov/publication/57126#footnote-055.
[6] *Id*. at 5.

C: Research and Development Costs and Recoupment

BMS continues to remain highly concerned the data elements that CMS will use to establish the MFP do not adequately capture the value and benefit of a drug to patients and the broader health care system. CMS should balance these factors such that the Agency prioritizes rewarding innovation and preserving advancements in patient care. In contrast, placing a greater emphasis on R&D recoupment, as the Agency seeks to do, is a flawed approach that ignores certain biopharmaceutical realities—such as the high risk-reward of pharmaceutical innovation and the wide range of costs incurred beyond R&D. CMS must consider metrics that provide a more complete picture of the drug development and commercialization process to contextualize this broader investment. BMS strongly urges CMS to place a lesser emphasis on R&D recoupment, and more emphasis on the selected drug's therapeutic and clinical attributes which is the true measure of innovation.

Our specific and thematic comments on the Research and Development Costs and Recoupment elements follow.

- Application of Indirect Costs: Question 2 (Basic Pre-Clinical Research for All FDA-Approved Indications of the Selected Drug) is the only question in Section C that contemplates consideration of *indirect* costs. BMS strongly asserts that post-IND, abandoned and failed product costs, and all other direct R&D costs do not, but should, account for indirect costs as well. Indirect costs represent genuine and legitimate costs of performing research that is not easily attributable to individual activities. Examples of indirect research costs can include: depreciation of research equipment and buildings; laboratory utilities (*e.g.*, light, heating and cooling, or power); hazardous chemical and biological agent management; libraries; internet; data transmission and storage; radiation safety; insurance; administrative services; and compliance with federal, state, and local regulations, among other items. Moreover, the federal government recognizes the validity and legitimacy of indirect research costs in other contexts—and universities conducting federal research are partially reimbursed for these expenses.[7] We strongly encourage CMS to not only include manufacturers' indirect costs in Question 2 but apply this methodology to *all* applicable questions in the Research and Development Costs and Recoupment section.
- Global and U.S. Total Lifetime Net Revenue for the Selected Drug: BMS strongly opposes CMS' intent to use global, total lifetime manufacturer net revenue for the selected drug. This requirement would include net sales information from countries outside of the U.S. and has no place in establishing an MFP that is specifically based on a U.S. policy change intended for the U.S. market—and even then, is intended for the Medicare market only, which is a subset of the U.S. market. While CMS notes it only intends to include R&D costs for FDA-approved indications, which is a U.S. cost and regulatory metric, the Agency seems to be calculating the "recoupment" of these U.S. costs by comparing them to global total lifetime net revenues, thereby violating a matching principle of expenses incurred and revenues earned, which will likely unfairly disadvantage manufacturers. In addition, by considering indirect R&D costs only in some instances (*i.e.*, Basic Pre-Clinical Research for All FDA-Approved Indications), but not in others, CMS is asking manufacturers to count *some* costs associated with the selected medicine and comparing those costs to *all* revenues. In addition, the total net revenues earned in countries outside of the U.S. are already subject to manufacturer-payer agreements. Inclusion of those agreement (by virtue of capturing global net sales) in the CMS Initial Offer development is a double dip that further penalizes manufacturers. If CMS is set on its approach and intends to utilize global, total lifetime manufacturer net

[7] *See* https://www.aau.edu/key-issues/frequently-asked-questions-about-facilities-and-administrative-fa-costs-federally. According to the Association of American Universities (AAU), indirect costs are essential costs of conducting research, and "the federal government's longstanding recognition and payment of these costs has helped U.S. colleagues and universities build and support the required research infrastructure that has made American research enterprise the best in the world."

revenue then, at a minimum, the Agency should recognize the costs of ongoing research and significant, necessary expenditure incurred for international product launches and line extensions. And as noted, R&D costs are not complete if indirect costs are not considered, further disadvantaging manufacturers.

D: Current Unit Costs of Production and Distribution

In general, BMS notes that there are several challenges with obtaining CMS' requested information about current unit costs of production and distribution at the drug-specific level. Manufacturers will be responsible for submitting certain data that will serve as the basis for "Offers" and "Counteroffers," and these costs and data inputs should be determined and reported in accordance with generally accepted accounting principles. We reiterate our concerns that the Current Unit Costs of Production and Distribution is too narrow in scope and does not reflect the realities of bringing a selected medicine to market. In addition, we note that there could be legitimate business transactions necessitated by patient access concerns that result in manufacturers incurring transfer prices; we ask CMS to be flexible with its approach and consider a broad view of costs of production and distribution related to patient access to medicines.

E: Prior Federal Financial Support

BMS continues to maintain that the only prior federal financial support that should be reported is funding that directly resulted in a patent application containing a Government Interest Statement and/or research where a patent assignee was a U.S. government agency. Accordingly, we disagree with CMS' decision not to narrow this definition.

F: Patents, Exclusivities, and Approvals

BMS supports protection of intellectual property (IP) rights and believes that an effective IP framework is essential for the viability of the biopharmaceutical industry and efforts to deliver innovation that addresses unmet patient needs. The discovery and development of new medicines is a long, complex, and rigorous process. BMS is concerned that CMS' proposals could contradict the framework that was intended to protect and encourage innovation. CMS' requests for patent information relating to the selected drug is overbroad and ambiguous. The ambiguity is further complicated by the newly imposed a 300-word limit on the Explanation of Patents (Expired and Non-Expired) and Patent Applications (Question 13).

G: Market Data and Revenue and Sales Volume Data

The IRA statute only refers to the submission of a manufacturer's non-FAMP, and not the other pricing metrics in the current ICR. BMS strongly objects to CMS requesting data on pricing metrics that do not reflect an actual Medicare price and therefore have no bearing on a Medicare-negotiated price. By creating a Medicare negotiation scheme, Congress has directed CMS to use market data, revenue, and sales volume data to come up with a new pricing metric reflective of the Medicare market. And by referring to final FSS and Big Four prices, for example, CMS would be capturing complexities of those calculations that should not apply to IRA price setting. Reference to FSS and Big Four prices could have the unintended consequence of reducing or eliminating manufacturers' voluntary discounts that lead to lower prices for those government channels. Such pricing may be inherently short-term and thus would serve as an inappropriate benchmark for setting a longer-term price. CMS also seeks to create new methodologies, such as multiple variations of U.S. commercial unit prices. And practically speaking, only information that is currently available via standard price reporting conventions should be included in the manufacturer's submission (*e.g.*, CMS' proposed "Manufacturer Net Part D Price" is not a standard metric that is reported anywhere throughout the federal programs and an inappropriate attempt to aggregate price concessions from supply chain entities across the pharmaceutical

supply chain and should not form the basis of a Medicare price). Not only are these methodologies not relevant in establishing a Medicare-based price, but they would be near impossible for manufacturers to develop and validate within a 30-day timeframe. BMS asserts that only information germane to establishing an MFP for the Medicare market should be included in the manufacturer's submission (*i.e.*, commercial and/or non-Medicare government pricing information should not form the basis of a Medicare price). Accordingly, BMS urges CMS to remove these extraneous reporting requirements.

When contemplating the Manufacturer U.S. Commercial Average Net Unit Price and the Manufacturer U.S. Commercial Average Net Unit Price-Best (Question 24), CMS requests that manufacturers submit total unit volumes. However, these two price points are likely offered on completely different sets of volumes (*i.e.*, the Manufacturer U.S. Commercial Average Net Unit Price-Best is often offered to a very limited set of customers, likely no more than one, and therefore applies to a very limited volume of units). By examining the units in total, CMS could erroneously interpret the data and correlate the best price with the total commercial unit volume. This misinterpretation could lead CMS to skew the MFP offer towards a figure that does not accurately represent market dynamics. While the most appropriate approach would be for CMS to exclude the commercial-best price from the MFP determination, at a minimum, CMS should separate the total unit volumes between the Manufacturer U.S. Commercial Average Net Unit Price and the Manufacturer U.S. Commercial Average Net Unit Price-Best.

We also ask CMS to only finalize submission requirements that are essential for operationalizing the MFP process and to do so in the least burdensome way possible. The Agency cannot, and should not, impose an obligation to divulge virtually *all* pricing information for the drug, including proprietary, otherwise reported, and irrelevant information. BMS objects to CMS' proposed information collection in this section based on appropriateness, relevance, duplication, excessive scope, and undue burden.

I: Evidence on Alternative Treatments

BMS continues to urge CMS to deeply consider a robust body of information when assessing a selected drug's impact on unmet need and therapeutic advance. This holistic consideration should go beyond rigid health care costs and health outcomes to consider the impact of medicines on society—such as improvements to patients' and caregivers' lives, efficiency and quality in the health care system, and equity across populations. When considering added benefits of a selected medicine, BMS also encourages CMS to consider several critical elements in order to capture the full- and long-term value of a treatment, including: health outcomes, both from clinical trials and real world evidence, medical association guidelines and Medicare-recognized compendia, and health equity and subpopulation benefits. Randomized clinical trials (RCTs) often represent a drug's data close to the time of initial approval in the US market, while real world evidence (RWE) reflects a breadth of relevant data collected over time across a broader patient population in real world clinical settings. As such, RWE should be weighted equal to RCTs if published in a peer reviewed journal. Equally important is an emphasis on health outcomes and benefits, including but not limited to reduction in burden to the health care system, patient preferences, treatment adherence, and scientific spillover. Non-clinical benefits should be weighted heavily when establishing the starting point for the MFP. Also, important to consider is situations in which medicines treat conditions with a limited number of treatment alternatives, as well as the innovation and societal progress that is achieved in treating serious medical conditions, including incremental success achieved to address unmet needs and provide hope for patients.

While we have been encouraged that CMS appears receptive to a broad and holistic view of value, we remain deeply concerned with the significantly limited opportunity proposed for manufacturers to share evidence about alternative treatments. It is extremely difficult for manufacturers to respond with constrained limits and provide comprehensive

evidence on un-specified therapeutic alternatives across multiple indications. The burden associated with this is tremendous, and the Agency could alleviate some of this burden by creating scoping discussions to improve efficiency for both manufacturers and CMS. To ensure the proper consideration of information between a selected drug and alternatives, manufacturers should also have insight into CMS' literature review and the opportunity to comment on the accuracy of the proposed value capture.

In the general instructions, we appreciate that CMS states that "information provided in response to an individual question does not need to be duplicated across additional responses…" as CMS "will review submissions holistically across the entire submission."[8] BMS is seeking clarification on whether individuals reviewing the responses will be reading responses to all questions across all sections or only reading responses to specific questions and then coming together later to consider holistically. We note our strong preference for the former to ensure continuity and burden reduction in this process. We also ask CMS to make Question 63 mandatory to ensure that neither Quality-Adjusted Life Year (QALY) nor QALY-adjacent metrics are not used in any context.

In addition, we strongly oppose CMS' follow-up question to "Other" in Question 29 (*i.e.*, *"are you or your organization affiliated with the manufacturer of the selected drug or its therapeutic alternative(s)?"*).[9] This characterization fails to acknowledge that other conflicts of interest exist in this process. We urge CMS to remove, or at a minimum, revise the question to not dissuade comments from completing the submission and also recognize that there are many conflicts of interest beyond "affiliated with the manufacturer."

Our specific and thematic comments on the Evidence About Alternative Treatments elements follow.

Manufacturer-Focused Questions

- Off-Label Use: BMS cautions CMS on the usage of off-label therapeutic alternatives, as well as those in different pharmacologic classes, unless supported in either one or more of the compendia or in peer-reviewed medical literature; CMS must prioritize the most appropriate therapeutic alternatives and seek input from manufacturers and other stakeholders on these alternatives through a separate scoping process before comparative effectiveness evidence is submitted to focus those submissions on only prioritized alternatives, reducing burden to both manufacturers and CMS.
- Potential Therapeutic Alternatives: BMS supports CMS' decision to consider FDA-approved resources when identifying indications for a selected drug as well as the body of information that will be considered (manufacturer/public data, clinical guidelines, peer reviewed studies) when identifying therapeutic alternatives. CMS should also consider off-label, medically accepted indications as supported in either one or more of the compendia or in peer-reviewed medical literature, particularly for selected medicines used in an anti-cancer chemotherapeutic regimen. As CMS prepares to examine a large volume of evidence across multiple indications and multiple therapeutic alternatives within each indication and conduct several simultaneous assessments, BMS strongly recommends that CMS plan for additional, early dialogue with manufacturers, who have the most expertise with the selected drug, or at minimum, issue advance notice about the possible selection and the therapeutic alternatives that are likely to be considered by the Agency. It places an incredible burden on manufacturers to complete ICR submissions without knowing to which therapeutic alternatives the selected drug will be compared. Importantly, therapeutic alternatives should be selected based on clinical appropriateness and not narrowed based on least costly alternatives. BMS also requests the opportunity to

[8] CMS, Negotiation Data Elements ICR, p. 45.
[9] *Id.* at 44.

submit comparative effectiveness evidence data after CMS has identified indications and therapeutic alternatives. For example, oncology therapies can have dozens of indications, and the value proposition across these indications is unique given unique patients' needs; and for fixed-dose combinations, as well as single agents used in combination, value assessments have additional complexity. The consequences of inaccurate value determination can lead to restricted patient access. To prepare for this unprecedented task within a short amount of time with essentially no framework or examples on which to rely, BMS recommends that CMS plan for additional consultation with stakeholders. To do so, BMS requests that CMS issue additional guidance, as well as allow for a scoping meeting, prior to the evidence submission for a complex situation like medicines being used in combination.

- Clinical Comparative Effectiveness Evidence: BMS appreciates CMS' commitment to ensuring that it not use evidence from comparative clinical effectiveness research in a manner that treats extending the life of an individual who is elderly, disabled, or terminally ill as of lower value, which also includes excluding QALYs from the assessment. While new methods like generalized cost-effectiveness analysis (CEA) are being explored to account for differential value of health improvement in different contexts, there is no consensus yet on the ability of these methods to adequately address health equity considerations for special populations. For example, while Equal Value of Life Years Gained (evLYG) has gained traction in limited academic settings, most methodological and ethical limitations of the QALY still apply to the evLYG and could be used to limit patient access by utilizing value-for-money comparisons to arbitrary thresholds. Further, CMS has not sought public comment from patients and other stakeholders on willingness to pay and appropriate cost-effectiveness thresholds for IRA assessments in general. Therefore, BMS strongly recommends that CMS not anchor value assessments for selected drugs on CEA. Any consideration of CEA should merely be a part of a broader and holistic assessment of value and should only be used for a positive, upward adjustment for a selected drug. Additionally, BMS strongly recommends that CMS not only perform its own checks and due diligence to ensure that any analyses based on QALY are excluded from review, but also allow manufacturers to validate CMS' evidence evaluations, which would provide further safeguards against discriminatory metrics being used to assess value of important medicines. As a clarifying question, we ask whether manufacturers should submit patient reported outcome (PRO) data in Question 32 (use in treatment and clinical comparative effectiveness evidence) or in Question 35 (specific populations and patient experience).
- Therapeutic Advance and Unmet Medical Need: BMS urges CMS to take a broad, holistic view of unmet medical need. As CMS will assess medications in the middle of their life cycles, BMS recommends that unmet need be considered from initial approval to the time of assessment. Additional value should be particularly considered for those medications that treat serious medical conditions, including those that make incremental steps toward curative goals or significantly reduce the risk of adverse events compared to alternatives. For example, comparative effectiveness evidence in difficult-to-treat or underserved populations can demonstrate that a selected medicine addresses an unmet medical need. Further, unmet need should be viewed from the perspective of patients and providers. Unmet need should accordingly encompass a spectrum of characteristics, such as: alternative dosing regimens; route of administration; reduction of side effects; and shorter treatment periods. BMS urges CMS to clearly state how the Agency came to a determination that a selected drug did or did not represent a therapeutic advance or address an unmet medical need. While we support driving towards patient-centered outcomes, CMS should provide more transparency into how qualitative considerations translate into an adjustment to the starting point. As a practical matter for clarity, we ask CMS to modify the definition of unmet need by replacing "existing" with "alternative": "A drug or biological product may be considered to address an unmet medical need if the drug or biological product treats a disease or condition in cases where no other treatment options exist or *alternative* treatments do not adequately address the disease or condition" (emphasis added). Additionally, to improve clarity and quality of information provided, we strongly

urge CMS to provide examples of what evidence it would consider as sufficiently supporting therapeutic advance and/or addressing an unmet need.

- Specific Populations and Patient Experience: CMS indicates that priority will be given to studies focusing on special populations (including individuals with qualifying disabilities, patients with End-Stage Renal Disease [ESRD], and Medicare-aged populations) over studies for which these populations were not the primary focus. While BMS agrees that benefits and risks to these special populations are critical to assess, depending on the size of the special population relative to the overall patient population, there may be numeric differences in outcomes for a selected drug compared to its therapeutic alternative that are not statistically significant (or may not be replicable in a similar population). We recommend that CMS consider subgroup/population analysis as a core assessment with safety and efficacy and that evidence from these studies be considered of equal priority to evidence from larger studies that are better powered to draw comparative effectiveness conclusions. We also encourage CMS to consider evidence in other subpopulations, including patients with comorbidities and different ethnicities, when data is available, and ask that CMS require submitters to speak to the quality of evidence and/or be prepared to assess that quality during the Agency's internal review process.
- Dossier Submission: We strongly support CMS' proposal allowing manufacturers to submit a comprehensive evidence package in the Academy of Managed Care Pharmacy (AMCP) dossier format, which is a widely used, gold standard dossier submission format for value assessment purposes. However, we are concerned that CMS' request for a manufacturer to submit an outline of the location of information addressing manufacturer-focused questions along with providing word-constrained responses to the questions further increases burden and duplication. BMS requests clarification whether CMS will review tables of information and/or text in responses to other visual representation questions as well, or if the dossier is the only way to provide this information.

Patient-Focused Experience, Clinical-Focused Experience, Research-Focused Experience, and Other Public Input

BMS supports CMS' efforts to directly and actively solicit focused input from patients, beneficiaries, caregivers, and consumer and patient organizations as it implements IPAY 2027. It is critical for CMS to consider a variety of perspectives throughout the data submission and review process, and we are pleased to see that CMS is improving the data collection process with information more closely aligned to respondents' area of expertise. We applaud CMS for proposing to approach different stakeholders uniquely and provide a more appropriate forum and method for stakeholders to deliver the information relevant to their areas of expertise, as opposed to a one-size-fits-all ICR submission.

While this is a good first step, BMS recommends the Agency adopt a structured consultation process where relevant stakeholders are permitted to provide input in a format most suited to their expertise; this type of tailored approach could underscore the importance and value of stakeholders' submissions and involvement and ultimately encourage more participation. We also urge CMS to make the stakeholder input process as user-friendly as possible. While we appreciate CMS adding focused questions by stakeholder in a more lay-friendly format, we have some additional, non-exhaustive suggestions:

- Tailored Questions: When respondents select their identifying descriptions in Question 29, we urge CMS to consider only having respondents populate the relevant subset of questions that correspond with those identifying descriptions. For example, if a respondent selects "a patient who has experience taking the selected drug or its therapeutic alternatives(s)," we recommend that CMS direct that respondent to answer Questions 38-44 (Patient- or Caregiver-Focused Input), as well as direct that respondent to optionally answer Questions 59-62 (Other Public Input). We believe that this type of tailored approach would be more relevant to respondents, and in turn, boost participation in the process.

- Improved Input: Based on the IPAY 2026 process, we had heard from stakeholders that there was a high degree of confusion with the ICR submission process. We urge CMS, to the extent feasible, to move beyond the HPMS system for non-manufacturer respondents and use a more user-friendly system for feedback. BMS also encourages CMS to remove arbitrary word limits for stakeholders to fully capture the experience using, prescribing, and/or researching the selected drug. In addition, it might be challenging for certain stakeholders to answer questions about things like "therapeutic alternatives" or "off-label use." While CMS includes these terms in the ICR instructions, we recommend the Agency create a user-friendly glossary or allow stakeholders to hover their computer mouse over a term and have the definition pop up embedded within the question itself. Accordingly, we encourage CMS to weigh responses, particularly clinical responses, based on the appropriateness and expertise of the respondent.
- Targeted Beneficiary Outreach: We also urge CMS to conduct targeted proactive beneficiary outreach to boost participation and create user-friendly materials and resources for completing the submission. For example, CMS could create a step-by-step "how to" guide or video and share proactively with patients, patient advocacy organizations, and medical societies interested in completing the ICR submission.

Above all, we encourage CMS to continue working with the stakeholder community[10] to consider a variety of perspectives throughout the data submission and review process. BMS also asks CMS to work with FDA to leverage shared learnings on the FDA's Patient-Focused Drug Development Process.[11]

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BMS appreciates the opportunity to comment on the Negotiation Data Elements ICR. We would be pleased to discuss these comments in further detail. Should you have any questions or concerns, please contact Caroline Tucker, Director, Executive Branch Strategy, at caroline.tucker@bms.com.

Sincerely,

/s/

Amy Demske
Executive Director, U.S. Policy & Executive Branch Strategy
U.S. Policy & Government Affairs & Policy Communications

[10] *See* Chronic Care Policy Alliance, "Advocating for Patient Voices: CCPA's Letters to CMS on Medicare Drug Price Negotiations" (July 18, 2024), *available at* https://chroniccarealliance.org/advocating-for-patient-voices-ccpas-letters-to-cms-on-medicare-drug-price-negotiations/.
[11] FDA, "FDA Patient-Focused Drug Development Guidance Series for Enhancing the Incorporation of the Patient's Voice in Medical Product Development and Regulatory Decision Making" (February 14, 2024), *available at* https://www.fda.gov/drugs/development-approval-process-drugs/fda-patient-focused-drug-development-guidance-series-enhancing-incorporation-patients-voice-medical.

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August 30, 2024

VIA ELECTRONIC FILING – REGINFO.GOV

CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
7500 Security Boulevard
Baltimore, Maryland 21244–1850
Attention: Document Identifier/OMB Control Number: CMS–10849, Room C4–26–05

RE: [CMS-10849] Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act Information Collection Request

To Whom It May Concern,

Eli Lilly and Company (Lilly) appreciates the opportunity to respond to certain sections of the Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act Information Collection Request (ICR) (CMS–10849).[1] The Centers for Medicare & Medicaid Services (CMS) has requested stakeholder feedback "regarding [the] burden estimates or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions [and] the accuracy of the estimated burden."

We believe CMS continues to meaningfully underestimate the time, effort, and level of seniority of the individuals required to develop and implement this novel data reporting framework – a framework that is inconsistent with any other existing data reporting paradigm. We estimate the number of personnel-hours needed will likely exceed 1000 and will include time and effort from key finance and legal resources, including mid-level and senior financial leaders.

As we have previously highlighted, CMS is proposing to require that manufacturers provide extensive and unnecessary data, and at a level of detail and categorization that is not required by the authorizing statute and that is inconsistent with the manufacturer's audited financial statements, generally accepted accounting principles (U.S. GAAP), and/or U.S. Securities and Exchange Commission (SEC) reporting standards.[2] Because the ICR proposals go beyond U.S. GAAP and SEC requirements, the burden they impose on manufacturers is specific to the Program and the time and resources needed to comply, described previously, would be in addition to existing manufacturer obligations to track and monitor product R&D, production, distribution, and other costs. And for IPAY 2027, CMS is proposing to request even more data and/or categorization, not less. This high data collection burden is not necessary to ensure the "proper performance of the agency's functions." Moreover, it is unclear whether and to what extent CMS used the vast amounts of data collected from manufacturers in the first year of the "Medicare Drug Price Negotiation Program" (Program). It is incumbent on CMS to right-size the ICR to reduce the data requested to only those subjects and formats reasonably necessary to support the Program and as provided for by the statute.

[1] 89 Fed. Reg. 54,824 (Jul. 2, 2024); Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act Information Collection Request (ICR) (CMS–10849) (Jul. 2, 2024).

[2] As we highlighted in our comments to the Draft Guidance, the U.S. SEC and other governmental bodies do not require external reporting of costs (including research and development costs) or profits at a product-specific level, and manufacturers may not prepare standard financial statements with this data at a product-specific level.

Ultimately, the proposed ICR is inconsistent with the Paperwork Reduction Act (PRA),[3] which requires that agencies collect data in the least burdensome way necessary – that enables the agency's function, complies with the authorizing statute, and achieves the applicable agency objectives – and ensures practical utility.[4] The ICR sets up an excessively burdensome reporting regime that exceeds the needs of, and offers limited utility to, the Program.

Below we offer several suggestions to lower the burden of data collection and reporting while maintaining or improving the consistency and reliability of data reported to CMS. We implore CMS to carefully consider these and other comments as it modifies the data reporting requirements for the Program.

General Comments

1. CMS Should Expand Word Limits to Allow Manufacturers to Fully Explain the Values Reported.

Throughout the ICR, CMS proposes to require that manufacturers describe or explain the reported financial values in great detail, "including any calculations or conversions and any assumptions made."[5] In addition (and as we highlight in more detail below), the proposed ICR requirements are often inconsistent with U.S. GAAP or other existing financial data calculation or reporting requirements, and CMS states that manufacturers must "[d]escribe the policies and methodologies used in the calculations . . . , as well as the standard used if it is inconsistent with GAAP."[6] Certain questions require even more specificity. For example, in Question 2c, CMS indicates that manufacturers must:

> Explain how the basic pre-clinical research costs were calculated, including the allocation and apportionment methods. This explanation should include the percentage of direct and indirect spending on the selected drug out of the total direct and indirect basic-clinical research costs for the Primary Manufacturer, an explanation of the values used in the direct and indirect cost calculation, and the length of the basic pre-clinical research period used.[7]

Several other questions include additional specific prompts.[8]

Notwithstanding these extensive explanation requirements, CMS is proposing to impose character limits on all free text questions (in most cases, approximately 500 words). Given the instructions for Question 2 exceed 200 words, this limit on manufacturer responses is unduly burdensome and will likely impact CMS's ability to fully understand the data.

We recommend that CMS expand the word limits of these fields to allow for a fulsome explanation of the reported values, helping ensure the data can be meaningfully understood.

2. CMS Should Provide Clear Explanations of Evidence Used and Give Stakeholders Adequate Time to Understand Prior to ICR Submission

To give meaning to the agency's stated goal of promoting transparency, we urge CMS to commit to including timely and meaningful explanations as to how the evidence on alternative treatments were utilized, how such factors (and any other information) were

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[3] *See 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) (explaining that the PRA was enacted in response to the "enormous growth of our federal bureaucracy" and "its seemingly insatiable appetite for data").
[4] 5 C.F.R. § 1320.5(d)(1)(i)-(iii).
[5] ICR at 11
[6] *Id.* at 5
[7] *Id.* at 14-15.
[8] See, e.g. *id.* at Questions 1, 3d, 4b, 5c, 6a, 6b, and 8.

weighed and considered, and any non-manufacturer sources of information relied upon. We additionally ask CMS to release the explanation of MFPs, including drugs identified as therapeutic alternatives for negotiations, and any non-proprietary evidence before the ICR data collection process concludes for IPAY 2027 selected medicines. Today, CMS is required to publish their explanation of MFP by March 1, 2025 for IPAY2026, the same day stakeholders are required to submit data on the ICR form.[9,10] This creates a scenario where stakeholders are submitting information before understanding what CMS evaluates in their price-setting process. The lack of transparency limits all stakeholders' ability to provide the most impactful information to the agency.

Section C. Research and Development (R&D) Costs and Recoupment – General Comments

1. CMS Should Allow Manufacturers to Stipulate to R&D Recoupment. Alternatively, CMS Should Streamline R&D Reporting to Ensure its Approach is the Least Burdensome Necessary to Achieve the Statutory and Program Objectives.

In the Draft Guidance[11] and the ICR, CMS proposes to continue to require that manufacturers identify R&D expenses for a selected drug, determine whether such expenses should be reported in one of five categories defined by CMS, determine whether such expenses are "direct" or "indirect" or are "incurred for an a [Food and Drug Administration (FDA)] approved indication," and perform various ad hoc calculations to include, exclude, or allocate such expenses pursuant to CMS's specific and novel instructions. This collection goes well beyond the statutory requirement to submit information on "research and development costs of the manufacturer for the drug," which does not require manufacturers to subdivide and categorize this information as proposed in the ICR.[12] The statute merely requires manufacturers to report on "the extent to which the manufacturer has recouped research and development costs," which requires neither the proposed strict categorization of R&D data nor the reporting of global or U.S. lifetime net revenue.[13] And, as we have described previously, neither U.S. GAAP nor SEC require external reporting of R&D costs at a product-specific level, nor are manufacturers otherwise required to categorize and calculate R&D data in this way. Manufacturers will incur meaningful data collection burden to generate the data in the manner that CMS proposes.

CMS indicates in the Draft Guidance that it will use R&D costs to determine whether to adjust the preliminary price upward or downward; it does not specify whether or how it will use the breakdown of R&D into five distinct categories as distinct from total R&D costs.[14] CMS can achieve these purposes without requiring that manufacturers mine their financial systems and other books and records to attempt to identify transactions (some of which could be decades-old and captured in since-retired systems) and develop new and manual methodologies to categorize, calculate, and allocate the requested data across CMS' five R&D data categories, in the way CMS prescribes, solely for the purposes of the Program. Simply, CMS does not need all the information it is requesting, and it is requesting an unprecedented amount of information.

For the purposes of drastically reducing the reporting burden on manufacturers and improving consistency of manufacturer data submissions, we recommend that CMS amend its reporting requirement to allow a single global response in which a manufacturer can attest whether it has recouped its R&D costs. If a manufacturer certifies that it has recouped its R&D costs, then CMS need not

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[9] Centers for Medicare and Medicaid Services (CMS). Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026. June 30, 2023. Available: https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf.

[10] ICR at 2.

[11] CMS, *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027* (May 3, 2024) [hereinafter Draft Guidance].

[12] Social Security Act (SSA) §§ 1193(a)(4), 1194(e)(1)(A).

[13] *Id.*

[14] Draft Guidance at 87 ("[I]f a Primary Manufacturer has not recouped its R&D costs, CMS may consider adjusting the preliminary price upward. Conversely, if a Primary Manufacturer has recouped its R&D costs, CMS may consider adjusting the preliminary price downward or apply no adjustment.").

gather any additional information, either as to R&D costs or global and U.S. lifetime net revenue. If a manufacturer does not or cannot certify that it has recouped its R&D costs, then the manufacturer can provide additional information.

Alternatively, CMS should significantly streamline the R&D reporting requirement to better align with how manufacturers capture and report R&D data in their financial systems today. Specifically, CMS should collect R&D data in two 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. Such approach would both materially reduce reporting burden on manufacturers and improve consistency of manufacturer data submissions.

Either approach would comply with the statute and enable CMS to achieve its purposes under the Program but would do so in a way that is more consistent with the PRA.

2. CMS Should Not Limit the Definition of R&D Costs to Costs Associated with "All FDA-Approved Indications of a Drug."

CMS proposes to limit the definitions of R&D costs to those incurred "for all FDA-approved indications of a drug." First, this definition risks excluding costs that are necessary to the R&D process and that are otherwise included in the manufacturer's audited and publicly disclosed financial statements and U.S. GAAP. It also risks excluding material costs incurred by manufacturers (e.g., to conduct trials that further the understanding of approved molecules, to invest in R&D for indications approved in non-U.S. markets – indications that may be approved by the U.S. FDA at a later time).[15]

Moreover, manufacturer systems generally are not configured to assign costs to a specific indication, particularly in early stages where research is indication-agnostic and focused on the molecule safety, toxicity and general efficacy. Additionally, late phase research efforts may support a portion of or the entirety of a manufacturer's portfolio and would not be assigned to a specific molecule or indication. As a result, manufacturers will likely need to develop assumptions and customize their calculations in a manner inconsistent with current financial reporting, solely for the purposes of the Program, to determine whether and to what extent expenses (particularly those not associated with a specific clinical trial) are reasonably associated with an FDA-approved indication.

To further standardize and improve consistency of submitted information, aid in CMS's interpretation of the submitted information, and significantly reduce the reporting burden on Primary Manufacturers, we recommend that CMS define R&D costs without limiting those costs to those incurred for FDA-approved indications. Alternatively, we recommend that CMS specify that certain categories of research, e.g., basic pre-clinical research, is assumed to be for FDA approved indications.

3. CMS Should Not Exclude "Costs Associated with Ongoing Basic Pre-Clinical Research, Clinical Trials, and Pending Approvals" from the Definition of R&D Costs.

CMS proposes to exclude "costs associated with *ongoing* basic pre-clinical research, clinical trials, and pending approvals" from the definition of R&D costs. As we previously noted, this definition excludes costs that are otherwise included in the manufacturer's audited and publicly disclosed financial statements and U.S. GAAP. It also ignores meaningful expenses incurred by manufacturers to research and seek approval of innovative therapies, for example, when manufacturers continue to conduct trials to gain approval for additional indications of a drug.

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[15] CMS's proposed limitation of certain R&D costs to FDA-approved indications is also inconsistent with CMS's proposal regarding how to identify therapeutic alternatives to a selected drug; there, the ICR indicates that CMS will look to on- and off-label indications. Manufacturers may be in the process of incurring R&D expenses for indications not yet approved by FDA and should be able to include those costs in reported R&D, consistent with the identification of therapeutic alternatives.

Importantly, under CMS guidance, once a selected drug is subject to an MFP, such MFP applies to all *future* indications of the drug unless a new MFP is established through the renegotiation process at some future point. Renegotiation of the MFP in the event a new indication is required by statute only where CMS "expects renegotiation is likely to result in a significant change in the maximum fair price otherwise negotiated."[16] CMS has not yet committed to renegotiate whenever a new indication is approved. This means material R&D costs for these future indications (e.g., costs that may have been *ongoing* at the time of the drug's selection) may never be reported to CMS by a manufacturer in support of the negotiation or renegotiation of the MFP, and the drug's MFP – which will apply to all indications of that drug – will be determined without consideration of such costs.

Moreover, manufacturers may need to manually identify and exclude these costs from the data they report to CMS, in a manner inconsistent with their reporting under U.S. GAAP and to the SEC. To further standardize and improve consistency of submitted information, aid in CMS's interpretation of the submitted information, and significantly reduce the reporting burden on Primary Manufacturers, we recommend that CMS define R&D costs to include ongoing costs. Such approach better reflects the treatment of these expenses under existing financial reporting requirements, results in a more appropriate R&D cost recoupment calculation (i.e., the comparison of lifetime revenue to lifetime costs, which include ongoing costs), and better aligns with the underlying structure of the Program (e.g., which applies the MFP to all future indications).

4. CMS Should Not Exclude Indirect Costs from the Calculation of Various R&D Costs

In Questions 3-5 of the ICR, CMS proposes to limit manufacturer calculations of R&D costs to direct expenses only. As above, this limitation not only *excludes* costs that are otherwise included in the manufacturer's audited and publicly disclosed financial statements and U.S. GAAP but also ignores material costs incurred by manufacturers. This adds to manufacturer data calculation burden but offers limited utility to the Program.

To further standardize and improve consistency of submitted information, aid in CMS's interpretation of the submitted information, and significantly reduce the reporting burden on Primary Manufacturers, we recommend that CMS define all R&D costs to *include* indirect costs.

5. CMS Should Not Require that Manufacturers Deduct Federal Funding from the Final Calculated Numerical Amounts in Questions 2-5.

The ICR instructs manufacturers as follows:

> If [a] Primary Manufacturer received any prior Federal financial support, as defined in Section E, for any of the costs listed in Questions 2 through 5 (e.g., basic pre-clinical research, clinical trials, etc.), deduct such funding from the final calculated numerical amount before answering the relevant question and note that deduction in the applicable free response field. CMS will be collecting additional information on prior Federal financial support in Questions 9, 10, and 11.[17]

This requirement is unduly burdensome as it is inconsistent with U.S. GAAP, ambiguous, and largely duplicative to another CMS reporting requirement.

Specifically, this requirement creates another new and material reporting burden inconsistent with U.S. GAAP and other financial reporting requirements. Manufacturers are not required to carve out federal funding from their financial statements or disclosures. Moreover, CMS provides no guidance as to how such funding should be deducted or allocated. For example, manufacturers may

[16] SSA § 1194(f)(3)(C).

[17] ICR at 11. CMS defines "Federal financial support" as including "tax credits, direct financial support, grants or contracts, in-kind contributions (e.g., support in the form of office/laboratory space or equipment), and any other funds provided by the federal government that support discovery, research, and/or development related to the selected drug." *Id.* at 24.

make different assumptions with respect to how to proportionally deduct tax credits across the various numeric responses, which will create inconsistency in the data that is submitted to CMS. Finally, CMS already requires manufacturers calculate and extensively describe federal financial support in a separate question in Section E (i.e., Questions 9 and 10), such that CMS will already know what portion of reported manufacturer R&D costs were offset by federal financial support, regardless of whether manufacturers take on the additional burden of deducting these costs from R&D and with no guidance from CMS on how to do so across the distinct R&D cost categories to be reported.

Thus, this requirement is unnecessarily burdensome while providing no utility to the Program: it is inconsistent with U.S. GAAP, ambiguous for manufacturers to implement consistently, and largely duplicative to information CMS requests in a different question of the ICR. Consistent with the PRA, we recommend that CMS adopt the "least burdensome approach necessary" and not require that manufacturers exclude federal research from R&D costs, particularly since federal financial support must be reported and fully explained in a different section of the ICR.

Section C. Research and Development (R&D) Costs and Recoupment – Specific Comments

1. Question 2: Basic Pre-Clinical Research for All FDA-Approved Indications of the Selected Drug

CMS proposes to define basic pre-clinical research costs as "all discovery and pre-clinical developmental costs incurred by the Primary Manufacturer with respect to the selected drug during the basic pre-clinical research period and are the sum of (1) direct research expenses and (2) the appropriate proportion of indirect research expenses."[18] CMS's definitions and instructions in this section create meaningful data collection burden and may result in inconsistency in manufacturer submissions.

First, the overwhelming majority of – if not all – pre-clinical research costs are reasonably associated with or are "for" an FDA approved indication, as these early costs provide an understanding of toxicity and safety of a potential medicine. Ultimately, many of the pre-clinical expenses result in information that is submitted to FDA when seeking drug approval. Also, in most cases, a manufacturer will not know the expected FDA label until the end of the R&D cycle, well after pre-clinical costs were incurred, and there is no "flag" in manufacturer financial systems that links pre-clinical R&D costs to an FDA approved indication.

Accordingly, to help drive consistency in manufacturer submissions and reduce manufacturer reporting burden, we recommend that CMS allow all relevant pre-clinical expenses to be reported, regardless of whether those expenses are explicitly tied to an FDA-approved indication. Alternatively, we recommend CMS explicitly acknowledge that pre-clinical research costs are presumed to be for an FDA-approved indication.

Second, in the ICR for Program year IPAY 2027, CMS has increased the manufacturer reporting burden by asking additional questions, including requiring a "list of the direct research expenses and indirect research expenses for the selected drug" in Question 2b, separate and distinct from CMS's request for a detailed explanation of preclinical expenses (including "an explanation of the values used in the direct and indirect cost calculation") in Question 2c.[19] This requirement creates redundancy in manufacturing reporting with no clear benefit to CMS- particularly given that, here too, the proposed ICR is unclear as to how CMS intends to use this information. Thus, we recommend that CMS combine questions 2b and 2c and allow manufacturers to describe their methodologies holistically.

2. Question 3: Post-IND Costs for All FDA-Approved Indications of the Selected Drug

[18] *Id.* at 13.
[19] *Id.* at *14.*

The definitions in this R&D cost category are also limited to only those expenses "for each FDA-approved indication."[20] In addition, CMS does not allow reporting of indirect expenses or any "ongoing" research. These limitations exclude transactions that are otherwise included in manufacturers' financial statements and meaningfully limit the data that can be reported to CMS. If CMS does not accept our recommendation to allow reporting of "ongoing" research in all R&D cost categories, we recommend that CMS allow the reporting of "ongoing" research in this category specifically. This would reduce reporting burden and facilitate a better understanding and interpretation by CMS of the research and development costs of a selected drug that will be subject to an MFP for all future indications.

3. Question 4: Costs of Failed or Abandoned Products Related to the Selected Drug

The definitions in this R&D cost category are also limited to only direct expenses. We recommend that CMS allow reporting of indirect expenses to reduce manufacturer reporting burden and better depict the expenses incurred.

4. Question 5: Direct Costs of Other R&D for the Selected Drug Not Accounted for Above

We again encourage CMS to allow reporting of ongoing direct and indirect costs in this category to reduce data collection burden. Also, CMS has *added* to the reporting burden in this question by requiring additional responses and itemization that create redundancy in manufacturer responses without providing any practical utility to CMS. We recommend that CMS combine questions 5b and 5c to remove redundancy, lessen burden, and offer more utility to the Program by allowing manufacturers to describe their methodologies holistically.

5. Question 6: Global and U.S. Total Lifetime Net Revenue for the Selected Drug

CMS has meaningfully increased the burden of reporting in this question. Instead of seeking the lifetime net revenue as a single response, CMS is now requiring manufacturers "report the *per calendar year revenue* for the global total lifetime net revenue."[21] Some products selected for the Program have been on the market for many years, and CMS has no need for revenue by calendar year to evaluate R&D cost recoupment. This new requirement adds to the reporting burden of manufacturers but does not provide any practical utility. Thus, if CMS does not accept our recommendation to allow manufacturers to certify to R&D expense recoupment, we recommend CMS revert to the prior requirement for a single response of global, total lifetime net revenue and U.S. lifetime net revenue, without adding a requirement for per-calendar year revenue.

Section D. Current Unit Costs of Production and Distribution – General Comments

1. CMS Should Align the Definition of Relevant Production and Distribution 12-month Period to a Quarter Close.

The Draft Guidance indicates that manufacturers must provide "[a]verage unit costs during the 12-month period ending October 31, 2024 (for selected drugs for initial price applicability year)."[22] This date range that is inconsistent with SEC reporting periods. Most manufacturers, particularly those who are also publicly traded companies, have systems, processes, and controls that are performed on a quarterly or annual basis to help ensure accurate external financial reporting. Under the Draft Guidance and ICR, manufacturers will need to implement additional controls to assess the completeness and accuracy of production and distribution cost data on an off-cycle basis. To alleviate this burden, and assuming CMS continues to want a 12-month average cost, we recommend that CMS request production and distribution data as of the close of the company's most recent fiscal year to align with the company's external financial reporting. Alternatively, we propose CMS align its request date to a quarter close, e.g., September 30, 2024 or December 31, 2024.

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[20] *Id.* at 15.

[21] *Id.* at 20 (emphasis added). CMS is also requiring per calendar revenue for U.S. lifetime net revenue. See *Id.* at 21.

[22] *Id.* at 22; Draft Guidance at 131.

Section I. Evidence on Alternative Treatments – General Comments

1. **Organizations Submitting Evidence Should Meet Thorough Standards to Ensure Organizational Independence, Patient-Centered Procedures, and Methodological Rigor**

When determining therapeutic alternatives for a selected drug, CMS should rely on external organizations for purposes of evidence synthesis or technology assessment only if such organizations meet specified standards. Such standards should ensure organizational independence, patient-centered procedures, methodological rigor, and transparency. CMS should apply these same rigor and transparency standards to its internal "claims analysis" and review when adjusting the MFP starting point based on clinical evidence.

2. **Manufacturers Should Not Be Penalized if a Dossier is Not Submitted**

Lilly appreciates the opportunity for manufacturers to submit a dossier in Question 36.[23] While we support allowing manufacturers to submit relevant supplementary information in their responses, like a dossier, a supplementary response may not always be necessary. Given the breadth of potentially excessive information in these documents and that these are not always kept up to date, a manufacturer should not be penalized for choosing not to submit if the answers are otherwise sufficient.

***

Lilly appreciates the opportunity to comment on certain sections of this ICR. We reserve the right to submit additional comments on other issues to IRARebateandNegotiation@cms.hhs.gov. We urge you to thoughtfully consider the issues discussed in this letter and would be happy to speak with you regarding any of the letter's content. Please do not hesitate to contact Derek Asay at Asay_Derek_L@Lilly.com with any questions.

Sincerely,

Derek L. Asay
Senior Vice President,
Government Strategy and Federal Accounts

Shawn O'Neail
Senior Vice President,
Global Government Affairs

[23] ICR at 49.

September 3, 2024

VIA ELECTRONIC SUBMISSION —

William N. Parham, III
Director
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10849
Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

RE: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) Forms (CMS-10849, OMB 0938-1452)

Dear Director Parham,

GSK is writing in response to the Centers for Medicare and Medicaid Services' (CMS or the Agency) recent IPAY 2027 Information Collection Request (ICR). GSK reasonably believes that one or more GSK product(s) may be directly impacted and subject to price setting under the Inflation Reduction Act (IRA). Given those potential implications, GSK has a vested interest in the development, interpretation, and application of the final IPAY 2027 regulations that will be issued by CMS. As CMS finalizes this ICR, GSK appreciates the Agency's willingness to solicit comments to understand stakeholder impacts and concerns related to implementation. While GSK is a member of both BIO and PhRMA and supports each organization's respective comments on this issue, we respectfully submit these more targeted comments in response to CMS's Proposed ICR Forms.[1]

GSK is a global biopharma leader with the ambition and purpose to unite science, technology, and talent to get ahead of disease together. With a clear and defined focus on leading the way in disease prevention, GSK's aim is to positively impact the health of more than 2.5 billion people over the next ten years. GSK supports policy solutions that transform our healthcare system to one that rewards innovation, prevents the onset and progression of disease, improves patient outcomes, and achieves higher-value care.

GSK appreciates CMS proposing changes to the ICR data elements that will facilitate submission of more data and evidence on the benefits a drug brings to patients and society. Specifically, GSK is supportive of the expanded questions and word limits in Section I, including the option to submit a dossier document and the addition of questions aimed specifically at clinicians, patients, and researchers. This will allow for

[1] GSK recognizes that CMS will receive many comments on this ICR. GSK lays out the letter in this framework in order to ensure that CMS knows where to consider our recommendations within the larger ICR.

the submission of additional information to provide the agency with a more robust and accurate understanding of the value of drug products.

GSK has some technical recommendations to Section G of the ICR that will help manufacturers comply with the information request:

Clarifying Reminder: GSK appreciates CMS's efforts to use National Council for Prescription Drug Programs (NCPDP) Billing Unit Standards (BUS) to promote consistency in the definition of weight across different price types. However, Non-FAMP, the Federal Supply Schedule, and Big 4 Prices are all calculated at the package level. As a clarifying reminder, if CMS compares the various pricing metrics provided in Section G, where some pricing metrics are reported in package size and others at the NCPDP unit, a conversion factor would be necessary to compare across pricing metrics.

Recommendation: GSK recommends CMS provide a timeline to report metrics using the most recent three years ending with the fourth quarter of 2024.

CMS does not explicitly provide timelines for data submissions related to the Manufacturer U.S. Commercial and Medicare Part D Average Net Unit Prices. We believe that CMS may have inadvertently excluded the timeframe for which they expect pricing to be reported for these metrics. A three-year timeline aligns with the timelines specified in other parts of Section G (e.g., Wholesale Acquisition Cost Unit Prices, Federal Supply Schedule Prices, Big 4 Prices), and therefore makes the most sense in terms of consistency and simplicity.

Recommendation: GSK recommends that CMS clarify whether the Manufacturer U.S. Commercial and Medicare Part D Average Net Unit Prices include data from U.S. Territories.

Effective January 1, 2023, the definition of "States" and "United States" under the *Medicaid Drug Rebate Program* includes the U.S. Territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands (collectively, "the U.S. Territories").[2] The Federal Supply Schedule has different rules for treatment of the U.S. Territories, including Puerto Rico. The ICR does not specify whether the Manufacturer U.S. Commercial and Medicare Part D Average Net Unit Prices should include data associated with the U.S. Territories. GSK recommends CMS clarify whether the Manufacturer U.S. Commercial and Medicare Part D Average Net Unit Prices should include data associated with the U.S. Territories.

Recommendation: GSK recommends CMS ease the burden on Primary Manufacturers associated with collecting data on behalf of Secondary Manufacturers.

CMS's expectations for Primary Manufacturers to collect, report, and certify data on behalf of Secondary Manufacturers are burdensome and infeasible. Primary Manufacturers do not have access to all of a Secondary Manufacturer's information, such as Non-FAMP and Best Price data, which is proprietary information. Furthermore, a Primary Manufacturer cannot obligate (i.e., legally compel) the Secondary Manufacturer to provide the data and cannot ensure the data is accurate. Simply put, a Primary Manufacturer has no means to enforce compliance by a Secondary Manufacturer. Moreover, requiring Primary Manufacturers to submit data related to Secondary Manufacturers could be in violation of contractual agreements or legal obligations, such as competition laws. Given these complexities, CMS should require the Primary and the Secondary Manufacturer to submit and to certify their respective data. Alternatively, CMS should engage and request responses and/or data directly from the Secondary Manufacturer(s). If the Agency chooses not to do either, it should exercise caution related to the timeline

[2] 42 C.F.R. § 447.502

for data submission and/or the issuance of civil monetary penalties, given the untenable and burdensome position on Primary Manufacturers.

Overall, these technical adjustments would help manufacturers report accurately and make the entire submission process more efficient and user-friendly.

****

GSK appreciates the opportunity to comment on the IPAY 2027 ICR. Please contact me at harmeet.s.dhillon@gsk.com if you have any questions about the topics discussed in our comments or if GSK can provide any further information.

Sincerely,

Harmeet Dhillon

www.HaystackProject.org

VIA ELECTRONIC DELIVERY to: IRARebateandNegotiation@cms.hhs.gov

September 3, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244–1850

RE: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849)

Dear Administrator Brooks-LaSure:

Haystack Project appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS') Information Collection Request for Negotiation Data Elements and Drug Price Negotiation Process for initial price applicability year (IPAY) 2027 (the ICR).

Haystack Project is a 501(c)(3) non-profit organization enabling our growing membership of rare and ultra-rare disease patient advocacy organizations to coordinate and focus efforts that highlight and address systemic reimbursement obstacles to patient access. Our core mission is to evolve health care payment and delivery systems with an eye toward spurring innovation and quality in care toward effective, accessible and affordable treatment options for all Americans. We strive to amplify the patient and caregiver voice in these disease states where unmet need is high and treatment delays and inadequacies can be catastrophic.

Patients with rare and ultra-rare conditions recognize that their hope for an FDA-approved treatment hinges on whether investors and sponsors are confident that they can recoup the costs of research and development. If there is uncertainty that costs can be recouped, either through the price of the new drug or its use in other patient populations, Haystack Project's patient and caregiver communities have little reason to hope that resources will be invested in advancing the treatments we need. Our comments (attached) to CMS' Draft Guidance implementing the Drug Price Negotiation Program under the Inflation Reduction

Act (IRA) for IPAY 2027 articulate our concern that the negotiation processes will fail to consider treatment value for rare patients and ultimately negate the incentives that have enabled development of new treatments and maintained commercial viability of existing therapies.

Haystack Project appreciates that CMS has sought feedback from patients and patient advocacy organizations to improve its patient engagement throughout the drug negotiation process. We believe meaningful patient engagement and input are crucial to any effort to ascertain the value of a treatment and its therapeutic alternatives. CMS' expanded patient engagement proposals represent a significant improvement over last year's process. Unfortunately, the impact of patient input is limited by the framework CMS has created for selecting and negotiating prices for drugs. Increased engagement opportunities, while welcomed, are unlikely to resolve the potential for unintended consequences on patient access to existing treatments and development of new rare and ultra-rare disease treatments.

As more fully detailed below, Haystack Project is concerned that the underlying policies and statutory interpretations for the ICR increase the potential that a single negotiated price will fail to reflect the cost of a 30-day treatment, the value of the selected drug, or the cost of therapeutic alternatives and could create variable burdens for manufacturers of selected drugs. For example, including all NDAs/BLAs held by a manufacturer a a single selected drug will distort pricing data if dosing and therapeutic alternatives vary by indication. Similarly, the Primary/Secondary Manufacturer concept can leave Primary Manufacturers that are commercialization partners without ready access to information on research costs and those holding a NDA/BLA while licensing one or more indication facing barriers to obtaining confidential pricing data.

Last year, we expressed our concern that the policies and interpretations within the Initial Guidance for IPAY 2026 were finalized without public notice and comment. We remain hopeful that CMS will carefully consider our comments to this ICR and the Draft Guidance for IPAY 2027 and revise its implementation policies and statutory interpretations in a manner that effectuates the plain language of the statute and avoids disrupting access to current and future treatments in rare and ultra-rare conditions.

Background

Despite existing incentives for orphan drug development, significant unmet need predominates in extremely rare conditions and rare cancers:

- Of the approximately 7,000 rare diseases identified to date, 95% have no FDA-approved treatment option.
- 80% of rare diseases are genetic in origin, and present throughout a person's life, even if symptoms are not immediately apparent.

- Patients often progress to more serious and more costly disease states by the time they receive a diagnosis.
- If a diagnosed condition has no FDA-approved option, treatment often involves off-label use of existing products.
- lack of disease-specific natural history severely complicates research toward new, targeted treatments.

Haystack and its member organizations appreciate that the IRA Part D benefit redesign provisions offer significant financial relief to our patient communities. We expect that the Part D out-of-pocket cap will reduce financial stress on patients and their families so that more patients can base their treatment decisions on medical need rather than financial resources. Since most ultra-rare disease patients will routinely reach the $2000 out-of-pocket cap within the initial months of the plan year, it is unlikely that they will receive the financial benefits from the MDPNP that individuals with more common conditions treated by less costly drugs receive.

Our communities of patients and caregivers are, however, fully aware of the economic tightrope rare disease innovators walk – their lives and/or those of their loved ones can literally hang in that balance. The economic calculation of unmet patient needs, research and development costs, projected risk, and population-based revenue estimates is complex and often fragile. As affected populations dwindle below 20,000 or even into and below the hundreds, the balance can be far more tenuous, and risks or uncertainties often discourage the investor interest required to take promising therapeutic candidates from bench to market. We cannot overstate our fear that unless CMS recognizes the potential impacts the MDPNP might have on rare and ultra-rare disease patients, its implementation of the negotiation program will likely disrupt the balance of incentives and risks inherent to developing new treatments and new uses of existing treatments for ultra-rare conditions.

Haystack Project has analogized rare and ultra-rare disease patients to the “canary in the coal mine” when it comes to unintended consequences that might arise from reimbursement policy and landscape changes. The IRA’s drug price negotiation program, and its simultaneous implementation with the statute’s Part D redesign provisions, represent uncharted territory for Medicare, its beneficiaries, manufacturers, distributors, and pharmacy benefit managers. Rare and ultra-rare disease patients have learned that uncertainties create risk and fear that if CMS pursues aggressively low negotiated prices despite these uncertainties, it will be extremely difficult to reverse any disruptions in the incentive frameworks driving discovery and development of new treatment options. We therefore ask that CMS take a cautious approach when considering initial offers significantly below the ceiling price in the initial years of the MDPNP and that it do so only when there is a compelling, patient-centered justification.

CMS' criteria for identifying off-label uses and therapeutic alternatives does not fully account for uses in ultra-rare conditions.

Haystack remains concerned that CMS' implementation of the MDPNP fails to consider ultra-rare patients for whom unmet need is a near-universal reality. For IPAY 2026, CMS sought information on use of the selected drug and its therapeutic alternatives that met the definition of "medically accepted use," and included off-label uses. It appears that for IPAY 2027 CMS will rely solely on labeled uses of the selected drug but consider off-label uses, including those in clinical guidelines and/or peer-reviewed studies when identifying therapeutic alternatives.

Since most ultra-rare disease patients have no FDA-approved treatment, our patient communities rely on off-label use to relieve disease symptoms and/or slow progression. We urge CMS to retain its concept of medically accepted use for both the selected drug and its therapeutic alternatives and, for ultra-rare uses, broaden the set of evidence sources to include clinical guidelines and/or peer-reviewed studies.

Haystack Project appreciates CMS' proposals to expand its patient engagement within the negotiation process.

Haystack Project appreciates that CMS streamlined and simplified its ICR mechanisms by incorporating the negotiation data elements and negotiation process into this ICR. We have met with CMS to express our member organizations' concerns with the listening session format for patient engagement and included our feedback and recommendations in our comments to the Draft Guidance for IPAY 2027. As outlined in those comments and below, we strongly support CMS' efforts to enhance and expand opportunities for patients to contribute to CMS' decision processes through patient-focused events. In particular, we support CMS' proposal to conduct events that are patient-focused and facilitate discussion among speakers and dialogue between speakers, attendees and CMS staff.

We urge CMS to:

- Leverage relationships with patient advocacy organizations, including Haystack, by enabling CMS participation in events organized by these organizations. We expect that patient participation and willingness to engage in candid dialogue would be more robust when conducted within the familiar context of an advocacy organization event.
    - Participation through patient advocacy organizations will also expand CMS' reach beyond those notified through a Federal Register notice.
- Provide clear information on the types of information CMS seeks.

    - Patients need to understand how CMS intends to use their information in arriving at an initial offer for a selected drug.

- Permit questions from patients and clinicians on the MDPNP generally as well as the impact negotiation might have on the patient's access to and cost of the selected drug.

    - Most listening session participants believed that the savings from the negotiation would be passed on to Medicare patients in the form of reduced out-of-pocket costs. There was little awareness of the OOP cap.

- Ensure that patients and clinicians are informed on applicable formulary requirements, including limitations on adverse tier placement, step therapy protocols, and burdensome prior authorization requirements so they can advocate for their access to the selected drug and/or alternative therapies.

    - Haystack Project conducts webinars and other patient education events that enable our patient communities to advocate for themselves and bring any access problems to our attention.

- Create an environment conducive to a dialogue between and among patients, providers, researchers, and CMS. Our patient communities agreed that the listening session format did not lend itself to the type of dialogue likely to result in meaningful information.

- Allow participants and attendees to submit data and other information to CMS after the stakeholder engagement event. This will enable CMS to more fully consider the information presented through patient engagement events.

Finally, throughout CMS' implementation of the MDPNP for IPAY2026, patient advocacy organizations struggled with the constricted timeframes allotted to review drafts, assess the potential impact on the patient community, and incorporate learnings from patients into a cohesive document to inform CMS' next steps. This year, CMS' expanded timeframe to respond to the model documents for the Medicare Prescription Payment Program (MPPP) and Draft Guidance for IPAY2027 enabled our organizations to conduct the thorough review and patient outreach that is essential to our mission. We appreciate that CMS responded to feedback from stakeholders and extended its comment periods when it had discretion to do so.

CMS' definition of qualified single source drug is a broad interpretation of the IRA that frustrates Congress' intent to consider therapeutic alternatives and reduces the utility of the sets of data elements in the ICR.

Haystack Project has repeatedly expressed its concerns that CMS' definition of qualified single source drug (QSSD) will shape the MDPNP and could negate existing incentives for manufacturers to secure new approvals in small population conditions. In reiterating its intent to maintain its policy of defining QSSD through active moiety or active ingredient, CMS stated that:

> This approach to identifying a potential qualifying single source drug aligns with the requirement in section 1192(d)(3)(B) of the Act to use data aggregated across dosage forms and strengths of the drug, including new formulations of the drug. Consistent with this statutory instruction, this approach is also appropriate because CMS is aware that existing NDA / BLA holders have obtained approval for new dosage forms or different routes of administration of the same active moiety/active ingredient under different NDAs or BLAs.

Haystack once again urges CMS to reconsider its approach. The IRA's timeline for negotiation eligibility begins at FDA approval of an NDA or BLA, not the manufacturer's first NDA or BLA approval for an active moiety/active ingredient. CMS' failure to consider the substantial investment required to achieve FDA approval in disparate disease states runs counter to longstanding public policy favoring pursuit of new NDAs/BLAs that enable on-label use of treatments in multiple diseases and conditions rather than reliance on off-label use. The downstream impact on manufacturer selection of initial indications and interest in pursuing follow-on would likely be less significant if the IRA did not create a ceiling on negotiated prices based on the assumption that the elapsed time from approval to negotiation would enable recoupment of research and development costs. By wrapping all treatments with the same active moiety/active ingredient into a single QSSD, CMS' efforts to reduce incentives that deter generic competition are so broad that they also neutralize incentives that further public policy goals and align with FDA processes and determinations for granting new NDAs/BLAs to existing treatments.

We believe that CMS' QSSD definition will have a significant detrimental effect on new approvals of existing drugs, particularly in ultra-rare diseases for which statutory exclusivity has helped drive research and development. It is unlikely, if not impossible, that a manufacturer could recoup the costs of achieving FDA approval in an ultra-rare follow-on indication for a drug subject to a negotiated price, particularly given the relatively short timeline to renegotiation to a lower price based on a change in status to long monopoly drug.

Just as importantly, CMS is directed to consider the cost of therapeutic alternatives to a selected drug in reaching an initial offer. As the examples below illustrate, this makes far less sense within the context of multiple indications in divergent disease states with diverse sets of recommended dosages and alternative therapies.

- Imbruvica provides an example of divergent uses and therapeutic alternatives. Imbruvica's highest volume of use in Medicare is for Chronic Lymphocytic Leukemia (CLL) but a year before its selection for negotiation, it was approved for pediatric chronic graft versus host disease (cGVHD).

    - cGVHD is a very rare indication for which many of the underlying conditions leading to transplant are extremely rare.

    - Imbruvica is scheduled for renegotiation as a "long monopoly" drug for IPAY 2030.

    - Haystack is concerned that the MDPNP will discourage manufacturers of newer BTK inhibitors from pursuing new approvals in cGVHD given that the high proportion of Medicare patients (due to the CLL indication) will drive a short timeline to selection for negotiation followed by relatively rapid selection for renegotiation.

- Gavorestat is an investigational aldose reductase inhibitor currently studied in two orphan indications, Galactosemia and sorbitol dehydrogenase deficiency (SORD), a recently discovered type of Charcot-Marie-Tooth disease. Future studies are also being considered in PMM2 congenital disorder of glycosylation (*PMM2*-CDG).

    - These conditions do not fall into a single orphan designation and the product would be ineligible for the MDPNP orphan drug exclusion despite the extremely low volume of use in any single indication.

    - A manufacturer could adjust its launch price or limit approvals to a single orphan indication to mitigate the risk that the MDPNP might hamper its ability to generate sufficient revenue to cover research and development costs and recognize an acceptable return on investment.

    - While these rare disease treatments are unlikely to be selected for negotiation immediately upon eligibility, they are also unlikely candidates for generic competition and, if the MDPNP continues indefinitely, selection of a broad set of orphan drugs becomes inevitable.

- Although introduction of a biosimilar may prevent CMS' selection of the biologic denosumab, its divergent uses and dosages illustrate the unintended consequences of CMS' active moiety/active ingredient definition of QSSD.

    - Prolia is administered as 60 mg subcutaneous injection every 6 months for its FDA-approved indication in treating osteoporosis.

- Denosumab is also approved under the brand name Xgeva for bone metastasis, multiple myeloma (approximately 37,000 cases per year) and in giant cell tumors of the bone (an extremely rare (1 in 1,000,000) predominantly noncancerous condition that destroys the bone).

- The recommended dose of XGEVA is 120 mg administered as a single subcutaneous injection once every 4 weeks additional 120 mg doses on days 8 and 15 of the first month of therapy.

- CMS' definition of QSSD creates problems that make it all but impossible to utilize the statutory process and require data elements to arrive at any initial offer reflecting the cost of treatment based on therapeutic alternatives for any indication. Differential dosing and extremely divergent therapeutic alternatives are relatively common for products with multiple approvals and especially so when one or more approval is in an ultra-rare condition.

The ICR did not fully consider that the manufacturer burden will be substantially greater if there is a Primary Manufacturer as well as one or more Secondary Manufacturers.

Haystack Project expects that the ICR's estimate of manufacturer burden in complying with the information request did not consider burdens arising from the Primary/Secondary Manufacturer distinction. We remain concerned that CMS' definition of QSSD drove the need to create the distinction between Primary/Secondary Manufacturer relationships and introduced an additional layer of complexity and potential burden. It is common for smaller manufacturers to fund research and development efforts through licensing arrangements providing for exclusive commercialization rights for one or more indications to another manufacturer. These arrangements may, but do not always, provide for the licensing manufacturer to hold the NDA/BLA. Under CMS' QSSD definition, whether these separate NDAs/BLAs for distinct indications are considered one drug for negotiation eligibility purposes will depend solely on whether pre-IRA contract terms provided for the manufacturer with commercialization rights to hold the NDA/BLA. Although it appears that CMS policies and guidance would permit the Primary Manufacturer to transfer the NDA/BLA to the Secondary Manufacturer, CMS' QSSD definition and delegation of all MDPNP responsibilities and liabilities to the Primary Manufacturer significantly impacts both the value of the NDA/BLA and the relative negotiation positions between the parties.

We urge CMS to carefully consider the potential that a Primary Manufacturer may face significant difficulties as it seeks to comply with the IRA requirements for data submission. It is also possible that contractual arrangements between parties would create intentional impediments to information disclosures related to pricing and contracting strategies. Put simply, Primary Manufacturers may not have a legal path to provide CMS with the

information it seeks throughout the negotiation process and, if they do, it could substantially increase the burden and time needed for compliance.

Conclusion

Haystack appreciates the opportunity to submit feedback on the ICR for IPAY 2027. We thank you for your consideration of our comments and look forward to a substantive discussion to ensure that all Medicare beneficiaries have access to the treatments they need.

If you have any questions, please contact me at Kara.berasi@haystackproject.org or our policy consultant, Kay Scanlan of Consilium Strategies at mkayscanlan@consilstrat.com.

Very truly yours,

Kara Berasi
CEO
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September 3, 2024

VIA Electronic Filing at regulations.gov

Meena Seshamani, M.D., Ph.D.
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8016

Re: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849)

Dear Administrator Seshamani:

On behalf of Johnson & Johnson (J&J), we submit the following comments in response to the Centers for Medicare & Medicaid Services' (CMS, the Agency) **Information Collection Request (ICR): Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year (IPAY) 2027 under Sections 11001 and 11002 (ICR)**.

At Johnson & Johnson (J&J), we are driven by a passion to achieve the best version of health for everyone, everywhere, for as long as possible. In the next decade, we will see more transformation in health than in the past century – and we are ready to lead the way. Focusing exclusively on transformational healthcare innovation allows us to move with purpose and speed to tackle the world's toughest health challenges. Innovating across the full spectrum of healthcare solutions puts us in a unique position today to deliver the breakthroughs of tomorrow. Our strength in both biology and medical technology means we're accelerating advances in care – from cell therapy to AI-assisted robotic surgery. We are using our wide range of expertise to address healthcare challenges that can be tackled by both medical technology and innovative medicine such as cancer, cardiovascular disease, and eye health. Our reach and depth across a continuum of healthcare and technology solutions give J&J the ability to profoundly impact health for humanity.

J&J urges CMS to revise and align the ICR with the three principles advanced in our previous ICR comments.

1. Align reporting requirements directly with, and not exceeding, the statute;
2. Prioritize operational feasibility and simplicity, including leveraging data already required for federal reporting programs, utilizing information and resources otherwise available within the Government; and

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3. Commit to prioritizing those factors that emphasize value to the Medicare beneficiary. This flexibility is offered in the statute.

We are concerned that CMS has not aligned the ICR with these principles and has made minimal changes to the ICR since IPAY 2026. As with the ICR for IPAY 2026, this ICR requires a significant volume of information that is in excess of the statutory requirements needed for the factor analysis, is overly focused on cost factors instead of the data requirements for the evidence required to assess a drug's value over time for the Medicare population, and imposes substantial requirements conflicting with current best business, financial and operational practices, and systems.

We remain concerned that the ICR fails to comply with the criteria outlined within the Paperwork Reduction Act (PRA). These criteria require that information collection:

> *"(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."*[1]

We continue to strongly urge CMS to reduce unnecessary reporting burden by removing reporting requirements that exceed statutory requirements or duplicate submission of data already available to the Agency, provide flexibility in the form and format of data reported, including removal of word limitations, and prioritize value to beneficiaries.

Negotiation Data Elements ICR Form

General Instructions

Remove Restrictive Word Limitations

CMS is updating the ICR form to remove character limitations imposed for IPAY 2026 and replace those with word limitations for IPAY 2027. J&J is concerned with any limits imposed on manufacturers' ability to provide complete information. Word or character limits impose an undue burden on manufacturers by requiring them to truncate complete responses, restricting the ability of manufacturers to provide complete information. Considering the significant ramifications of providing incomplete or inaccurate information, including the risk of civil monetary penalties, manufacturers should have the ability to provide as much detail as needed in

[1] 5 C.F.R. § 1320.5(d)(1)(i)-(iii)

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the ICR form in order to provide complete and accurate information. Therefore, we urge CMS to remove word limitations throughout the ICR form.

Recommended Improvements to the HPMS System

J&J recommends CMS make improvements to the HPMS system to reduce data entry challenges experienced in IPAY 2026 and improve the user experience. Considering the significant volume of information required for submission, the HPMS system was cumbersome to use, particularly for uploading information and reviewing and verifying information submitted. We recommend CMS ensure the HPMS System is better equipped to support the submission of large amounts of data. An updated system should enable rapid data entry without freezing during data input and submission, provide simple cut and paste capabilities, enable attachments including charts and tables to be part of the record, allow manufacturers to access and review submitted data and information prior to certification, and provide report downloading capabilities to facilitate systematic manufacturer review and verification. We recommend CMS allow manufacturers to submit the required data using an upload template instead of requiring manual entry through the system.

CMS Should Limit Timely Notification Requirements for Standard Refiles

In the instructions, CMS states that manufacturers must "timely notify" CMS of any changes to the submitted information. J&J notes that the Medicaid Drug Rebate Program requires a standard refile. Medicaid Best Price refiles can occur quarterly and often reflect a nominal change in the Best Price. Therefore, to reduce the burden on manufacturers for insignificant changes resulting from standard refiles, we recommend CMS implement a minimum threshold to define the minimum change from Best Price refiles for which timely notification would be required.

We further recommend that CMS set a date after the conclusion of the "negotiation" period and establishment of the "maximum fair price" (MFP) on which manufacturers would stop reporting changes to submitted information. For example, for IPAY 2026, we recommend that CMS clarify that manufacturers would no longer be required to notify CMS of changes to submitted information after September 1, 2024.

Allow Flexibility in Format for Reporting Monetary Amounts

J&J is concerned with the rigid format and detail required for reporting monetary amounts. We continue to urge CMS to limit the data required for submission to that data outlined in the statute and to provide flexibility in reporting detail and format with the opportunity for manufacturers to explain values reported. Specifically for monetary amounts, we urge CMS to provide manufacturers with the ability to report a range of estimates with the ability to explain rather than an exact figure. This format would better align with the PRA requirement to ensure the collection of information "is the least burdensome for the proper performance of the agency's functions to comply with legal requirements and achieve program objectives".

Selected Drug Information (Section A)

Primary Manufacturers Cannot Be Held Responsible for Secondary Manufacturers or Third Party Manufacturers with Whom They Have No Contracts

Under Section A, CMS outlines the requirement for Primary Manufacturers to review the list of NDC-11s prepopulated by CMS for a selected drug, correct the list, and provide required information outlined in Section A for those NDC-11s. We are concerned with this requirement given CMS' use of the Primary/Secondary Manufacturer construct. CMS's Primary/Secondary Manufacturer construct is inoperable and disregards the reality that different participants in the pharmaceutical supply chain are free to create new NDCs without express consent or authorization from or knowledge of the NDA/BLA holder. Primary Manufacturers have no control over or timely visibility into their NDC updates. The Secondary Manufacturer definition overreaches to encompass repackers for which Primary Manufacturers neither have a contract with nor have authorized the provision of repacking services or creation of NDCs. Actions to update NDCs may be taken by third parties with which manufacturers may have no relationship and no visibility into independent arrangements where they create new NDCs for repacking purposes. Therefore, CMS should remove any requirement for Primary Manufacturers to report Selected Drug Information for NDC-11s not created or expressly authorized by the Primary Manufacturer.

Moreover, to collect and report information not maintained and often unknown by Primary Manufacturers would require significant time beyond what is already required in the "negotiation" process. CMS indicates its intent to publish the NDC-11 listing on February 1 and require Primary Manufacturers to collect, submit and certify all selected drug information by March 1. Especially for NDCs that are unknown to Primary Manufacturers, compliance with CMS's reporting requirement will require substantial investigative work that cannot be completed in 29 days. Therefore, at a minimum, we urge CMS to provide Primary Manufacturers with additional time to report selected drug information for the selected NDCs by providing Primary Manufacturers with a preliminary listing of the NDCs in advance of the February 1 publication. Providing Primary Manufacturers with a preliminary listing of NDCs prior to publication on February 1 will provide Primary Manufacturers with additional time to start the review and investigative process for "unknown" NDC-11s.

CMS Should Clarify Definitions for Private Label Distributor and Discontinued Date

In addition, CMS outlines definitions for Section A in the ICR, including for "Private label distributor." J&J recommends CMS revise the definition for "Private label distributor" to clarify that the definition applies only when drugs are commercially distributed. The revised definition should read: "With respect to a particular drug, a person who did not manufacture, repack, relabel, or salvage the drug but under whose label or trade name the drug is commercially distributed (21 C.F.R. § 207.1)."

In section A, CMS outlines the requirement for manufacturers to indicate if the NDC-11 has been discontinued and to provide the date of discontinuation if so. In order to improve clarity, J&J recommends CMS provide a definition to represent the last lot expiration date of the drug or,

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if applicable, the date on which the drug was withdrawn. "Withdrawn" here references when the product is pulled from the shelf by the manufacturer for health or safety reasons.

Research and Development Costs (Section C)

Urge CMS to Simplify R&D Reporting

We continue to be concerned that CMS is requesting collection of information exceeding what is necessary for CMS to perform its function to assess research and development (R&D) costs and the extent drug developers have recouped these costs. Further, CMS does not provide an explanation regarding the utility of this data in this manner and why it is essential to implementing the Program.

In this ICR, CMS is revising the format of questions for Section C to break the questions down individually rather than listing them in one table, as was the format in IPAY 2026. This revised format increases reporting burden beyond the IPAY 2026 ICR, which was already overly burdensome on Primary Manufacturers, and is contrary to the tenets of the PRA. In addition, we are concerned that this revised format further restricts the word limits. Therefore, we ask CMS not to finalize this revised format.

As we previously stated in our past comments, we encourage CMS to simplify the R&D reporting requirements outlined in the ICR to allow the Primary Manufacturer to offer an attestation in instances where the manufacturer believes it has fully recouped R&D costs for the selected drug. In instances where the manufacturer indicates that R&D costs have been recouped, then CMS does not need additional information. The burden associated with the historical data gathering that will be required to satisfy the reporting requirements under this section is significant, and CMS should not impose such significant burden in instances where manufacturers indicate they have recouped R&D costs.

However, in instances where the manufacturer has not recouped costs, manufacturers should provide relevant information to the Agency. In those cases, CMS should allow increased flexibility in manufacturers' responses to this question to allow for the appropriate cost determination that aligns with internal and/or industry financial practices. Additionally, in these instances, CMS should allow manufacturers to include indirect R&D costs after pre-clinical development. These are actual costs to the manufacturer and are currently not accounted for under the details that CMS provided for R&D.

J&J remains concerned with the flawed definition of R&D costs that does not reflect actual costs or align with statute. For example, under Question 6, Global and U.S. Total Lifetime Net Revenue for the Selected Drug, CMS describes that it will "use both the Primary Manufacturer's global and U.S. total lifetime net revenue for the selected drug to determine the extent to which the Primary Manufacturer has recouped R&D costs for the selected drug." We continue to encourage the Agency to employ great caution in avoiding discrepancies in their calculation for R&D costs and recoupment by seeking to understand "global lifetime revenue" but only considering R&D costs associated with "FDA-approved indications." Limiting R&D investments

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to those that have only been approved in a US setting while seeking global revenue represents a significant flaw in the Agency's approach.

Current Unit Costs of Production and Distribution (Section D)

CMS Should Remove Its Overly Prescriptive Methodology for Determining Production and Distribution Costs

Aligned to our previous comments, J&J continues to be concerned with the burden on manufacturers stemming from CMS' prescriptive methodology for determining production and distribution costs. This methodology is not outlined in statute and relies on data that may not be available to manufacturers. For example, certain costs may not be available at the product level, such as various overhead functions. While CMS does allow manufacturers to explain methodology, it will require substantial time and resources to perform the needed calculations and allocations that are not typical in our current operations. Therefore, we urge CMS to remove this overly prescriptive methodology for determining production and distribution costs.

Prior Federal Financial Support (Section E)

Streamline Prior Federal Financing Support Reporting and Remove R&D Tax Credit Reporting Requirement

J&J urges CMS to leverage data available from other sources, such as data directly available through government grant programs that provide financial support to manufacturers. To reduce the reporting burden, we ask CMS to permit manufacturers to submit a single federal financial support number along with an explanation detailing the support included.

Further, we continue to be concerned that the requirement for manufacturers to submit information on R&D tax credits exceeds the statutory requirements. The US tax credit for R&D is a credit for increasing R&D activity, requiring entities to surpass a baseline level of R&D spend. It is aggregated and cannot be directly correlated between dollars spent and credit received for any single product. For example, for J&J, the R&D credit is based on the consolidated filing of all J&J legal entities included in the filings, which spans beyond pharmaceuticals and includes consumer goods, medical technology, etc. Therefore, these tax credits which are not product-specific and not required by the IRA should not be considered for this section as it is impossible to allocate the credit at a product-specific, or even sector-specific, level.

Patents, Exclusivities, and Approvals (Section F)

CMS Should Remove Word Restrictions that Hinder Ability to Answer Questions 13 – 15

As stated above, we are opposed to the restrictive word limits throughout this ICR, including for Questions 13 - 15. We are particularly concerned that for Question 13, the word limit has decreased significantly from 2026. This decrease is problematic because this question requires reporting of explanations of active, expired and pending patents, which may be a lengthy submission. In view of the significant fines for providing information that is perceived as

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inaccurate or misleading, CMS should remove these word limits which hinder the ability of Primary Manufactures to comply with the ICR, and the onerous reporting for Questions 13-15.

CMS Should Remove Question 12 and 14 on Expired Patents and Regulatory Exclusivities

Given that under CMS' definition for qualifying single source drug, a product is aggregated based upon active moiety (e.g., across dosage forms and strengths), the required reporting of *expired* patent information and exclusivities is overly burdensome. The utility of such information to the negotiation is questionable. The PRA requires a straightforward utility for collected data, and therefore, we urge CMS to remove these questions.

Market Data and Revenue and Sales Volume (Section G)

CMS Does Not Have Authority to Require Submission of Pricing Data Aside from Non-FAMP

CMS does not have the authority to require submission of pricing data aside from Non-FAMP, as Non-FAMP is the only pricing metric specified in the IRA. J&J does not support mandatory reporting of additional pricing data points from other federal and commercial programs that are proprietary and unnecessary for program implementation. This pricing data is not required for the Program, as they are reflected in prices from separate and distinct programs, which should have no bearing on the determination of the MFP. The statute does not require the submission of this data, and therefore, J&J urges CMS to remove questions in this section that require the submission of pricing data beyond Non-FAMP.

We are also concerned with the significant and unnecessary burden imposed on manufacturers by the required reporting of data points included under this section that are already reported to federal agencies (including Best Price, Federal Supply Schedule (FSS) price, Big Four price). Because these data are already available to CMS from within the Government, under the PRA, it is inappropriate to impose reporting burden when the 2024 data is already available to the Agency. We are concerned that CMS is requiring manufacturers to submit information that is duplicative with other programs including some price points for Q4 2024 that manufacturers will still be calculating at the time of submission for IPAY 2027 in March 2025 (e.g. validation of unit rebate amount (URA), 340B calculations; etc).

Moreover, several of the data points outlined under Section G represent new and significant reporting requirements not already calculated or reported by manufacturers for any other programs. For example, J&J does not calculate or disclose many of the data elements outlined under these questions including Commercial and Medicare Part D average unit net price, average net unit price without patient assistance programs, and best average net unit price; and we also do not calculate gross to net revenue deductions at the NDC level, as these calculations are performed across an entire brand.

Lastly, as stated above, we urge CMS to improve the HPMS system to allow for an upload template instead of the cumbersome manual key in approach from IPAY 2026, with the ability to download submissions for validation prior to certification.

Ensure Consistency in Three Year Reporting Under Section G

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Under Section G, CMS is revising the submission timeframe from five years to three years. While we appreciate this update, we note that question 18 asks "Was a Medicaid best price determination ever made for a calendar quarter for the selected drug during the most recent five years?". Therefore, we ask CMS to revise this question to align to three years.

Strongly Oppose Addition of the Medicare Part D Price Points

J&J urges CMS to remove Questions 26 and 27 on Manufacturer Net Medicare Part D Price from the required manufacturer data. We note that CMS removed Net Medicare Part D Price from the required data for IPAY 2026 in its previous Revised ICR, and we are opposed to CMS' re-introduction of it for 2027. J&J underscores these data points are not contemplated as information for submission in the statute and would impose a significant organizational burden on manufacturers, as they do not align with existing reporting requirements or accounting procedures.

Certification of Submission of Sections A through G for Primary Manufacturers (Section H)

CMS Should Update the Certification to Recognize the Need for Reasonable Assumptions and Account for the Restrictive Word Limitations

J&J continues to have concerns with the certification statement. As we have previously commented, given the word limitations, which we oppose, it is not reasonable to require certification that information is "complete" when the ability to provide information is restricted, and therefore, we ask CMS to remove this from the certification statement. Furthermore, while we agree that the information submitted should be accurate, we reemphasize our ask for CMS to explicitly acknowledge that manufacturers will have made reasonable assumptions given CMS' vague requirements and the significant challenges stemming from conflicts between the requirements outlined in ICR and manufacturer and industry accounting practices.

Evidence on Alternative Treatments (Section I)

Urge CMS to Clarify Its Approach for Comparative Value Assessment

J&J remains concerned and opposes CMS' emphasis on manufacturer-specific and cost-related data, which undervalues and discredits the importance of a drug's clinical benefit as compared to its therapeutic alternative. As currently proposed, the approach is at odds with determining a drug's unique value based on its impact on beneficiaries' health and lives. This is evidenced by the overemphasis on what the Agency considers the mandatory submission of manufacturer-specific data, which is approximately 90 percent of the entire set of questions, compared to what the Agency set as optional submission to questions on the evidence focused on therapeutic impact and comparative effectiveness, unmet need and prescribing. Additionally, we are concerned that the counter-offer meetings for selected drugs do not provide for sufficient opportunity for meaningful engagement and discussion of these critical value factors prior to CMS offering its determination of the "MFP".

CMS should also outline its approach for an exchange that defines the parameters of its comparative value assessment. Instituting a more inclusive and transparent process would help CMS to fully understand the evidence landscape and receive feedback on the necessary steps of the selection of therapeutic alternatives. The Agency should rely on meaningful disease-specific and patient-centric instruments that more accurately capture the impact of treatments on patients and their caregivers to aid in understanding the total value of selected therapies for each population.

CMS Should Provide Timely Public Access to Medicare Data

We are concerned with the lack of transparency and timely availability of data that may be required for the ICR, including reporting prevalence and utilization estimates. For example, Medicare spend data has a 2-year lag, and Medicare patient claims data is not publicly available. Therefore, we ask CMS to make public, in a timely manner, Medicare spending and claims data to allow manufacturers to prepare for drug selection.

CMS Should Allow for Submission of an Executive Summary that Highlights Manufacturer Priority Information

J&J urges CMS to allow the submission of an executive summary. The executive summary is a clear succinct summation of the factors outlined in section 1194(e)(1) of the Act enabling CMS reviewers to comprehend and utilize the information as the basis for the initial assessment and offer. The executive summary is the only place where the manufacturer can tell the full value story for the selected product across the responses to the multiple questions in the ICR. The executive summary should be reviewed to ensure consistency of interpretation of evidence across reviewers and to highlight the manufacturer prioritized comments.

We also ask CMS to p*rovide greater flexibility for manufacturer-focused questions (Questions 30 – 37)*

- *Question 30*: Off-label Use
  J&J notes that manufacturers may have limited evidence of off-label use due to guardrails around manufacturers on studying off-label use of a product, and restrictions on promoting off-label uses. To be consistent with FDA compliance standards, CMS should consider if off-label use is appropriate to ask manufactures to submit.

  While CMS is allowing manufacturers to submit optional information on off-label use for selected drugs, we note that therapeutic alternatives must have the same FDA indications and should not be identified through off-label use. When it is not possible to find therapeutic alternatives with the same indication, therapeutic alternatives without the same indications should be assessed differently than products that have the indication.

- *Question 31:* Potential Therapeutic Alternatives
  This question requests a list of therapeutic alternatives. J&J urges CMS to increase word count and allow for manufacturers to submit a rationale for therapeutic alternatives listed.

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We also ask CMS to provide manufacturers with the opportunity to provide input on drugs that are not appropriate to consider as a therapeutic alternative and why.

- *Question 34*: Therapeutic Advance and Unmet Medical Need
  J&J urges CMS to consider improvements in patient and provider experience as part of therapeutic advance. For example, this could include new routes of administration which improve patient experience.

- *Question 37*: Visual Representations to Support Responses to Questions 30 Through 35
  While CMS states that up to 10 PDF files may be submitted, we ask that CMS clarify that each PDF may have multiple figures.

Patient and Caregiver Focused Input Questions Must Be Clear (Questions 38-44)

The process for patients and caregivers to provide focused input for IPAY 2026 was not readily known and was not user friendly, which resulted in a missed opportunity for individuals and organizations to provide accurate and authentic feedback to CMS. It is critical that CMS make the process of providing patient and caregiver feedback simple, and we recommend that CMS minimize any questions requesting personal health information (PHI), which could deter patients and caregivers from engaging in the process. Additionally, we recommend that CMS provide greater transparency to manufacturers regarding how the patient/caregiver input is used, including a summary of findings and explanation of how the information impacted the Agency's assessment of the selected drug before the initial offer.

While we appreciate that CMS has made some improvements to the wording for the patient / caregiver focused input questions, we continue to encourage the Agency to clarify these questions further. For example, CMS should clarify further the information Question 38a2 is seeking, including whether this question is looking to establish the time of diagnosis from the patient's perspective. For Question 40a2, CMS provides as an example a list of factors that may have affected the choice of medication. We recommend that CMS provide a more comprehensive list and include insurance coverage, physician recommendations based on clinical guidelines, and physician recommendations based on clinical experience. For Question 43, we request CMS allow patients/caregivers to provide citations to support their decision-making and responses.

For the Clinical-Focused Experience Questions, CMS Should Include Additional Questions to Better Understand the Responding Physician's Level of Experience with the Selected Drug or Therapeutic Alternatives (Questions 45-51)

J&J strongly advises CMS to consider input primarily from clinicians with documented experience prescribing and managing patients with the selected drug or therapeutic alternatives. J&J recommends CMS add additional questions to fully understand the respondent's clinical experience in order to determine if it is appropriate to include responses in the selected drug's evaluation. For example, we recommend CMS add questions to understand a clinician's years of experience, number of patients treated, and specialized training in the disease area where the

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selected drug is indicated must be assessed for level of experience and expertise to enable CMS to determine if the Agency should include a responder's input in its evaluation of the selected drug. Moreover, we recommend that CMS ask respondents to provide citations to support subjective claims in Question 46b, and recommend CMS ask respondents how much significance/weight they give guidelines in treatment decisions and which specific guidelines they used.

*****

J&J appreciates the opportunity to submit comments in response to the *Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request.* We urge CMS to revise the ICR to align reporting requirements directly with the statute, prioritize operational feasibility and simplicity, and prioritize those factors that emphasize value to the Medicare beneficiary. For questions, please contact jroche8@its.jnj.com.

Sincerely,

Jacqueline Roche
Head, Payment and Delivery Policy & Global Policy Institute
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September 3, 2024

Submitted electronically to Regulations.gov

William N. Parham, III
Director
Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10849
Room C4–26–05
7500 Security Boulevard Baltimore, Maryland 21244–1850

RE: Information Collection Request Form for Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849, OMB 0938-1452)

Dear Mr. Parnham:

The Massachusetts Biotechnology Council ("MassBio") appreciates this opportunity to submit comments on the above-referenced Information Collection Request (ICR).

MassBio represents the premier global life sciences and healthcare hub of Massachusetts, which has a vibrant biomedical research and development community that is a global leader for medical discovery and innovation. MassBio's 1,700+ member organizations are dedicated to preventing, treating, and curing diseases through transformative science and technology that brings value and hope to patients. MassBio's mission is to advance Massachusetts' leadership in the life sciences to grow the industry, add value to the healthcare system, and improve patient lives.

MassBio remains concerned about the impact the Medicare Drug Price Negotiation Program (the "Negotiation Program") will have on the future development of innovative and life-saving therapies, as well as on the world-leading small and emerging biotech companies based in Massachusetts. The data collected through the ICR will be the foundation of the Negotiation Program's activities for IPAY 2027. Therefore the ICR should be carefully constructed to mitigate these potential harms. In that light, we wish to raise two issues for CMS's consideration in design of the ICR.

1. With respect to the manufacturer-specific factors, in many cases CMS is proposing to collect data from manufacturers that CMS already has. This data collection will burden manufacturers and sap resources needed elsewhere.

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2. The instructions for public input should clearly describe how CMS will use public comments in the negotiation process, so the public can tailor their comments to CMS's needs.

CMS Should Not Collect Data Already in the Agency's Possession

Several of the categories of data CMS is proposing to collect from manufacturers describe information that CMS already has in its ready possession, or data that CMS could easily obtain from other federal agencies. For example, the collection and maintenance of Medicaid Best Price data and Part D Net price information is the responsibility of CMS, and CMS could use its own data sources for negotiation. The Federal Supply Schedule and Big Four prices could likewise be obtained through a request to colleagues across the federal government.

Nonetheless, CMS is proposing that manufacturers themselves collect and submit this data on CMS's behalf. The purpose of the Paperwork Reduction Act is to "minimize the paperwork burden for individuals, small businesses . . . and other persons resulting from the collection of information by or for the Federal Government." Accordingly, the very purpose of PRA's notice requirements is to impose upon CMS the duty to "evaluate whether the proposed collection of information is necessary," and to "minimize the burden of the collection of information on those who are to respond."[1] Certainly, the federal government re-collecting data from the public that it already collects is an unnecessary exercise. And CMS could easily reduce that burden by removing the duplication.

To the extent CMS has concerns about the accuracy of data, CMS could adopt procedures like it has done for other data elements like NDCs: pre-populate information compiled by CMS and make it available for manufacturers to review and confirm, or correct, CMS's sources.

Public Participation in the Negotiation Program

We appreciate that CMS has taken steps above and beyond those required under the Inflation Reduction Act to allow for public participation. The written submissions and listening sessions will provide an important opportunity for patients and others to have a meaningful voice in the Negotiation Program.

Recognizing the importance of public input, we urge CMS to structure the input process in a way that will maximize the usefulness of patient comments. As currently proposed, the instructions for public commentary do not detail how CMS will make use of information submitted, if at all. Patients are being asked to submit a lengthy and burdensome response, with no assurances or guidance on how CMS will take account of their views, if at all. This makes it difficult for the public to appropriately tailor their submissions to meet CMS's needs. And the lack of information my discourage the public from submitting comments altogether, if it feels that comments are not appreciated or useful. To help prevent this, CMS should add additional detail to the instructions making clear how public comments will be

[1] 44 U.S.C. § 3501, 3506.

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used and, ideally, take steps to conduct outreach to affected stakeholder groups to ensure their robust participation.

MassBio thanks CMS for your consideration of our comments. Please don't hesitate to contact me at (617)-674-5148 or kendalle.oconnell@massbio.org if you have any questions or would like any additional information to consider our comments.

Sincerely,

Kendalle Burlin O'Connell
CEO & President

NATIONAL HEALTH COUNCIL

September 3, 2024

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

RE: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) Forms (CMS-10849, OMB 0938-1452)

Dear Administrator Brooks-LaSure:

The National Health Council (NHC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) Forms (CMS-10849, OMB 0938-1452) (IRA 2027 Drug Price Negotiation ICR).

Created by and for patient organizations over 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, equitable, and sustainable health care. Made up of more than 170 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

The NHC appreciates CMS' efforts to gather patient-centered data as part of this ICR and its commitment to making the process more relevant for patients and patient organizations. We are pleased to see several of our recommendations, such as the grouping of questions by respondent type, the inclusion of questions requesting detailed descriptions of what it is like to live with a medical condition treated by a selected drug or its therapeutic alternatives, and the focus on factors that matter most to patients when assessing the value of a drug, reflected in the ICR. While we acknowledge these improvements, it is important to note that some aspects of the data collection process may remain challenging. Of note, the reduction in word count limits across multiple instances in the ICR may restrict stakeholders' ability to provide comprehensive and nuanced insights into the holistic value of drugs. The NHC suggests that CMS reconsider these constraints to allow for more detailed and meaningful responses.

Overall, while the NHC appreciates CMS' intent to streamline the data submission process and make it more accessible, we encourage ongoing dialogue and adjustments to ensure that the process remains patient-centered, efficient, and capable of capturing the full spectrum of information necessary to inform meaningful drug price negotiations.

While most of our comments are focused on the questions in the patient and caregiver section, we note that CMS states that any and all parties can comment on any and all questions, so we have included select questions we think are particularly important to the patient community.

Manufacturer-Focused Input

***Question 30: Off-Label Use*.** CMS has appropriately highlighted the significance of off-label use information, providing a specific avenue for manufacturers to submit data on off-label uses supported by evidence-based guidelines listed in CMS-recognized Part D compendia. Off-label use is particularly relevant to patients, as it often represents an option for those who may not respond to standard treatments or who have conditions for which no approved therapies exist. Patients and caregivers are directly impacted by the availability and accessibility of off-label uses, as these can offer life-changing, and sometimes lifesaving, treatment alternatives. Given the critical role that off-label use can play in patient care, it is essential that the data submitted is clear and consistent. However, the question could benefit from additional guidance on the format for submitting this information to ensure consistency and ease of review. Providing a standardized format for submissions would improve the clarity and consistency of the data collected, making it easier for CMS to evaluate the data provided. For patients, ensuring that off-label use information is accurately captured and evaluated can mean better access to effective treatments and more informed decision-making by health care providers.

Question 34: Therapeutic Advance and Unmet Medical Need. This question emphasizes the need to understand the therapeutic advances and unmet medical needs addressed by the selected drug, which are crucial for evaluating its value. However, the question could be improved by explicitly requesting data on the relative improvement over existing therapies and specific metrics used to define "therapeutic advance." Additionally, CMS can request patient experience data that demonstrates the unmet medical needs are based on outcomes that matter to the patient population.

***Question 35: Specific Populations and Patient Experience*.** By asking about specific populations and patient experiences, CMS ensures that the evaluation process includes diverse patient perspectives and real-world outcomes. However, the question could be enhanced by explicitly requesting data on health disparities and the impact of social determinants of health on treatment outcomes. Including specific prompts for information on health disparities and social determinants of health would provide a more comprehensive understanding of how different populations are affected by the selected drug. Furthermore, question 35b could be improved by asking about the side effects that are typically experienced by certain populations but not others, and how these differences impact patient experience and the use of the drug. This would help CMS

better understand the varied effects of the drug across diverse groups and inform more tailored approaches to patient care.

***Question 36: Dossier Submission*.** Allowing for the submission of a dossier provides manufacturers with the opportunity to present comprehensive, structured evidence supporting their responses. However, clear guidelines on the preferred format and content of the dossier are necessary to ensure consistency and completeness. Providing a template or detailed guidance on the expected structure and content of the dossier, including specific sections and data types, would facilitate more uniform and comprehensive submissions.

Patient- or Caregiver-Focused Input

The NHC appreciates the effort CMS has made to rethink the framing of questions in this section, where input is sought from individuals with direct lived experience. Gathering insights from patients and caregivers is essential to ensuring that the Medicare Drug Price Negotiation Program reflects real-world experiences and addresses the needs of those most impacted by these decisions. Overall, we believe this question set represents a meaningful step forward in terms of understandability and approachability, which are key factors in encouraging meaningful participation from everyday people.

A central focus of our feedback is on the practical usability of these questions for the average person – those who may not have prior experience with formal data collection or survey participation. While the questions have been thoughtfully framed, it is crucial that they are presented in a way that is clear, concise, and easily navigable. The substantial number of questions in this section may pose a barrier for some patients who may become overwhelmed. To help overcome this issue and ensure patients respond, the NHC recommends that CMS state as clearly and often as possible that it is not required to answer all questions and that the language used in this section be free of jargon and technical terms that could create barriers to understanding. Ensuring that the questions are truly patient-friendly will maximize the quality and depth of the responses CMS receives from patients and caregivers. To further enhance this effort, the NHC recommends that CMS directly involve patients in reviewing the final format and phrasing of these questions before they are fully implemented. Although this ICR process serves as a key step in refining the questions, real-world feedback from those who will actually be answering them is invaluable in identifying potential issues and ensuring that the questions are as accessible as possible.

The NHC appreciates the use of a conditional logic format in the questions, where separate paths are provided based on respondents' answers (i.e., whether they select yes or no). This method can streamline the experience for respondents by ensuring they are only asked relevant questions. However, the success of this format heavily depends on the overall approachability of the ICR portal – how intuitive and user-friendly it is. The NHC observed significant frustration with the portal during the IPAY 2026 process, where many participants found it difficult to navigate or understand how to properly submit their input. We strongly urge CMS to address these issues in the IPAY 2027 portal to ensure that all participants, regardless of their familiarity with technology or

survey formats, can contribute their insights without unnecessary difficulty. Additionally, CMS must ensure that this technology is accessible for people with disabilities.

Finally, the NHC recommends that CMS incorporate feedback from a diverse group of patients and caregivers during the design and testing phases of the ICR portal. This real-world user feedback is crucial for identifying potential challenges and ensuring that the final platform is accessible to all, particularly those who may not be technologically proficient or who have limited experience with similar data collection efforts.

***Question 38: Background*.** The structured approach of gathering whether patients or caregivers have experience with the selected drug provides a clear starting point for collecting relevant information. However, there should be an option for respondents to elaborate on why the selected drug was chosen over others initially, including the role of health care providers in that decision.

Question 39: Information on Your Condition(s) or Condition(s) of Someone You Care For. The questions comprehensively cover the daily impact of the condition, its progression, management priorities, and challenges faced. This allows for a detailed understanding of the patient's journey. We particularly appreciate the focus on how symptoms may impact daily living such as work, family, and/or hobbies. We recommend adding education to this list of examples, as it is also critical to know how the patient's education is affected by their condition, which can in turn affect their employment.

We also recommend a more explicit addressing of the emotional and mental health impacts of managing chronic conditions. Adding questions about the emotional and mental health impacts of the condition would provide a more holistic view of the patient's experience.

Question 40: Information on the Current Medication to Treat Your Condition. These questions effectively capture patient experiences with current medications, including benefits, drawbacks, and factors influencing the choice of medication. However, a more comprehensive understanding of patient experiences could be achieved by addressing additional factors that influence medication efficacy, access, management, and the broader context of patient care.

First, the NHC recommends adding a question that asks whether there are any symptoms that impact the patient's daily life but are not adequately addressed by their current treatment. This would provide insight into areas where existing therapies may fall short and highlight unmet needs from the patient's perspective.

Access to medication is a critical issue that encompasses several interconnected factors, including formulary design, utilization management practices, affordability, and availability. These issues significantly influence whether patients can obtain and maintain their prescribed treatments. For example, formulary restrictions, such as medications not being covered or requiring prior authorization, may impact the

timeliness and ease with which patients can access their prescribed treatments.[1,2,3,4,5,6] The NHC suggests expanding the current question about "whether your local pharmacy could get it" to explore these access barriers more thoroughly. Additionally, the question about local pharmacies should be expanded to include other types of pharmacies, particularly as a significant number of patients now receive their medications through home delivery services; CMS should consider collecting data on any access barriers associated with home delivery pharmacies.

Additionally, the NHC recommends including questions that explore challenges related to the cost of medications, insurance coverage decisions, and availability through pharmacies, such as shortages or supply chain issues. Directly asking patients and caregivers if they have encountered any of these access issues – whether related to cost, insurance coverage, utilization management, or availability – can provide valuable insights into the factors influencing patient access to medications. Identifying these issues is essential not only for understanding current challenges but also for monitoring and improving the implementation of the Medicare Drug Price Negotiation Program.

Furthermore, it is crucial to understand how patients perceive the communication and support they receive from health care providers regarding the management of their medications. Including a question about the quality of communication and support when discussing medication options, especially in the context of overcoming access barriers, could provide valuable insights into the patient experience. This information can help identify areas where health care providers might improve their communication strategies to better assist patients in navigating challenges related to access, affordability, and availability of medications.

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[1] Jacobsen, G., Leonard, F., Sciupac, E., and Rapoport, R. (2024). What do Medicare beneficiaries value about their coverage? Findings from the Commonwealth Fund 2024 value of Medicare survey. Retrieved from https://www.commonwealthfund.org/publications/surveys/2024/feb/what-do-medicare-beneficiaries-value-about-their-coverage

[2] American Medical Association. (2023). 2022 AMA prior authorization (PA) physician survey. Retrieved from https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[3] Kyle, M. and Keating, N. (2023). Prior authorization and association with delayed or discontinued prescription fills. *Journal of Clinical Oncology, 42(8)*. https://doi.org/10.1200/JCO.23.01693

[4] Chino, F., Baez, A., Elkins, I., Aviki, E., Ghazal, L., and Thom, B. (2023). The patient experience of prior authorization for cancer care. *JAMA Network Open, 6(10)*. doi: 10.1001/jamanetworkopen.2023.38182

[5] Jew, O., Okawa, J., Barbieri, J., McCaffrey, J., Hayward, E., and Werth, V. (2021). Evaluating the impact of prior authorizations with complex dermatological conditions. *Journal of the American Academy of Dermatology, 83(6)*, 1674-1680. doi: 10.1016/j.jaad.2020.06.998

[6] American College of Cardiology. (2017). Barriers to new medications for cardiovascular disease: insights from CardioSurve. Retrieved from https://www.acc.org/latest-in-cardiology/articles/2017/02/21/12/42/barriers-to-new-medications-for-cardiovascular-disease-insights-from-cardiosurve?__hstc=117268889.c6acac5669d4f1e6063a774e6d96c6b5.1716560813145.1716560813145.1716560813145.1&__hssc=117268889.1.1716560813145&__hsfp=3523199817

By expanding the scope of these questions to include these critical factors, CMS can gain a more comprehensive understanding of the real-world challenges that patients face in managing their conditions with their current medications. This, in turn, will allow for a more patient-centered approach to evaluating treatment effectiveness and ensuring that the Medicare Drug Price Negotiation Program better addresses the needs of those it serves.

Question 41: Information on the Medication(s) Used in the Past to Treat Your Condition. The historical perspective on past medications provides valuable insights into treatment pathways and reasons for changing therapies. However, to gain a more comprehensive understanding of patient experiences, it is important to explore how these transitions have impacted overall condition management, particularly in the context of access considerations related to prior authorization and step therapy.

As with current medications, CMS should collect information on whether patients experienced difficulties accessing past treatments due to prior authorization requirements or step therapy protocols. Step therapy is a utilization management process where patients are required to try an alternative treatment before gaining access to the prescribed medication. Understanding these considerations is important for assessing continuity of care and understanding the factors that may influence patient transitions between medications.

Additionally, the NHC recommends including questions that explore how these access challenges were communicated and managed by health care providers. This could provide valuable insights into the patient experience during transitions in therapy and help identify areas where additional support or improved communication might alleviate some of the burdens associated with navigating complex formulary and utilization management processes. By ensuring that this information is collected for both current and past medications, CMS can develop a more patient-centered understanding of the real-world challenges that patients encounter, particularly when transitioning between treatments. This comprehensive approach will better inform the Medicare Drug Price Negotiation Program and help ensure that it addresses the full spectrum of patient needs.

Question 42: Additional Information. The open-ended nature of this question allows respondents to provide unique and qualitative data that may not be captured in structured questions. However, clear guidance on the types of additional information that might be most useful could help respondents provide more focused and relevant insights. Providing examples or categories of useful additional information (e.g., specific barriers to access, additional side effects not previously mentioned) could help respondents provide more targeted feedback.

Question 43: Visual Representations. Allowing for visual representations such as tables, charts, and graphs can enhance the clarity and impact of the information provided. However, ensuring respondents have clear instructions on how to create and submit these visuals in a format that is useful for CMS' review process is essential. Including detailed instructions and examples of effective visual representations would help respondents provide more useful and standardized submissions.

Question 44: Demographic Questions. Collecting demographic information is essential for contextualizing patient responses and ensuring that the diverse experiences of different population groups are considered in the evaluation. However, the current demographic categories may not capture all aspects of diversity that can impact patient experiences. To enhance the comprehensiveness of the demographic data collected, the NHC recommends several key additions and adjustments:

1. **Inclusion of a "Prefer Not to Answer" Option:** For each demographic field, there should be an option for respondents to select "prefer not to answer." This ensures that respondents can maintain their privacy and comfort while participating in the survey.
2. **Separate Demographic Information for Caregivers:** For respondents who are caregivers, CMS should include an option to complete demographic information for both the caregiver and the person receiving the treatment. This would provide valuable insights into how caregiver demographics might influence the caregiving experience and the patient's treatment outcomes.
3. **Urban, Suburban, or Rural Living Environment:** The NHC suggests adding a question that asks whether the respondent lives in an urban, suburban, or rural area. This information is crucial as access to health care resources, including medications, can vary significantly based on geographic location.
4. **Gender or Gender Identity:** The demographic section should include a question about gender identity. This would provide a more inclusive understanding of how gender-related factors might impact patient experiences with treatment.
5. **Expanded Race/Ethnicity Categories:** The current race and ethnicity categories are quite basic. Aligning these categories with the more granular standards used by the Office of Management and Budget (OMB) is recommended.[7] This approach would allow for a more nuanced understanding of how different racial and ethnic groups experience health care and access to medications, and it may create better research and data with more consistent data collection across the federal government.
6. **Inclusion of Socioeconomic Status and Education Level:** Expanding the demographic questions to include socioeconomic status and education level would provide a more comprehensive view of how these factors influence patient experiences. Differences in income, educational attainment, and occupational status can all impact access to care, treatment adherence, and health outcomes. Furthermore, including questions that address housing and food insecurity can provide insight into the social drivers of health that affect patient experiences. Understanding the stability of basic needs like housing and food can reveal underlying challenges that impact health outcomes and access to care, further informing CMS' evaluation of treatment effectiveness and patient support needs.
7. **Primary Language Utilized:** To better understand communication needs and potential barriers, the NHC recommends including a question about the primary

[7] Office of Management and Budget, "Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity," *89 Fed. Reg. 18530* (2024) (to be codified at 44 C.F.R. pts. 1, 2, and 3). https://www.federalregister.gov/documents/2024/03/29/2024-06469/revisions-to-ombs-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and

language spoken by respondents. This information would help identify language access issues and ensure that communication about treatment options is effective and inclusive.

Clinical-Focused Experience

Question 45: Background Questions. The NHC appreciates CMS' efforts to gather background information on health care providers prescribing the treatment. To enhance the value of this data, we recommend expanding this section to include additional demographic information about both the providers and the patients they serve. For instance, while Question 45a1 asks about the area of specialization, practice type, and practice site, it would be beneficial to also collect information on the demographics of the provider's patient population. Furthermore, we suggest including questions about the providers' own demographic characteristics, such as age, race/ethnicity, gender or gender identity, and geographic location. Collecting this information would enable CMS to analyze and compare prescribing practices across different groups of providers, leading to a deeper understanding of how demographic factors may influence treatment decisions and outcomes.

Question 46: Treatment-related Questions. The NHC appreciates CMS' focus on understanding treatment goals, outcomes, and clinical practices related to the selected drug. To improve the quality and relevance of responses, we offer the following recommendations.

When asking about treatment goals, CMS should provide specific prompts, such as whether the goal is disease remission, symptom management, or quality of life improvement. This structured approach will help respondents provide more comprehensive and comparable answers.

For outcomes and assessments of improvement, CMS should clarify the types of outcomes being referred to – whether clinical, functional, or patient-reported. We recommend prioritizing outcomes that matter most to patients, including impacts on daily living and quality of life. Respondents should also specify the thresholds that indicate meaningful change, whether through clinical markers or patient-centered outcomes. This will ensure the evaluation captures what is truly important to patients. To better understand variability in treatment effectiveness, CMS should provide examples of subpopulations that may experience different outcomes, such as those based on age, comorbidities, or genetic factors.

The NHC also recommends including questions about utilization management practices like prior authorization and step therapy, as these may influence treatment access and patient outcomes. Gathering this information from both patients and providers is essential, as both parties often deal with these coverage issues. Therefore, we suggest incorporating these questions into the broader assessment, including Questions 40 and 41.

Finally, CMS should ask respondents to explain how evidence-based clinical practice guidelines are applied in practice, particularly when there is divergence from standard

recommendations or when guidelines lag behind current practice. Understanding these nuances will help contextualize the clinical decision-making process.

Question 47: Treatment-related Questions. The NHC appreciates CMS' emphasis on understanding how the selected drug fits into current treatment paradigms, as this is crucial for ensuring that the Medicare Drug Price Negotiation Program accurately reflects real-world clinical practices and patient needs. To enhance the evaluation, we suggest reframing the benefit-risk assessment questions to focus on how patients perceive the trade-offs between benefits and risks, providing valuable insights into patient priorities and preferences for a truly patient-centered approach.

In considering the selected drug as a treatment option or comparing it to alternatives, it is important for respondents to specify the clinical scenarios, patient characteristics, or prior treatment failures that typically lead to the drug's use. This should include considerations of efficacy, safety, patient preferences, cost-effectiveness, and factors related to prior authorization or step therapy protocols, which will clarify the drug's role within the broader therapeutic landscape.

CMS should also prompt respondents to elaborate on the relative importance of various factors such as efficacy, safety, administration route, patient characteristics, and cost in treatment selection. This will capture the nuanced trade-offs that influence both clinician and patient decisions. To better understand variability in clinical practice, CMS should seek examples of how real-world prescribing may differ from clinical guidelines, including any debates or uncertainties that might affect drug selection.

Lastly, when discussing patient subgroups that may benefit more or face greater risks, it is essential to include considerations of health disparities, genetic factors, and comorbid conditions. This will help CMS gain a comprehensive understanding of the drug's differential impact across diverse populations, ensuring more equitable and effective health care outcomes.

Question 48: Health Equity and Patient Experience. The NHC strongly supports the inclusion of considerations related to health equity and patient experience in the evaluation of selected drugs. Addressing health equity is essential to ensuring that all patients, regardless of their background or socioeconomic status, have access to effective treatments.

We recommend that CMS offer more specific sub-questions, similar to other questions in the document, aimed at prioritizing the identification of health disparities that may affect access to and outcomes from the selected drug. This includes considering social determinants of health, such as income, education, geographic location, and race/ethnicity, which can influence both the availability of the drug and the effectiveness of its use. By focusing on these factors, CMS can better understand how different patient populations may experience varying levels of access to the selected drug and its therapeutic alternatives.

Additionally, it is important to assess whether there are specific barriers that patients from underserved communities might face in accessing the selected drug. These could

include cost, insurance coverage limitations, availability of the drug in certain geographic areas, or cultural and language barriers that could affect a patient's ability to understand and adhere to treatment recommendations.

The NHC also encourages CMS to incorporate patient-reported outcomes and experiences into the evaluation process. These insights can provide a more comprehensive understanding of how the drug impacts daily life, including the ability to manage symptoms, maintain independence, and improve overall quality of life. By integrating these patient-centered measures, CMS can ensure that the evaluation process reflects the real-world experiences of those who rely on the selected drug.

Question 49: Therapeutic Advance and Unmet Medical Need. When considering whether the selected drug represents a therapeutic advance, the NHC recommends that CMS take into account both clinical and patient-centered outcomes. This includes evaluating improvements in efficacy, safety, quality of life, and the ability to manage daily living activities. Additionally, it is important to assess whether the drug provides benefits over existing therapies in terms of reducing treatment burden, improving adherence, and offering new modes of administration that may be more patient friendly.

To better align with patient-centered care, the NHC suggests reframing the concept of unmet medical needs to focus on the impacts that are most important to patients. This includes asking respondents to identify and prioritize the outcomes and challenges that matter most to their patients, thereby ensuring that the evaluation reflects the real-world needs and preferences of those who use the drug.

Research-Focused Experience

Question 54: Comparative Clinical Evidence. The NHC acknowledges the importance of robust methodologies and frameworks in evaluating the clinical comparative effectiveness of the selected drug and its therapeutic alternatives. To ensure that CMS' evaluation process is comprehensive and patient-centered, the NHC offers the following recommendations.

Regarding relevant clinical outcome measures, the NHC believes it is essential to consider both clinical efficacy and safety outcomes, as well as patient-reported outcomes that reflect quality of life, treatment burden, and functional status. By including these measures, CMS can ensure that the evaluation process captures the full impact of the drug on patients' lives.

In terms of specific evidence, the NHC encourages CMS to gather data from a variety of sources, including head-to-head trials, pragmatic clinical trials, and real-world studies that provide insights into the drug's performance in diverse patient populations. Additionally, it is important to consider evidence that highlights differences in outcomes among subpopulations, particularly those that are often underrepresented in clinical trials.

Question 55: Specific Populations and Patient Experience. The NHC strongly supports the emphasis on understanding patient experiences and the impact of the

selected drug on specific populations. This approach is vital to ensuring that all relevant patient perspectives are considered in the evaluation process.

Regarding patient experiences, the NHC recommends that CMS collect evidence related to patient priorities and preferences, including how patients perceive the benefits and drawbacks of the selected drug compared to its therapeutic alternatives. This should include insights into the treatment burden, the overall impact on quality of life, and how the drug influences daily activities and well-being. Additionally, patient-reported outcomes should be emphasized, as they provide a direct measure of the drug's effectiveness from the patient's perspective.

For specific populations or subgroups, the NHC suggests that CMS identify and assess how different patient subgroups, such as those defined by age, race, ethnicity, socioeconomic status, or comorbid conditions, are impacted by the selected drug and its alternatives. Understanding how these groups experience the drug's benefits and risks will provide a more comprehensive picture of its effectiveness and safety across diverse populations. Studies focusing on health disparities and differential outcomes should be prioritized to ensure that the evaluation process addresses the needs of all patients.

Regarding considerations of access, health equity, and disparities, the NHC suggests that CMS explore factors affecting access, including cost, availability, insurance design, and social determinants of health, which may influence the use of the selected drug in different populations.

Other Public Input

The NHC recognizes that this section provides an opportunity for any other interested parties to contribute additional public input on the evaluation process. In this context, we emphasize the importance of a comprehensive approach that fully captures the selected drug's broader impact on patient care. We recommend that CMS consider the full range of indications for which the drug is used, including both FDA-approved and off-label indications supported by clinical evidence. This broader perspective will ensure that the evaluation process reflects the drug's significance in treating conditions with high unmet needs, as reported by patients and caregivers.

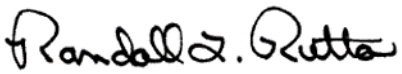
For all interested parties providing input, it is crucial for CMS to consider a wide range of evidence, including real-world data, patient-reported outcomes, and studies focusing on health disparities. These considerations are essential for understanding how different populations, particularly those that are underserved or marginalized, experience the benefits and risks associated with the drug. By incorporating these insights, CMS can better promote health equity and improve outcomes for all Medicare beneficiaries.

Moreover, the use of visual representations, such as patient experience maps and data on health equity impacts, can provide valuable insights into how the drug affects diverse populations. The NHC encourages CMS to include such visual aids in its evaluation to enhance understanding and support more informed decision-making.

Conclusion

The NHC appreciates the opportunity to provide input on the IRA 2027 Drug Price Negotiation ICR. Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs, at egascho@nhcouncil.org if you or your staff would like to discuss these comments in greater detail.

Sincerely,



Randall L. Rutta
Chief Executive Officer

NATIONAL HEALTH COUNCIL

July 2, 2024

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

RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027

Dear Administrator Brooks-LaSure:

The National Health Council (NHC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year (IPAY) 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027 (2027 draft guidance).

Created by and for patient organizations more than 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, equitable, and sustainable health care. Made up of 170 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

General Comments

The NHC appreciates CMS' commitment to actively engaging with stakeholders, including patients, consumer advocates, and health experts, in implementing the Medicare Drug Price Negotiation Program (DPNP). We believe that patient-centric engagement is essential to ensure that the negotiation process leads to outcomes that genuinely benefit patients. As noted in our previous communications, while the NHC would prefer a more traditional Notice and Comment rulemaking opportunity that would ensure the Agency directly responds to stakeholder feedback, we welcome this opportunity to express our reactions to CMS' thinking on the negotiation program.[1] And

[1] National Health Council. (2023). NHC comments on IRA guidance response. Retrieved from https://nationalhealthcouncil.org/wp-content/uploads/2023/04/NHC-IRA-Guidance-Response.pdf

we appreciated CMS' thorough responses to comments for IPAY 2026 and hope the Agency will replicate this for this comment opportunity. Our comments below highlight specific areas where we believe additional improvements can be made to ensure all Medicare beneficiaries, particularly those with chronic diseases and disabilities, have increased access to affordable, high-value, equitable, and sustainable health care.

Patient Engagement

The NHC recognizes and commends CMS' willingness to improve the listening sessions and the data submission processes. It is encouraging to see CMS' commitment to actively engaging with patients and patient organizations to ensure their voices are heard and considered in the DPNP. The NHC provides the following comments to CMS to improve on the steps it has already taken to date.

Improving the Listening Sessions. In our effort to enhance opportunities for patient input, the NHC held a Roundtable discussion that included patients, caregivers, patient organizations, and CMS representatives. The goal of this Roundtable was to chart a course for improving patient engagement in the DPNP and ultimately in other programs and activities of the Agency. The discussion focused on CMS' 2023 listening sessions during implementation of the first round of negotiations and identified lessons learned to inform future listening sessions and broader patient engagement strategies. Based on the discussions and insights from the Roundtable, the NHC offers the following recommendations to:

Improve Clarity and Communication about the Intent of the Listening Sessions.

- Clarify What Information is Sought from Speakers
- Report on Data Utilization
- Host Educational Webinars Before Listening Sessions
- Market as Stakeholder Listening Sessions if They Have Broader Representation

Improve the Structure of the Listening Sessions.

- Enhance Dialogue-Based Engagement
- Clarify Required Disclosures
- Allow HIPAA Waivers if Feasible
- Clarify Speaker Selection Process
- Allow for Data Submissions After Sessions

Increase Engagement.

- Increase Ways for Stakeholders to Engage
- Provide More Advance Notice
- Enhance Efforts to Engage Diverse Speakers
- Partner with Patient Organizations
- Record Listening Sessions

Improve the Speaker Experience.

- Provide Accommodations
- Allow More Speaking Time and Use a Timer
- Show CMS Representatives on Screen

Our report, *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement*, offers greater detail and specificity on these recommendations. We also include additional information later in this letter when responding to Section 60.4.

Improving the Data Collection (ICR) Process. The NHC supports the focus on patient-centered data and emphasizes the importance of clear guidelines and support to help patient organizations navigate the data submission process. We appreciate CMS' stated willingness to improve this process to make it more relevant for patients and patient organizations.

We were especially pleased to see CMS indicate that they may make clearer that they are seeking detailed descriptions of what it is like to live with a medical condition treated by the selected drug or its therapeutic alternatives, and the factors that matter most to patients when assessing the value of a drug. We feel this is an optimal use of the ICR process and recommend that this framing also be used as part of the description of the listening sessions.

We also support CMS' potential grouping of questions related to manufacturer input, patient or caregiver experience, clinical experience, and health research, which can streamline the data collection process, aligning information more closely with respondents' areas of expertise. However, it is essential to ensure that the complexity and nuances of patient experiences are not oversimplified. Pilot testing this format with various stakeholders can help identify potential challenges and refine the process accordingly.

To enhance the ICR process, clarifying what qualitative and quantitative information is needed and how it will be used in determining the MFP will help patient organizations better prepare and ensure their data is relevant. Hosting educational webinars to prepare patient groups and stakeholders on information requirements will also be beneficial.

Finally, we encourage CMS to consider a longer time horizon for the submission of data. While some organizations may have access to existing data, others may want to collect new data through surveys or other activities that may be more fit for CMS' needs. Further, if this period is extended beyond the listening sessions, there may be gaps identified during the sessions that can be filled by additional research. While we understand this timing may not allow for the data to be incorporated into CMS' initial offer, it can still be useful during later stages of the negotiation process.

Utilization of Patient Experience Data. The NHC commends CMS for acknowledging the importance of patient experience data in the negotiation process. It is crucial that this data is given significant weight in determining the MFP. Patient

experience data provides valuable insights into how medications impact patients' daily lives, including their ability to manage symptoms, maintain independence, and improve their quality of life.

We urge CMS to consider a broad range of patient experience data, including both clinical and non-clinical outcomes. Factors such as treatment adherence, patient-reported outcomes, and quality of life measures should be integral to the negotiation process. Additionally, CMS should engage with patient organizations to identify the most relevant and impactful data points. By doing so, CMS can ensure that the MFP reflects the true value of medications from the patient's perspective. Furthermore, ongoing dialogue and reporting on how patient engagement information is incorporated into negotiations and establishing a feedback loop with patient organizations will reinforce CMS' commitment to truly patient-centered care.

Clarification on QALY Metrics

The NHC appreciates CMS' commitment to excluding Quality-Adjusted Life Years (QALYs) from the negotiation process as outlined in the 2027 draft guidance. Valuing life differently based on disability status, age, or other special populations is inappropriate. All patients deserve equal treatment, and we applaud CMS' decision to exclude QALY metrics. However, we are concerned about the potential use of studies with QALY-related data from secondary sources or the over-exclusion of valuable analyses. The NHC requests more clarity on how CMS will exclude QALY-based metrics and highlight when they have been removed from consideration in MFP justification documentation. Additionally, we recommend that CMS be more transparent regarding the forms of cost-effectiveness analysis it is considering using, as many approaches are not well understood or tested.

Patient value is multi-faceted and attempts to distill important dimensions of patient value and benefit into a single number are problematic. While QALYs are excluded by statute, CMS should not rely on a single metric and instead use a wide variety of sources for a holistic approach. Multi-criteria decision analysis (MCDA) is one such approach that considers a wide range of factors, including patient preferences and quality of life.[2] By adopting a holistic approach to value assessment, CMS can ensure that the negotiation process is fair and inclusive of all patient populations.

Continuous Improvement and Feedback Mechanisms

The NHC supports the establishment of a robust infrastructure for continuous patient engagement, including a patient ombudsman and regular public roundtables with patient and disability communities. Continuous improvement is essential for adapting the negotiation program to changing needs and ensuring that it remains effective and patient-centered over time.

Creating a patient ombudsman position would provide patients with a dedicated advocate within CMS who can address their concerns and ensure that their voices are

[2] National Health Council. (n.d.). Patient-centered multi-criteria decision analysis. Retrieved from https://nationalhealthcouncil.org/additional-resources/patient-centered-multi-criteria-decision-analysis/

heard. This role would be instrumental in facilitating ongoing dialogue between CMS and the patient community, helping to identify areas for improvement and ensure that patient feedback is integrated into policy decisions.

Regular public roundtables and advisory committees can also provide valuable insights into the patient experience and help CMS stay informed about emerging issues. These forums should include diverse representation from various patient communities to capture a wide range of perspectives. Additionally, CMS should establish clear processes for incorporating feedback from these engagements into the negotiation program, ensuring that patient input leads to tangible changes.

Comments on Specific Sections of the 2027 Draft Guidance

Transparency and Stakeholder Engagement (Section 30)

The NHC emphasizes the need for CMS to maintain a high level of transparency in its negotiation processes. This includes providing detailed justifications for the MFP and ensuring that patient input, especially through patient listening sessions, is transparently incorporated into decision-making. Moreover, stakeholder engagement should be a continuous process, with CMS actively seeking input from diverse patient organizations and other stakeholders at every stage. Aggregation of stakeholder feedback should be methodical and comprehensive, ensuring that no significant patient perspectives are overlooked. These elements were previously highlighted in our comments in response to the IPAY 2026 guidance, and we continue to stress their importance for the 2027 draft guidance.

Active Moiety and Single Source Qualifying Drugs (Section 30.1)

The NHC remains concerned about the effects that the aggregation of drugs with the same active moiety or active ingredient in the selection process could have on subsequent research.[i] We want to ensure that manufacturers are not discouraged from developing new indications, forms of administration, or combination products that may improve patient adherence and outcomes. Without appropriate guardrails, CMS' broad definition of drugs eligible for negotiation may discourage these types of improvements. While manufacturers would ideally bring products to market with as many indications as possible, one potential consequence could be a significant delay in initial market entry and access. The NHC aligns with CMS' desire to eliminate potential gaming of extending patent life or time before negotiation. However, we fear this may be an overly broad approach that does not consider the patient perspective on whether new formulations, combination products, or forms of administration improve patient care.

We believe there are better approaches to address this issue, including using patient engagement to determine whether new formulations, combination products, or routes of administration are considered by patients to be important improvements. For example, innovations in biologic drugs used to reduce inflammation in autoimmune diseases like arthritis have made injections much less painful, significantly improving the quality of life for patients. Similarly, long-acting insulin analogs provide more stable blood sugar control and reduce the number of daily injections needed for diabetes patients. Extended-release psychotropic formulations for mental health conditions improve

treatment adherence and overall patient outcomes by reducing the frequency of dosing. Combination products, such as fixed-dose combinations for hypertension or HIV, simplify treatment regimens and enhance adherence.

Such innovations underscore the importance of encouraging new forms of administration, combination products, and other advancements that enhance patient experience and adherence. Therefore, incorporating robust patient engagement practices is essential to accurately capture the value and necessity of these advancements from the patient's perspective. This ensures that the negotiation process genuinely aligns with patient needs and preferences, ultimately leading to better health outcomes and improved quality of life.

Medicare Transaction Facilitator (Section 40.4.1)

The NHC appreciates the opportunity to provide feedback on the role of the Medicare Transaction Facilitator (MTF) within the Medicare DPNP. The MTF plays a critical role in ensuring that the negotiated MFPs are effectively implemented and that all stakeholders, including patients, manufacturers, and dispensing entities, experience minimal disruption during the transition. To achieve this, it is essential that the MTF operates with consistency, uniformity, and transparency while ensuring robust data security measures.

Standardization and uniformity are essential for the nearly 70,000 pharmacies that bill for Medicare Part D.[ii] Implementing a standardized process will streamline operations, reduce administrative burdens, and enhance patient access to the program. By ensuring consistency and transparency, CMS can facilitate the efficient and equitable implementation of the MFPs, enabling all parties involved to operate smoothly and effectively. This approach will ultimately lead to better patient outcomes and reduced administrative burdens for manufacturers and dispensing entities.

To maintain impartiality and integrity, it is crucial to consider the nature of any potential conflicts of interest from entities involved in the pharmaceutical supply chain. These conflicts can significantly influence formularies and patient access to medications.[iii] Transparency and careful evaluation of these conflicts are essential to ensure trust and fairness in the process for all stakeholders. By prioritizing transparency and conflict mitigation, CMS can help ensure that the MTF operates in a manner that is trusted by all stakeholders and that the negotiation outcomes are unbiased and equitable. Ensuring that the selected MTF does not have inappropriate conflicting business interests is vital for maintaining stakeholder confidence.

The NHC supports prioritizing specific MTF functions that can yield immediate benefits and alleviate the burdens faced by beneficiaries, manufacturers, and dispensing entities. Timely reimbursement is of critical importance to ensure uninterrupted access to essential drugs for beneficiaries. When pharmacies are compelled to hold onto funds for extended periods as part of the retrospective payment process, it can strain their financial resources, potentially leading to difficulties in maintaining sufficient medication supplies and disrupting patient access.[iv] This delay or uncertainty in reimbursement

may result in increased costs, potentially impacting patients through higher co-pays or out-of-pocket expenses, potentially limiting their ability to afford necessary medications.[v]

The NHC also underscores the utmost importance of implementing robust data security measures to safeguard patient data throughout the MTF process. To this end, we recommend that CMS clarify that the MTF is designated as a covered entity under the Health Insurance Portability and Accountability Act (HIPAA), ensuring full compliance with patient data privacy and security laws. The NHC recommends the implementation of advanced encryption to secure all data exchanges and prevent unauthorized access to sensitive patient information. Additionally, strict access controls should be implemented to restrict data access exclusively to authorized personnel, fortifying data confidentiality. It is also crucial to maintain comprehensive data audit trails to monitor data access and modifications, enhancing accountability and data integrity. Furthermore, conducting regular security audits and assessments is essential to systematically identify vulnerabilities and proactively address them. The NHC firmly believes that these security measures will not only protect patient data but also foster trust in the MTF process among all stakeholders involved.

Evaluation Criteria and Patient-Centered Metrics (Section 50.2)

The NHC reemphasizes the need for comprehensive evaluation criteria that prioritize patient-centered metrics. These metrics should include patient-reported outcomes, quality of life measures, and other indicators that reflect the real-world impact of medications on patients' lives. The inclusion of such metrics will ensure that the negotiation process genuinely reflects the value of treatments from the patient's perspective.

To this end, the NHC recommends that CMS consider non-QALY-related models that focus on the quality of evidence and strength of recommendations, which can provide a more nuanced and patient-centered assessment of treatment value. Furthermore, the NHC suggests that CMS utilize the NHC's patient principles and rubric as a checklist to ensure that any methodology considered is patient-centered. The *National Health Council Rubric to Capture the Patient Voice: A Guide to Incorporating the Patient Voice into the Health Ecosystem* was developed through a multi-stakeholder process to elevate meaningful patient engagement. This rubric encompasses seven domains of patient-centered engagement and methodological practices: 1) patient partnership; 2) transparency; 3) representativeness; 4) diversity; 5) outcomes patients care about; 6) patient-centered data sources and methods; and 7) timeliness. By incorporating these domains, CMS can prioritize patient experience data in the negotiation process and develop a standardized methodology for incorporating this data into decision-making. This methodology should outline how patient experience data will be collected, analyzed, and weighted against other factors, such as research and development costs. Transparency in this process is essential to build trust and ensure that patient perspectives are genuinely influencing the outcomes.

Standardized Methodology and Real-World Evidence (Section 50.4)

We also highlight the importance of a standardized methodology for applying therapeutic alternatives data, as outlined in Section 50.4. The methodology should be

transparent and consistent, leveraging real-world evidence to provide a comprehensive understanding of treatment benefits and risks. This approach aligns with our previous calls for a holistic evaluation that incorporates diverse data sources and patient experiences.

Use of Clinical Guidelines (Section 50.6)

Clinical guidelines provide evidence-based recommendations that can help ensure treatments align with the best available scientific evidence. **The NHC supports CMS' use of these guidelines as one of many evidence sources to ensure therapies are selected and valued based on clinical efficacy and appropriateness for patients.** Emphasizing clinical guidelines and other evidence-based recommendations helps prevent the inappropriate use of cost considerations as the primary driver of decision-making, which could undermine patient care by prioritizing cheaper treatments that may not be the most effective or suitable for patient needs. CMS should balance the use of clinical guidelines with patient-centered outcomes and real-world evidence and ensure evidence is as current as possible to keep the negotiation process focused on what is best for patients. **As CMS works to achieve this balance, the NHC would like to emphasize several limitations associated clinical guidelines**:

- **Off-Label Usage:** Clinical guidelines typically do not cover off-label uses of medications, which can be significant for many patient populations, especially those with rare or complex conditions. Off-label usage often emerges from real-world clinical practice and patient experiences, which might not be reflected in the guidelines. It is crucial to consider how off-label uses will be evaluated and incorporated into the negotiation process. Ignoring these uses could lead to decisions that do not fully capture the value of a medication for all patients. CMS should develop a framework to evaluate and include off-label uses in the negotiation process. This could involve consulting with clinical experts, patient organizations, and reviewing peer-reviewed literature and real-world evidence that supports off-label use cases.
- **Pace of Guideline Updates:** The process for updating clinical guidelines can be slow, often lagging behind the latest clinical research and real-world evidence. This delay can result in outdated recommendations that do not reflect current best practices or emerging treatment options. CMS should ensure that the negotiation process is flexible enough to incorporate new evidence and adapt to changes in clinical practice swiftly. CMS should establish mechanisms to expedite the integration of new clinical evidence into the guidelines used for negotiation. This could involve setting up rapid review panels or interim updates to guidelines based on emerging data.
- **Lack of Patient Input**: Clinical guidelines often lack robust patient input, focusing predominantly on clinical outcomes rather than patient-centered outcomes such as quality of life, treatment adherence, and patient preferences. Incorporating patient perspectives into the guideline development process is essential to ensure that the recommendations reflect what matters most to patients. CMS should work with stakeholders to increase patient involvement in guideline development and consider patient-reported outcomes in the negotiation process and ensure that patient-centered outcomes are given significant weight

in the evaluation of treatments. There are some notable instances of clinical guidelines developed in collaboration with patient organizations that emphasize patient-centered outcomes in atrial fibrillation and arthritis (specifically osteoarthritis and juvenile idiopathic arthritis) that showcase models of how patient engagement can enhance the development and implementation of clinical guidelines.[vi,vii,viii]

Patient Engagement during the Negotiation Process (Section 60.4)

The NHC appreciates CMS' detailed outline in Section 60.4 regarding the patient-focused listening sessions and the overall negotiation process for determining the MFP. We commend CMS for its commitment to improving these sessions and provide the following detailed recommendations.

First, CMS should specify the type of information it seeks from speakers during patient-focused events. Clear communication about the objectives and desired outcomes will help participants prepare more effectively and contribute valuable insights. For example, CMS could outline the specific aspects of patient experiences and therapeutic alternatives it is interested in, which will enable participants to provide more targeted and relevant input. It is also essential for CMS to report on how the patient engagement information and qualitative data collected during these sessions are incorporated into the negotiations. This transparency will build trust and demonstrate that patient voices are genuinely influencing the outcomes, which can lead to greater and more representative participation moving forward. Hosting educational webinars in advance of the listening sessions can further ensure stakeholders are well-prepared. These webinars can provide detailed information on the structure of the sessions, the types of data CMS is seeking, and how this data will be used in the negotiation process. If CMS continues to include stakeholders other than patients, they should be marketed as stakeholder listening sessions. This will make it clear that the outreach includes all members of a disease community, including patients, caregivers, and practitioners. This inclusive approach will help gather a diverse range of perspectives and experiences, enriching the data collected.

CMS should focus on creating opportunities for real-time dialogue with smaller groups of patients rather than merely holding listen-only events. This approach can help gather deeper insights and foster a more interactive and engaging approach. For instance, roundtable discussions and focus groups could facilitate more meaningful interactions among participants. The required disclosures should be clarified in a manner that explains why they are needed and how they affect the testimony. This will help participants understand the necessity of these disclosures and provide informed consent. CMS should also allow patients and speakers the ability to waive HIPAA requirements, if legally permissible. This flexibility can facilitate more open and honest sharing of experiences, which is crucial for understanding the real-world impact of medications. Additionally, CMS should clearly communicate the process for selecting speakers and ensure diversity in the selection process to include a broad spectrum of voices and perspectives. Allowing for data submissions after the listening sessions can enable participants to provide additional insights that may arise from the discussions, ensuring that all relevant information is captured.

CMS should increase ways for patients and other relevant stakeholders to engage, such as through written statements or recorded testimonies for those who cannot participate in live sessions due to job constraints, privacy concerns, or lack of broadband access. Providing more advance notice for listening sessions will allow organizations time to identify relevant patients and conduct surveys to gather insights. Enhancing efforts to engage speakers from diverse backgrounds is essential, and this can be achieved by working with the Office of Minority Health and minority-led patient organizations to ensure that the sessions reflect the diversity of the patient population. Partnering with patient organizations to monitor the program's impact, especially on access to treatments, will help ensure that the program is meeting its goals. Recording the listening sessions will allow stakeholders to review the testimony and ensure that all voices are heard and considered. Sharing redacted transcripts can help maintain transparency while protecting privacy.

To improve the speaker experience, CMS should provide accommodations for patients with disabilities and non-native English speakers to ensure that all participants can engage fully. This includes providing translation services, accessible venues, and other necessary support. Allowing speakers more time (at least five minutes) and including a timer on the Zoom screen to help manage pacing can make the experience more comfortable and effective, ensuring that participants do not feel rushed and can share their experiences thoroughly. Showing CMS representatives on the Zoom screen can make speakers feel more comfortable and ensure they feel heard. This visual presence can help build rapport and foster a sense of engagement and interaction.

Explanation for the MFP (Section 60.6.1)

It is crucial that CMS provides clear and detailed explanations for the MFP, explicitly explaining how patient listening sessions and patient-submitted data are utilized. Transparency in these justifications will build trust and ensure that the negotiation outcomes are genuinely patient-centered. The NHC urges CMS to release the justifications for 2026 before starting the 2027 process, despite the statutory timeline requiring publication by March 1 of the year prior to the initial price applicability year. Early release will allow for better preparation and more informed stakeholder engagement. Furthermore, CMS might also consider releasing a template for these explanations in advance and soliciting feedback on that template to ensure the information meets the guidance's transparency goals.

Part D Formulary Inclusion of Selected Drugs (Section 110)

Finally, we reiterate our concerns regarding Part D formulary inclusion of selected drugs, as expressed in our previous letters. Ensuring that negotiated drugs are included in formularies without undue restrictions is critical for maintaining patient access to essential medications. Additionally, it is important to consider how negotiation could impact access to competitors of selected drugs, potentially affecting the overall availability of effective treatments.

To protect patients from potential negative consequences of the negotiation program, such as increased utilization management or formulary restrictions, CMS should establish clear guardrails and conduct ongoing oversight. It is essential that the

negotiation process does not inadvertently create barriers to accessing necessary medications. Patients must be assured that cost-saving measures will not come at the expense of their health and well-being.

One key area of concern is the potential for increased utilization management practices, such as prior authorization and step therapy, which can delay or deny access to necessary treatments.[ix,x,xi,xii,xiii,xiv] CMS should establish stringent guidelines to ensure that these practices are not used excessively or inappropriately. Additionally, CMS should monitor the impact of these practices on patient access and adjust policies as needed to protect patients from undue burden.

CMS' recent interoperability and prior authorization final rule emphasizes the need for streamlined prior authorization processes and enhanced transparency, which was supported by many stakeholders, including patient organizations, providers, health plans, and pharmaceutical groups.[xv] The NHC urges CMS to consider developing parallel rules specifically for prescription drugs to ensure comprehensive coverage and protection for patients.

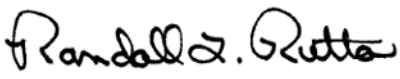
Ongoing oversight is critical to ensuring that the goals of the negotiation program are achieved without compromising patient care. CMS should implement a robust monitoring system to track the program's impact on drug prices, access, and patient outcomes. This includes collecting data on utilization management practices, formulary changes, and patient experiences. Patient organizations are willing and able to assist in collecting information from their populations to share with CMS if the appropriate structure is established to allow for this reporting. Regular reporting and public transparency will help identify any unintended consequences and allow for timely corrective actions.

Conclusion

The NHC strongly believes that a patient-centered approach is vital for the success of the DPNP. We urge CMS to consider these recommendations to ensure that the program not only achieves cost savings but also enhances access to high-value, life-saving medications for Medicare beneficiaries.

We appreciate the opportunity to provide input on this important issue and look forward to continuing our collaboration with CMS. Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs, at egascho@nhcouncil.org if you have any questions or require further information.

Sincerely,



Randall L. Rutta
Chief Executive Officer

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[ii] Office of the Inspector General, U.S. Department of Health and Human Services. (2020). Key Medicare tools to safeguard against pharmacy fraud and inappropriate billing do not apply to Part D. Retrieved from https://oig.hhs.gov/oei/reports/oei-02-15-00440.pdf

[iii] National Health Council. (2022). NHC comments to the FTC on PBM business practices and the impact on independent pharmacies and consumers. Retrieved from https://nationalhealthcouncil.org/wp-content/uploads/2022/05/NHC-FTC-PBM-Comments-Final-Plain-Letterhead.pdf

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[v] Durham, D., Landon, B., Casalino, L., and Richman, B. (2021). Pharmacy benefit managers: transparency, accountability, and impact on patient care. *Journal of Managed Care & Specialty Pharmacy, 27(7),* 903-907.

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[xv] Medicare and Medicaid programs; patient protection and Affordable Care Act; advancing interoperability and improving prior authorization processes for Medicare Advantage organizations, Medicaid managed care plans, state Medicaid agencies, Children's Health Insurance Program (CHIP) agencies and CHIP managed care entities, issuers of qualified health plans on the federally-facilitated exchanges, Merit-based Incentive Payment System (MIPS) eligible clinicians, and eligible hospitals and critical access hospitals in the Medicare Promoting Interoperability Program, 89 Fed. Reg. 8758 (2023) (to be codified at 42 C.F.R. pts. 422, 431, 435, 438, 440, 457, and 45 CFR pt. 156). https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

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September 3, 2024

The Honorable Meena Seshamani, M.D., Ph.D.
CMS Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard Baltimore, MD 21244
Submitted Electronically via regulations.gov

RE: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849)

Dear Deputy Administrator Seshamani:

The National Pharmaceutical Council (NPC) appreciates the opportunity to submit comments regarding the Centers for Medicare & Medicaid Services (CMS) Information Collection Request (ICR) *Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849).* NPC is a health policy research organization dedicated to the advancement of good evidence and science and to fostering an environment in the United States that supports medical innovation. We have rich experience conducting research and disseminating information about the critical issues of evidence, innovation and the value of medicines for patients. Our research helps inform important healthcare policy debates and supports the achievement of the best patient outcomes in the most efficient way possible.

There is robust evidence demonstrating the value of biopharmaceuticals on public health, including associated improvements in life expectancy,[1] reductions in total healthcare costs,[2] and reductions in other poor health outcomes.[3] The biopharmaceutical industry invests over $276 billion in research and development annually,[4] yet our research shows that the Inflation Reduction Act (IRA) may reduce new treatments and indications.[5] The IRA creates a new price-setting mechanism that will change the economic incentives for bringing new medicines to market, and evidence shows

[1] Buxbaum JD, Chernew ME, Fendrick AM, Cutler DM. Contributions Of Public Health, Pharmaceuticals, And Other Medical Care To US Life Expectancy Changes, 1990-2015. Health Aff (Millwood). 2020 Sep;39(9):1546-1556. doi: 10.1377/hlthaff.2020.00284. PMID: 32897792.
[2] Roebuck MC, Liberman JN, Gemmill-Toyama M, Brennan TA. Medication adherence leads to lower health care use and costs despite increased drug spending. Health Aff (Millwood). 2011 Jan;30(1):91-9. doi: 10.1377/hlthaff.2009.1087. PMID: 21209444.
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[4] Chandra A, Drum J, Daly M, et al. Comprehensive Measurement of Biopharmaceutical R&D Investment. Nature Reviews Drug Discovery. August 2024. https://www.nature.com/articles/d41573-024-00131-2
[5] Patterson J, Motyka J, O'Brien JM. Unintended Consequences of the Inflation Reduction Act: Clinical Development Toward Subsequent Indications *Am J Manag Care. 2024;30(2):82-86. https://doi.org/10.37765/ajmc.2024.89495*

manufacturers are already responding to those incentives.[6] There are growing concerns about the potential unintended consequences of the IRA and the Medicare Drug Price Negotiation Program. NPC research highlights that these consequences will likely include delay of access to new medicines, and fewer diseases getting additional approved treatment options.[7,8]

In accordance with the Paperwork Reduction Act (PRA), NPC's comments aim to ensure that CMS is accurately assessing the burden of data collection in the ICR form. Furthermore, we aim to ensure that CMS is clearly communicating the utility of collected data to increase efficiency among the stakeholders involved in the ICR evidence collection and reporting process.

Our comments on the ICR for IPAY 2027 are below:

I. Administrative Burden and Transparency
- A. Reducing Administrative burden for patients and manufacturers
- B. Increasing Transparency and Revising Timelines between the Evidence Collection and Review

II. Section I: Evidence about Alternative Treatments
- A. Data on Therapeutic Alternatives
- B. Patient-Specific Data Elements
- C. Treatment Costs and Offsets
- D. Unmet Medical Need

III. Drug Price Negotiation Process ICR Form
- A. Opportunities for meaningful in-person CMS-manufacturer engagement

[6] Grogan J. (2022) The Inflation Reduction Act Is Already Killing Potential Cures. WSJ. https://www.wsj.com/articles/the- inflation-reduction-act-killing-potential-cures-pharmaceutical-companies-treatment-patients-drugs-prescriptions-ira- manufacturers-11667508291; IRA survey: Biotechs bracing for impact. Biocentury. March 16, 2023. Slabdokin, Greg. IRA Drives Pfizer's Decision to Focus on Biologics, Not Small Molecules. BioSpace. March 4, 2024. Available at: https://www.biospace.com/article/ira-drives-pfizer-s-decision-to-focus-on-biologics-not-small-molecules/. US IRA May Weigh on Long-Term Global Pharma Growth. FitchRatings. September 2023. https://www.fitchratings.com/research/corporate-finance/us-ira-may-weigh-on-long-term-global-pharma-growth-22-09-2023.

[7] Patterson J, Motyka J, O'Brien JM. Unintended Consequences of the Inflation Reduction Act: Clinical Development Toward Subsequent Indications *Am J Manag Care. 2024;30(2):82-86. https://doi.org/10.37765/ajmc.2024.89495*

[8] O'Brien J, Motyka J, Patterson JA. How The IRA Could Delay Pharmaceutical Launches, Reduce Indications, And Chill Evidence Generation, Health Affairs Forefront. November 2023. DOI: 10.1377/forefront.20231101.123865

I. Administrative Burden and Transparency

A. Reducing Administrative burden for Patients and Manufacturers

Many stakeholders are closely watching CMS's IRA implementation process. The price-setting process is being studied not just by manufacturers, but by the broader patient advocacy, health policy, and pharmacoeconomic communities.[9,10] The credibility of CMS's process will be judged by the agency's use of good evidence and appropriate methods in a transparent and patient-centered process.

We are concerned with the administrative burden placed on patients to complete the ICR form. The ICR form includes 10 sections with 64 specific questions, many of which have multiple sub-questions. In particular, Section I of the ICR provides one of the two current opportunities for patients to provide critical evidence on the effectiveness of the selected medicines in comparison to therapeutic alternatives. However, for patients to provide comments to CMS on Section I, there needs to be a sufficient comment period timeline. We are concerned patients will not have sufficient time to complete the ICR form given the one-month timeline between the date that CMS will announce the selected drugs for IPAY 2027 (February 1st) and the deadline to submit the ICR comments (March 1st). A 30-day comment period will be particularly burdensome for small and/or low-resourced patient groups, who lack full-time dedicated staff to devote all their resources to respond to CMS.

For IPAY 2026, CMS received 106 submissions from individuals and organizations on Section 1194(e)(2), with 55 percent of these submissions from organizations. CMS is estimating that it will receive approximately three times as many public submissions for IPAY 2027, estimated at 150 submissions from individual respondents and 175 from organizations.[11] We ask CMS to publicly release information on how many individuals and organizations respond to the ICR for IPAY 2027, and to stratify data based on respondent type, including patients and patient advocacy organizations. Sharing this information will help CMS and the public understand who CMS receives feedback from, and to address gaps in respondent types if there is limited feedback from respondent types. In particular, CMS should monitor how many responses it receives from patients, as it is critical that the patient voice is heard within the price-setting process.

[9] O'Brien JM and Hansen J. Section 50 of the Inflation Reduction Act Drug Price Negotiation Program: Considerations for the Centers for Medicare Medicaid Services, Manufacturers, and the Health Economics and Outcomes Research Community. Value in Health. 2023; 26 (12).
[10] Tollen L. Is It Working? Evaluating The First Round of Medicare Drug Price Negotiations. Health Affairs. August 2024. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.00994.
[11] Centers for Medicare and Medicaid Services. Supporting Statement – Part A. Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) (CMS-10849, OMB 0938-1452). July 2, 2024. Available at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849

To decrease burden on patients, we recommend that patients should have greater flexibility and autonomy to better engage with CMS on evidence about alternative treatments. This recommendation could be accomplished by implementing the following:

- Increase the modalities for patients and caregivers to submit data (e.g., video submissions, focus groups, and one-on-one interviews), outside of the ICR form and patient-focused listening sessions.
- Increase the ICR comment period for patients and caregivers to submit data on Section I to at least 60 days.
- Monitor the amount and breadth of information submitted from patients and caregivers in the 2024 ICR form. *Decreased input from patients and caregivers could signal that the method of collection is burdensome for patients and/or CMS's goals and approaches are not targeted enough.*

Manufacturers also face administrative burdens to complete the ICR form. Manufacturers are required to submit the manufacturer-specific and other evidence within the ICR form one month after their drugs are selected for negotiation. CMS estimates that it should take each manufacturer 500 hours[12] to collect evidence for the ICR form, which we suspect to be an underestimate. We are concerned that CMS has not provided sufficient clarity on certain definitions in Section I of the ICR form, such that the minimal amount of data is requested and collected from manufacturers. For example, definitions of therapeutic advance, and comparative effectiveness are not adequately defined.

We suggest that CMS should provide clarity on the definitions relevant to Section I of the ICR form. If the definitions of key terms remain ambiguous, then manufacturers will not have sufficient information to efficiently submit the ICR form.

The following definitions for key terms should be clarified:

- Therapeutic advance: US government organizations, such as the Food and Drug Administration, have a definition of unmet medical need. We recommend that CMS continue to clarify the definition of therapeutic advances, including signals such as:
    - Representation of a significant impact among a socially or economically vulnerable population, which is not evident among non-vulnerable populations; or
    - Patient-focused improvements in the symptoms or health outcomes associated with a disease (e.g., reduction of symptoms, ability to perform daily functions); or
    - Improvements on a validated clinical outcome assessment, for the disease state
- Comparative effectiveness: The IPAY2027 ICR states that "relevant comparative evidence may include, but is not limited to: head-to-head randomized controlled trials, pragmatic clinical trials, network meta analyses, observation studies, and real-world evidence." We recommend that CMS provide direction on which type of comparative evidence carries the most weight and their

[12] Centers for Medicare and Medicaid Services. Supporting Statement – Part A. Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) (CMS-10849, OMB 0938-1452). July 2, 2024. Available at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849

order of preference. We suggest that CMS release the framework for evaluation of comparative effectiveness research and the other metrics for evaluating the quality of data on drugs and their alternatives. We also suggest that CMS release clear approaches for the evaluation of regulatory and other health outcomes measures; such that the highly evaluated evidence is prioritized by manufacturers and other stakeholders. Lastly, we recommend that CMS shed light on how comparative effectiveness evidence will be evaluated across different potentially suitable clinical comparators.

- Cost of Therapeutic Alternatives: We recognize that the statute contemplates that CMS will collect information regarding "the costs of . . . existing therapeutic alternatives." However, we do not believe it is appropriate to consider these costs for the purposes of identifying therapeutic alternatives. Instead, we recommend that CMS clarify that the sole function of collecting this information is to identify the starting point for the negotiation process, which CMS has proposed will begin with the price of the selected drug's therapeutic alternatives.
- Therapeutic Alternatives: As stated in our comments to CMS on the IPAY 2027 Draft Guidance, we encourage CMS to incorporate the following during the selection of therapeutic alternatives:
    - Publicly communicate proposed therapeutic alternatives and solicit feedback from manufacturers, clinicians with specific expertise in the treating the disease, patients and caregivers, and other stakeholders before proceeding with comparative effectiveness analyses that inform the initial offer.
    - Ensure guidelines used in identifying therapeutic alternatives are up-to-date and incorporate the latest evidence.[13]
    - Include patient preferences and priorities that inform shared decision-making between appropriate treatment options.[14]
    - Invite manufacturers of the selected drug to proactively present clinical information focused on the relative clinical benefit of their products compared to therapeutic alternatives during the process of comparator selection and give manufacturers the opportunity to respond to CMS's choices of therapeutic alternatives. Early manufacturer communication is also consistent with practices employed by state Medicaid agencies, other federal agencies and commercial payers.
    - Seek input from clinicians with specific expertise in treating the indication of the selected drug to define appropriate therapeutic alternatives among Medicare patient sub-populations, including patients with multiple comorbidities and varying levels of disease severity. There is a long history of multiple stakeholders working together to develop clinical guidelines, including NIH's National Center for Advancing Translational Sciences.[15]

[13] National Health Council. A Dialogue on Patient-Centered Value Assessment: Overcoming Barriers to Amplify the Patient Voice. December 2018. Available from: https://www.nationalhealthcouncil.org/dialogue-patient-centered-value-assessmentovercoming-barriers-amplify-patient-voice

[14] Schmidt T, Valuck T, Riposo J, et al. Impact of Shared Decision-Making and Patient Decision Aids on Health Care Cost and Utilization in the US: A Systematic Review. J Clin Pathways. 2022;8(8):33-43. doi:10.25270/jcp.2022.12.0

[15] Shekelle PG, Woolf SH, Eccles M, Grimshaw J. Clinical guidelines: developing guidelines. BMJ. 1999 Feb 27;318(7183):593-6.; NIH National Center for Advancing Translational Sciences. Toolkit for Creating Clinical Care Guidelines: https://toolkit.ncats.nih.gov/module/after-fda-approval/creating-clinical-care-guidelines/guideline-development-process/

- Consider the use of comparative effectiveness studies and real-world evidence to support the selection of therapeutic alternative.

In addition to clarifying the definitions in Section I, we also recommend that CMS aim to decrease the administrative burden on manufacturers by implementing the following:

- Collect evidence from manufacturers on the approximate time-period required to collect evidence for the submission of the ICR form and adjust the comment period accordingly. For example, if the manufacturer reported time to collect data for the ICR is double the expected time, then the comment period timeline should be correspondingly doubled.
- Reduce the request for evidence that is publicly available (e.g., peer-reviewed papers). For example, CMS could provide manufacturers with a report of publicly available literature on the effectiveness of the drugs – presented in a table format at the time of drug selection. Manufacturers could review the information for any missing information and provide that information to CMS in the ICR form.
- Shift back to word-count (instead of character-counts) for manufacturer and other stakeholder relevant data, which can decrease administrative burden.

B. Increasing Transparency and Revising Timelines between the Evidence Collection and Review

We are concerned that CMS's lack of clarity on the influence of patient-derived and other data into the Medicare DPNP for IPAY 2027 will result in the collection of data that ultimately has decreased utility for the agency. This is partly because CMS is not required to release an explanation of the MFPs for the selected drugs for IPAY 2026 until the date that the subsequent year's ICR evidence is due (i.e., March 1, 2025).[16] Therefore, stakeholders will need to submit information on the ICR form without understanding what CMS valued in the price-setting process for IPAY 2026. The lack of clarity on the evidence around the information that most influenced CMS's price setting process – at the time when the ICR data are due for the next cycle of selected drugs – limits patients', researchers', and others' ability to leverage insights from the first cycle of the price-setting process as it enters its second cycle.

We also suggest the following:

- **We recommend that CMS increase the transparency of the evidence that informed the MFPs for IPAY 2026 by releasing the explanation of the MFPs at least one month prior to the date that the ICR for 2027 is due.** In addition, we encourage CMS' explanation of the IPAY 2026 MFPs include a complete and transparent methodology – revealing how each domain of collected data informed MFPs. A clear methodology framework of the inner

[16] Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027. May 2024. Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/medicare-drug-price-negotiation-draft-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf

workings of the MFPs will help to reduce administrative burden for stakeholders and increase transparency of this novel program.

- **We recommend that CMS continue to outline safeguards around the protection of confidential information submitted during the ICR process.** The ICR form requests highly confidential information from manufacturers and other stakeholders. We support CMS's inclusion of questions 28 and 64, which allows manufacturers and other stakeholders to clarify which data that should be withheld by CMS under the Freedom of Information Act exemptions. However, we request that CMS provide greater clarity on the safeguards of submitted, confidential data.

II. Section I: Evidence about Alternative Treatments

A. Data on Therapeutic Alternatives

In any assessment of the relative clinical or economic benefits of a drug, the choice of the comparator is a fundamental driver in the outcomes and validity of the assessment with significant implications for patients, payers, and prescribers. We are concerned that CMS has neither provided further information on the literature review informing the selection of therapeutic alternatives nor publicly released more information on the specific outcomes that will be of greatest interest to CMS for developing MFPs. More clarity and guidance are needed to reduce unnecessary administrative burden. **We recommend the following regarding evidence about therapeutic alternatives:**

- Publicly release detailed information on evidence surrounding the selection of the therapeutic alternatives concurrently with CMS's public release of the names of the drugs selected for price setting. In the current process, manufacturers and other stakeholders are required to submit the ICR form, without details on the selection of the therapeutic alternative. We recommend that CMS publicly release the selection of potential therapeutic alternatives that the agency will consider at the time of release of the selected drugs for the MDPNP. CMS should release the list of "potential" therapeutic alternatives and the search strategy opportunity for public comment on the selection and strategy at least one month before the ICR form is due. Increasing transparency in the selection of the therapeutic alternatives will aid in reducing the collection of data of therapeutic alternatives that are not of interest to the agency.
- Shift definition of therapeutic alternative back to the IPAY 2026 guidance definition. CMS changed the definition of a therapeutic alternative in the IPAY 2027 guidance from the IPAY 2026 guidance. The former guidance stated that the therapeutic alternative may refer to "a subset of the most clinically comparable therapeutic alternatives." The new definition of a therapeutic alternative is a change in the wrong direction, away from what is most clinically appropriate. The selection of a less-costly therapeutic alternative that is "clinically comparable" but not in the subset of "most clinically comparable" and lacks the safety, efficacy, and other clinical benefits of a selected drug – solely to lower the initial starting point of the price-setting process – fails to recognize the value of modern treatments and threatens to reverse the incentives that currently encourage innovation and access. We recommend that CMS return to the IPAY 2026 definition of a therapeutic alternative to support clinical decision making. Given

that researchers and others have a limited character count for the submission, we recommend that CMS be more specific about the selection of the therapeutic alternative(s).

B. Patient-Specific Data Elements

CMS has made significant revisions to collected data from the patient perspective. We support CMS's efforts to better solicit patient-centered data. NPC and others have also emphasized the need for CMS to prioritize diversity and a multi-modal approach in outreach at all phases of the DPNP implementation.[17,18] Robust engagement with underrepresented communities through outreach and ongoing dialogue is needed to promote an equity-focused implementation process.[19] While CMS included several questions about the demographics of the patient populations, CMS should allow patients and caregivers to include further demographic and socioeconomic data, if they prefer to share such information with CMS. For example, patients can select their geographic region, but information about the rurality of a patient's residence or gender is not requested. Our research shows that a patient's medication expenses vary across geographies and race/ethnicity.[20]

As CMS considers how to improve upon its patient engagement strategy through revisions in the ICR, CMS should seek feedback from patients, caregivers, and providers about ways to engage patients to complete the ICR forms, including the character-count limits. CMS should also be transparent about the number of comments received from patients on the CMS website.

As such, we recommend that CMS prioritize the following in collecting patient-specific data elements:

- Move towards best practices for patient engagement throughout the DPNP process, such as those developed by NPC and ISPOR. [21,22]
- Increase planned engagement strategies with underrepresented groups with the entire DPNP process, including outreach for submission of evidence for the ICR form.
- Increase the collection of demographic data about patients, as consented to by patients.
- Shift back to word-count (instead of character-counts) for patient relevant data, which can decrease administrative burden.

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[17] National Organization for Rare Disorders. NORD Recommendations: Future Medicare Drug Price Negotiation Program Patient and Provider Listening Sessions [Internet]. 2024.

[18] Miller M, van Geertruyden S, Saxton MC, Savage CY, Weir D, Werner S. A summit on amplifying voices of patients, caregivers, and people with disabilities in Inflation Reduction Act drug price negotiations. J Manag Care Spec Pharm. 2024 Mar 1;30(3):247-251. doi: 10.18553/jmcp.2024.23278. Epub 2024 Jan 30. PMID: 38289281; PMCID: PMC10906444.

[19] The Center for Innovation & Value Research (formerly Innovation and Value Initiative). Comments on the draft guidance for implementation of the Medicare Drug Price Negotiation Program (DPNP) for initial price applicability year 2027 and manufacturer effectuation of the maximum fair price (MFP) in 2026 and 2027. Available at: https://valueresearch.org/the-center-formerly-ivi-provides-comments-on-cms-drug-price-negotiation-program/

[20] Wagner TD, Sahu M, Beauchamp M, et al. Variation in per Beneficiary Prescription Utilization and Spending by Race/Ethnicity in Medicare and Medicaid Insurance Claims. ISPOR 2024 Conference. Available at: https://www.npcnow.org/resources/variation-beneficiary-prescription-utilization-and-spending-raceethnicity-medicare-and

[21] Harrington RL, Hanna ML, Oehrlein EM, Camp R, Wheeler R, Cooblall C, et al. Defining Patient Engagement in Research: Results of a Systematic Review and Analysis: Report of the ISPOR Patient-Centered Special Interest Group. Value in Health. 2020; 23 (6). Available at: https://www.sciencedirect.com/science/article/pii/S1098301520301418

[22] Guiding Practices for Patient-Centered Value Assessment (2024). National Pharmaceutical Council. Jan 2024.

- Clarify that submitted data on a patient's "affiliation" with a manufacturer (i.e., Question 29) will not detract from CMS's evaluation of the patient-centered information. We are concerned that requesting data from patients and other stakeholders around an "affiliation" with a manufacturer may decrease the number of meaningful responses from stakeholders, who interact with manufacturers for a number of reasons.

C. Treatment Costs and Offsets

NPC appreciates that CMS requests evidence related to healthcare resource utilization and usage patterns. Reviewing data related to healthcare resource utilization and usage, with consideration of evidence-based medicine, will provide insight into the economic benefits of selected drugs and their impacts on patient health. However, it remains unclear how CMS will use this information, the methods it will employ to analyze it, and how it will inform their evaluations, and transparency on these points is necessary to evaluate whether this evidence will be used appropriately.

In our comments on the DPNP IPAY 2027 draft guidance, we encouraged CMS to also include comprehensive assessments of the economic benefits of selected drugs, in addition to the costs of the treatments themselves. **We also recommend that the utilization of data on treatment costs and offsets be transparent in the ICR form.**[23] Treatments may have up-front costs that lead to long-term improvements in patient health. Those improvements may yield "cost offsets," or savings due to reduction in healthcare resource needs, such as reduced hospitalizations, or societal gains (e.g., improved productivity, reduction in caregiver burden). The full value of treatment can only be assessed by including both the treatment costs and other associated cost offsets it may produce, while also including clinical benefits of drugs without discretely quantifiable impacts on costs (e.g., improvements in the overall care of the patient). Only considering the treatment costs but not the potential cost offsets would lead to an incomplete assessment of value.

D. Unmet Medical Need

NPC believes assessments of unmet medical need should include a multifaceted definition informed by the patient perspective, as guided by peer-reviewed literature.[24] The ICR asks, participants several questions about unmet medical need, including: "For the condition(s) treated by [the selected drug], describe the extent to which [the selected drug] currently represents (or does not represent) a therapeutic advance as compared to its therapeutic alternative(s)."[25] NPC is concerned that a lack of transparency surrounding what specific factors CMS will consider related to unmet need will result in an approach that is too narrow.

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[23] National Pharmaceutical Council. Guiding Practices for Patient-Centered Value Assessment. 2024. Washington, DC. Available at: https://www.npcnow.org/sites/default/files/2024-01/2024%20Guiding%20Practices%20for%20PatientCentered%20Value%20Assessment%20January.pdf

[24] Levine AA. Kowal S. Chambers J. Unmet Medical Need Under the IRA. Health Affairs Forefront. July 2024. 10.1377/forefront.20240729.713230

[25] Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) Forms (CMS-10849, OMB 0938-1452). Centers for Medicare & Medicaid Services. July 2024. Available at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849

Rigorous methods can be used to elicit consensus from clinician experts and have been used to identify unmet medical needs to achieve optimal treatment goals throughout the natural history of a disease.[26] These methods have identified patient-centered unmet needs, including patient quality of life, poor adherence, severe stages of a disease that are hard to treat, and patient preferred routes of administration.[27] A determination of unmet medical need should encompass all of these factors and more. A recent survey of over 300 patients aged 65 and older in the US asked patients their perspectives on CMS's definition of unmet medical need in the 2023 guidance of the Medicare DPNP.[28] The study reports that patients believe the "accurate definition of unmet medical need is far broader, more engaging of patients, and more nuanced than the definition CMS has proposed [in 2023]."

The FDA's definition of unmet need, as outlined in its guidance for expedited programs, includes improved efficacy, reduced toxicity and/or potential drug-drug interactions, and improvements in other benefits such as adherence.[29] Notably, the FDA definition of unmet need also highlights conditions for which there is significant heterogeneity in response to existing treatment options. Patients may respond differently to available treatment options due to pharmacologic differences, genetic risk, or social determinants of health, creating unmet need despite existing treatments.[30]

NPC requests CMS clarify and provide greater specificity in the definitions and utilization of unmet medical need for MFP, including the following:

- Broaden the definition of unmet medical need to encompass meeting a public health need and/or health outcomes important to patients, such as: quality of life, time off of work, and caregiver outcomes.
- Specify and publicly report the submitted data that CMS considers to be evidence of meeting a medical unmet need.
- Provide the public and manufacturers with selected products, detailed evidence on the factors considered in determining if a product meets/or does not meet an unmet medical need.

III. Drug Price Negotiation Process ICR Form

A. Provide opportunities for meaningful CMS-manufacturer engagement during the counteroffer process

[26] Danese S, Allez M, Van Bodegraven AA, et al. Unmet Medical Needs in Ulcerative Colitis: An Expert Group Consensus. Digestive Diseases. 2019;37(4):266-283. doi:10.1159/000496739

[27] Danese S, Allez M, Van Bodegraven AA, et al. Unmet Medical Needs in Ulcerative Colitis: An Expert Group Consensus. Digestive Diseases. 2019;37(4):266-283. doi:10.1159/000496739

[28] DeMattis C, Karmo M, Gawuga C. Defining "Unmet Medical Need" in the Inflation Reduction Act for the Maximum Fair Price: Reflecting on Patient Input. Partnership to Fight Chronic Diseases. 2023. Available at: https://www.fightchronicdisease.org/unmet-medical-need

[29] Food and Drug Administration. Guidance for Industry Expedited Programs for Serious Conditions – Drugs and Biologics. U.S. Department of Health and Human Services. May 2014. Silver Spring, MD. Available at: https://www.fda.gov/files/drugs/published/Expedited-Programs-for-Serious-Conditions-Drugs-and-Biologics.pdf

[30] National Pharmaceutical Council. The Myth of Average: Why Individual Patient Differences Matter. 2022. Washington, DC. Available at: https://www.npcnow.org/sites/default/files/2022-01/The_Myth_of_Average_01.2022.pdf

In the IPAY 2027 DPNP Draft Guidance, CMS sought feedback on whether three meetings between the manufacturer of a selected drug and CMS are necessary, and whether it would be preferable to have an additional written offer in lieu of one or more meetings. This ICR notes that up to three in-person, virtual, or hybrid negotiation meetings may occur if the Primary Manufacturer's written counteroffer is not accepted by CMS.

NPC continues to urge CMS to provide significant opportunities for engagement between CMS and manufacturers during the counteroffer process. Additional written offers, the potential for additional in-person meetings, and clear communication surrounding next steps will enhance the "negotiation" process.

Conclusion

The National Pharmaceutical Council appreciates the opportunity to submit comments in response to this ICR and looks forward to additional opportunities to engage with CMS as it implements the second cycle of the Medicare Drug Price Negotiation Program. Please contact me at john.obrien@npcnow.org or (202) 827-2080 if we may provide any additional information.

John O'Brien, PharmD, MPH
President & Chief Executive Officer

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September 3, 2024

The Honorable Meena Seshamani, M.D., Ph.D.
CMS Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard Baltimore, MD 21244
Submitted Electronically via regulations.gov

RE: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849)

Dear Deputy Administrator Seshamani:

The National Pharmaceutical Council (NPC) appreciates the opportunity to submit comments regarding the Centers for Medicare & Medicaid Services (CMS) Information Collection Request (ICR) *Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849).* NPC is a health policy research organization dedicated to the advancement of good evidence and science and to fostering an environment in the United States that supports medical innovation. We have rich experience conducting research and disseminating information about the critical issues of evidence, innovation and the value of medicines for patients. Our research helps inform important healthcare policy debates and supports the achievement of the best patient outcomes in the most efficient way possible.

There is robust evidence demonstrating the value of biopharmaceuticals on public health, including associated improvements in life expectancy,[1] reductions in total healthcare costs,[2] and reductions in other poor health outcomes.[3] The biopharmaceutical industry invests over $276 billion in research and development annually,[4] yet our research shows that the Inflation Reduction Act (IRA) may reduce new treatments and indications.[5] The IRA creates a new price-setting mechanism that will change the economic incentives for bringing new medicines to market, and evidence shows

[1] Buxbaum JD, Chernew ME, Fendrick AM, Cutler DM. Contributions Of Public Health, Pharmaceuticals, And Other Medical Care To US Life Expectancy Changes, 1990-2015. Health Aff (Millwood). 2020 Sep;39(9):1546-1556. doi: 10.1377/hlthaff.2020.00284. PMID: 32897792.
[2] Roebuck MC, Liberman JN, Gemmill-Toyama M, Brennan TA. Medication adherence leads to lower health care use and costs despite increased drug spending. Health Aff (Millwood). 2011 Jan;30(1):91-9. doi: 10.1377/hlthaff.2009.1087. PMID: 21209444.
[3] Ho PM, Bryson CL, Rumsfeld JS. Medication adherence: its importance in cardiovascular outcomes. Circulation. 2009 Jun 16;119(23):3028-35. doi: 10.1161/CIRCULATIONAHA.108.768986. PMID: 19528344.
[4] Chandra A, Drum J, Daly M, et al. Comprehensive Measurement of Biopharmaceutical R&D Investment. Nature Reviews Drug Discovery. August 2024. https://www.nature.com/articles/d41573-024-00131-2
[5] Patterson J, Motyka J, O'Brien JM. Unintended Consequences of the Inflation Reduction Act: Clinical Development Toward Subsequent Indications *Am J Manag Care. 2024;30(2):82-86. https://doi.org/10.37765/ajmc.2024.89495*

manufacturers are already responding to those incentives.[6] There are growing concerns about the potential unintended consequences of the IRA and the Medicare Drug Price Negotiation Program. NPC research highlights that these consequences will likely include delay of access to new medicines, and fewer diseases getting additional approved treatment options.[7,8]

In accordance with the Paperwork Reduction Act (PRA), NPC's comments aim to ensure that CMS is accurately assessing the burden of data collection in the ICR form. Furthermore, we aim to ensure that CMS is clearly communicating the utility of collected data to increase efficiency among the stakeholders involved in the ICR evidence collection and reporting process.

Our comments on the ICR for IPAY 2027 are below:

I. Administrative Burden and Transparency
- A. Reducing Administrative burden for patients and manufacturers
- B. Increasing Transparency and Revising Timelines between the Evidence Collection and Review

II. Section I: Evidence about Alternative Treatments
- A. Data on Therapeutic Alternatives
- B. Patient-Specific Data Elements
- C. Treatment Costs and Offsets
- D. Unmet Medical Need

III. Drug Price Negotiation Process ICR Form
- A. Opportunities for meaningful in-person CMS-manufacturer engagement

[6] Grogan J. (2022) The Inflation Reduction Act Is Already Killing Potential Cures. WSJ. https://www.wsj.com/articles/the- inflation-reduction-act-killing-potential-cures-pharmaceutical-companies-treatment-patients-drugs-prescriptions-ira- manufacturers-11667508291; IRA survey: Biotechs bracing for impact. Biocentury. March 16, 2023. Slabdokin, Greg. IRA Drives Pfizer's Decision to Focus on Biologics, Not Small Molecules. BioSpace. March 4, 2024. Available at: https://www.biospace.com/article/ira-drives-pfizer-s-decision-to-focus-on-biologics-not-small-molecules/. US IRA May Weigh on Long-Term Global Pharma Growth. FitchRatings. September 2023. https://www.fitchratings.com/research/corporate-finance/us-ira-may-weigh-on-long-term-global-pharma-growth-22-09-2023.

[7] Patterson J, Motyka J, O'Brien JM. Unintended Consequences of the Inflation Reduction Act: Clinical Development Toward Subsequent Indications *Am J Manag Care. 2024;30(2):82-86. https://doi.org/10.37765/ajmc.2024.89495*

[8] O'Brien J, Motyka J, Patterson JA. How The IRA Could Delay Pharmaceutical Launches, Reduce Indications, And Chill Evidence Generation, Health Affairs Forefront. November 2023. DOI: 10.1377/forefront.20231101.123865

I. Administrative Burden and Transparency

A. Reducing Administrative burden for Patients and Manufacturers

Many stakeholders are closely watching CMS's IRA implementation process. The price-setting process is being studied not just by manufacturers, but by the broader patient advocacy, health policy, and pharmacoeconomic communities.[9,10] The credibility of CMS's process will be judged by the agency's use of good evidence and appropriate methods in a transparent and patient-centered process.

We are concerned with the administrative burden placed on patients to complete the ICR form. The ICR form includes 10 sections with 64 specific questions, many of which have multiple sub-questions. In particular, Section I of the ICR provides one of the two current opportunities for patients to provide critical evidence on the effectiveness of the selected medicines in comparison to therapeutic alternatives. However, for patients to provide comments to CMS on Section I, there needs to be a sufficient comment period timeline. We are concerned patients will not have sufficient time to complete the ICR form given the one-month timeline between the date that CMS will announce the selected drugs for IPAY 2027 (February 1st) and the deadline to submit the ICR comments (March 1st). A 30-day comment period will be particularly burdensome for small and/or low-resourced patient groups, who lack full-time dedicated staff to devote all their resources to respond to CMS.

For IPAY 2026, CMS received 106 submissions from individuals and organizations on Section 1194(e)(2), with 55 percent of these submissions from organizations. CMS is estimating that it will receive approximately three times as many public submissions for IPAY 2027, estimated at 150 submissions from individual respondents and 175 from organizations.[11] We ask CMS to publicly release information on how many individuals and organizations respond to the ICR for IPAY 2027, and to stratify data based on respondent type, including patients and patient advocacy organizations. Sharing this information will help CMS and the public understand who CMS receives feedback from, and to address gaps in respondent types if there is limited feedback from respondent types. In particular, CMS should monitor how many responses it receives from patients, as it is critical that the patient voice is heard within the price-setting process.

[9] O'Brien JM and Hansen J. Section 50 of the Inflation Reduction Act Drug Price Negotiation Program: Considerations for the Centers for Medicare Medicaid Services, Manufacturers, and the Health Economics and Outcomes Research Community. Value in Health. 2023; 26 (12).
[10] Tollen L. Is It Working? Evaluating The First Round of Medicare Drug Price Negotiations. Health Affairs. August 2024. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.00994.
[11] Centers for Medicare and Medicaid Services. Supporting Statement – Part A. Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) (CMS-10849, OMB 0938-1452). July 2, 2024. Available at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849

To decrease burden on patients, we recommend that patients should have greater flexibility and autonomy to better engage with CMS on evidence about alternative treatments. This recommendation could be accomplished by implementing the following:

- Increase the modalities for patients and caregivers to submit data (e.g., video submissions, focus groups, and one-on-one interviews), outside of the ICR form and patient-focused listening sessions.
- Increase the ICR comment period for patients and caregivers to submit data on Section I to at least 60 days.
- Monitor the amount and breadth of information submitted from patients and caregivers in the 2024 ICR form. *Decreased input from patients and caregivers could signal that the method of collection is burdensome for patients and/or CMS's goals and approaches are not targeted enough.*

Manufacturers also face administrative burdens to complete the ICR form. Manufacturers are required to submit the manufacturer-specific and other evidence within the ICR form one month after their drugs are selected for negotiation. CMS estimates that it should take each manufacturer 500 hours[12] to collect evidence for the ICR form, which we suspect to be an underestimate. We are concerned that CMS has not provided sufficient clarity on certain definitions in Section I of the ICR form, such that the minimal amount of data is requested and collected from manufacturers. For example, definitions of therapeutic advance, and comparative effectiveness are not adequately defined.

We suggest that CMS should provide clarity on the definitions relevant to Section I of the ICR form. If the definitions of key terms remain ambiguous, then manufacturers will not have sufficient information to efficiently submit the ICR form.

The following definitions for key terms should be clarified:

- Therapeutic advance: US government organizations, such as the Food and Drug Administration, have a definition of unmet medical need. We recommend that CMS continue to clarify the definition of therapeutic advances, including signals such as:
    - Representation of a significant impact among a socially or economically vulnerable population, which is not evident among non-vulnerable populations; or
    - Patient-focused improvements in the symptoms or health outcomes associated with a disease (e.g., reduction of symptoms, ability to perform daily functions); or
    - Improvements on a validated clinical outcome assessment, for the disease state
- Comparative effectiveness: The IPAY2027 ICR states that "relevant comparative evidence may include, but is not limited to: head-to-head randomized controlled trials, pragmatic clinical trials, network meta analyses, observation studies, and real-world evidence." We recommend that CMS provide direction on which type of comparative evidence carries the most weight and their

[12] Centers for Medicare and Medicaid Services. Supporting Statement – Part A. Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) (CMS-10849, OMB 0938-1452). July 2, 2024. Available at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849

order of preference. We suggest that CMS release the framework for evaluation of comparative effectiveness research and the other metrics for evaluating the quality of data on drugs and their alternatives. We also suggest that CMS release clear approaches for the evaluation of regulatory and other health outcomes measures; such that the highly evaluated evidence is prioritized by manufacturers and other stakeholders. Lastly, we recommend that CMS shed light on how comparative effectiveness evidence will be evaluated across different potentially suitable clinical comparators.

- Cost of Therapeutic Alternatives: We recognize that the statute contemplates that CMS will collect information regarding "the costs of . . . existing therapeutic alternatives." However, we do not believe it is appropriate to consider these costs for the purposes of identifying therapeutic alternatives. Instead, we recommend that CMS clarify that the sole function of collecting this information is to identify the starting point for the negotiation process, which CMS has proposed will begin with the price of the selected drug's therapeutic alternatives.
- Therapeutic Alternatives: As stated in our comments to CMS on the IPAY 2027 Draft Guidance, we encourage CMS to incorporate the following during the selection of therapeutic alternatives:
    - Publicly communicate proposed therapeutic alternatives and solicit feedback from manufacturers, clinicians with specific expertise in the treating the disease, patients and caregivers, and other stakeholders before proceeding with comparative effectiveness analyses that inform the initial offer.
    - Ensure guidelines used in identifying therapeutic alternatives are up-to-date and incorporate the latest evidence.[13]
    - Include patient preferences and priorities that inform shared decision-making between appropriate treatment options.[14]
    - Invite manufacturers of the selected drug to proactively present clinical information focused on the relative clinical benefit of their products compared to therapeutic alternatives during the process of comparator selection and give manufacturers the opportunity to respond to CMS's choices of therapeutic alternatives. Early manufacturer communication is also consistent with practices employed by state Medicaid agencies, other federal agencies and commercial payers.
    - Seek input from clinicians with specific expertise in treating the indication of the selected drug to define appropriate therapeutic alternatives among Medicare patient sub-populations, including patients with multiple comorbidities and varying levels of disease severity. There is a long history of multiple stakeholders working together to develop clinical guidelines, including NIH's National Center for Advancing Translational Sciences.[15]

[13] National Health Council. A Dialogue on Patient-Centered Value Assessment: Overcoming Barriers to Amplify the Patient Voice. December 2018. Available from: https://www.nationalhealthcouncil.org/dialogue-patient-centered-value-assessmentovercoming-barriers-amplify-patient-voice

[14] Schmidt T, Valuck T, Riposo J, et al. Impact of Shared Decision-Making and Patient Decision Aids on Health Care Cost and Utilization in the US: A Systematic Review. J Clin Pathways. 2022;8(8):33-43. doi:10.25270/jcp.2022.12.0

[15] Shekelle PG, Woolf SH, Eccles M, Grimshaw J. Clinical guidelines: developing guidelines. BMJ. 1999 Feb 27;318(7183):593-6.; NIH National Center for Advancing Translational Sciences. Toolkit for Creating Clinical Care Guidelines: https://toolkit.ncats.nih.gov/module/after-fda-approval/creating-clinical-care-guidelines/guideline-development-process/

- Consider the use of comparative effectiveness studies and real-world evidence to support the selection of therapeutic alternative.

In addition to clarifying the definitions in Section I, we also recommend that CMS aim to decrease the administrative burden on manufacturers by implementing the following:

- Collect evidence from manufacturers on the approximate time-period required to collect evidence for the submission of the ICR form and adjust the comment period accordingly. For example, if the manufacturer reported time to collect data for the ICR is double the expected time, then the comment period timeline should be correspondingly doubled.
- Reduce the request for evidence that is publicly available (e.g., peer-reviewed papers). For example, CMS could provide manufacturers with a report of publicly available literature on the effectiveness of the drugs – presented in a table format at the time of drug selection. Manufacturers could review the information for any missing information and provide that information to CMS in the ICR form.
- Shift back to word-count (instead of character-counts) for manufacturer and other stakeholder relevant data, which can decrease administrative burden.

B. Increasing Transparency and Revising Timelines between the Evidence Collection and Review

We are concerned that CMS's lack of clarity on the influence of patient-derived and other data into the Medicare DPNP for IPAY 2027 will result in the collection of data that ultimately has decreased utility for the agency. This is partly because CMS is not required to release an explanation of the MFPs for the selected drugs for IPAY 2026 until the date that the subsequent year's ICR evidence is due (i.e., March 1, 2025).[16] Therefore, stakeholders will need to submit information on the ICR form without understanding what CMS valued in the price-setting process for IPAY 2026. The lack of clarity on the evidence around the information that most influenced CMS's price setting process – at the time when the ICR data are due for the next cycle of selected drugs – limits patients', researchers', and others' ability to leverage insights from the first cycle of the price-setting process as it enters its second cycle.

We also suggest the following:

- **We recommend that CMS increase the transparency of the evidence that informed the MFPs for IPAY 2026 by releasing the explanation of the MFPs at least one month prior to the date that the ICR for 2027 is due.** In addition, we encourage CMS' explanation of the IPAY 2026 MFPs include a complete and transparent methodology – revealing how each domain of collected data informed MFPs. A clear methodology framework of the inner

[16] Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027. May 2024. Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/medicare-drug-price-negotiation-draft-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf

workings of the MFPs will help to reduce administrative burden for stakeholders and increase transparency of this novel program.

- **We recommend that CMS continue to outline safeguards around the protection of confidential information submitted during the ICR process.** The ICR form requests highly confidential information from manufacturers and other stakeholders. We support CMS's inclusion of questions 28 and 64, which allows manufacturers and other stakeholders to clarify which data that should be withheld by CMS under the Freedom of Information Act exemptions. However, we request that CMS provide greater clarity on the safeguards of submitted, confidential data.

II. Section I: Evidence about Alternative Treatments

A. Data on Therapeutic Alternatives

In any assessment of the relative clinical or economic benefits of a drug, the choice of the comparator is a fundamental driver in the outcomes and validity of the assessment with significant implications for patients, payers, and prescribers. We are concerned that CMS has neither provided further information on the literature review informing the selection of therapeutic alternatives nor publicly released more information on the specific outcomes that will be of greatest interest to CMS for developing MFPs. More clarity and guidance are needed to reduce unnecessary administrative burden. **We recommend the following regarding evidence about therapeutic alternatives:**

- Publicly release detailed information on evidence surrounding the selection of the therapeutic alternatives concurrently with CMS's public release of the names of the drugs selected for price setting. In the current process, manufacturers and other stakeholders are required to submit the ICR form, without details on the selection of the therapeutic alternative. We recommend that CMS publicly release the selection of potential therapeutic alternatives that the agency will consider at the time of release of the selected drugs for the MDPNP. CMS should release the list of "potential" therapeutic alternatives and the search strategy opportunity for public comment on the selection and strategy at least one month before the ICR form is due. Increasing transparency in the selection of the therapeutic alternatives will aid in reducing the collection of data of therapeutic alternatives that are not of interest to the agency.
- Shift definition of therapeutic alternative back to the IPAY 2026 guidance definition. CMS changed the definition of a therapeutic alternative in the IPAY 2027 guidance from the IPAY 2026 guidance. The former guidance stated that the therapeutic alternative may refer to "a subset of the most clinically comparable therapeutic alternatives." The new definition of a therapeutic alternative is a change in the wrong direction, away from what is most clinically appropriate. The selection of a less-costly therapeutic alternative that is "clinically comparable" but not in the subset of "most clinically comparable" and lacks the safety, efficacy, and other clinical benefits of a selected drug – solely to lower the initial starting point of the price-setting process – fails to recognize the value of modern treatments and threatens to reverse the incentives that currently encourage innovation and access. We recommend that CMS return to the IPAY 2026 definition of a therapeutic alternative to support clinical decision making. Given

that researchers and others have a limited character count for the submission, we recommend that CMS be more specific about the selection of the therapeutic alternative(s).

B. Patient-Specific Data Elements

CMS has made significant revisions to collected data from the patient perspective. We support CMS's efforts to better solicit patient-centered data. NPC and others have also emphasized the need for CMS to prioritize diversity and a multi-modal approach in outreach at all phases of the DPNP implementation.[17,18] Robust engagement with underrepresented communities through outreach and ongoing dialogue is needed to promote an equity-focused implementation process.[19] While CMS included several questions about the demographics of the patient populations, CMS should allow patients and caregivers to include further demographic and socioeconomic data, if they prefer to share such information with CMS. For example, patients can select their geographic region, but information about the rurality of a patient's residence or gender is not requested. Our research shows that a patient's medication expenses vary across geographies and race/ethnicity.[20]

As CMS considers how to improve upon its patient engagement strategy through revisions in the ICR, CMS should seek feedback from patients, caregivers, and providers about ways to engage patients to complete the ICR forms, including the character-count limits. CMS should also be transparent about the number of comments received from patients on the CMS website.

As such, we recommend that CMS prioritize the following in collecting patient-specific data elements:

- Move towards best practices for patient engagement throughout the DPNP process, such as those developed by NPC and ISPOR. [21,22]
- Increase planned engagement strategies with underrepresented groups with the entire DPNP process, including outreach for submission of evidence for the ICR form.
- Increase the collection of demographic data about patients, as consented to by patients.
- Shift back to word-count (instead of character-counts) for patient relevant data, which can decrease administrative burden.

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[17] National Organization for Rare Disorders. NORD Recommendations: Future Medicare Drug Price Negotiation Program Patient and Provider Listening Sessions [Internet]. 2024.

[18] Miller M, van Geertruyden S, Saxton MC, Savage CY, Weir D, Werner S. A summit on amplifying voices of patients, caregivers, and people with disabilities in Inflation Reduction Act drug price negotiations. J Manag Care Spec Pharm. 2024 Mar 1;30(3):247-251. doi: 10.18553/jmcp.2024.23278. Epub 2024 Jan 30. PMID: 38289281; PMCID: PMC10906444.

[19] The Center for Innovation & Value Research (formerly Innovation and Value Initiative). Comments on the draft guidance for implementation of the Medicare Drug Price Negotiation Program (DPNP) for initial price applicability year 2027 and manufacturer effectuation of the maximum fair price (MFP) in 2026 and 2027. Available at: https://valueresearch.org/the-center-formerly-ivi-provides-comments-on-cms-drug-price-negotiation-program/

[20] Wagner TD, Sahu M, Beauchamp M, et al. Variation in per Beneficiary Prescription Utilization and Spending by Race/Ethnicity in Medicare and Medicaid Insurance Claims. ISPOR 2024 Conference. Available at: https://www.npcnow.org/resources/variation-beneficiary-prescription-utilization-and-spending-raceethnicity-medicare-and

[21] Harrington RL, Hanna ML, Oehrlein EM, Camp R, Wheeler R, Cooblall C, et al. Defining Patient Engagement in Research: Results of a Systematic Review and Analysis: Report of the ISPOR Patient-Centered Special Interest Group. Value in Health. 2020; 23 (6). Available at: https://www.sciencedirect.com/science/article/pii/S1098301520301418

[22] Guiding Practices for Patient-Centered Value Assessment (2024). National Pharmaceutical Council. Jan 2024.

- Clarify that submitted data on a patient's "affiliation" with a manufacturer (i.e., Question 29) will not detract from CMS's evaluation of the patient-centered information. We are concerned that requesting data from patients and other stakeholders around an "affiliation" with a manufacturer may decrease the number of meaningful responses from stakeholders, who interact with manufacturers for a number of reasons.

C. Treatment Costs and Offsets

NPC appreciates that CMS requests evidence related to healthcare resource utilization and usage patterns. Reviewing data related to healthcare resource utilization and usage, with consideration of evidence-based medicine, will provide insight into the economic benefits of selected drugs and their impacts on patient health. However, it remains unclear how CMS will use this information, the methods it will employ to analyze it, and how it will inform their evaluations, and transparency on these points is necessary to evaluate whether this evidence will be used appropriately.

In our comments on the DPNP IPAY 2027 draft guidance, we encouraged CMS to also include comprehensive assessments of the economic benefits of selected drugs, in addition to the costs of the treatments themselves. **We also recommend that the utilization of data on treatment costs and offsets be transparent in the ICR form.**[23] Treatments may have up-front costs that lead to long-term improvements in patient health. Those improvements may yield "cost offsets," or savings due to reduction in healthcare resource needs, such as reduced hospitalizations, or societal gains (e.g., improved productivity, reduction in caregiver burden). The full value of treatment can only be assessed by including both the treatment costs and other associated cost offsets it may produce, while also including clinical benefits of drugs without discretely quantifiable impacts on costs (e.g., improvements in the overall care of the patient). Only considering the treatment costs but not the potential cost offsets would lead to an incomplete assessment of value.

D. Unmet Medical Need

NPC believes assessments of unmet medical need should include a multifaceted definition informed by the patient perspective, as guided by peer-reviewed literature.[24] The ICR asks, participants several questions about unmet medical need, including: "For the condition(s) treated by [the selected drug], describe the extent to which [the selected drug] currently represents (or does not represent) a therapeutic advance as compared to its therapeutic alternative(s)."[25] NPC is concerned that a lack of transparency surrounding what specific factors CMS will consider related to unmet need will result in an approach that is too narrow.

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[23] National Pharmaceutical Council. Guiding Practices for Patient-Centered Value Assessment. 2024. Washington, DC. Available at: https://www.npcnow.org/sites/default/files/2024-01/2024%20Guiding%20Practices%20for%20PatientCentered%20Value%20Assessment%20January.pdf

[24] Levine AA. Kowal S. Chambers J. Unmet Medical Need Under the IRA. Health Affairs Forefront. July 2024. 10.1377/forefront.20240729.713230

[25] Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) Forms (CMS-10849, OMB 0938-1452). Centers for Medicare & Medicaid Services. July 2024. Available at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849

Rigorous methods can be used to elicit consensus from clinician experts and have been used to identify unmet medical needs to achieve optimal treatment goals throughout the natural history of a disease.[26] These methods have identified patient-centered unmet needs, including patient quality of life, poor adherence, severe stages of a disease that are hard to treat, and patient preferred routes of administration.[27] A determination of unmet medical need should encompass all of these factors and more. A recent survey of over 300 patients aged 65 and older in the US asked patients their perspectives on CMS's definition of unmet medical need in the 2023 guidance of the Medicare DPNP.[28] The study reports that patients believe the "accurate definition of unmet medical need is far broader, more engaging of patients, and more nuanced than the definition CMS has proposed [in 2023]."

The FDA's definition of unmet need, as outlined in its guidance for expedited programs, includes improved efficacy, reduced toxicity and/or potential drug-drug interactions, and improvements in other benefits such as adherence.[29] Notably, the FDA definition of unmet need also highlights conditions for which there is significant heterogeneity in response to existing treatment options. Patients may respond differently to available treatment options due to pharmacologic differences, genetic risk, or social determinants of health, creating unmet need despite existing treatments.[30]

NPC requests CMS clarify and provide greater specificity in the definitions and utilization of unmet medical need for MFP, including the following:

- Broaden the definition of unmet medical need to encompass meeting a public health need and/or health outcomes important to patients, such as: quality of life, time off of work, and caregiver outcomes.
- Specify and publicly report the submitted data that CMS considers to be evidence of meeting a medical unmet need.
- Provide the public and manufacturers with selected products, detailed evidence on the factors considered in determining if a product meets/or does not meet an unmet medical need.

III. Drug Price Negotiation Process ICR Form

A. Provide opportunities for meaningful CMS-manufacturer engagement during the counteroffer process

[26] Danese S, Allez M, Van Bodegraven AA, et al. Unmet Medical Needs in Ulcerative Colitis: An Expert Group Consensus. Digestive Diseases. 2019;37(4):266-283. doi:10.1159/000496739

[27] Danese S, Allez M, Van Bodegraven AA, et al. Unmet Medical Needs in Ulcerative Colitis: An Expert Group Consensus. Digestive Diseases. 2019;37(4):266-283. doi:10.1159/000496739

[28] DeMattis C, Karmo M, Gawuga C. Defining "Unmet Medical Need" in the Inflation Reduction Act for the Maximum Fair Price: Reflecting on Patient Input. Partnership to Fight Chronic Diseases. 2023. Available at: https://www.fightchronicdisease.org/unmet-medical-need

[29] Food and Drug Administration. Guidance for Industry Expedited Programs for Serious Conditions – Drugs and Biologics. U.S. Department of Health and Human Services. May 2014. Silver Spring, MD. Available at: https://www.fda.gov/files/drugs/published/Expedited-Programs-for-Serious-Conditions-Drugs-and-Biologics.pdf

[30] National Pharmaceutical Council. The Myth of Average: Why Individual Patient Differences Matter. 2022. Washington, DC. Available at: https://www.npcnow.org/sites/default/files/2022-01/The_Myth_of_Average_01.2022.pdf

In the IPAY 2027 DPNP Draft Guidance, CMS sought feedback on whether three meetings between the manufacturer of a selected drug and CMS are necessary, and whether it would be preferable to have an additional written offer in lieu of one or more meetings. This ICR notes that up to three in-person, virtual, or hybrid negotiation meetings may occur if the Primary Manufacturer's written counteroffer is not accepted by CMS.

NPC continues to urge CMS to provide significant opportunities for engagement between CMS and manufacturers during the counteroffer process. Additional written offers, the potential for additional in-person meetings, and clear communication surrounding next steps will enhance the "negotiation" process.

Conclusion

The National Pharmaceutical Council appreciates the opportunity to submit comments in response to this ICR and looks forward to additional opportunities to engage with CMS as it implements the second cycle of the Medicare Drug Price Negotiation Program. Please contact me at john.obrien@npcnow.org or (202) 827-2080 if we may provide any additional information.

John O'Brien, PharmD, MPH
President & Chief Executive Officer

August 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Meena Seshamani, M.D., Ph.D.
Deputy Administrator and Director of the
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Dear Administrator Brooks-LaSure and Deputy Administrator Seshamani:

On behalf of the more than 30 million Americans living with one of the over 10,000 known rare diseases, the National Organization for Rare Disorders (NORD) thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on the Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849). Millions of Medicare beneficiaries are living with a rare disease, and many struggle with high out-of-pocket prescription drug costs.[1] Implementation of the Medicare Drug Price Negotiation Program (MDPNP) will have a significant impact on our rare disease community, and we are encouraged by the continued solicitation of further ways to better include affected communities in the information collection process.

NORD is a unique federation of non-profits and health organizations dedicated to improving the health and well-being of people living with rare diseases. NORD was founded more than 40 years ago, after the passage of the Orphan Drug Act (ODA), to formalize the coalition of patient advocacy groups that were instrumental in passing that landmark law. Our mission has always been, and continues to be, to improve the health and well-being of people with rare diseases by driving advances in care, research, and policy.

We greatly appreciated CMS' efforts to engage patients as part of the 2026 MDPNP implementation. NORD recognizes the time pressure under which CMS established last year's ICR and patient listening sessions, and we value the extensive efforts to incorporate patient perspectives. Furthermore, NORD is grateful for the various opportunities we have had to share our expertise in patient engagement with CMS and has collaborated with other stakeholders and

[1] *Prescription Drug Affordability among Medicare Beneficiaries*. HHS- ASPE Office of Health Policy. (19 January, 2022). https://aspe.hhs.gov/sites/default/files/documents/485edf2a2d4870f88a456df61c8ff471/prescription-drug-affordability.pdf

patient advocacy groups to provide detailed recommendations to CMS to ensure the perspectives of the patient community are appropriately represented in the listening sessions.[2]

In seeking to improve collection of patient perspectives for future iterations of the MDPNP, we and others have identified a number of aspects related to last year's processes that were barriers or challenges that might have made it prohibitively difficult for some patients and caregivers to participate.[3,4] Our concerns included: premature closing of the written submission portal for patients; limited speaking time for patients and interactions with CMS staff in the listening sessions; and limited transparency into how the patients responses would be used. Though encouraged by CMS' repeated commitments to learn from prior years, improve the program for future years and to increase accessibility of both the listening sessions and the ICR to patients, we are disheartened to see a number of promised elements are not explicitly addressed in this ICR (or currently otherwise available to the public).[5,6]

For example, the May 3rd CMS draft guidance on implementation of the MDPNP for Initial Pay Applicability Year 2027 stated the "ICR will incorporate lessons learned pertaining to the collection process, question format, and content received from respondents for initial price applicability year 2026." Though we recognize that an additional ICR with a 30-day comment period is set to come out later this year, we have not seen any specific discussion of lessons learned, or meaningful changes to the questions, format, or content in this iteration of the ICR in response to last year's challenges that would improve the process for patients, caregivers, or healthcare providers.

Similarly, in the July 2nd email announcing the ICR, CMS referenced plans for a "publicly available web link" for members of the public to submit evidence about therapeutic alternatives.[7] We agree with CMS that the ICR submission process for manufacturers (through an HPMS link) is neither patient friendly nor an appropriate pathway for the voluntary submission of patient experience data and we support CMS's plans to create a separate, stand-alone portal.[8] Unfortunately, we have not seen a link for the general public to provide relevant information. In

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[2] *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement.* National Health Council (NHC). (March, 2024). https://nationalhealthcouncil.org/wp-content/uploads/2024/03/Amplifying-the-Patient-Voice-Roundtable-and-Recommendations-on-CMS-Patient-Engagement.pdf

[3] *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement.* National Health Council (NHC). (March, 2024). https://nationalhealthcouncil.org/wp-content/uploads/2024/03/Amplifying-the-Patient-Voice-Roundtable-and-Recommendations-on-CMS-Patient-Engagement.pdf

[4] https://rarediseases.org/wp-content/uploads/2024/07/NORD-Comments-MDPNP-IPAY-2027_F.pdf

[5] *Draft Guidance on the Medicare Drug Price Negotiation Program.* CMS- Center for Medicare. (May 3, 2024). https://www.cms.gov/files/document/medicare-drug-price-negotiation-draft-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf

[6] *Medicare Drug Price Negotiation Program: Negotiation Data Elements and Drug Price Negotiation Process Initial Information Collection Request Published for Comment.* CMS- Center for Medicare. (July 2, 2024).

[7] *Medicare Drug Price Negotiation Program: Negotiation Data Elements and Drug Price Negotiation Process Initial Information Collection Request Published for Comment.* CMS- Center for Medicare. (July 2, 2024).

[8] Ibid

our comments on the IPAY 2027 guidance, we emphasized the importance of beginning the public solicitation process early and partnering with trusted stakeholders to ensure the public facing portals are sufficiently approachable. Without timely access and testing with the population using the portal, we are concerned that the public submission process will continue to stumble. Therefore, we encourage CMS to describe in detail the data elements and questions for the public submission and to stand up the publicly available web link as soon as possible.

Recognizing their crucial role in assessing the impacts of the MDPNP, we are pleased to provide the following specific recommendations for the successful engagement of patients, their caregivers and healthcare providers[9] through listening sessions and the Information Collection Request (ICR) for the 2027 MDPNP:

1. Decouple and simplify the collection of patient experience data through this ICR or the subsequent ICR relevant to the 2027 MDPNP
2. Leverage the ICR and externally-led patient-listening sessions to complement data collection efforts
3. Pilot-test the questions and engage patient engagement experts as well other relevant government, academic, and private sector experts at every step of the data collection process

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1. Follow through on decoupling and simplifying the collection of patient experience data in this ICR or the subsequent ICR relevant to the 2027 MDPNP

The primary purpose of this specific ICR is to facilitate the mandatory collection of manufacturer data, guided by statutory data elements, rigid processes, and tight timelines. The collection of patient experience data is both qualitatively and quantitatively very different from this primary purpose as collecting patient experience data is neither subject to statutory data elements nor does it have to follow the very tight timelines for manufacturer-provided data that would be virtually impossible for most patients to navigate. The type of data elements collected are also different, as evident from the ICR – with the manufacturer data mostly quantitative and clearly defined, capturing highly concrete issues such as a drug's annual sales volume, unit price of production, or patents and exclusivities.

In contrast, the patient-reported data is by design significantly more qualitative and much less precisely defined, capturing issues such as the extent to which a drug provides a meaningful advantage over an alternative therapy, or the extent to which an unmet medical need is not adequately addressed by available therapies. In fact, even the key audience for the patient reported data elements is significantly different from the manufacturers, and is likely to include patients and families, health care providers, academic researchers, and other relevant

[9] *Draft Guidance on the Medicare Drug Price Negotiation Program.* Ibid.

stakeholders. Additionally, the number of individual potential respondents is exponentially higher than for the manufacturer data. As a result, the ICR is unlikely to be an effective tool for capturing patient-reported data and we strongly support CMS's intention to create a separate, stand-alone process.

NORD continues to be concerned CMS' plans to largely rely on this ICR for voluntary data submissions by the public will be unsuccessful. As proposed, the data collection will occur on very short timelines, without meaningful data standardization, using complicated forms written at too advanced reading levels and depending on hard-to-navigate processes that are neither intuitive nor patient-friendly. Based on experiences with last year, NORD is specifically concerned that patients will either not become aware of the data collection effort in time, or struggle to navigate the complex submission process. The extent to which individual data submissions will be confidential and protected from disclosure will be confusing to patients, and we worry the burden for patients not familiar with a process that was developed for manufacturers may be significantly higher than estimated, in particular for patients who may navigate additional challenges such as language barriers, visual impairments, or lack of (broadband) internet access. In addition, the required attestations are worded in a way that will likely discourage many patients from submitting data, and to the extent patients will feel compelled to submit data containing Personal Identifiable Information (PII) and Personal Health Information (PHI), the data collection raises privacy concerns.

Moreover, NORD foresees challenges in aggregating and analyzing individual patient and provider experience data submitted through this process; the data will be collected without a sampling frame and likely not representative while the collection method essentially makes it impossible to determine or account for such inherent biases in the data. In addition, the lack of standardized questions and scientific rigor will likely render this data largely anecdotal as opposed to data collected following appropriate qualitative and/or quantitative research methodologies to collect this information in a scientifically rigorous and reproducible manner as is currently done with data collected through the FDA's patient-focused drug development meetings or patient surveys. FDA's Guidance "Patient-Focused Drug Development: Collecting Comprehensive and Representative Input"[10] for instance, provides detailed and tangible guidance on operationalizing and standardizing data collection and data management in a way that works for the rare disease patient community.

To achieve these goals, NORD urges CMS to:

- **Decouple the collection of patient-reported data from the ICR.** As outlined above, the collection of patient data has virtually nothing in common with the mandatory submission of manufacturer data. Decouple the collection of this important patient data from a process that was never meant to collect this type of data - or to engage this number and diversity of respondents.

[10] FDA GFI: Patient-Focused Drug Development: Collecting Comprehensive and Representative Input; available at https://www.fda.gov/media/139088/download; accessed 4/2023

- **Simplify and streamline the data submission process for patients, caregivers, and providers so that it is workable and does not provide undue barriers to providing the requested information**. Decoupling the process from manufacturer provided data will allow CMS to create a data collection process that is designed to be patient-centered, with input and guidance from patients at every step of the process. This should include pre-testing the forms, attestations, and instructions with representatives of the relevant community to ensure they are clearly understood and easy to navigate, including by individuals with visual and other impairments. Because this data submission is voluntary and not subject to the statutory data submission timeline for mandatory manufacturer-provided data, CMS should work with the patient community to establish feasible timelines that will be workable for the community. Other concerns, such as ensuring the respondents are in fact patients, caregivers, or families afflicted by the disease and report their own experiences and perspectives, will require careful consideration, in close collaboration and with guidance from the patient community. FDA listening sessions, patient-focused drug development meetings, and other FDA-led initiatives routinely navigate these challenges and collect meaningful patient experience data in ways that work for rare disease patients and families and can serve as a valuable guide and resource for CMS, including all applicable attestations and data protections.

- **Clarify now what information the agency is seeking from patients and in what format to allow data standardization and aggregation.** The short time period outlined for the negotiation process makes it imperative to provide detailed instructions as early as possible, before the negotiation period begins, to facilitate and streamline the collection and submission of meaningful data from a patient perspective. Clarifying the key data elements in sufficient granularity ahead of time will also empower patient advocacy groups and other important stakeholders to proactively collect and collate relevant information in a way that is scientifically rigorous and representative of the relevant patient community.

2. Intentionally leverage the ICR and externally-led patient-listening sessions to complement data collection efforts and engage a maximum number of patients, caregivers, and healthcare providers

NORD thanks CMS for recognizing the unique and nuanced value drugs can bring to specific subsets of the patient population, including rare disease patients who often have few or no therapeutic options. NORD commends CMS' efforts to consider data on clinical benefit, therapeutic alternatives, and unmet medical need in the negotiation process. The agency's stated objective to assess value in an indication-specific manner including some off-label uses, is critical to CMS understanding the complex tradeoffs and unmet needs that exist within the rare disease patient community. Moreover, we are encouraged that CMS has explicitly recognized the value of patient experience data, including its nuances, and the expectation that not all patients

are necessarily sharing the same views and experiences. For instance, the science of patient engagement has long recognized that patient experience data may reflect differences depending on disease progression or a patient's cultural, geographic, and socio-economic background. While we are grateful CMS recognizes the value of patient experience data, we strongly encourage CMS to expand the opportunities and strengthen the processes for providing such input.

The external data CMS staff plan to rely on in the negotiation often does not exist for most rare diseases, creating an added burden for CMS and the affected community to collect this data. CMS plans to supplement the data submitted by the public through this ICR with relevant published data, relying on such data being readily available to CMS staff through literature searches. Unfortunately, it is a recognized challenge that for many rare diseases, data relevant to determine a negotiated product's clinical benefit, therapeutic alternatives, or unmet medical need often does not currently exist in peer-reviewed journals or consensus treatment guidelines. FDA's Voice of the Patient (VOIP) reports, which are trying to fill this void, are playing an increasingly important role in patient-focused drug development and frequently collect meaningful information on how patients evaluate therapeutic alternatives or characterize the unmet need and clinical benefit of alternatives. However, these data are not indexed in a way that would clearly find them in a traditional literature search. In addition to ensuring CMS considers all relevant data collected as part of the FDA approval process in the negotiation process, patient and provider engagement will be critical to ensure CMS is aware of and able to leverage all available data. This is particularly important for rare diseases because the lack of disease-specific International Classification of Disease (ICD-10) codes for most rare diseases makes strategies relying on existing real-world data (RWD) from sources such as electronic health records (EHRs) or medical claims data largely infeasible for many rare diseases.

CMS will have to collect data on treatment alternatives, clinical benefit, and unmet medical need for rare diseases *de novo,* including from patients, caregivers, and providers. In fact, patients and caregivers have key insights on issues such as determining the value of a therapy and how it compares to potential alternate treatment options. For instance, rare disease patients are often uniquely positioned to share the challenges associated with unmet medical needs - when there are no or very few options available to treat their condition - and the benefits to themselves, their families, and the community from a safe and effective therapy. Patient experience data will be particularly important given CMS' desire to evaluate price on an indication-specific level including certain off-label uses, which are common in the rare disease space albeit notoriously hard to study.[11] Because published data to assess these specific uses remain scarce, patients and providers are often the best experts from which to elicit such information for the rare disease community.

[11] Fung A, Yue X, Wigle PR, Guo JJ. Off-label medication use in rare pediatric diseases in the United States. Intractable Rare Dis Res. 2021 Nov;10(4):238-245. doi: 10.5582/irdr.2021.01104. PMID: 34877235; PMCID: PMC8630459.

To achieve these goals, NORD urges CMS to:

- **Partner with key stakeholders on externally-led patient listening sessions specific to selected drugs to collect representative data to inform CMS' initial offer for a negotiated price.** In planning these sessions, CMS should use FDA patient listening sessions as a roadmap and work closely with the impacted patient communities to develop a representative and meaningful data collection effort. For instance, while we appreciate CMS intends to only focus on pharmaceutical alternatives and to primarily consider alternatives in the same drug class, we recognize non-pharmaceutical options such as surgery are often the only viable alternative for our patient populations and that therapeutic alternatives in other drug classes and with other mechanisms of actions may be the most appropriate alternatives for some of our patients. Engaging the patient community in planning the listening session will help ensure that these alternatives are appropriately considered. Having external groups take a leadership role can also help address both CMS staffing shortages and concerns about administrative and logistical issues (e.g., compliance with administrative and legal requirements for federal data collection).

- **Patient listening sessions will likely be most effective if they focus on one negotiated drug and one (or potentially multiple closely related) uses or indications.** This may require prioritization among drugs and indications that will be part of the negotiation program and should be guided by considerations such as to what extent the patient listening session will generate unique data to close key data gaps and to what extent the generated data is likely to materially impact the price negotiation. Transparency and engagement of the stakeholder community in this decision-making will be key to success. In fact, pre-meeting community surveys and enrollment strategies such as snowball sampling, when used appropriately, can be effective in helping to ensure the listening sessions will truly reflect the affected community.

- **Other considerations include issues such as:** ensuring appropriate representation and diversity of perspective among the meeting participants; identifying and prioritizing questions for meeting participants ahead of time to provide time to prepare; carefully designing and pre-testing questions with consideration for well-established heuristics and cognitive biases (e.g., anchoring and adjustment, bandwagon effect, availability); and developing tools and approaches to capture the meeting outcomes in a way that is scientifically valid and allows participants to review the summary. Here again, FDA's experience with patient listening sessions and patient-focused drug development meetings will be able to provide valuable lessons learned.

- **Include consistent and granular summaries of the data and assumptions on which each negotiation was based, including patient experience data.** Recognizing CMS has until March 1, 2027 to release information on how negotiated prices were determined, we

urge CMS to report, as soon as possible, a detailed and standardized summary of the data relied upon in the negotiation process including the therapeutic alternatives, clinical benefit, off-label use, and unmet need for each indication and the data sources relied upon. CMS should further break out the use of patient experience data and patient-reported outcomes; list data identified by CMS through literature searches and guideline review as well as primary data, such as claims, EHR, or other real-world evidence (RWE), generated and collated by CMS. This level of transparency will be key to create consistency and trust in the negotiation process now and for subsequent rounds. Clearly breaking out the use of different data will also motivate the creation of valuable patient experience data for future negotiation years. In fact, much of the data for rare diseases collected through this process will be unique and useful beyond this specific negotiation process.

3. Pilot-test the questions and engage patient engagement experts as well other relevant government, academic, and private sector experts at every step of the data collection process

As CMS works to integrate patient perspectives in the MDPNP, the agency can draw upon a rich set of existing data, relevant scientific knowledge, and experience. For instance, considerable deliberation and research has gone into defining and measuring key concepts such as unmet medical need or therapeutic advantage.[12] Rather than reinventing these concepts, CMS can draw upon decades of practice in the FDA space to streamline and fast track the process. Similarly, the science of patient engagement has made tremendous progress in the past decade. The academic literature is full of scientific studies seeking to identify best practices, develop tools to streamline the process, and capture the value of patient engagement. In fact, a 2014 systematic review of patient engagement in research identified 142 studies that met the inclusion criteria[13] – and hundreds more studies have been published in the decade since. FDA has made leaps in developing patient engagement best practices and tools that are largely applicable across FDA's product centers and through every step of the product life cycle.

CMS itself has a long history of successfully engaging patients and families. Tools such as CMS' Person and Family engagement strategy[14] have been instrumental in empowering patients and families to be meaningful partners in the design, delivery, and evaluation of their care. NORD also brings a wealth of experience engaging patients in various parts of the drug development and reimbursement space, and a range of other non-profit and academic institutions from the Patient-Centered Outcomes Research Institute (PCORI) and the Milken Institute's FasterCures Center to the Medical Device Innovation Consortium (MDIC) to a range of more disease-

[12] https://www.fda.gov/files/drugs/published/Expedited-Programs-for-Serious-Conditions-Drugs-and-Biologics.pdf
[13] https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-89
[14] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/QualityInitiativesGenInfo/Person-and-Family-Engagement

specific patient groups and many, many, others will have meaningful advice to offer. Relying on this wealth of experience and tried-and-true best practices, concepts and approaches will prove helpful in ensuring that patients will be meaningfully engaged in this data collection effort – but the right experts will have to be at the table when the data collection strategy for patient experience data is developed, implemented, and assessed.

To achieve these goals, NORD urges CMS to:

- **Engage with FDA patient engagement experts and other relevant government, private and non-profit sector experts.** This will help lay the foundation for a resilient and sustainable patient engagement system to rigorously engage patients and leverage the best practices and approaches to maximize the efficiency and chance of success.

In addition to these ICR-specific recommendations, we would like to re-iterate our recommendations regarding the structure, format and content of the listening sessions:

Make the solicitation and consultation process with patients, caregivers, and health care providers more transparent, predictable, and inclusive and streamline the process to build and refine year-over-year capacity.

NORD appreciated that the patient and health care provider listening sessions for the 2026 MDPNP were livestreamed and available for the public to view. Our recommendations are based on learnings from these sessions, as well as our extensive patient engagement experience and informed by a review of the relevant literature.[15] These recommendations are intended to be complementary to recommendations provided previously, including in a recent National Health Council (NHC) white paper to which NORD was honored to contribute.[16]

Our recommendations to strengthen the solicitation and consultation processes are primarily informed by three main findings with the 2026 MDPNP listening sessions:

1. The format of the listening sessions inadvertently left out some important voices in our community (*e.g., because the public format was uncomfortable for many patients; because of language, logistical, and technology barriers; because many patients were not aware of the listening sessions; because the ICR closed before the listening sessions and patients had no opportunity to submit written comments after the listening session, and because of questions about who was eligible to participate*).

[15] *Three Ways to Improve the Patient-Focused Listening Sessions In The Medicare Drug Price Negotiation Program.* Vandigo et. Al. Health Affairs (24 June, 2024). https://www.healthaffairs.org/content/forefront/three-ways-improve-patient-focused-listening-sessions-medicare-drug-price-negotiation

[16] *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement.* National Health Council. (24 March, 2024). https://nationalhealthcouncil.org/wp-content/uploads/2024/03/Amplifying-the-Patient-Voice-Roundtable-and-Recommendations-on-CMS-Patient-Engagement.pdf

2. Patient listening sessions provided limited data to directly inform the negotiation process and maximum fair price calculation (*e.g., because the 3-minute speaking slots were very short; because patient, caregivers, and health care providers lacked guidance on what insights would be most informative; and because the ridged session format prevented dialogue or clarifying questions*).

3. Patient listening sessions lacked standardization and were very heterogenous, generating inconsistent and widely varying outputs even for products in the same therapeutic area (*e.g., because listening sessions were organized by product rather than indication; included variable mixes of patients, caregivers, and providers; and because they lacked a standard set of questions*).

To ensure the listening sessions can help inform CMS about the true value of the selected therapies to the patient community and other select stakeholders, NORD is pleased to offer specific recommendations around key priorities:

1. Start preparing for the listening sessions ahead of time; be transparent and standardize the outreach and engagement processes; maximize patient engagement including from historically underserved and other harder to engage communities; build long-term relationships, capacity and support in communities that are likely impacted in this and future plan years; and smooth out agency activity and workload on patient engagement over the plan year.

a. Identify therapeutic areas that are likely impacted by the selected drugs (e.g., oncology, lung, cardiovascular, diabetes); proactively begin outreach activities to these communities now; intentionally engage harder-to-reach communities; and with a goal of building long-term partnerships.

One of the most crucial elements of a successful and inclusive public participation campaign is to begin early; partnering with trusted community voices, proactively messaging important timelines, and explaining the information to be gathered (and why) as early as possible is vital to broader participation. While we commend CMS for implementing last year's iteration of the listening sessions on a tight timeline, the reality is that limited runway in advance of the listening sessions resulted in suboptimal patient and provider representation.

Although we recognize the logistical challenges CMS faces regarding proactive patient engagement, we believe this is a largely solvable problem. By the nature of the diseases that are prevalent in the Medicare population, and considering long-standing Medicare spending patterns, it appears almost certain that a limited number of therapeutic areas, including for instance oncology, lung, cardiovascular, and diabetes and related comorbidities, will likely be disproportionately represented amongst the selected products in the 2027 MDPNP as well as in

future plan years.[17] CMS should proactively engage now with key stakeholder groups representing patients impacted by these diseases, and develop these relationships as long-term engagements to leverage in this year as well as future plan years.

Starting now and building out the engagement over time will allow CMS to engage a broader spectrum of diverse stakeholder groups, and to create sustainable, trusting, and fruitful partnerships over time. Moreover, approaching patient engagement by therapeutic area, rather than product, may lead to more diverse stakeholder engagement; for instance, while a given product may not be used by a specific patient group (e.g., because of label restrictions), that patient group may have valuable insights for this and future plan years. In addition, early and sustained partnerships with patient groups can have additional downstream benefits, such as helping to increase written comments and more robust participation in focus group sessions as the community builds capacity and individuals develop levels of familiarity and comfort with the process.

To ensure representation from patients, advocates, providers, and industry leaders from across the country, we encourage CMS to utilize their regional offices and ties to local communities to ensure appropriate patient engagement across different geographic regions. One effective way to do this is through in-person meetings; this would ideally include in-person outreach and education (e.g., at regional patient summits or health care provider meetings) and in-person listening sessions (e.g., at regional offices). While we recognize engaging individuals living in rural areas poses particular challenges, regional education and outreach will allow for richer, and more inclusive engagement than focusing outreach primarily nationally or on those located in, or able to travel to, the DC metro area. This is another area where year-over-year capacity building will be particularly valuable.

b. Develop educational and patient engagement materials that can be leveraged across products, therapeutic areas, and plan years; refine and revise these materials with input from the stakeholder community; and begin publicizing the listening sessions as early as possible BEFORE the selected drug list for negotiation is released.

CMS should begin developing and deploying educational materials and tools now to facilitate effective patient engagement in the drug price negotiation and refine and revise them with input from trusted partners (e.g., patient groups or providers with vested interest in the patient populations utilizing the likely selected therapies). This should include outreach materials in languages other than English, and particular care should be given to ensure these materials are linguistically and culturally appropriate. These activities can and should start long before the announcement of the MDPNP 2027 selected products and build on learnings and successes year over year. Because these materials can be reused in future plan years, we urge CMS to create a feedback process that can be used to refine and revise these materials over time.

[17] *Drugs likely subject to Medicare negotiation, 2026-2028.* Dickson, Sean and Hernandez, Inmaculada. National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10387900/

We encourage CMS to be as specific as possible in the materials about the logistics of the sessions to maximize transparency and give stakeholders a clear understanding of expectations. This transparency is vital to building trust and will mean more participants may be inclined to share their information and provide more meaningful responses. Specifically, in the lead up to the public listening sessions, we encourage CMS to be transparent with participants about how their data will be used and if / how they will be identified. Moreover, CMS should clarify how information from different population subgroups may be considered; for instance, patients who were formerly on a therapy may have inherently different experiences than the patients who are currently on it, and different patient populations may have different therapeutic alternatives available.

Information about how CMS intends to handle real or perceived conflicts of interest will be equally important. The lack of standardized processes or the required disclosure of professional or personal affiliations with interest groups led to inconsistent conflict of interest interpretation and implementation last year, which threatens to undermine trust in the process. We strongly recommend implementing a standardized mandatory disclosure process for professional or personal affiliations as a prerequisite for session participation.

Moreover, while CMS may not be able to release the names of the selected drugs until February 1, 2027, the agency can and should proactively set dates, times, structures, and locations (virtual and/or in person) for each listening session, focus group, or other engagement opportunity (preferably by therapeutic area). Scheduling these sessions early will make it easier for patients, caregivers, and providers to participate, and provide community partners more time to advertise the sessions and prepare their communities for the sessions. CMS should publicize the date and format (including speaker type) for the public engagement sessions even BEFORE the drug negotiation list is published. We encourage CMS to publish whether the sessions will include indication specific reviews, and if so, which of the sessions will be reserved for less common indications (including rare diseases).

A common challenge in the rare disease space is small patient populations. In addition, many rare disease patients experience several comorbidities which can make it harder to travel or rearrange pre-planned health care appointments. Announcing which sessions will be reserved for less common indications will make it easier for rare disease communities to plan, maximizing the chance of robust participation. This will allow for tailored outreach based on the therapeutic area and speaker type and allow umbrella organizations and other key stakeholders to begin socialization of the sessions as early as possible to maximize awareness.

2. Reconsider the session format; provide more options to meet patients where they are; include opportunities for patient engagement that protect patients' privacy and make it easier for all relevant patient populations to engage; better integrate the written and verbal opportunities for feedback and make the written process easier to navigate.

Following the success of the first year, we hope CMS will develop a process to continue to identify incremental improvements for future years. To ensure success of the program in future years, we encourage CMS to create a variety of virtual and in-person engagement opportunities, including smaller focus group style sessions targeted at both patients and caregivers and health care providers (we recommend separate focus groups for health care providers and for patients/caregivers); provide opportunities for more meaningful engagement between CMS staff and participants during the listening session; and provide opportunities for anonymous or closed-door engagement to lower the bar to participation for patients or caregivers who do not feel comfortable sharing their information with the public; provide opportunities for engagement specifically for patients or caregivers whose primary language is not English and those that need other types of accommodations (including opportunities for asynchronous input for those in our community who cannot take off time from work or school to participate during the scheduled times).

a. Streamline the public comment opportunities; provide opportunities for audio-only participation and for patients whose primary language is not English (e.g., Spanish-language listening sessions or real-time translation services); work with the patient advocacy groups and other key stakeholders to prepare patients better for the sessions; and continue to refine and revise the format for the listening sessions year over year.

As last years' experience clearly showed, not all patients feel comfortable sharing highly personal information about their disease or other aspects of their daily life on camera in publicly recorded settings. Furthermore, providing English-only engagement opportunities threatens to leave out important parts of the community. Establishing a system where participants can provide responses that will be deidentified and/or aggregated before being publicly posted has been shown to improve the quality of responses.[18] We urge CMS to continue to work with the affected communities to provide options that meet their needs.

b. Simplify and better integrate the written and verbal comment process to provide patients with a range of options to engage and share feedback without having to engage publicly.

After last year's data submission process, we are pleased to see there will be additional opportunities to strengthen written public comment. To ensure the public data submission process is captured in a meaningful way, we encourage CMS to increase timelines for participation, standardize the data capture process, and increase accessibility for patients with lower literacy comprehension and/or who need other accommodations to navigate the process (e.g., because of chronic diseases or physical or mental disabilities). Specifically, in our opinion, last year's public written comment process was terminated prematurely by closing it before the listening session. By failing to leave the written comment process open throughout the duration of the listening sessions, patients were forced to comply with tight timelines and opportunities

[18] *How Transparency Affects Survey Responses.* Connors, et. Al. Public Opinion Quarterly. (18 June 2019). https://academic.oup.com/poq/article/83/S1/185/5520299

for engagement were missed. Although we recognize that CMS was given a herculean task to accomplish within a short period of time, the short process was a significant barrier to participation for many patients, together with the complexity of navigating the process.

For this upcoming year, we recommend clearly publishing the timeline for public participation well in advance of the opening, alongside the questions that will be asked during the submission process. To our point on transparency above as well, we encourage CMS to share how the written submission will be considered differently than or in addition to the oral participation.

Moreover, we urge CMS to simplify and streamline the data submission process. Last year's data submission process included a complex series of mandatory forms with complicated and potentially concerning language utilizing terms that were not patient friendly. We encourage CMS to use short, simple forms at no greater than an eighth grade reading level to ensure language comprehension is less of a barrier. We view the written submission as a vital opportunity to supplement and complement the other engagement methods, including the collection of information from patient groups who may have difficulty (or wish not to) participating in oral sessions, such as individuals who speak English as a second language, or those who are impacted by audio-visual or physical challenges. All forms should be read with this in mind, and we strongly urge CMS to make the forms available in languages other than English.

To better understand who leverages the written process for future years we encourage CMS to collect voluntary demographic information from participants and/or to collect some of this information from stakeholder partners as appropriate. Moreover, we recommend streamlining the data collection process and prioritizing the information that is most important to CMS. Specifically, NORD recommends prioritizing the collection of plain-language information on:

- Demographic information, such as age, gender, race/ ethnicity, zip code
- Diagnosis and time since diagnosis
- Degree of disease progression
- If the information is provided by a patient or a caregiver
- What therapies the patient uses to manage their disease and for how long
- If the patient has tried other therapies in the past
- Degree of disease progression on treatment
- Most significant challenges in accessing medications
- How the patient feels and functions on the disease, and what symptoms remain unaddressed
- Challenges patient experienced associated with switching from one therapy to another
- What therapeutic alternatives the patient may have considered or may consider

It is also important for CMS to be clear about how written and oral submissions will be analyzed. For a variety of reasons, some patients may prefer submitting a written statement over participating in a live session. CMS may also not be able to find representatives for each of the

indications that a selected product covers and the written responses may provide meaningful ways to substantiate and expand upon the data collected in the listening sessions. However, without clarification on how patient and stakeholder submission will be analyzed, we are concerned that components of the patient populations that are more difficult to survey may fall through the cracks during the negotiation process, and that the written submission form will not be used to its maximum extent. Certain types of patients, such as those with psychiatric conditions, cognitive limitations, and sight deficiencies, are often particularly difficult to include in surveys; specific, intentional efforts will be required to allow for meaningful inclusion of these populations.[19]

Additionally, we are concerned that without clarification of how the oral and written submissions are processed, patients could feel that submitting written comments would be a less valuable contribution. Establishing a system where participants are assured that their (deidentified) responses will be publicly posted has been shown to improve the quality of responses.[20] Even if exact weights for each of the types of responses relative to other factors cannot be shared or may vary by drug and indication, simply sharing the types of analysis used (i.e. quantitative vs. qualitative), will be helpful in how patients may structure their responses to be maximally beneficial.

c. Provide opportunities for more direct interaction with CMS through focus-group sessions in addition to the public listening sessions; this will allow the agency to ask clarifying questions and better understand varied patient perspectives on the most influential aspects of the MDPNP calculations including nuanced thinking around appropriate therapeutic alternatives (in particular in therapeutic areas like oncology or immunology where switching among products may have significant and hard-to predict impacts on long-term patient outcomes).

In our prior experience hosting patient listening sessions, NORD has found smaller focus-group listening sessions to be most effective to gain granular and nuanced input. These closed-door sessions make it more comfortable for patients to share personal details about their disease and how it impacts their daily life. We recommend sessions to be limited to five to 10 participants and set between 60 and 90 minutes. Each session should be limited to patients, providers, or caregivers, depending on the focus of the specific session – and may be further tailored (e.g., by geographic area, population subgroup, or to explore specific questions such as patients' experience switching across therapeutic alternatives).

Maintaining independence of each of the sessions and limiting them to a single stakeholder type will allow participants to develop a greater level of trust, both with one another and with the moderator, and help guard against issues like halo and bandwagon effects. Including different stakeholder types risks changing the power dynamic, where some participants feel their

[19] *Barriers to Participation in a Patient Satisfaction Survey: Who Are We Missing?* Gayet-Ageron, et. Al. National Library of Medicine. (26 October, 2011). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3202588/

[20] *How Transparency Affects Survey Responses.* Connors, et. Al. Public Opinion Quarterly. (18 June 2019). https://academic.oup.com/poq/article/83/S1/185/5520299

commentary is less worthy than others, or may become more deferential, rather than all participants viewing each other as equals. In addition, we recommend each focus group to be facilitated by a skilled facilitator knowledgeable in appropriately handling group dynamics in scientifically rigorous ways.

After participants have been selected for each of the respective sessions, we encourage CMS to proactively communicate expectations and solicit requests for accommodations. Some individuals may require additional time to process the questions in advance; sending around what each of the participants will be asked is helpful in ensuring all are able to respond on time and feel comfortable doing so. We also encourage CMS to ensure the participants understand what expectations for timing are, and to help stakeholders navigate the timekeeping requirements. While the first year of the listening sessions successfully kept the conversation within the confines of time requirements, the abrupt cut off while patients were telling their stories and no response permitted from CMS staff was suboptimal. Informing participants of the time limits and setting expectations for types of follow-up questions from CMS staff will be crucial in improving the quality of responses from participants moving forward.

We also encourage CMS to consider protecting participant privacy by exclusively releasing a redacted transcript after the conclusion of these focus group sessions. Potential participants may feel dissuaded from taking part in the sessions, or not feel comfortable fully participating in the session, if their identifiable information were to be released to the general public. As we saw in the first sessions, some patients are willing to share sensitive information, and we commend the patients who were willing to share their stories. To encourage participants to share their perspective, however, and to provide more granular responses with the nuance necessary to ascertain the true value of the selected products, extending privacy protections is crucial.

3. Develop a standardized set of questions that are most relevant to CMS; develop a process to tailor these questions to each given therapeutic area, product, or patient group as needed; and focus on the key insights CMS needs most to inform the MDPNP; partner with key stakeholders to optimize the phrasing of these questions for clarity and consistency and explain how this data informs the negotiation process.

We urge CMS to introduce more structure into the sessions compared to last year. While last year's sessions included some general guidelines for how participants should respond to questions, we encourage much more specificity to standardize the feedback the agency receives and ensure the agency can utilize participant answers.

a. Determine which data elements are most meaningful to CMS (e.g., therapeutic alternatives, remaining unmet medical need), both in general and specific to each therapeutic area; prioritize the written and verbal data collection for these critical data elements, and partner with relevant patient groups and other stakeholders to educate the patient community and collect the most meaningful input on these negotiation factors.

Not all data elements that can be informed by patients, caregivers, and health care providers will be equally important to CMS or have the same impact on the negotiation or maximum fair price calculation. Given the large number of products and indications CMS must consider, we strongly urge CMS to prioritize what insights will be most impactful and to be clear and transparent in communication and education to targeted stakeholders. We encourage CMS to clearly communicate how patient experience data informed the drug price negotiation and the final offer for each negotiated product.

b. Standardize the data collection efforts to ensure robustness and comparability across products and plan years while providing for sufficient flexibility to address the unique aspects of each product, therapeutic area, or patient population.

We encourage CMS to consider consistently asking questions specific to three thematic areas: 1. how the patient feels, functions and survives (on the treatment, an alternative treatment, or without any therapy); 2. cost and access; and 3. therapeutic alternatives. We recognize that these questions cannot be meaningfully answered in three minutes and appreciate CMS' flexibility to reconsider the session format. We also recognize that some of these questions may vary in pertinence based on therapeutic area, patient population, or other factors, and we encourage CMS to work with the relevant stakeholder community to prioritize and refine these questions as needed; however, we believe that this is a useful starting point for CMS' listening sessions.

Thematic area 1: How the patient feels, functions and survives:

- How does this disease impact you?
- How has your disease changed since you have been using this treatment?
- How long have you been using this treatment?
- What side effects have you been experiencing with this treatment?
- What formulation do you use for this treatment (if applicable)?
- Does this formulation best fit your needs?
- Rank the importance of the different characteristics of the treatment?
- What symptoms remain unresolved, and how is this impacting your day-to-day life?
- How does this product impact your social and emotional well-being?
- What would it mean to your daily life to no longer have access to the therapy?

Thematic area 2: *Cost and access:*

- Do you find this medication to be affordable? What does affordable mean to you?
- How much do you pay out of pocket annually for this medication?
- Did your insurance company make you try any other medications before agreeing to pay for this medication? If so, how many alternative medications were you required to try?
- Has this medication caused you any financial problems?
- Have you ever skipped a dose of this medication because you could not afford it?

- Have you ever skipped a dose of another medication because this medication was too expensive?
- What would cause you to stop taking this medication?
- Does your insurance company require prior approval before you fill this medication?

Thematic area 3: Therapeutic alternatives:

- What would you consider a therapeutic alternative to your current therapy? What characteristics make it a therapeutic alternative?
- Have you tried using any other medication to treat your condition? What has been your experience?
- How have you felt or functioned on the other therapy, and how does that differ from how you feel or function on the current therapy? Has that changed over time?
- Why did you switch / stop using that medication? Or why have you not tried other therapeutic options?
- How effective do you feel this other medication was compared to the medication you are using now?
- How does the price of your other medication compare to the medication you are using now?
- How were the side effects of the other medication compared to the medication you are using now?
- Did you find the other product(s) easier or harder to use than your current medication?
- What was your experience switching from one product to another?
- Would you consider switching products? Why or why not?

To further refine these questions, we encourage CMS to work with the impacted patient communities, as well as FDA and other stakeholders who have conducted successful patient engagement sessions to identify strategies best able to accomplish the goals of the patient listening sessions. FDA's Voice of the Patient Sessions are a crucial component of FDA's Patient Focused Drug Development (PFDD) sessions. To date, over 200 sessions have been completed on a wide variety of conditions, including both rare and non-rare conditions, and may be a strong resource to supplement listening sessions and focus groups, particularly for rare conditions where participants may be more challenging to source.

Part of FDA's success with the Voice of the Patient Sessions derives from individual modifications made to each session reflective of each of the diseases under consideration. We encourage CMS to individualize each of the patient listening sessions towards both the indications under consideration and the population involved in the sessions. Tailoring individual indications under consideration while adhering to a common structure will allow patients to speak directly to their own experience and provide valuable feedback on the product's value for patients in specific situations.

We urge CMS to further refine and revise these questions with input from key stakeholders for future plan years and to establish a process to consistently learn from and revise these questions with each subsequent plan year. We are particularly concerned about how CMS will select therapeutic alternatives for consideration. As CMS considers how to best identify therapeutic alternatives, it is crucial to solicit information from patients, caregivers, health care providers, and other key stakeholders on when, and when not, certain therapies can be identified as an alternative. We also want to raise two areas of concern regarding information gathering on therapeutic alternatives: prohibitions on medical switching and off-label use of products.

As the listening sessions last year clearly showed, for many diseases, particularly immune conditions and cancers, the use of a treatment can have significant impacts on the effectiveness of other treatments, because of, for instance, emerging tumor resistance or a secondary loss of response due to antibody formation to the drug.[21,22] This raises concerns about the prospect of therapeutic alternatives. Although there may be alternatives available on the market, if they are not available to the patient for medical reasons, they should be given consideration independent of therapeutic alternatives for other indications.

Due to the lack of treatment options available for so many rare diseases, both providers and patients frequently rely on prescription medications without an FDA-approved indication for their condition on the label, known as off-label use. Physicians frequently rely on clinical compendia to make decisions about whether treatment options would be appropriate for their patients. Off-label use accounts for up to one third of all prescriptions, and up to 97% in certain populations.[23] We recognize that CMS has indicated their intent to conduct literature reviews on therapeutic alternatives for each of the selected products in the past; to ensure all relevant therapeutic alternatives, we strongly recommend CMS consider including off-label uses of products

We thank CMS again for the opportunity to comment on this information collection request and look forward to working with CMS to ensure rare disease patients can fully participate in and benefit from the Medicare Drug Price Negotiation Program. For questions related to this letter, please contact Karin Hoelzer, Director of Policy and Regulatory Affairs at KHoelzer@rarediseases.org or Mason Barrett, Policy Analyst at MBarrett@rarediseases.org.

Sincerely,

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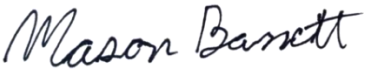
[21] *What to Do When Biologic Agents Are Not Working in Inflammatory Bowel Disease Patients.* Dalal, et. Al. National Library of Medicine. (October, 2015). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4849518/

[22] *Clone Wars: Quantitatively Understanding Cancer Drug Resistance.* Yates, et. Al. JCO Clinical Cancer Informatics. (28 October, 2020). https://ascopubs.org/doi/10.1200/CCI.20.00089

[23] *Off-Label Use vs Off-Label Marketing of Drugs.* Van Norman, Gail. National Library of Medicine. (27 February, 2023). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9998554/#:~:text=Off%2Dlabel%20use%20of%20drugs%20is%20common%2C%20constituting%20up%20to,off%2Dlabel%20use%20of%20drugs.



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September 3, 2024

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Mr. William N. Parham, III
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Baltimore, MD 21244

Re: Inflation Reduction Act (IRA) Drug Price Negotiation Data Elements Information Collection Request for Initial Price Applicability Year 2027 (CMS-10849)

Dear Mr. Parham:

The Pharmaceutical Care Management Association (PCMA) appreciates the opportunity to comment on the U.S. Centers for Medicare & Medicaid Services' (CMS) information collection request (ICR) for the initial price applicability year (IPAY) 2027 of the Medicare Drug Price Negotiation Program ("Negotiation Program").[1]

PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans and operate specialty pharmacies for more than 275 million Americans with health coverage through Fortune 500 companies, health insurers, labor unions, Medicare, Medicaid, the Federal Employees Health Benefits Program, and plans offered for sale on the Exchanges established by the Affordable Care Act. PBMs negotiate price concessions with manufacturers on their brand medications to improve the value of the Part D program. These price concessions reduce premiums for all beneficiaries and provide access to preferred drugs with reduced cost sharing. Negotiated drugs under the Inflation Reduction Act (IRA) will be priced no higher than the prices PBMs are already able to negotiate on average, and in many cases will be priced higher than an individual Part D plan is already paying. We have an interest in ensuring that manufacturers do not find loopholes in the CMS program, so that Part D plans and their contracted PBMs have certainty as we continue to negotiate on behalf of the program for both these drugs and those not selected by CMS.

In our earlier comments in response to the IPAY 2026 ICR, PCMA provided feedback which we hereby incorporate by reference,[2] to the degree that the points raised continue to be relevant. This includes, but is not limited to, the recommendation to re-evaluate the emphasis placed on R&D expenses during negotiation processes and the importance of maintaining effective communication channels between relevant agencies across the Federal government to authenticate the information provided by manufacturers.

[1] https://www.regulations.gov/docket/CMS-2024-0198/document.
[2] https://www.regulations.gov/comment/CMS-2023-0043-0011.

Pharmaceutical Care Management Association
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www.pcmanet.org

For IPAY 2027, PCMA has several comments and recommendations on the IPAY 2027 ICR, which are summarized below:

- CMS should segregate and pinpoint the influence of manufacturer assistance programs on the average net unit price within the commercial sector, as these programs can distort drug pricing and obscure the effects of public payer pricing.
- CMS should corroborate the information provided by manufacturers on the net price for Medicare Part D, after accounting for discounts provided through the Coverage Gap Discount Program.
- CMS should carefully consider off-label use and its limitations, and prioritize high-quality, peer-reviewed, and publicly available evidence over low-quality, non-peer-reviewed, and proprietary evidence when assessing alternative treatments.
- CMS should use caution in incorporating the patient experience into formulary decisions given the challenges of quantifying and comparing this subjective metric across different medications and therapeutic classes.
- CMS should adopt the proposed definition of "therapeutic advance" which focuses on a selected drug's relative "substantial improvement," or lack thereof compared to the selected drug's therapeutic alternative(s) on an indication-specific basis, or on the drug's impact on the underlying disease state when no alternatives are available.

We discuss these recommendations in more detail below.

Section G: Market Data and Revenue Sales Volume Data

PCMA supports CMS's proposed collection of the "U.S. commercial average net unit price" and its distinction from the "U.S. commercial average net unit price—net of patient assistance program." We suggest this data be collected through a syndicated subscription service to ensure standardized and aggregated data collection allowing for accurate data research and analysis.

Our reading of the ICR indicates that the "U.S. commercial average net unit price" metric represents the average price paid for a drug by commercial entities, such as group or individual health plans, both on and off the health insurance exchanges. This price:

- Excludes Medicare (Parts A, B, and D), Medicaid, and manufacturer-run patient assistance programs.
- Includes a wide array of discounts and concessions offered by manufacturers to purchasers.
- Is reported at the National Drug Code (NDC) 11-digit level, which provides specificity regarding the exact product being priced.

Conversely, the "U.S. commercial average net unit price—net of patient assistance program" mirrors the aforementioned definition but also factors in the effects of patient assistance programs run by manufacturers on the pricing data.

We support CMS's approach to segregate and pinpoint the influence of manufacturer assistance programs on the average net unit price within the commercial sector. These assistance programs by manufacturers are frequently executed through less transparent methods, leading to potential obscurity regarding their influence on the pricing structures adopted by public payers for medications. Although we acknowledge that the data collected by CMS will remain confidential, the mere act of mandating manufacturers to report this information to the government could prompt a heightened awareness among them about the distorting effects that their cost-sharing assistance programs exert on drug pricing. We also encourage CMS to require the reporting of not only manufacturer-run patient assistance programs, but also any funds that manufacturers contribute to charitable organizations, particularly when these contributions can be linked to or are reflective of the prices set for specific drugs, such as donations earmarked for assistance programs that predominantly support patients using those medications."

Section I: Evidence About Alternative Treatments

PCMA commends CMS for the agency's thoughtful revisions to its collection of information about alternative treatments for the selected drugs under the Negotiation Program, particularly as it relates to explicit consideration of off-label uses and the patient/caregiver experience, and a proposed definition for "therapeutic advance." PBMs have extensive experience and expertise in evaluating the clinical and economic evidence of drugs and their therapeutic alternatives, and applying this evidence to inform formulary design, benefit design, and utilization management policies. We offer the insights below based on our own experiences.

Off-Label Use

Based on our experience, CMS must carefully consider off-label use and understand its limitations. CMS must prioritize the following factors in its consideration of off-label uses: the quality and strength of the evidence, including the study design, methodology, data sources, sample size, endpoints, comparators, and limitations. CMS should give more weight to high-quality, peer-reviewed, and publicly available evidence than to low-quality, non-peer-reviewed, and proprietary evidence. CMS should consider consistency and comparability of the evidence across different sources, studies, and outcomes. CMS should assess how the evidence aligns or diverges with the existing clinical guidelines, standards of care, and best practices for the indications of the drugs and their alternatives.

CMS should also consider the relevance and applicability of the off-label evidence to the Medicare population, including the characteristics, preferences, and needs of different subgroups of beneficiaries. CMS should consider how the evidence reflects the real-world use, effectiveness, safety, and value of the drugs and their alternatives in the Medicare population, and how it accounts for the heterogeneity, comorbidities, and social drivers of health of beneficiaries. CMS should ensure that manufacturers do not blur the lines between off-label and on-label pricing and therapeutic value, as this could skew the negotiation process for a particular drug—especially given Part D's statutory limitations on covering certain uses. For example, anti-obesity medications (AOMs) are frequently used off-label for weight loss, but the

Part D program excludes agents used for weight loss from the definition of a “covered Part D drug,” making such off-label use out-of-scope, even if it offers tangible benefits to patients.[3]

Patient Experience

CMS should proceed with caution in incorporating the patient experience into formulary decisions as such a task can be challenging in our experience. The most obvious challenge with the patient experience is its subjective nature. Due to its subjectivity, the patient experience can vary widely between individuals. There is also no universally accepted metric for measuring the patient experience. This makes it difficult to quantify and systematically compare the patient experience across different medications and therapeutic classes. These challenges result in a formulary decision-making process that is as subjective as the patient experience it purports to assess.

Formulary decisions also tend to rely on cost-benefit analyses that may not fully capture the nuances of patient experience. The focus of the current formulary development process tends to be on clinical outcomes and cost savings rather than on quality of life or patient satisfaction due to the challenges of quantifying these metrics, as discussed above. Since it is easier to objectively assess the medical appropriateness of medications than patients' subjective experiences, we generally consider formularies based on quantifiable clinical benefits as potentially more equitable.

Therapeutic Advance

PCMA supports CMS’s proposed definition of “therapeutic advance” which focuses on a selected drug’s relative “substantial improvement” compared to the selected drug’s therapeutic alternative(s) on an indication-specific basis. This approach resonates with the methodologies employed by PCMA’s members. When assessing the value of a drug, our members meticulously compare the drug's advancements to those of existing competitor products. This comparison is crucial during drug negotiations as it helps in determining the drug's value proposition and its potential to offer better health outcomes or improved patient care compared to other available treatments.

Furthermore, PCMA supports CMS's definition of "therapeutic advance" in scenarios where no therapeutic alternatives are available. In such instances, the assessment shifts focus from comparative improvement to the drug's impact on the underlying disease state. The evaluation of "substantial improvement" in these cases is based on the drug's ability to significantly enhance the management or prognosis of the disease. This could involve a range of factors, including but not limited to, slowing disease progression, reducing the severity of symptoms, or potentially offering a cure where none was previously available.

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[3] Social Security Act § 1860D-2(e)(2).

PCMA appreciates CMS's consideration of our comments and recommendations on the IPAY 2027 ICR. PCMA stands ready to work with CMS to ensure the success of the Negotiation Program and to advance the common goals of lowering drug costs and improving access and quality of care for Medicare beneficiaries. If you need any additional information, please reach out to me at tdube@pcmanet.org.

Sincerely,

Tim Dube

Tim Dube
Senior Vice President, Policy and Regulatory Insights

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May 22, 2023

VIA ELECTRONIC FILING - REGULATIONS.GOV

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CMS Deputy Administrator and Director of the Center for Medicare
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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.

-----s-----
Jennifer Bryant
Executive Vice President
Policy, Research, and Membership
PhRMA

----s-----
James C. Stansel
Executive Vice President and General Counsel
PhRMA

July 31, 2023

VIA ELECTRONIC FILING - REGINFO.GOV

Office of Management and Budget (OMB)
725 17th St NW
Washington, DC 20503
Attn: OMB Desk Officer

Re: ICR Reference Number: 202306-0938-013. Information Collection Request for Negotiation Data Elements under Sections 11001 and 11002 of the Inflation Reduction Act (CMS-10847).

To The OMB Desk Officer:

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, ICR Form (CMS-10847, OMB, 0938-NEW), and the Comment Summary Responses submitted to the Office of Management and Budget.[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 submitted lengthy comments on CMS' original ICR, proposed March 21st, 2023, for a 60-day comment period and attached with this submission as Appendix B. Unfortunately, CMS fails to address the vast majority of such comments, which focused on key considerations under the Paperwork Reduction Act (PRA): (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) burden estimate.

Rather than reiterate prior comments, PhRMA is attaching our comments on CMS' initial Guidance (Appendix A) and our comments to CMS in response to the original ICR (Appendix B), as well as outlining in this letter the main reasons CMS' ICR continues in its failure to comply with the letter and spirit of the PRA. Importantly, CMS deviates from PRA regulations, which require an agency to take "every reasonable step to ensure that the proposed collection of information:

> (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

[1] 88 Fed. Reg. 42,722 (July 3, 2023). Centers for Medicare and Medicaid Services (CMS), Information Collection Request for Negotiation Data Elements under Sections 11001 and 11002 of the Inflation Reduction Act; Supporting Statement – Part A (June 30, 2023). Available at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10847;). Information Collection Request for Negotiation Data Elements under Section 11001 and 11002 of the Inflation Reduction Act, ICR Form (June 30, 2023). Available at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10847. CMS, Responses to Public Comments Received for CMS-10847, Final clean 60-Day Data Elements Comment Summary Responses (Uploaded June 29, 2023). Available at: https://www.reginfo.gov/public/do/PRAViewDocument?ref_nbr=202306-0938-013.

> (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."[2]

Because CMS' revised ICR fails OMB's regulatory test for the PRA, it is incumbent on OMB to now work with CMS to further modify the form.

I. Concerns with Respect to Burden

CMS acknowledges it received comments that the proposed submission requirements (i) are burdensome; (ii) request a large volume of data and/or level of detail Primary Manufacturers may not have access to; (iii) are unreasonable in light of the narrow, 30-day time frame manufacturers have to respond to the ICR; and (iv) would be better effectuated if respondents could employ reasonable assumptions regarding data submission.[3] Nevertheless, CMS makes only de minimis changes to the form. CMS has deleted a few questions (as further discussed below), yet the ICR continues to extend for 47 pages, with each question comprised of multiple subparts. The form continues to require Primary Manufacturers to obtain data from "Secondary Manufacturers," and to submit all data within just 30 days. In a number of cases, CMS also refuses to allow reasonable assumptions, despite stating that doing so "may reduce reporting burden."[4] CMS also argues that reporting to the SEC and under the Medicaid Drug Rebate Program demonstrates that manufacturers have experience providing "similar data."[5] But CMS fails to address the ways these collections differ significantly (in granularity, volume of information requested, and the ability to employ reasonable assumptions) from the revised ICR. For example, in prior comments PhRMA noted:

> PhRMA does not believe that CMS should be capturing [research and development (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."

CMS does not address how much more burdensome its revised ICR is as compared to SEC filings, or Medicaid reporting. OMB should therefore perform due diligence and require CMS to support or correct its assertions on the SEC and Medicaid Drug Rebate Program.

Finally, despite numerous comments to the contrary, CMS adheres to its initial reporting estimate that manufacturers (across all team members working on a submission) will spend 500 hours each to gather and submit the information CMS requires (at a cost of about $51,600 per respondent). Such an estimate is unreasonable on its face, but especially given CMS' estimate that the Agency will spend more than 60 times this amount for its own work (at approximately $3,450,000 -- $3,131,538 for CMS staff plus $316,116 for staff and contractors to build HPMS) (Supporting Statement, Tables 2, 6 and 7).

II. Concerns with Respect to Duplicated Information

The PRA requires agencies to ensure they do not demand data already available, so as to avoid duplication. CMS admits it is requesting available data but states it will require submission by the Primary Manufacturer to ensure data is up to date.[6] CMS also asserts: "the Primary Manufacturer is best positioned to provide the requested data and the statute provides the manufacturers participating. . .will submit the requested data."[7] CMS fails to explain why it cannot be sure data are complete or up to date if

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[2] 5 C.F.R. § 1320.5(d)(1)(i)-(iii).
[3] CMS, Response to Public Comments Received for CMS-10847 at 1-2.
[4] *Id.* at 2.
[5] *Id.*
[6] *Id*. at 3.
[7] *Id.*

the Agency uses already available information, such as "publicly available" "Federal Supply Schedule" and "Big Four Prices." Nor does CMS explain why the PRA would permit an agency to impose heavy burdens on respondents for the possibility that data could be marginally more up to date. CMS further fails to respond to industry comments that it may comfortably interpret its statutory authority to allow a manufacturer to agree that CMS' use of a specific source of data would constitute the manufacturer's "submission" of such data and be tantamount to an affirmative submission.[8] OMB should review PhRMA's already submitted comments on the ICR, and work with CMS to identify any data that duplicates already available information. To the extent information is already available, OMB should require CMS to use such sources, as required under the PRA.

III. General Comments and Other Concerns

Please refer as well to our prior comments on other aspects of CMS' proposed ICR, including but not limited to:

Unnecessary Word Limits:

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. At the very least, given that it is in the first year of the program, CMS should eliminate word limits, and if responses provide extraneous information on certain questions, CMS could then implement revised word limits on those questions in subsequent years of the program. In the alternative, CMS could *recommend* certain word limits, explain Agency limits on staffing, and state that it is best able to review responses if the responses comply with certain word limits. In particular, by imposing word limits on the questions on therapeutic alternatives (particularly for questions 28-31), CMS is depriving respondents of the ability to provide important contextual and narrative information in a way that is user-friendly and less burdensome. Further, CMS announcing in advance that it will cut patients and caregivers off partway through a potential written explanation of their experiences potentially sends a message to these patients and caregivers that discourages them from providing input.

Unnecessary Citation Limits:

Similar to our concerns over word limits, we feel that unnecessary citation limits may prevent CMS from fully understanding the full benefits that a selected drug may bring to patients. CMS should seek out all relevant information, especially during the first year of the program. That said, we acknowledge CMS' clarification that tables, charts, and graphs are permitted to be submitted as additional materials for certain questions.

Data Submission Deadlines:

We appreciate CMS' inclusion of planned meetings by CMS (with manufacturers and public, patient-focused "listening sessions") in the fall of 2023 that will provide an opportunity for interested stakeholders to "share new information on the Section 1194(e)(2) factors" and provide context on the 1194(e)(1) submission.[9] However, PhRMA believes that CMS has broader discretion to accept additional written data from manufacturers and members of the public related to 1194(e)(1) and (e)(2) factors. Although the Guidance now allows for up to 50 pages of material to be shared with the Agency to aid the pre-initial offer meeting between CMS and manufacturers held after October 2nd, the Agency has not created explicit mechanisms to enable additional data from manufacturers and the public under its guidance or ICR form on data elements. Furthermore, the patient and provider groups which serve

[8] 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).
[9] Negotiation Program Final Guidance at 5.

underserved or underprivileged communities – who will likely be most impacted by the unnecessarily short data submission window – still do not have additional opportunities to submit data. *Note:* If CMS and OMB embrace PhRMA's statutory interpretation that the Agency may accept such data after October 2nd, CMS would no longer be collecting large amounts of proprietary data, solely so the Agency has the data it *might* need to determine the initial offer. CMS has requested large amounts of data (sometimes five years of data) – without fully explaining why or how it needs such data. And instead of finding flexibility where it can, the Agency instead imposes additional burden on respondents. By collecting such large volumes of proprietary data, the Agency increases the severity of any potential breach. OMB should work with CMS to re-examine the ability to gather just the information the Agency knows it will use, and then to supplement such information, only when necessary.

Identify and Protect Proprietary Information:

Under the MFP process, it will be critically important for CMS to protect proprietary data. Although CMS has identified the HPMS portal for data submission, CMS has failed to identify a secure, alternative data submission portal if HPMS is not ready by the end of the data submission window. In the supporting statement to the revised ICR, CMS notes that "[i]f CMS HPMS is not used for submission because the CMS HPMS tool is delayed, responses to this ICR should be sent by email to IRARebateandNegotiation@cms.hhs.gov." PhRMA believes that the alternative submission process via email is not an acceptable way to secure confidential information. CMS should guarantee an encrypted alternative submission mechanism if HPMS is unavailable.

In addition, accurately identifying data that are proprietary represents a critical first step, and CMS should create room on the ICR form so manufacturers may easily identify information as proprietary. While CMS states it will consider certain information proprietary, it does not offer manufacturers the opportunity to identify data as proprietary, as PhRMA previously requested in comments to the Agency.

Access to Secondary Manufacturer Information:

Primary Manufacturers may not necessarily have access to Secondary Manufacturers' information, particularly within the deadlines required under the Program. While CMS notes that Primary Manufacturers may have "agreements" with Secondary Manufacturers, it fails to address or even acknowledge the narrow window for revising such agreements (i.e., revised guidance not issued by CMS until June 30th, just about three months before data submission will be due to CMS, and only approximately one month between drug selection and data submission). OMB should prevail on CMS to further explain its reasoning on this issue and create exceptions for Primary Manufacturers unable to revise their agreements.

IV. Manufacturer Data

Please refer as well to our prior comments on other aspects of CMS' proposed ICR, including but not limited to:

Non-FAMP Data:

CMS has statutory authority to align with Veterans' Affairs Non-FAMP data so as to avoid duplicating information, in accordance with the PRA. OMB should explore with CMS why it failed to read the statute in a more reasonable manner that would reduce reporting burden and encourage CMS to adopt such a reading.

R&D Costs and Recoupment:

While CMS makes minor revisions to the reporting of R&D costs, it will still break R&D costs into five categories, along with a sixth and seventh category for R&D recoupment (global total lifetime net revenue, along with U.S. lifetime net revenue). As PhRMA previously explained in comments, this

seven-part subdivision is well beyond how manufacturers report such data in other contexts, how they organize data, and potentially contravenes manufacturers' document retention policies. OMB should consider the fact that some companies do not readily have access to this information. In addition, CMS failed to adequately define and clarify components of R&D cost data, causing ambiguity that further hinders companies' ability to respond. For example, neither the ICR nor the June 30th guidance adequately define "same therapeutic class", which could be interpreted as FDA Established Pharmacologic class, USP Drug Class, or something else. OMB should require CMS to avoid ambiguity of such terms or fully define them.

CMS also states that the statute does not permit the Agency to allow for an attestation, as PhRMA recommended. CMS, however, does not specify why or how the statute, which requires "consideration" of "research and development costs of the manufacturer for the drug and the extent to which the manufacturer has recouped research and development costs,"[10] would prohibit an attestation. CMS also fails to justify the utility of its proposal. Why is the seven-part test essential to arriving at an MFP offer? CMS provides no clarity for how recoupment data will be evaluated or weighed. As discussed in our comments, we would appreciate justification for why global lifetime net revenues are necessary, and how CMS will account for global sales of non-Food and Drug Administration (FDA)-approved indications.

PhRMA urges OMB to require robust, detailed explanations from CMS as to why it requires the excruciating level of detail it has proposed. If CMS cannot justify its requests or cannot adequately explain why the IRA provides no flexibility to request information in a more reasonable and less burdensome manner, OMB should work with the Agency to significantly streamline the form.

Current Unit Costs of Production and Distribution:

PhRMA notes that CMS' definition of "marketing costs" in the ICR conflicts with CMS' final guidance policy on bona fide marketing. In the ICR, CMS defines "marketing costs" as "expenditures incurred in the introduction or delivery for introduction into interstate commerce of a drug product, specifically including media advertisements, direct-to-consumer promotional incentives including patient assistance programs, promotion of the drug to health professionals, and other paid promotion."

Prior Federal Financial Support:

We appreciate CMS accepting the comment that if CMS is to limit R&D manufacturer costs to only 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. However, PhRMA still has significant concerns with CMS' overall approach to the calculation of R&D costs. Manufacturer systems may not have the necessary data to identify, calculate, or allocate R&D of Federal funding in the manner in which CMS prescribes. In particular, these costs have never been required to be "assigned" or "allocated" to an FDA-approved indication, and it is likely many manufacturers will not have the information or ability to comply with CMS' proposal, particularly for historical costs, some of which could be decades old. In order to attempt to calculate their responses, manufacturers may necessarily need to develop allocation assumptions, based on the information that is available to them. Alternatively, we urge OMB to call on CMS to adopt one of the three proposals in PhRMA's original comments.

Beyond the concerns with R&D costs and Federal funding outlined above, CMS fails to articulate directions for allocating tax credits or other support to research and development with the selected drug specifically. OMB should prevail upon CMS to acknowledge that respondents may take a variety of methodological approaches to the allocation of broadly applicable support to their selected drugs specifically. We appreciate CMS accepting the comment that if CMS is to limit R&D manufacturer costs

[10] SSA § 1194(e)(1)(A).

to only 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. However, CMS fails to articulate directions for allocating tax credits or other support to research and development with the selected drug specifically. OMB should prevail upon CMS to acknowledge that respondents may take a variety of methodological approaches to the allocation of broadly applicable support to their selected drugs specifically.

We also appreciate CMS clarifying that prior Federal financial support is reported only for the period starting from when the manufacturer acquired the drug. However, CMS is still requiring an inordinate amount of detail for Federal financial support (including, for example, a listing of "*each* licensing agreement, pricing agreement, purchasing agreement, and other agreement in place between your company and any federal government agency related to the discovery, research and/or development of the selected drug"), without explaining precisely why a disaggregated amount is necessary to support an MFP initial or final offer. CMS makes a tautological statement that a disaggregated amount will allow for a more "complete understanding,"[11] but does not explain why this "complete" understanding (as compared to an understanding based on an aggregated amount) will or should affect CMS' initial offer or final offer. If a company has received Federal financial support, will the type of support (tax credit versus grant) affect how CMS calculates the initial or final offer? The Agency does not say. We urge OMB to require more of CMS. If CMS cannot justify why its multi-layered request is essential, OMB should insist upon one rolled-up figure for prior Federal financial support, as doing so complies with IRA statutory requirements and is consistent with the PRA's "least burdensome" requirement or should adopt one of PhRMA's proposals.

Patents, Exclusivities, Applications, and Approvals:

Please see our prior comments on how CMS can, in accordance with the PRA, use already-available information, along with our discussion of CMS' statutory authority to do so.

We also recommend that OMB require CMS to explain why it needs each piece of requested patent, exclusivity, application, and approval data. For example, CMS demands information on patents and patent applications related to the selected drug that "include, but are not limited to" "any patents that are, have been, or may be listed for the selected drug in the FDA Orange Book or Purple Book; utility patents that claim the drug product (formulation or composition), drug substance (active ingredient), metabolites or intermediaries of a selected drug, method(s) of using the drug, or method(s) of manufacturing the drug; and design patents that, for example, claim a design on the packaging of the selected drug." CMS does not explain why it must request such a burdensome list of data: a list that is more expansive and more burdensome to comply with than the prior version. OMB's PRA oversight responsibility – as well as its commitment to reducing burden wherever possible – makes it incumbent on your Office to require specific justifications for each element of data and if these elements cannot be justified, to work with CMS to reformulate this request to reduce the associated burden.

Market Data, Revenue, and Sales Volume Data:

We support CMS's decision to remove metrics related to "manufacturer average net unit price to Part D Plan sponsors," 340B ceiling price, and 340B Prime Vendor Program price. Even so, CMS continues to engage in serious overreach, collecting an extreme amount of data, when the IRA simply requires the Secretary consider the factor of: "Market data and revenue and sales volume data for the drug in the United States." The IRA does not require the metrics CMS has proposed, with the exception of "non-FAMP." CMS has also not responded to PhRMA's questions as to why data must be reported for each quarterly period in the most recent five years, presenting a substantial burden without any basis in statute.

[11] CMS, Response to Public Comments Received for CMS-10847 at 11.

Nor does CMS address PhRMA's concerns related to "Primary Manufacturers" reporting these data on behalf of "Secondary Manufacturers," when such reporting could be inconsistent with contractual agreements, without sufficient time to revise such agreements. CMS also fails to explain why it continues to rely on FSS and "Big Four" pricing when the Senate overwhelmingly rejected (by 99-1) amendments that would have incorporated FSS and "Big Four" pricing into the IRA.[12] In regards to CMS' three newly minted metrics of: (1) U.S. commercial average net unit price; (2) U.S. commercial average net unit price – without patient assistance program; and (3) U.S. commercial average net unit price – best; CMS fails to address comments that the new metrics are not defined with specificity and the lack of clear definitions will likely result in inconsistencies,[13] and the requirement for manufacturers to provide data on these new metrics covering quarterly periods for five years creates a particularly excessive burden. The excessive burden is attributed to the requirement of manufacturers having to develop and launch a new transaction-level data collection and analysis infrastructure for the new U.S. commercial average net unit price measures, on an extremely expedited timeline, due especially to the added complexity of having to account for supported provided to purchasers and potentially including patients – such as "coupons" and "goods in kind"—as "concessions" in the average net unit price calculation. However, CMS' interpretation is at odds with industry's view and treatment of such support services. If Congress had wanted CMS to base the MFP on commercial "best" price or similar metric, it would have required disclosure of such a proprietary metric. If it does maintain these ultra vires metrics, CMS should explicitly exclude all prices that are not prices to commercial customers.

OMB should ensure that CMS complies with the law, and direct CMS to eliminate from the ICR all pricing metric requests that go beyond non-FAMP (as opposed to market, revenue, or sales data).

Certification for Sections A through G:

PhRMA notes that CMS has created two certification statements – one for Sections A through G of the ICR, and one for all respondents for Section I of the ICR. For the first certification, CMS responds to comments only by comparing such certification statement to "other information collection requests related to the Negotiation Program."[14] As noted in PhRMA's prior comments, CMS will require respondents to acknowledge that responses may "give rise to liability, including under the False Claims Act." Other than False Claims Act liability, CMS does not specify what kind of liability the form "may" give rise to. CMS also cites no other program – other than IRA price-setting – that requires an analogous certification threatening False Claims Act liability for an information collection. Despite comments on this issue, CMS also did not delete, or even further specify, the unclear and open-ended requirement that respondents "timely notify" the Agency if "I become aware that any of the information submitted in this form has changed." Notably, CMS responds to comments on the certification statement only by comparing the statement to "other information collection requests related to the Negotiation Program." As noted in PhRMA's prior comments, CMS will require respondents to acknowledge that responses may "give rise to liability, including under the False Claims Act." Other than False Claims Act liability, CMS does not specify what kind of liability the form "may" give rise to. [15] also cites no other program – other than IRA price-setting – that requires an analogous certification threatening False Claims Act liability for an information collection. Despite comments on this issue, CMS also did not delete, or even further specify, the unclear and open-ended requirement that respondents "timely notify" the Agency if "I become aware that any of the information submitted in this form has changed."

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[12] 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.

[13] 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.

[14] CMS, Response to Public Comments Received for CMS-10847 at 15.

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. While we appreciate that CMS did revise some areas of this section, including expanding the number of respondent types and adding a new question on the Patient and Caregiver experience, we still have some concerns with this section. Please refer to Section V of our prior comments for our concerns over this section of the ICR, including but not limited to:

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 1194(e)(2) on alternative treatments and should share information with the manufacturers of selected drugs and therapeutic alternatives as quickly as possible.

Clarification of Terms:

While PhRMA appreciates that the Agency clarified some key themes and terminology included in the ICR, CMS still leaves many definitions unclear. As stated in Section V of our comments to CMS on the Data Elements ICR, since Section I of the ICR is open to the public with various levels of pre-existing knowledge regarding CMS' price-setting process, it is critically important that CMS provides clear definitions for all stakeholders at the beginning of each question and in the instructions to help stakeholders understand what information CMS is seeking. In addition to the key terms outlined in our comments to CMS, additional examples of areas of concern are set forth below:

- Therapeutic Alternative: While the additional details regarding the definition of "Therapeutic Alternative" provided in Questions 27 and 28 are helpful, they fall short on several points. The first deficiency is using terms such as "drug class," "chemical class," and "therapeutic class," without formal definitions or relationships to established definitions. Consequently, the definition of therapeutic alternative remains ambiguous and subjective. Additionally, when many potential therapeutic alternatives exist (highly probable for most potential drugs under review), CMS may focus on alternatives that are "most clinically comparable." How will clinical comparability be defined? By whom? This again adds a degree of subjectivity to the definition that makes a reliable and predictable response highly unlikely. CMS apparently recognized this issue and noted in its crosswalk that it had "added a definition of therapeutic class," but then did not add such a definition to the form itself.[16]

- Therapeutic Impact: CMS declined to include a definition of therapeutic impact in the ICR. CMS should provide additional detail on what this entails or use and clearly define an alternative term.

- Unmet Medical Need: While PhRMA appreciates that CMS expanded their definition of "unmet medical need" to align more closely with the definition currently in use by the FDA, this does not capture the full range of unmet needs and may inadvertently undervalue the needs and values of certain communities. As such, OMB should explore with CMS the option of expanding this

[16] Negotiation Data Elements ICR Crosswalk of Changes Between 60-Day Notice and 30-Day Notice. https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10847

definition to 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.

Patient-Focused Listening Sessions:

PhRMA appreciates CMS' final guidance that it will host patient-focused listening sessions that will be open to the public, including patients, beneficiaries, caregivers, patient/public advocacy organizations, and other interested parties to share patient-focused input on therapeutic alternatives and other Section 1194(e)(2) information regarding selected drugs. CMS should ensure that these listening sessions are meaningful in line with engagement standards from key stakeholders such as the Patient-Centered Outcomes Research Institute[17] or the International Society for Pharmacoeconomics and Outcomes Research.[18] At least one, if not more than one, listening session per selected drug should occur, and the listening sessions should last long enough for patients, caregivers, and other stakeholders to present their real-word perspectives on the benefits of a selected drug, along with the comparator therapeutic alternative(s). In addition, as stated in our previous comments, the breadth and complexity of the information that CMS is evaluating, and its importance to patients, caregivers and public health all reinforce the importance of the Agency establishing supplementary mechanisms for gaining ongoing stakeholder input (for example, from patients, caregivers and clinicians) cannot be understated. CMS will not be able to ensure a patient-centered process nor 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, clinicians, and other stakeholders on an ongoing basis.

PhRMA previously commented that CMS should announce at least the potential therapeutic comparators the Agency is considering prior to the data submission deadline of October 2nd. CMS could announce the comparators when it releases the list of selected drugs, and doing so would focus responses from stakeholders. Now that CMS has announced listening sessions, advance notice is even more essential. Commentators will need to understand exactly which therapeutic comparators CMS is considering so that they can adequately prepare to discuss their experiences.

Quality-Adjusted Life Years:

PhRMA appreciates CMS' statement that it will require respondents to identify whether cost-effectiveness measures are used in submitted evidence, and if so whether the measure used treats extending the life an individual who is elderly, disabled, or terminally ill as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill. OMB should explore with CMS whether it believes this clarification will ensure against the use of quality-adjusted life-years (QALYs) or similar measures, as prohibited by both Sections 1182(e) and 1194(e)(2) of the Social Security Act, or whether having a respondent certify or attest that their submitted research does not use QALYs or similar measures would be a more effective option. It also is unclear how CMS will ensure

[17] 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.

[18] Harrington R. L., Hanna M. L., Oehrlein E. M., et al. Defining patient engagement in research: Results of a systematic review and analysis: Report of the ISPOR Patient-Centered Special Interest Group. *Value Health*. 2020;23(6):677-688.

that the evidence it reviews does not rely on QALYs or similar measures. If in response to the question of whether the submitted evidence "treat[s] 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 respondent checks no, or fails to check boxes at all, what will CMS do? Will CMS commit to reviewing the underlying literature submitted and ensuring QALYs or similar measures are not the basis for the conclusions in the study regarding comparative effectiveness? Will CMS share such underlying literature with manufacturers of selected drugs as a check on CMS consideration of QALYs or similar measures?

Certification of Submission of Section I for All Respondents:

PhRMA appreciates CMS significantly revising the certification by removing, among other things, the clause that stated that "any misrepresentations may also give rise to liability, including under the False Claims Act." PhRMA continues to believe that patients and caregivers, responding in their individual capacity, may be chilled by a requirement to sign any certification whatsoever.

VI. Conclusion

PhRMA appreciates the opportunity to submit comments on the revised ICR. This letter includes our key priorities but does not represent the totality of our concerns with CMS' voluminous ICR. We urge OMB to review PhRMA's prior comments, and ensure CMS complies with the PRA in implementing the price-setting provisions of the IRA.

Please contact Judith Haron at jharon@phrma.org and/or Randy Burkholder at rburkholder@phrma.org if there is additional information we can provide or if you have any questions about our comments.

----s-----
Judith Haron
Deputy Vice President and
Assistant General Counsel
PhRMA

-----s-----
Randy Burkholder
Vice President
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June 20, 2023

VIA ELECTRONIC FILING - REGULATIONS.GOV

Meena Seshamani, M.D., Ph.D.
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 Drug Negotiation Process under Sections 11001 and 11002 of the Inflation Reduction Act (CMS-10849, OMB, 0938-NEW)

Dear Deputy Administrator Seshamani:

The Pharmaceutical Research and Manufacturers of America (PhRMA) is pleased to submit comments in response to the Centers for Medicare & Medicaid Services' (CMS, the Agency) *Information Collection Request for Drug Negotiation Process under Sections 11001 and 11002 of the Inflation Reduction Act* (ICR or the ICR), including the Federal Register Notice, Supporting Statement – Part A, and the ICR Form (Counteroffer Form) (CMS-10849, 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.

Under the "Medicare Drug Price Negotiation Program" (the Program) established in Sections 11001 and 11002 of the Inflation Reduction Act of 2022 (P.L. 117-169), codified in Sections 1191 through 1198 of the Social Security Act (SSA or the Act), a manufacturer of a selected drug may opt to submit a written counteroffer within 30 days of receipt of a written initial offer from CMS as part of the process the agency employs to set a "lowest maximum fair price" as required under the Act. The ICR and Counteroffer Form set forth the process and format CMS intends to follow for operationalizing the counteroffer process. Below we discuss several substantive and procedural concerns with the ICR and Counteroffer Form and recommend revisions to address them, including:

(1) Eliminating the primary/secondary manufacturer construct proposed by CMS;

(2) Developing a process for earlier, more effective communication between the manufacturer and CMS by providing for meetings earlier in the process;

[1] 88 Fed. Reg. 23,680 (Apr. 18, 2023); Centers for Medicare and Medicaid Services (CMS), Information Collection Request for Drug Negotiation Process under Sections 11001 and 11002 of the Inflation Reduction Act (CMS-10849, OMB, 0938-NEW), Supporting Statement – Part A (Apr. 18, 2023), https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849; CMS, Information Collection Request for Drug Negotiation Process under Sections 11001 and 11002 of the Inflation Reduction Act, ICR Form (Apr. 18, 2023), https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849.

(3) Creating a tool to provide information on the "30-day equivalent supply" so manufacturers can assess potential maximum fair prices (MFPs) at the level of specific National Drug Codes (NDC);

(4) Developing a template for the "concise justification" CMS will provide as part of its initial offer, so the manufacturer can understand how evidence and factors informed the offer;

(5) Eliminating the word limit on the manufacturer counteroffer justification;

(6) Modifying the certification requirement so it is not unduly burdensome;

(7) Recalculating the reporting burden estimate; and

(8) Ensuring that any proprietary information is protected in accordance with statutory requirements.

Eliminate the Primary/Secondary Manufacturer Construct

Consistent with our April 14th comments (attached with this submission as Appendix A) on CMS' initial Guidance[2] (Guidance, or the Guidance) on the Medicare Drug Price Negotiation Program and May 22nd comments (attached with this submission as Appendix B) on CMS' draft Information Collection Request for Negotiation Data Elements[3] (Negotiation Data Elements ICR), PhRMA strongly recommends that CMS eliminate the "Primary/Secondary" manufacturer construct in its entirety from the Program, including in the counteroffer process. The ICR Form indicates that a counteroffer must be submitted by a "Primary Manufacturer" of a selected drug. To the extent that more than one entity satisfies the IRA's definition of "manufacturer" for a selected drug, CMS plans to designate the entity that holds the New Drug Application(s) (NDA(s))/Biologics License Application(s) (BLA(s)) for the drug to be the "Primary Manufacturer."

"Primary Manufacturers" legally do not have access to "Secondary Manufacturer" information and, thus, the proposed Primary/Secondary Manufacturer policy contemplated in the Guidance should be eliminated. As Primary Manufacturers will not be able to procure and certify to information from Secondary Manufacturers, CMS is proposing an unrealistic standard that will often be impossible for manufacturers to meet. CMS should instead enter into separate agreements with each entity that satisfies the definition of manufacturer to obtain any essential information throughout the MFP setting process, including as it pertains to the counteroffer process.

Develop Process for Earlier, More Meaningful Manufacturer Engagement, Including Meetings Prior to the Counteroffer

In the Guidance and ICR, CMS proposes to allow up to three potential in-person or virtual meetings between a manufacturer and CMS as part of the MFP decision-making process, but only at the end of the process in instances where a manufacturer's written counteroffer is not accepted by CMS. Meetings at this stage, while useful, come far too late in the process to enable communication between the manufacturer and CMS that will be essential at earlier stages of the process. As recommended in prior comments, PhRMA urges CMS to revise its process to allow earlier, more meaningful manufacturer engagement to include meetings *before* the counteroffer stage of the process. Earlier meetings will be particularly important given the broad range and disparate types of data from manufacturers and public stakeholders that will factor into MFP decision-making, as well as the difficulty CMS will face in

[2] *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*

[3] 88 Fed. Reg. 16,983 (Mar. 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 (Mar. 21, 2023), https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10847; CMS, Information Collection Request for Negotiation Data Elements under Section 11001 and 11002 of the Inflation Reduction Act, ICR Form (Mar. 21, 2023), https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10847..

evaluating submitted data and conveying it to the manufacturer in a timely way. Given the broad range of data required throughout this price setting process, we also would encourage CMS to consider notifying manufacturers that their drugs are being considered for selection prior to the formal public announcement and initiation of the information collection request. As discussed in Section III.h. of our Guidance comments, PhRMA recommends that CMS offer manufacturers the opportunity to meet a minimum of three times *prior to* a counteroffer, including after drug selection but prior to initiation of the price setting process; prior to presentation of an initial offer; and, after presentation of the initial offer. PhRMA requests that CMS consider the concerns we raised in our comments on the Guidance, including, but not limited to, the insufficient number of meetings in the price setting process.

Create a Tool or Spreadsheet for Manufacturers to Evaluate How a Proposed MFP for a Selected Drug's "30-Day Equivalent Supply" Breaks Down by National Drug Code (NDC)

The Counteroffer Form requires manufacturers to submit a price for a selected drug in the form of a "single price per 30-day equivalent supply." The Form indicates that this format should be used "rather than unit – such as tablet, capsule, injection – or per volume or weight metric" and should be weighted across dosage forms and strength, as applicable. PhRMA reiterates the request from Section III.m. of our comments on the Guidance for CMS to provide better clarity as to how CMS plans to compute 30-day equivalent supplies to aid manufacturers in understanding the Agency's application of a single Maximum Fair Price (MFP) across dosage forms and strengths. We urge CMS to provide manufacturers with CMS' calculated 30-day equivalent supply for each NDC-9; the total number of units dispensed for each NDC-9 in the 2022 Part D Prescription Drug Event (PDE) data; and an electronic tool or Excel spreadsheet with CMS' 10-step calculation approach for applying the MFP across different dosage forms and strengths. Given the novelty of the program, the complexity of CMS' calculation, and the need to verify data inputs, it is imperative that manufacturers be able to review both the data and calculation methodology used by CMS.

Include in the ICR a Template that Describes How Submitted Data and MFP Factors Influenced CMS' Initial Offer

CMS notes in the proposed Counteroffer Form that it will provide a manufacturer with a "concise justification" for its initial offer based on factors described in Section 1194(e), as required by the SSA. This justification will play an important role in a manufacturers' consideration and development of a counteroffer, but the agency provides no detail on what it will or will not include in its concise justification. CMS should revise the ICR to include a template that will be used by the agency to provide the "concise justification" for its initial offer at a level that enables manufacturers to understand how data and MFP factors influenced the agency offer. Because these evaluations will need to occur on an indication-specific level (as reflected in CMS' Guidance), the template should convey summary information on data and factors on an indication-by-indication basis. As discussed in Section III.j. of our comments on the Guidance, PhRMA recommends that the template include information similar to the final published explanation, and that such justifications identify key pieces of information, including:

- Therapeutic alternative(s) for a selected drug (for each indication) and the rationale for selecting each therapeutic alternative;
- How CMS calculated the ceiling price;
- CMS's starting point and how it established this starting point;
- How each of the factors listed in section 1194(e) were weighed relative to one another in CMS' decision-making and details on how the starting point was adjusted upwards or downwards based on these factors;

- Data and analysis CMS developed and considered supporting each factor, including evidence provided by third parties CMS engaged formally or informally;
- If any data or evidence considered by CMS was generated from a study that referenced or relied on the Quality-Adjusted Life-Year (QALY) or other potentially discriminatory metrics;
- Benefits and impacts of a selected drug CMS considered; and
- Stakeholders (e.g., patients, caregivers, clinicians, and manufacturers), and other government agencies and organizations CMS engaged, formally or informally, including how stakeholder input explicitly informed CMS' determination of the MFP and selection of each therapeutic alternative.

We also believe that CMS should release information on the data and analysis that CMS received formally and informally (e.g., non-proprietary information on comparative effectiveness of treatments received through the Data Elements ICR process) but chose to not include in its determination of MFP as part of the initial justification. CMS should also outline any remaining questions or uncertainties that arose while formulating the initial offer. This information will allow manufacturers to be more responsive to CMS and tailor their counteroffer response to the information CMS deems most relevant and/or make the case for why CMS should reconsider information that may be particularly important to key stakeholders including patients and caregivers.

This detail and template are essential since the manufacturer must provide a justification in its counteroffer through a "Free Response" box that comprehensively responds to CMS' reasoning in the Agency's initial offer. As with the manufacturer justification of its counteroffer (addressed below), it is important for CMS to provide adequate detail in its concise justification of the initial offer. The statutory requirement to provide a "concise" justification simply means that the Agency should not include extraneous, unnecessary detail, but it does not permit an incomplete justification, and it does not relieve the Agency of the responsibility to explain how it considered, evaluated, and weighted each factor in deciding on an initial offer. CMS should provide more information on the substance of the template it will use for providing the initial justification and ensure it allows manufacturers to understand how various factors influenced the initial offer for different indications. CMS should also allow manufacturers the ability and sufficient time to review and refute the contents of CMS' justification before it is made public.

Eliminate Word Limit on Manufacturer Counteroffer Response

PhRMA urges CMS to eliminate all word limits across the data submission process including the 1,500-word limit on a manufacturer's justification of its counteroffer in the "Free Response" portion of the Counteroffer Form. A 1,500-word limit equals only about 2.5 pages. Based on the breadth of data CMS seeks for manufacturers to submit and the requirement for manufacturers to provide a justification for a counteroffer based on these factors, a response limited to 1,500 words will not allow for a meaningful response that covers the essential elements that are to be considered in the process. Manufacturers will inevitably be required to eliminate key details to meet the word limit requirement. Given the potential widespread impacts on patients and innovation from the MFP process, CMS would benefit from being able to evaluate the full scope of data on each selected product and therapeutic alternatives. Thus, CMS should remove any limitations on the breadth and type of data submitted by manufacturers when data is both initially shared with CMS and as part of this counteroffer process. Additionally, similarly to Negotiation Data Elements ICR, CMS should provide space for manufacturers to attach studies or other key pieces of information that support the manufacturer's counteroffer response.

Modify the Certification Requirement

The Certification statement of the Counteroffer Form requires manufacturers to certify that the submission is "complete and accurate" and requires manufacturers to "timely notify CMS" if information submitted has changed. In addition, it requires signing a statement regarding liability under the False Claims Act. In alignment with our comments on the Negotiation Data Elements ICR, CMS should modify the terms of the certification to require all submitters to agree that information is accurate and prepared *in good faith and after reasonable efforts*, with no requirement for completeness. If CMS retains the requirement for completeness, at a minimum "complete" should be defined to mean all sections of the form have been filled out. It is simply not rational to require a certification to completeness and accuracy when CMS bases the counteroffer process on negotiation factors for which the Agency seeks an extensive set of data while simultaneously limiting the number of words in the "Free Response." Furthermore, as noted above and in previous comments to CMS, in some cases "Primary Manufacturers" legally do not have access to "Secondary Manufacturer" information which makes it impossible for "Primary Manufacturers" to certify the accuracy and completeness of this data.

CMS also should remove the requirement of timely notification of changed information to avoid unintended noncompliance of the certification and unnecessary burden. This term of the certification, with no specification of the applicability of a time limit, adds an ongoing burden for submitters. Given the ongoing nature of scientific discovery and clinical research, data on cost and evidence on the uses of medicines (both for a selected drug and treatment alternatives) will continue to evolve over time and that new data will continually become available. Taken literally, CMS' requirement would mean that respondents would have an ongoing obligation to regularly update the counter-offer explanation to represent the most current scientific discoveries and evidence. We do not believe CMS intends such a burdensome obligation; nor that CMS is authorized to threaten penalties for failure to engage in these ongoing updates. We urge CMS to excise the "changed information" requirement from its collection.

Recalculate Reporting Burden Estimate, Which Likely is a Significant Underestimate

CMS estimates a total burden of 792.5 hours (79.25 hours * 10 respondents) and a total cost of $99,870.10 ($9,987.01 per respondent * 10 respondents) for manufacturer completion and submission of information in the Counteroffer Form. CMS explains it expects each manufacturer respondent will use a team of lawyers, health care professionals, economists, and business operation specialists to complete the form. PhRMA requests that CMS recalculate this reporting burden estimate, which we view as significantly underestimating the total actual burden and cost of responding based on the breadth of data to be considered as a result of this ICR and business operations required to evaluate counteroffer options. The estimated burden and cost also raise questions about the substantive nature of the "concise justification" CMS intends to provide to manufacturers as part of the price setting process, as well as concerns about the comprehensiveness of such justification, if each manufacturer respondent's response is anticipated to require only 79.25 hours to complete. Notably, CMS' estimate of its own costs and hours (in Table 2 of the Supporting Statement) appears to assign significantly more time to the Agency than to the manufacturers who will be gathering, presenting, and distilling counter-offer information.

Ensuring That Any Proprietary Information is Protected in Accordance with Statutory Requirements

As discussed in our previous comments on the Guidance and the Negotiation Data Elements ICR, protection of manufacturer confidential data is critically important. We note that it is likely that manufacturers may submit proprietary data to CMS to help justify the submitted counteroffer. As such, PhRMA recommends that CMS protect confidential information beyond the protections of FOIA Exemption 4, share its confidentiality policy for comment, and ensure contractors and others with access to manufacturer data have agreements with CMS that adequately protect the high volumes of proprietary information CMS will collect. Please see Section I.d. of our Guidance comments for additional recommendations and feedback on the need for CMS to protect proprietary information.

Conclusion

PhRMA appreciates the opportunity to submit comments in response to the *Information Collection Request for Drug Negotiation Process under Sections 11001 and 11002 of the Inflation Reduction Act*, including the Federal Register Notice, Supporting Statement – Part A, and the ICR Form. PhRMA urges CMS to carefully consider our recommendations for revising the Counteroffer Form and related process.

Please feel free to 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.

Sincerely,

-----s-----
Jennifer Bryant
Executive Vice President
Policy, Research, and Membership
PhRMA

----s-----
James C. Stansel
Executive Vice President and General Counsel
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August 24, 2023

Via Electronic Filing - RegInfo.gov

Office of Management and Budget (OMB)
725 17th St NW
Washington, DC 20503
Attn: OMB Desk Officer

Re: Information Collection Request for Drug Price Negotiation Process under Sections 11001 and 11002 of the Inflation Reduction Act (CMS-10849, OMB, 0938-NEW).

To The OMB Desk Officer:

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 Drug Price Negotiation Process under Sections 11001 and 11002 of the Inflation Reduction Act (ICR or the ICR), including the Federal Register Notice, Supporting Statement – Part A, and the ICR Form (Counteroffer Form) (CMS-10849, OMB, 0938-NEW), and the Comment Summary Responses submitted to the Office of Management and Budget.[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 submitted comments on CMS' original ICR, noticed in the Federal Register on April 18th, 2023 for a 60-day comment period.[2] Unfortunately, CMS fails to address significant aspects of these comments, including: eliminating the primary/secondary manufacturer construct proposed by CMS; developing a template for the "concise justification" CMS will provide as part of its initial offer, so the manufacturer can understand how evidence and factors informed the offer; fully eliminating the word limit on the manufacturer counteroffer justification, particularly in the first year; and modifying the certification requirement so it is not unduly burdensome. While CMS has increased the burden estimate (from 79 to 204 hours per selected drug), PhRMA continues to believe that the Agency has significantly underestimated the burden of its demands.

Rather than reiterate prior comments, PhRMA is attaching our comments on CMS' initial Guidance (Appendix A), our comments to CMS and OMB in response to the initial and revised Negotiation Data

[1] See 88 Fed. Reg. 47880 (Jul. 25, 2023); https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849; https://www.reginfo.gov/public/do/DownloadDocument?objectID=133856200.
[2] 88 Fed. Reg. 23680 (Apr. 18, 2023).

Elements ICRs (Appendix B and C), and our comments to CMS on the initial Negotiation Process ICR (Appendix D) as well as outlining in this letter the main reasons CMS' ICR continues in its failure to comply with the letter and spirit of the PRA.

Unnecessary Word and Other Limits

While PhRMA recognizes CMS increased the word limit on a manufacturer's justification of its counteroffer in the "Free Response" portion of the Counteroffer Form from 1,500 words to 2,500 words, PhRMA still urges the Agency to eliminate all word limits across the data submission process, particularly in the first year. A word count of 2,500 words equals slightly more than half a page for each of the nine factors CMS must consider in price-setting.[3] This is insufficient for manufacturers to provide a meaningful and substantive justification. Moreover, CMS has subdivided these nine factors into multiple subparts, resulting in a 47-page information collection for the negotiation data elements.[4] Limiting manufacturers to five pages for the counter-offer justification, when CMS found it necessary to issue 47 pages for the initial negotiation data elements information collection, demonstrates how grossly disproportionate and unfounded CMS' word limits are and how limiting responses may affect the utility of the responses provided.

Further, while CMS will allow an option to upload tables, charts, and/or graphs alongside the counteroffer justification, it limits the submission to ten visual representations, and states that any tables or charts consisting of text only will not be considered. CMS does not explain or justify why a limit of ten is reasonable, nor why text-based charts or tables will not be considered. Charts or graphs may more clearly represent complicated data than text-based explanations; thus, it is particularly puzzling that CMS would place a limit on these visual attachments or refuse to consider text-based tables or charts. Likewise, CMS fails to offer any justification for a limit of fifty citations. Again, such limitations affect the utility of the information provided.

Access to Secondary Manufacturer Information

Primary Manufacturers may not necessarily have access to Secondary Manufacturers' information, particularly within the deadlines required under the MFP program. While CMS notes that Primary Manufacturers may have "agreements" with Secondary Manufacturers, it fails to address or even acknowledge the narrow window (revised guidance and template Final Agreement not issued by CMS until late June/early July, just three months before data submission will be due to CMS; only 30 days between drug selection and data submission) for revising such agreements. OMB should prevail on CMS to further explain its reasoning on this issue and create exceptions for Primary Manufacturers unable to revise their agreements with Secondary Manufacturers or unable to provide data from such Secondary Manufacturers.

Written Communication to Facilitate Manufacturer Input

While we appreciate that the revised Guidance allows for one additional meeting between selected drug manufacturers and CMS (which would occur before CMS makes its initial offer), we still are concerned

[3] SSA § 1194(e).
[4] https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10847.

by the lack of clarity regarding what information CMS will evaluate and how CMS will evaluate this information. CMS notes in the Counteroffer Form that it will provide a manufacturer with a "concise justification" for its initial offer based on factors described in Section 1194(e), as required by the SSA. Although this justification could play an important role in a manufacturers' consideration and development of a counteroffer, the Agency provides no detail or template on what it will or will not include in its concise justification.

This detail and template are essential since the manufacturer must provide a justification in its counteroffer through a "Free Response" box that comprehensively responds to CMS' reasoning in the Agency's initial offer. OMB should ensure that CMS creates and utilizes a template or some other form to ensure the justification provides adequate information to manufacturers that allows manufacturers to understand how various factors influenced the initial offer. This information will help reduce the burden on respondents by enabling manufacturers to be more responsive to CMS and tailor their counteroffer response to the information CMS deems most relevant and/or make the case for why CMS should reconsider information that may be particularly important to key stakeholders including patients and caregivers as needed.

The statutory requirement to provide a "concise" justification simply means that the Agency should not include extraneous, unnecessary detail, but it does not permit an incomplete justification, and it does not relieve the Agency of the responsibility to explain how it considered, evaluated, and weighted each factor in deciding on an initial offer. As such, OMB should work with CMS to make sure that a comprehensive form is created and used to make sure all selected drug manufacturers have sufficient information as outlined in our previous comments to CMS.

Certification Requirements

The Certification statement of the Counteroffer Form requires manufacturers to certify that the submission is "complete and accurate" and requires manufacturers to "timely notify CMS" if information submitted has changed.

CMS responded to comments asking that it remove the reference to "completeness," or at least define what constitutes a "complete submission," by stating: "a complete submission is a full submission that reflects the standards described in this ICR and the revised guidance and is within the respondent's information, knowledge, and/or experience."[5] This explanation sheds no further light on how CMS will evaluate completeness. The explanation incorporates unspecified, open-ended standards of the entire ICR, as well as CMS' revised guidance. CMS' explanation in response to comments uses the word, "full," without defining what a "full" submission means.

Consistent with our comments on the Negotiation Data Elements ICR, OMB should prevail upon CMS to modify the terms of the certification so that it requires submitters to agree that information is accurate and prepared in good faith and after reasonable efforts, without an ill-defined requirement for "completeness." If CMS retains the requirement for completeness, at a minimum, the Agency should define "complete" only to mean that all sections of the form have been filled out. It simply is not rational to require a

[5] https://www.reginfo.gov/public/do/DownloadDocument?objectID=133856200

certification to completeness and accuracy when CMS bases the counteroffer process on negotiation factors for which the Agency seeks an extensive set of data while simultaneously limiting the number of words in the "Free Response." Furthermore, as noted above and in previous comments to CMS, in some cases "Primary Manufacturers" legally do not have access to "Secondary Manufacturer" information which would make it impossible for "Primary Manufacturers" to certify the accuracy and completeness of these data if such data are included in a justification.

CMS also should remove the requirement of timely notification of changed information to avoid unintended noncompliance of the certification and unnecessary burden. CMS failed to respond to comments that this term of the certification is particularly burdensome and lacking in utility, because it has no time limit, fails to recognize the ongoing nature of scientific discovery and clinical research, and fails to recognize that data and information evolve over time.

In response to the initial round of comments on the counter-offer information collection, CMS could have clarified that information should be corrected if it becomes clear that, at the time of submission, the information was in error. Instead, CMS notes it "believes" that the "timely notification of changed information requirement in the certification is necessary for the Medicare Drug Price Negotiation Program as it ensures the MFP is negotiated based on the most current data." This statement fails to respond to the comments noted above. We urge OMB to work with CMS to update this certification and remove the problematic statement about changed information.

Finally, OMB should require CMS to eliminate its vague statement of liability that misrepresentations "may" give rise to an unspecified "liability," "including" liability under the False Claims Act. CMS responds to comments by noting that the certification language aligns with "other information collection requests related to the Negotiation Program."[6] But CMS' only point of comparison is the newly created "Negotiation Program" (that is, price-setting) under the IRA, not more established information collections. It is hardly compelling to justify the certification's liability statement by citing to other, newly created collections under price-setting, and not long-standing or even more recent agency information collections. OMB should work with CMS to ensure that its liability statement accords with more typical information collections, and prohibit CMS from creating its new, unspecified liability certification.

Burden Estimate

As stated in our previous comments to CMS, the burden estimate is likely a significant underestimate. We recognize CMS modified its estimate and now states that it expects each manufacturer respondent will have a burden of 204.25 hours and a total cost of $32,731.39 per respondent.[7] However, given (a) the novelty of the program, (b) the scope of information being requested, (c) the need to evaluate the section 1194(e)(2) data submitted by other respondents, and (d) the number and potential variety of national drug codes CMS includes as one "qualifying single source drug," PhRMA anticipates that time

[6] Id. at 9.
[7] Supporting statement at 8-9

spent preparing, evaluating, and submitting the counter-offer form will be several multiples of CMS' estimate. OMB should carefully evaluate CMS' burden estimate to ensure accuracy.

Conclusion

PhRMA appreciates the opportunity to submit comments on the revised ICR. This letter includes our key priorities but does not represent the totality of our concerns with CMS' ICR or the ICR process. We urge OMB to review PhRMA's prior comments, and ensure CMS complies with the PRA in implementing the price-setting provisions of the IRA.

Please contact Judith Haron at jharon@phrma.org and/or Randy Burkholder at rburkholder@phrma.org if there is additional information we can provide or if you have any questions about our comments.

----s-----
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-----s-----
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July 2, 2024

VIA Electronic Filing – *IRARebateandNegotiation@cms.hhs.gov*

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Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for the Initial Price Applicability Year 2027, and Manufacturer Effectuation of the Maximum Fair Price in 2026 and 2027

Dear Deputy Administrator Seshamani:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS, the Agency) *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027* (Guidance or the Guidance) which CMS released on May 3, 2024.[1] We represent 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. Our sector is one of the most research-intensive industries in the United States: over the last decade, PhRMA member companies have more than doubled their annual investment in the search for new treatments and cures, including nearly $101 billion in 2022 alone.[2]

PhRMA has longstanding concerns about the impact of government price setting on patients. Our concern is grounded in the industry's substantial and longstanding experience with price setting policies in foreign countries, where patients go without or face significant delays before accessing many important treatments.[3] We are deeply concerned that Medicare beneficiaries could see parallel access disruptions resulting from the IRA's price setting provisions. Those provisions are also creating considerable uncertainty that will hamper development of life-changing treatments and cures.

To an extent, patient access and innovation will always be under threat as long as the price setting provisions of the IRA remain in place. This is true to an even *greater* extent if policymakers are successful in their rushed

[1] CMS. (May 3, 2024). Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027. Available at: https://www.cms.gov/files/document/medicare-drug-price-negotiation-draft-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf.
[2] PhRMA. (July 26, 2023). 2023 PhRMA Annual Membership Survey. Available at: https://phrma.org/resource-center/Topics/Research-and-Development/2023-PhRMA-Annual-Membership-Survey
[3] PhRMA. (April 12, 2023). New Global Analysis Shows Patient Access Challenges Around the World. Available at: https://phrma.org/Blog/New-global-analysis-shows-patient-access-challenges-around-the-world

attempts to *expand* the Medicare Drug Price Negotiation Program (Program) to include additional drugs or market segments only two years following enactment of the law.[4] However, as we emphasized in our comments on the Initial Guidance for IPAY 2026, CMS has an opportunity to promote transparency, accountability, and confidentiality in the Program's operation through implementation.

We are disappointed that after more than a year of hearing concerns and feedback from stakeholders, CMS has largely[5] stayed its course in the Guidance for IPAY 2027. In this letter, we articulate our core concerns with CMS' Draft Guidance for IPAY 2027, as follows:

I. CMS is not negotiating with manufacturers; it is setting drug prices in an arbitrary manner that is highly susceptible to politicization.

II. CMS' implementation of the Program puts patient access to medicines in Medicare Part D at risk.

III. CMS' implementation of the Program undermines competitive marketplace dynamics, which successfully drives patient access to new medicines and cost containment.

IV. CMS' implementation of the Program will do irreparable harm to innovation, to the detriment of patients.

V. CMS has failed to implement proper safeguards to protect patients and clinicians in its implementation of the Program.

Aside from outlining our core concerns with the Guidance, we are attaching to this letter several Appendices that provide technical, in-depth input on specific issues. In many instances, the consensus-based recommendations outlined in the Appendices are in addition to feedback that PhRMA has previously provided to CMS in other comment letters or forums. The topics they focus on are of great importance to PhRMA's membership, and we welcome the opportunity to discuss them in more detail with CMS staff.

Appendix A: Drug Selection;

Appendix B: Effectuation of the Maximum Fair Price; and

Appendix C: Strengthening Access and Formulary Protections in Medicare Part D.

Despite our aforementioned concerns regarding government price setting, in advance of IPAY 2026, PhRMA recognized CMS' statutory obligation to implement the Program. Thus, in response to Initial Guidance for IPAY 2026[6], PhRMA articulated concrete, actionable recommendations for CMS on implementation of the Program in issue areas that were open for comment. Unfortunately, CMS disregarded most of PhRMA's recommendations, as it did with most stakeholder feedback in advance of IPAY 2026.[7] We strongly recommend CMS revisit and adopt PhRMA's prior recommendations in implementing the Program for IPAY 2027. We have attached those prior recommendations as Appendix D.

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[4] The White House. (March 7, 2024). Remarks of President Joe Biden – State of the Union Address as Prepared for Delivery. Available at: https://www.whitehouse.gov/briefing-room/speeches-remarks/2024/03/07/remarks-of-president-joe-biden-state-of-the-union-address-as-prepared-for-delivery-2/

[5] We are disappointed that CMS has, on most issues, not changed course on its implementation of the Program. However, PhRMA appreciates the significant expansion of Agency guidance covering effectuation of the Maximum Fair Price (MFP), although we continue to have concerns that the process for Primary Manufacturers to provide access to the MFP, as proposed by the Agency, creates significant financial and operational burdens on manufacturers and other supply chain stakeholders. PhRMA offers technical comments on this portion of the Guidance in Appendix B (Effectuation of the Maximum Fair Price) of this letter.

[6] PhRMA. PhRMA Comments on CMS Initial Guidance on Medicare Drug Price Negotiation Program. (April 14, 2023). Available at: https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Org/PDF/G-I/PhRMA-Comments-on-CMS-Initial-Guidance-on-Medicare-Drug-Price-Negotiation-Program22948.pdf

[7] CMS also intentionally did not solicit comments on foundational aspects of the IPAY 2026 guidance, such as Section 30 (discussing QSSD and bona fide marketing).

* * *

I. CMS is not negotiating with manufacturers; it is setting drug prices in an arbitrary manner that is highly susceptible to politicization.

The IRA and CMS label government price setting as "negotiation." Indeed, CMS' Guidance used this term nearly 400 times. But simply repeating the word does not make it true. In reality, the IRA provides for highly limited exchanges between manufacturers of "selected drugs" and CMS. As noted by those with experience in the negotiations that occur between insurance companies and biopharmaceutical manufacturers in the private sector, the Program in no way resembles such negotiations, and should not be mistaken for such.[8] Put simply, CMS has the unilateral, nearly unconstrained authority to both set any price it wishes below a statutory ceiling and impose severe penalties on manufacturers who do not agree to the CMS-set price, with little-to-no transparency on how CMS reached this price in the first place.

Below, we outline the specific aspects of the IRA price setting framework, and CMS' implementation of the Program, supporting our assertion that it does not constitute "negotiation."

"Negotiation" under the IRA does not in any way resemble negotiations that occur in the private market.

Manufacturer Penalties

If a manufacturer fails to agree to the price CMS sets, the manufacturer faces either exclusion from entire market segments or severe financial penalties that would be impossible for any company to sustain. Under the IRA, if a manufacturer doesn't agree to "negotiate" or agrees to negotiate but doesn't agree to the CMS-set price, it must withdraw *all* of its products from the entirety of the approximately 45 percent of the nationwide retail prescription drug market comprised of Medicare and Medicaid spending.[9] Manufacturers' only alternative is to accept an excise tax of up to 1,900 percent and, in some circumstances, civil monetary penalties. Those are not potential outcomes in actual negotiations. These penalties are severe and disproportionate to other penalties imposed by Medicare; they are clearly intended to command compliance, rather than encourage true negotiation.[10]

Moreover, the government is empowered to impose significant fines, including a $1 million dollar per day penalty on manufacturers if they do not produce an extremely broad array of information, much of it proprietary, difficult to accumulate, and not relevant to setting a Medicare price. However, manufacturers have no equivalent authority to demand information of the government related to its analysis and decision making. CMS' authority to compel a manufacturer to produce data under threat of severe penalties is another of many signs that the Program does not represent actual negotiation.

Ceiling Price

The IRA price setting framework, unlike actual negotiation, includes a ceiling, or absolute cap on a medicine's price in Medicare based in part on the time since the medicine was approved by FDA. This ceiling is not subject to negotiation and cannot be exceeded for any reason, including factors such as the drug meeting an unmet medical need, its superiority over alternative treatments, or new uses that recently obtained FDA approval or that are under development through ongoing clinical trials. We are not aware of any bona fide, private market negotiations in which the purchaser starts with a ceiling price set externally and enforces its chosen price with harsh penalties.

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[8] Shah S. (June 20, 2024). Here are four reasons Medicare drug-price 'negotiation' in NJ isn't truly a negotiation. Courier Post. Available at: https://www.courierpostonline.com/story/opinion/2024/06/13/medicare-drug-price-negotiation-in-nj-isnt-truly-a-negotiation/73896264007/

[9] CBO. (January 2022). Prescription Drugs: Spending, Use, and Prices. Available at: https://www.cbo.gov/publication/57772

[10] In fact, the Congressional Budget Office score for the IRA presumes that the excise tax will not generate any revenue independent of its effects on Medicare drug pricing through imposition of the government's MFP. See Congressional Budget Office, Estimated Budgetary Effects of Public Law 117-169, to Provide for Reconciliation Pursuant to Title II of S. Con. Res. 14 at 5 (Sept. 7, 2022). Available at: https://www.cbo.gov/system/files/2022-09/PL117-169_9-7-22.pdf.

Renegotiation

Finally, the result of an IRA "negotiation" can always be reopened by one party – the Secretary – but not by manufacturers, and the statute purports to insulate renegotiations from administrative and judicial review. Under Section 1194(f) of the Social Security Act (SSA), the Secretary will "renegotiate" a previously set "negotiated" price whenever "the Secretary determines there has been a material change" in any of the clinical or manufacturer-specific factors.[11] To date, the Secretary has declined to provide direction regarding what would constitute a "material change," leading to uncertainty in the commercial stability of the prices the Secretary imposes when a manufacturer is first subject to an MFP, and leading to concerns that the Secretary may seek to upend these previously set prices at an unknown future time.[12]

Other Elements

Beyond the aforementioned issues, it is also notable that IRA "negotiation" has none of the hallmarks of actual negotiation over drug prices that occur in the commercial market. Based on our membership's vast experience in such negotiations (experience that CMS is notably lacking), there are numerous other examples of how the Program diametrically differs from true private market negotiation, including the following:

- **Access Tradeoffs.** In true negotiation, drug prices are balanced against patient access to the drug, including issues such as formulary tiering and utilization management; under the Program the price of a selected drug is set without reference to the terms of that drug's coverage, other than it must be offered by Part D plans. The parameters of access for selected drugs remain to be determined by Part D plans, which, in exchange for needing to cover the selected drug, receive the government-set price as a *starting point* for negotiations with manufacturers, without regard to how they cover the medicine.

- **Terms and Conditions.** In a true negotiation, the parties can offer revision, clarification, amendment, or customization of the non-price terms and conditions of a contract; under the Program, CMS publishes a "one size fits all" contract of adhesion that manufacturers must sign – and that agreement contains unilateral amendment authority for CMS, but not the manufacturer;[13]

- **Timing of Contract.** In a true negotiation, parties sign a contract after agreeing to a price term; under the Program, manufacturers must sign an agreement before CMS offers a final price;

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[11] Section 1194(f) provides for renegotiation in additional circumstances.

[12] CMS and the Department of Justice (DOJ) have stated, without further explanation, that manufacturers may simply cease selling their products to Medicare. For example, DOJ argues that there is no "mechanism to force manufacturers to actually make sales of any drug," and that "after signing the agreement with CMS, [a manufacturer]" could "refuse to transfer [a selected drug] to Medicare at all," and "that would not be prohibited by the IRA." *Bristol Myers Squibb Co. v. Becerra*, No. 23-cv-03335-ZNQ (D.N.J., Dec. 22, 2023), ECF No. 84 at 32. In the draft guidance, CMS states that a manufacturer "is not obligated to make sales of the selected drug." Draft Guidance at § 40.4. Both CMS and DOJ fail to acknowledge that manufacturers do not "transfer" drugs to Medicare – they typically sell drugs to wholesalers, who sell to a pharmacy or other dispenser. Medicare is a payer – it does not purchase an inventory of drugs directly from manufacturers (or wholesalers). Further, the manufacturer does not have knowledge of the insurance status of the patient when it sells its drugs. CMS presumably understands the pharmaceutical supply chain and yet continues to make and allow statements that willfully ignore it. At the very least, if CMS and DOJ believe that blocking sales or transfers of drugs "to Medicare" is an option, the Agency should explain the logistical and legal rationales for how manufacturers could cease selling selected drugs to Medicare beneficiaries "at all."
CMS and DOJ have also argued that CMS may read the Agency's authority to *involuntarily* terminate Part D agreements for a manufacturer's knowing or willful violation or other good cause as somehow equivalent to a manufacturer *voluntarily* withdrawing using the manufacturer's own authority. *Compare* clause (i) and clause (ii) of SSA §§ 1860D-14A(b)(4)(B) and 1860D-14C(b)(4)(B), respectively. However, CMS does not explain how its reading accords with the canon of statutory construction that a term must be understood in light of "the neighboring words with which it is associated," *United States v. Williams*, 553 U.S. 285, 294 (2008), or is anything more than pretext to paint the IRA program in the light most favorable to the Agency's litigation posture without regard to the plain language in the law.

[13] The agreement states: "CMS retains authority to amend this Agreement to reflect changes in . . . guidance. When possible, CMS shall give the Manufacturer at least 60-day notice of any change to the Agreement." Available at: https://www.cms.gov/files/document/inflation-reduction-act-manufacturer-agreement-template.pdf.

- **Legal Recourse.** In a true negotiation, either party may seek to redress any legal and equitable claims; under the Program, the statute purports to limit manufacturers from seeking any form of judicial or administrative review of fundamental Agency actions; and

- **Disclosure of Information.** In a true negotiation, parties may – but certainly are not required to – turn over any manufacturing or distribution costs, sales forecasts, marketing budgets, or other trade secrets or proprietary data demanded by the other party; under the Program, CMS requires the submission of extensive, highly-sensitive data in a truly burdensome manner.[14,15]

These issues are further compounded by the lack of transparency stakeholders, including manufacturers of selected drugs, have into the price setting process. This lack of transparency limits the ability of the manufacturer to produce data that will be impactful and help inform CMS decision making. As such, manufacturers of selected drugs have found interactions with CMS thus far to be lacking in the type of information sharing and dialogue that would accompany a true negotiation. CMS seeks feedback on whether CMS should conduct fewer meetings with manufacturers of selected drugs in IPAY 2027. Based on the IPAY 2026 experience, however, fewer meetings would only exacerbate the opacity of the price setting process for manufacturers. PhRMA strongly recommends that CMS meet with the same frequency with manufacturers as in IPAY 2026 but also provide insight into its thinking, processes and next steps so that manufacturers may appropriately engage.

The IRA grants CMS broad price setting authority that is highly susceptible to politicization.

Lack of Transparent Methodology for Price Setting

Instead of establishing the "consistent process and methodology" required by Section 1194 of the SSA, CMS has stated it will take a "qualitative approach" to setting and adjusting the starting price based on the "totality of the relevant information and evidence" about the medicine and the identified "therapeutic alternative(s)". That price will then be adjusted by an undefined amount based on one or more of the "manufacturer-specific" factors listed in SSA Section 1194(e)(1)[16], with the factors considered "in isolation or in combination with other factors."[17]

Unfortunately, CMS' Guidance does not provide any insight into:

- How the evidence CMS develops on its own and receives from manufacturers and the public will be converted into conclusions about the factors;

- How the factors will be weighted;

- How CMS will determine whether and by how much to adjust the price for the factors that "may" be used to adjust price, and whether to consider those factors singly or in combination; and

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[14] Internal feedback based on company survey of experience indicates that the information collection process was extraordinarily more burdensome than CMS estimated despite the extensive recommendations PhRMA provided to CMS on how to more productively facilitate collection. CMS not only requested information that was almost impossible to collect but also in a manner that significantly differed from corporate record-keeping.

[15] Of note, in the most recent Guidance outlined in "Appendix A (Definitions for Purposes of Collecting Manufacturer-Specific Data), CMS includes a new "Market Data and Revenue and Sales Volume Data" element on Manufacturer net Medicare Part D price. Specifically, CMS seeks to collect the "net Medicare Part D price as calculated by the Primary Manufacturer," and goes on to elaborate that the Agency seeks "specific data to which the manufacturer has access including coverage gap discounts and other supply chain concessions (e.g., wholesale discounts) not reflected in the sum of the plan-specific enrollment weighted amounts calculation, and utilization that may differ from the PDE data". This data element is concerning. If viewed as an attempt to aggregate price concessions from supply chain entities across the pharmaceutical supply chain, it would not represent an accurate assessment of net Medicare Part D price at the NDC-11 level. This is not only an inaccurate accumulation of discounts for CMS to require but represents significant burden upon Primary Manufacturers that would be required to track and aggregate, at the NDC-11 level, "supply chain concessions". The term also is overly broad, particularly the references to "other supply chain concessions" and "wholesale discounts" with little direction for accurate data collection.

[16] CMS. (June 30, 2023). Revised Medicare Drug Price Negotiation Program Guidance. Available at: https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf, Section 60.3.3.1, pg. 149.

[17] Ibid, Section 60.3.4, pp. 150-51.

- How the evidence and factors will be translated into a specific price.

This lack of clear, objective standards or any explanation of how these criteria will be used in price setting means CMS can specify any price below the ceiling and will likely always be able to conjure a justification. Without a transparent and predefined protocol for the Agency's evidence identification and review process., experts within CMS risk targeting the wrong sources, omitting important evidence, and increased subjectivity and bias in their review – making it difficult to replicate findings. In fact, the Guidance itself contains clear examples of CMS putting its thumb on the scale to achieve lower prices beyond the authority it is granted in statute.[18]

Politicization of Price Setting

Per the IRA, Maximum Fair Prices are set by Secretary of Health and Human Services, a political appointee, who is accorded broad decision-making authority and whose decisions are purportedly exempt from administrative and judicial review for the most consequential aspects of the Program. CMS has also argued that the Agency need not engage in notice-and-comment rulemaking to consider the views and expertise of stakeholders.

Regardless of the approach taken by the Secretary, there is a significant threat that either a current or future Secretary could make predominantly political decisions regarding prices of selected drugs. For instance, a Secretary may decide that political circumstances dictate that an election year is an optimal time to renegotiate by determining a "material change" has occurred. Or the Secretary could set excessively low prices to demonstrate that an Administration is lowering seniors' costs. Although not every Secretary may be so politically motivated, the unconstitutional legislative authority delegated by the IRA (as discussed below) means that there exists broad opportunity and incentives for setting prices on a political basis, and the Program contains *absolutely no safeguards against politically set prices*. CMS appears to have declined its responsibility to address this issue in the Guidance.[19]

Unconstitutional Delegation of Authority

Indeed, the price setting authority under the IRA is so overly broad that it amounts to an unconstitutional delegation of legislative authority. CMS has already taken advantage of that unconstrained delegation, going beyond the statute to impose its own definition of what is a "Qualifying Single Source Drug" (QSSD), and its own vague standard for whether a generic drug or biosimilar product is "marketed" such that a listed or reference drug cannot be selected for price setting. CMS also has arbitrarily offered conflicting interpretations of what entities qualify as a "manufacturer" subject to price setting—imposing vicarious responsibility and liability on primary manufacturers for the information and actions of unrelated corporate entities that the Agency deems "secondary manufacturers," while simultaneously asserting that only a subsidiary corporation listed on an FDA application (and not a parent entity) has standing to sue.[20] In these ways, CMS has quickly demonstrated how

[18] CMS also proposes in Section 60.3 of the Draft Guidance to use, in certain cases, the "Part D total gross covered drug cost (TGCDC) net of DIR and CGDP [coverage gap discount program] payments . . . for the therapeutic alternative(s)," as part of establishing the starting point for developing an initial offer for a selected drug. This proposal violates the intent of the IRA and must not be finalized. Nothing in the IRA reflects a Congressional intent for CMS to consider manufacturer or coverage gap discounts in price-setting. To the contrary, the statute specifically excludes selected drugs from the definition of "applicable drugs" subject to the manufacturer discount in Part D, the successor to the CGDP. SSA § 1860D-14C(g)(2)(B). Yet, CMS' proposal would circumvent this intent by using – as the comparative starting point for establishing an MFP – a price that reflects these discounts. Effectively, CMS would be reincorporating the discounts into the MFP, when Congress specifically required that manufacturers of selected drugs are exempt from such discounts. We further note that Congress instructed CMS, as part of price setting, to include in the ceiling price the Part D "price concessions" that are received by the plan or pharmacy benefit manager on behalf of the plan and constitute direct or indirect remuneration. SSA § 1194(c)(2)(A). Congress did not direct CMS to include estimated Part D manufacturer or coverage gap discounts as part of this calculation.

[19] Examples of actions CMS could take to limit political influence over price setting include establishing a consistent methodology for arriving at prices for selected drugs or establishing a robust dispute resolution process.

[20] *Merck v. Becerra*, Case No. 1:23-cv-01615 (D.D.C.), ECF No. 24 at 19-20 (arguing lack of standing due to a subsidiary holding the NDA for the selected drug); *Dayton Area Chamber of Comm. v. Becerra*, Case No. 3:23-cv-00156 (S.D.Ohio), ECF No. 71 at 13-14 (arguing that Pharmacyclics, a subsidiary of AbbVie, is the only entity harmed by price setting).

unconstrained it views its authority. Indeed, CMS has even told a federal court that it is empowered to misread statutory language that is "clear as a bell," without any opportunity for judicial review.[21]

II. CMS' implementation of the Program puts patient access to medicines in Medicare Part D at risk.

In comments on CMS' Initial Guidance for IPAY 2026, many stakeholders raised concern that CMS price setting in Part D could disrupt patient access to care and result in barriers to needed medicines. The Agency acknowledged this in its IPAY 2026 Revised Guidance and repeated it again in the Draft Guidance for IPAY 2027, stating "… CMS is concerned that Part D sponsors may be incentivized in certain circumstances to disadvantage selected drugs by placing selected drugs on less favorable tiers compared to non-selected drugs, or by applying utilization management (UM) that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs."[22]

CMS' concern is well-placed. Disadvantaging drugs means disadvantaging *patients* who will face more barriers to obtaining the medicine they need. To guard against the negative impacts of price setting, which are compounded by other provisions of the IRA related to Part D, it is critical that CMS maintain and improve upon existing statutory and regulatory formulary standards. Nondiscrimination and formulary standards are essential elements of Part D;[23] to the extent those standards were adequate prior to enactment of the IRA, they are no longer likely to remain adequate under pressure from the effects of the IRA. Our detailed recommendations for improvements to Part D formulary standards are provided in Appendix C (Strengthening Access and Formulary Protections in Medicare Part D).

Medicare patients need timely access to a choice of medicines to ensure effective treatment of a range of serious diseases and conditions.

Patients' access to medicines is central to our ability to effectively improve health and reduce downstream costs. For example, medicines have profoundly changed what it means for a patient to have and be treated for cardiovascular and cerebrovascular diseases, many cancers, diabetes, HIV/AIDS, and depression. Leading researchers have attributed 35 percent of the 3.3-year gain in life expectancy from 1990-2015 to pharmaceuticals, compared to 13 percent attributable to other medical care.[24]

However, to improve patient health outcomes with medicines, patients must have timely access to medicines. This involves ensuring individual patients have access to the range of medicines they may need to meet their specific needs and circumstances. As a result, it is important to ensure that formulary coverage, tiering and UM operate as tools for health plans to effectively negotiate with manufacturers and appropriately control costs, and *not as* barriers to obtaining the right medicine for a given patient. It is precisely because it is important for patients and

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[21] *AstraZeneca v. Becerra*, Case No. 1:23-cv-00931, Tr. Oral Argument at 99-100 (D. Del. Jan. 31, 2024) ("THE COURT: Let's say this is. I read the statute. It's clear as a bell . . . So let's just say I agree with AstraZeneca on that. When would a drug company be able to challenge your designation of its blockbuster product? Let's say it only makes one product. When can it do that? MR. NETTER: So it wouldn't be able to, Your Honor. THE COURT: Ever? MR. NETTER: Ever? Well, unless they could try to convince Congress to change the statutory bar. But it's Congress' prerogative. THE COURT: That doesn't bother you, that you could have -- again, imagine it was, again, that there was no other ambiguity in the statute to shed doubt on AstraZeneca's interpretation. So you're saying that an Agency can come along and can issue a regulation that absolutely contradicts the explicit statutory text of Congress? And here -- and you're saying, tough noogies, there's no review? MR. NETTER: That is the outcome of the standard analysis on judicial bars.").

[22] Section 110. Presumably CMS' concern is rooted in the possibility that Part D plans will prefer non-selected drugs with higher list prices and higher rebates to selected drugs with lower list prices.

[23] Certain Part D formulary standards were premised on the Medicare Modernization Act's nondiscrimination requirements at Section 1860D-11(e)(2)(D)(i). Research on Part D and other programs suggests formulary design can be used as a way to encourage or discourage enrollment by certain beneficiaries, https://www.nber.org/papers/w22338 and https://www.aeaweb.org/articles?id=10.1257/pol.20170014. This underscores the need for improved formulary standards and risk adjustment as existing standards are challenged by dramatic program design changes that could encourage new barriers to patient access to medicines.

[24] Buxbaum J.D., Chernew M.E., Fendrick A.M., Cutler D.M. (September 2020). Contributions of Public Health, Pharmaceuticals, and Other Medical Care to US Life Expectancy Changes, 1990-2015. Health Affairs. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00284.

clinicians to have a choice of medicines that efforts by plans and PBMs to steer patients among drugs using strategies "not based on medical appropriateness" create cause for concern.

CMS' Guidance recognizes the fundamental principle that patients differ from one another, as do medicines, even when in the same therapeutic class. Because of differences in clinical circumstances and individual health needs and preferences, patients benefit from access to a range of treatment options, which has been repeatedly underscored by professional consensus and research.[25,26] Furthermore, a medicine's average effect will not always apply to all subsets of patients due to factors such as genetics, drug-drug interactions, age, and comorbidities.[27] For example, the American College of Rheumatology, notes that individual treatment decisions for rheumatoid arthritis patients should be made based on patients' values, goals, preferences, and comorbidities, citing 44 different recommendations.[28] As described in more detail below, the IRA is likely to exacerbate the trend of increasing formulary exclusions and coverage restrictions. Thus, it is vital for CMS to strengthen formulary standards and oversight to address this and protect beneficiary access to a range of treatment options in Part D.

The IRA puts patient access to both selected medicines and non-selected medicines at risk.

Since its inception, the Part D program has proved remarkably successful in providing Medicare beneficiaries access to a range of outpatient prescription medicines and keeping premiums low through a choice of competing health plans. Underscoring this success, beneficiary satisfaction with the program has consistently remained over 90 percent.[29] Large health plans and PBMs are able to demand substantial discounts and rebates from manufacturers that offer medicines that compete with other brand drugs or with biosimilars and generics. In some instances, rebates represent a discount of 50 percent or more off products' list price, and six of the ten drugs selected for price setting for 2026 are in therapeutic classes where the average rebate was 40 percent or more in 2021.[30]

The introduction of government price-setting for a subset of competing medicines will inevitably prove highly disruptive to this competitive dynamic and lead to unintended consequences that hinder beneficiary access to MFP-selected medicines and/or competing brand medicines. Health plans' and PBMs' continued reliance on manufacturer rebates as a source of income in Part D amplifies the disruptive effects of government price-setting, which likely will have the effect of reducing manufacturer rebates. This risk was underscored in CMS' most recent national health expenditure projection, in which the Agency estimated that government spending in Part D will *increase* by 12 percent in 2026, largely due to the loss of manufacturer rebates under IRA on MFP medicines.[31]

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[25] For instance, American College of Rheumatology. (2024). American College of Rheumatology Health Policy Statements: Remove Barriers to Patient Access to Treatment, Access to Treatment under Medicare Part D. Available at: https://assets.contentstack.io/v3/assets/bltee37abb6b278ab2c/bltd84782969d741aba/acr-health-policy-statements.pdf

[26] Kent D.M., Nelson J., Dahabreh I.J., et al. (December 1, 2016). Risk and Treatment Effect Heterogeneity: Re-Analysis of Individual Participant Data from 32 Large Clinical Trials. International Journal of Epidemiology. Available at: https://pubmed.ncbi.nlm.nih.gov/27375287/, https://pubmed.ncbi.nlm.nih.gov/15595946/

[27] Hayden CG. (September 4, 2023). IRA: Patient Access to Therapeutic Options. Available at: https://haydencg.com/ira-patient-access-to-therapeutic-options/.

[28] Fraenkel L., Bathon J.M., England B.R., et al. (July 2021). 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Available at: https://assets.contentstack.io/v3/assets/bltee37abb6b278ab2c/blt9e44ccb701e1918c/63360f6775c0be225b8d943a/ra-guideline-2021.pdf

[29] Medicare Today. (August 2023). Senior Satisfaction Survey. Available at: https://www.medicaretoday.org/resources/senior-satisfaction-survey

[30] MedPAC. (June 2023). MedPAC Report to Congress, Table 2-1. Available at: https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch2_MedPAC_Report_To_Congress_SEC.pdf

[31] CMS. (June 12, 2024). Office of the Actuary in the Centers for Medicare & Medicaid Services, National Health Expenditures Projections, National Health Expenditure Projections, 2023–32. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected. See also: Fiore J., Madison A., Poisal J, Cuckler G., Smith S., Sisko A., Keehan S., Rennie K., Gross A. (June 2024). National Health Expenditure Projections, 2023-32: Payer Trends Diverge as Pandemic-Related Trends Fade. Health Affairs. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00469

Despite CMS acknowledging the importance of patient access to a range of medicines, the sharp dislocations that the IRA brings to Part D are likely to create significant pressure on plans to strictly control utilization and maximize rebates and other discounts.[32] This could exacerbate plans' use of UM and coverage exclusions in ways that result in clinically inappropriate barriers to access. As a result of these changing dynamics, access to medicines selected for price setting as well as their non-selected competitors in the same therapeutic class may be threatened, with results varying depending on the dynamics within each therapeutic class. CMS should make use of the full extent of its authority to ensure patient access is not disrupted, including ensuring that patients who are stable on an MFP-selected drug or a treatment alternative in the same class are not inappropriately switched to a different medicine or face other barriers to continued access.

In its Revised Guidance for IPAY 2026 and the Draft Guidance for IPAY 2027, CMS proposes to remedy its concerns about access to selected drugs by requiring plans to provide a "reasonable justification" for disadvantaging selected drugs in coverage. CMS will "evaluate these justifications for compliance with applicable statutory and regulatory requirements" and only approve a plan if it complies with those requirements.[33] Unfortunately, there is no basis for knowing whether this approach will protect patients' access to selected drugs. As a group of academic leaders recently wrote, "CMS plans to assess formulary placement and use of UM tools that may influence access to negotiated drugs, but it has not yet provided guidance on how it will do so, nor on the consequences for plans' undesirable behavior."[34] Moreover, many of the underlying regulatory requirements that CMS will apply are vague, fluid and lack transparency (e.g., "best practices" and "current industry standards"[35]).

While we appreciate CMS' discussion of steps it will take to ensure beneficiary access to MFP selected medicines, we don't believe these steps are sufficient to protect beneficiaries. As CMS has acknowledged, there are circumstances in which plans and PBMs may be incentivized to establish increased access barriers for MFP selected drugs relative to competing medicines.[36] For example, in instances where CMS sets an MFP for a medicine within a competitive drug class that offers significant rebates, plans and PBMs may choose to give preferential status to a competing medicine and establish more significant UM or higher cost sharing for the MFP selected medicine.

At the same time, CMS also must recognize and address the risk of government price-setting disrupting access for Medicare beneficiaries receiving non-selected medicines that compete with the MFP drug. For example, there may be other instances where manufacturers of competing medicines are unable to match the CMS-set price of a MFP selected medicine, leading the plan to prefer the selected drug irrespective of whether it is the most clinically appropriate.

Recent research serves to reinforce concerns that beneficiaries will face increased, potentially inappropriate access barriers to clinically important treatment options as a result of government price setting.[37] For example, in one recent survey of payers, 65 percent said they expect to reduce the number of medicines covered on their formulary

[32] Kelly C. (April 16, 2024). Medicare Negotiated Drugs May Not Get Favorable Coverage in Part D: Will CMS Intervene? Pink Sheet. Available at: https://pink.citeline.com/PS150091/Medicare-Negotiated-Drugs-May-Not-Get-Favorable-Coverage-In-Part-D-Will-CMS-Intervene

[33] IPAY 2027 Initial Guidance at 123.

[34] Arad N., Hoover G., Evans R., McClellan M.B. (April 9, 2024). Medicare Drug Price Negotiations: Policy Implications of the First 10 Drugs' Features. Health Affairs. Available at: https://www.healthaffairs.org/content/forefront/medicare-drug-price-negotiations-policy-implications-first-10-drugs-features.

[35] CMS. Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements. Available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf, Section 30.2.2.

[36] IPAY 2027 Initial Guidance at 122.

[37] Fein A. (April 5, 2024). Implications of the IRA: Why the IRA Will Encourage Part D Plans to Prefer High-List, High-Rebate Drugs. Drug Channels. Available at: https://www.youtube.com/watch?v=F5Rjkw7h4gk

for therapeutic classes with selected drugs, and nearly half of payers reported they are likely to exclude most non-selected drugs in the same therapeutic class as a selected drug. [38]

We urge CMS to describe the specific steps it is taking to update and strengthen its formulary standards and oversight and to ensure these safeguards are applied both to MFP-selected medicines and competing medicines in the same class. CMS price-setting under the IRA will inevitably increase the risk of inappropriate UM and formulary restrictions that compromise beneficiary access to medically appropriate care. Thus, CMS must rethink its approach to formulary review for all Part D medicines – including selected drugs, non-selected medicines, and even to ensure adequate access to medicines in the six protected classes – and must engage patients, clinicians, and other stakeholders in a formal process to achieve this.[39]

The IRA threatens to exacerbate barriers to accessing medicines under Medicare Part D.

While UM strategies like prior authorization (PA) can play a useful role in ensuring that patients receive clinically-appropriate medicines and at lower costs, research shows that excessive UM restrictions may also harm Medicare beneficiaries by delaying treatment, substituting less effective medicines, and decreasing medication adherence – potentially leading to avoidable progression of diseases and harmful health effects.[40] The potential harms call for effective standards to assure that any UM imposed by PBMs or Part D plans is clinically appropriate, not a barrier to patients receiving the medicine they need.

A study published earlier this year in *Health Affairs* underscores that cause for concern, showing that Part D formularies have become significantly more restrictive over the past decade.[41] In 2011, Part D plans excluded an average of 20.4 percent of compounds from their formularies and placed PA or step therapy restrictions on another 11.5 percent. By 2020, those numbers jumped to 30.4 percent and 14 percent respectively. Part D plans placed the greatest number of access restrictions and exclusions on brand-name-only compounds, with a total of 68.4 percent of brand-name-only compounds facing some sort of UM restriction in 2020. These data underscore the importance of improving CMS' existing formulary and UM standards as IRA threatens to diminish access further.

Prior Authorization and Step Therapy

In recent years, multiple stakeholders have conducted analysis that demonstrates the negative effects of inappropriate UM on patients. For example, the National Health Council (NHC) released a report on the burden of PA on patients with chronic diseases, noting that PA processes can result in treatment delays, including delays for necessary drugs, and harm care quality. [42] Step therapy[43] can also be implemented in ways that have a negative impact on patients' adherence to their medicine regimens.[44] Indeed, one study found that low-income Medicare beneficiaries who faced PA restrictions on a drug reduced their use of that drug by 26.8 percent – with

[38] Magnolia Market Access IRA Payer Insights Survey. (2023). Respondents (n=26) represent ~259M covered US lives. See also: Myshko D. (March 19, 2024). Payers Question CMS' Ability to Get Discounts Through Drug Price Negotiation. Formulary Watch. Available at: https://www.formularywatch.com/view/payers-question-cms-ability-to-get-discounts-though-drug-price-negotiation

[39] See Appendix C (Strengthening Access and Formulary Protections in Medicare Part D) for further recommendations.

[40] Joyce G., Blaylock B., Chen J., Van Nuys K. (March 2024). Medicare Part D Plans Greatly Increased Utilization Restrictions on Prescription Drugs, 2011-20. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.00999. See also: Weeda E., Nguyen E., et al. (October 29, 2019). The Impact of Non-Medical Switching Among Ambulatory Patients: an Updated System Literature Review. Journal of Market Access & Health Policy. Available at: https://pubmed.ncbi.nlm.nih.gov/31692904/

[41] Joyce G., Blaylock B., Chen J., Van Nuys K. (March 2024). Medicare Part D Plans Greatly Increased Utilization Restrictions on Prescription Drugs, 2011-20. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.00999

[42] Pinn A., Witting L.L.Q., Gascho E., Escontrias O,A. (November 2023). NHC Report: Exploring the Burden of Prior Authorization on Patients with Chronic Disease. National Health Council. Available at: https://nationalhealthcouncil.org/wp-content/uploads/2023/11/NHC-Report-Exploring-the-Burden-of-Prior-Authorization-on-Patients-with-Chronic-Disease.pdf

[43] The previously cited Magnolia payer survey cited suggests such programs will become more common as a result of IRA.

[44] Joyce G., Blaylock B., Chen J., Van Nuys K. (March 4, 2024). Medicare Part D Plans Greatly Increased Utilization Restrictions on Prescription Drugs, 2011-20. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.00999

approximately half of those beneficiaries receiving no drug at all.[45] This underscores the importance of ensuring that any UM requirements are clinically appropriate. CMS should consider whether, in addition to reviewing a formulary's overall clinical appropriateness for the Medicare population, it should also more closely review the formulary's effects on beneficiary access and adherence to clinically appropriate medicines, particularly in drug classes with one or more drugs subject to CMS price setting.

The increased imposition of UM restrictions by health plans and PBMs in Part D already has taken a toll on Medicare beneficiaries, and these impacts stand to worsen under the IRA. This is because plans likely will have a financial incentive to deter access to certain medicines (depending on the circumstances, either a selected drug or its non-selected competitors), regardless of which medicine is most clinically appropriate for a given patient. Part D plans are not required under the IRA to cover medicines not subject to price setting, and plans retain latitude to apply UM to covered drugs. In the wake of IRA, Part D plans likely will rely on even more UM and other formulary controls, resulting in plans imposing financially motivated access barriers for patients. These dynamics are likely to disproportionately hurt disadvantaged groups, exacerbating health inequities.[46] There is great concern that a patient's access to the best treatment options will be impeded.[47]

Formulary Exclusions

In addition to the increases in PA and step therapy, Part D plans have increasingly excluded medicines from plan formularies, depriving patients of critical access to their medicines. While formulary exclusions historically were applied to brand drugs with generic equivalents or drug classes with multiple brands, plans are increasingly imposing exclusions for drugs for complex conditions such as cancers and autoimmune diseases.[48] As discussed, a recent payer survey reports that nearly two-thirds of plans expect to further increase formulary exclusions in classes with drugs selected for IRA price setting, which would inevitably create more barriers between patients and the medicines they need.

Formulary exclusion is a particularly harsh tool to restrict patient access to medicines, as it requires beneficiaries to successfully navigate the complicated and cumbersome process for formulary exceptions or pay out of pocket. And the narrower formularies imposed by Part D plans have negative consequences for patients – decreased choices of medicines and a reduced likelihood of being able to obtain a medicine that's optimal for their medical condition. These consequences are expected to worsen under the IRA and must be addressed by CMS.

CMS has failed to protect patients from reduced access to medicines resulting from government price-setting.

Even before the impacts of the IRA are fully realized, CMS' current formulary review standards have not kept pace with the increase in UM restrictions. CMS' current standards are mostly focused on process and are opaque, allowing plans to erect barriers to high value treatment at the expense of patients. For example, CMS' current formulary benefit review includes looking at criteria such as existing "best practices," "industry standards," and "appropriate guidelines," and asking Part D sponsors for a "reasonable justification" for practices falling outside of those practices/standards/guidelines.[49] These terms are not defined and are insufficient to ensure appropriate oversight of UM restrictions.

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[45] Brot-Goldberg, Z.C., Burn S., Layton T., Vabson B. (January 2023). Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare. National Bureau of Economic Research. Available at: https://www.nber.org/system/files/working_papers/w30878/w30878.pdf.

[46] Thorpe K.E. (June 27, 2024). Penny Wise And Pound Foolish: IRA Impact On Chronic Disease Costs In Medicare. Health Affairs. Available at: https://www.healthaffairs.org/content/forefront/penny-wise-and-pound-foolish-ira-impact-chronic-disease-costs-medicare.

[47] Hayden Consulting Group. (September 4, 2023). IRA: Patient Access to Therapeutic Options. Available at: https://haydencg.com/ira-patient-access-to-therapeutic-options/.

[48] Joyce G., Blaylock B., Chen J., Van Nuys K. (March 2024). Medicare Part D Plans Greatly Increased Utilization Restrictions on Prescription Drugs, 2011-20. Health Affairs. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2023.00999

[49] CMS. (January 15, 2016). Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements. Section 30.2.2. Available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf.

Given the changing incentives that IRA establishes, both for selected as well as non-selected medicines, and the growing risks to beneficiary access in Part D, CMS should update and strengthen current Agency oversight and standards for formulary design in Part D.

The Guidance, as well as existing CMS regulations and Part D sub-regulatory guidance, must be revised to fortify protections for patient access to medicines in the wake of the IRA. The current Guidance does little to account for the patient perspective, heterogeneity or clinical nuance and must be strengthened in these areas to better ensure medication access for patients and protect against plan adoption of increased UM. Specifically, we urge CMS to broadly establish stronger standards and oversight for Part D formularies, for all medicines in classes or categories with one or more selected drugs, as well as other therapeutic classes, including the six protected classes. For our detailed recommendations on what CMS can do to strengthen access and formulary protections in Medicare Part D, see Appendix C (Strengthening Access and Formulary Protections in Medicare Part D).

III. CMS' implementation of the Program undermines competitive marketplace dynamics, which successfully drive patient access to new medicines and cost containment.

Our health care system is designed to promote incentives for continued innovation and patient access while leveraging competition to achieve cost containment. Brand medicines face robust competition from generic drugs, biosimilars, and other brand medicines, which PBMs and insurers have historically leveraged to negotiate rebates and discounts from biopharmaceutical manufacturers. As noted above, this dynamic often occurs with multiple competing brand medicines in the same class. For example, less than a year after market entry of the first highly effective curative treatments for hepatitis C virus, multiple other products entered the market, some offering improved cure rates for patients. The resulting competition was so fierce that the average net daily cost for this class today is nearly 80 percent lower than the first product's launch price.[50] Further illustrating this point, a recent study found that new brand medicines launched between 2013 and 2017 led to an immediate decrease in the average net price of competitors already on the market.[51] As a result of competitive dynamics, medicines continue to represent just 14 percent of overall health care spending.[52]

The marketplace is also uniquely designed to promote innovation and affordability simultaneously through the product lifecycle. Underscoring this point, CBO found that the average net price per prescription in Medicare Part D and Medicaid declined between 2009 and 2018, despite the introduction of many new treatments and cures.[53] This is because over time, new medicines help to improve patient health and reduce overall health care costs while also paving the way for lower-cost generics and biosimilars. Similar cost containment mechanisms do not exist in other parts of our health care system.[54]

Unfortunately, the IRA and CMS' implementation of the Program undermine the success of this system by substituting government price setting for future competition from generics and biosimilars. Specifically, the IRA allows the government to impose such low prices on an innovator product that biosimilar and generic manufacturers may not be able to compete, discouraging them from bringing products to market in the first place. This risk is further heightened by the inability of generic and biosimilar manufacturers to predict with any

[50] Silseth S., Shaw H. (June 11, 2021). Analysis of prescription drugs for the treatment of hepatitis C in the United States. Milliman. Available at: https://www.milliman.com/en/insight/analysis-of-prescription-drugs-for-the-treatment-of-hepatitis-c-in-the-united-states
[51] Dickson S., Gabriel N., Hernandez I. (August 2023). Changes in Net Prices and Spending for Pharmaceuticals After The Introduction Of New Therapeutic Competition, 2011–19. Health Affairs. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00250
[52] Altarum Institute. (July 2022). Projections of the Non-Retail Prescription Drug Share of National Health Expenditures. Available at: https://altarum.org/sites/default/files/uploaded-publication-files/ProjectionsCMS20of%20NonRetail%20Drug%20Share%20of%20NHE%202022.pdf
[53] CBO. (January 19, 2022). Prescription Drugs: Spending, Use, and Prices. Available at: https://www.cbo.gov/publication/57050
[54] For example, the price of a medicine commonly used to prevent cardiovascular disease dropped 95% between 2007 and 2017, while the average charge for a surgical procedure to treat it increased 94% over the same period. PhRMA analysis of Healthcare Cost and Utilization Project (HCUP). National (Nationwide) Inpatient Sample (NIS) database. 2007, 2017. Available at: https://www.ahrq.gov/research/data/hcup/index.html; IQVIA analysis for PhRMA. Invoice price data for atorvastatin 10mg from IQVIA National Sales Perspectives data for 2007 (branded Lipitor) and 2017 (generic). June 2020.

certainty, when they need to make their investment and development decisions, whether or when the branded reference product they are seeking to compete against will be selected for price setting under the Program.

Specifically, regarding small molecule drugs, the IRA undermines existing incentives for generic competition by implementing price setting far earlier than current timelines for generic competition. Currently the average effective patent life for small molecule drugs before generics enter the market is 13 to 14 years.[55] Under the IRA, generics manufacturers must weigh the economic viability of entering the market to compete against a brand product that may already have a low government-set price. But generics rely on the ability to offer sharply lower prices to attract market share from brand competitors. In fact, generics often enter the market immediately upon patent expiration and are often adopted rapidly because of this successful dynamic. Today, 90 percent of prescriptions filled are filled with generic medicines and many capture as much as 90 percent of the market within 3 months of entry.[56] But the IRA's price setting provisions upend incentives that currently drive market entry.

Additionally, the IRA will strongly discourage biosimilar development, as the price-setting timelines imposed under the law are at odds with the framework created under the biosimilar regulatory pathway created under the Biologics Price Competition and Innovation Act (BPCIA). Under the Program, biologics may be eligible for price setting at year 11, with the government-set price going into effect 2 years later, unless there is an approved and marketed biosimilar. However, under the BPCIA, a biosimilar cannot be approved until at least 12 years after the first licensure of the reference biologic. To mitigate against this tension, a special rule was established in the IRA, which allows for potential biosimilar manufacturers to request a "pause" in the price setting process if there's a "high likelihood" for biosimilar marketing within the requisite timeframe. Unfortunately, the biosimilar pause provisions leave too much uncertainty as to whether a drug with a marketed biosimilar can qualify.

To make matters worse, CMS has also imposed an extra-statutory "bona fide marketing" standard, entirely of its own invention, that would leave significant ambiguity as to whether it will be possible to avoid price setting even when there is a marketed biosimilar. These realities make the decision to invest in biosimilar development extremely risky and potentially financially infeasible moving forward. Biosimilar manufacturers face long development timelines and significant costs due to the complexities of biologics manufacturing.[57] As a result of the uncertainty around navigating the pause and the prospect of competing against a government price-set product, the Program – if implemented as CMS has described in Draft Guidance - is likely to serve as a significant disincentive for biosimilar manufacturers in entering the market. For our recommendations on what CMS can do to mitigate against these disincentives and improve the biosimilar pause and its interpretation of "marketed," see Appendix A (Drug Selection) to this letter, which is focused on Drug Selection and related issues.

CMS' list of drugs selected for price setting in 2026 already illustrates the risk that government price setting will undermine market competition.[58] In fact, the majority of medicines on CMS' list of selected drugs for IPAY 2026 already have anticipated generic and biosimilar competition before the IPAY.[59] However, due to the provisions in the IRA and CMS' flawed interpretation, if the pending generic and biosimilar products are unable to reach the market in time for CMS to determine by August 1, 2024 that "bona fide" marketing exists, they will be forced to compete against price-controlled products. This jeopardizes future competition and savings driven by generics and

[55] Grabowski H., Long G., Mortimer R., Bilginsoy M. (January 2021). Continuing trends in U.S. brand-name and generic drug competition. Journal of Medical Economics. Available at: https://pubmed.ncbi.nlm.nih.gov/34253119/
[56] AAM. (September 2023). The U.S. Generic & Biosimilar Medicines Savings Report, September 2023. Available at: https://accessiblemeds.org/sites/default/files/2023-09/AAM-2023-Generic-Biosimilar-Medicines-Savings-Report-web.pdf
[57] Blackstone E.A., Joseph P.F. (September 2013). The Economics of Biosimilars. American Health & Drug Benefits. Available at: https://pubmed.ncbi.nlm.nih.gov/24991376/
[58] HHS. (August 29, 2023). HHS Selects the First Drugs for Medicare Drug Price Negotiation. Available at: https://www.hhs.gov/about/news/2023/08/29/hhs-selects-the-first-drugs-for-medicare-drug-price-negotiation.html
[59] Analysis based on publicly available information at FDA Orange Book and Purple Book and press sources. Additional generic applications may be pending with FDA beyond the 3 noted.

biosimilars in the years ahead. These savings totaled $408 billion last year alone, including $130 billion to Medicare.[60]

IV. CMS' implementation of the Program will do irreparable harm to innovation to the detriment of patients.

The IRA and CMS' implementation of the Program have also disrupted the incentives which have driven the development of innovative medicines over the years. The price setting framework sets an arbitrary ceiling on prices and allows CMS to set the price at any level below that ceiling for drugs 9 to 13 years after initial FDA approval (and for forms of a selected drug, price setting could occur even earlier due to CMS' approach to defining QSSD). In this section, we detail the mechanisms by which price-setting shifts existing R&D incentives and jeopardizes the future development of medicines in certain therapeutic areas with very real consequences for patients. While each of these disincentives may affect biopharmaceutical companies differently given varying areas of expertise and focus, across the market, the IRA, and CMS' interpretation of the statute, is anticipated to discourage:

- **Post-Approval Innovation.** CMS' broad definition of QSSD, as well as when drugs become eligible for negotiation within their lifecycle, discourage R&D that occurs after a drug or biological is initially FDA approved.
- **Development of Small Molecule Medicines.** By affording small molecule medicines less time on the market after FDA approval prior to entering negotiation, the IRA disincentivizes their development.
- **Development of Orphan Drugs.** Although the IRA exempts certain orphan drugs from negotiation, CMS' overly narrow interpretation of the exemption's eligibility criteria will further harm innovation for these diseases.
- **Development of Treatments for Chronic Diseases.** The list of drugs subject to negotiation is overwhelmingly comprised of medicines to treat common chronic illnesses, signaling that investing in these medicines may impose significant uncertainty and risk.

CMS' implementation of the Program will create disincentives to post approval R&D and the development of small molecule medicines which are critical for driving treatment advances in certain disease areas.

Under the framework, selected medicines will face price setting earlier than they may otherwise face generic or biosimilar competition. Shortening the timeframe by which manufacturers can earn revenues on medicines after initial approval and before price setting may occur is expected to upend existing R&D incentives.[61] Specifically, biopharmaceutical companies will now be forced to make difficult decisions about whether it is feasible to invest in R&D occurring after initial FDA approval that could lead to important new uses of already approved medicines. This is particularly true given it can take an additional four years or more to complete costly phase III clinical trials to support a post-approval indication, and companies must consider whether there will be sufficient time on the market to earn revenue before price setting may occur. Unfortunately, any advancements for patients are realized through continued investment in this form of R&D to bring new treatments for different diseases or patient populations.

Additionally, by affording small molecule medicines a shorter timeframe on the market relative to other medicines before price setting may occur, the "pill penalty" especially discourages the development of these critical treatments. Moreover, given the relatively shorter timeframe the pill penalty also particularly jeopardizes the post-approval R&D that is necessary to realize their full therapeutic potential. In fact, research shows more than half of

[60] AAM. (September 2023). The U.S. Generic & Biosimilar Medicines Savings Report, September 2023. Available at: https://accessiblemeds.org/sites/default/files/2023-09/AAM-2023-Generic-Biosimilar-Medicines-Savings-Report-web.pdf

[61] Philipson T.J., Ling Y., Chang R. (October 2023). The Impact of Price Setting at 9 Years on Small Molecule Innovation Under the Inflation Reduction Act. The University of Chicago. Available at: https://ecchc.economics.uchicago.edu/files/2023/10/Small-Molecule-Paper-Final-Oct-5-2023.pdf.

small molecule medicines approved a decade ago received additional indications in later years, and nearly half of those occurred seven or more years after initial approval.[62] One of the reasons small molecule medicines play such a critical role in the treatment of many diseases is their unique ability to reach therapeutic targets inside cells. For example, in diseases such as cancer where the genetic changes that drive cancer cell growth begin inside cancer cells, this feature makes these medicines an important part of the treatment arsenal. Similarly, the ability for these medicines to cross the blood-brain barriers also makes them critical in the treatment of disease with therapeutic targets inside the brain—including illnesses that impact the central nervous system, mental health conditions, neurodegenerative diseases, and many more.[63]

In disease areas where most medicines approved by the FDA are small molecules and post-approval R&D has been indispensable in driving progress for patients, the impact of price setting is expected to be substantial. For example, one study found more than 60 percent of small molecule *cancer* drugs approved between 2006 and 2012 received at least one post-approval indication, and nearly half of those occurred seven or more years after initial approval.[64] Similarly, another analysis examining *cardiovascular* medicines approved between 1995 and 2021 found 92 percent were small molecule medicines and among these, nearly half of approved indications were approved seven or more years after initial approval.[65] Unfortunately, many of these indications may be foregone moving forward. In fact, one analysis by researchers at the University of Chicago found the IRA's price setting provisions would translate to a total of 79 fewer small molecule medicines, and 188 fewer post approval indications over the next 20 years.[66]

Moreover, CMS' approach to setting that price may penalize manufacturers for having "recouped" R&D costs. Not only is this approach flawed but it is based on a fundamental misunderstanding of the biopharmaceutical investment model. As a result, biopharmaceutical companies now must not only consider R&D investment decisions in light of price setting but also how those decisions may affect the government-set price if price setting will apply. In both instances, the Program and CMS' approach to setting a price disrupt existing regulatory and market incentives which have historically aligned the R&D enterprise to drive innovation to meet the unmet needs of patients and instead realigned those incentives towards considering the application of government intervention and its consequences.

CMS' interpretation of the orphan drug exclusion threatens the development of new medicines to meet unmet needs for patients with rare diseases.

Unfortunately, CMS' interpretation of the orphan drug exclusion under the Program is overly narrow and undermines existing R&D incentives under the Orphan Drug Act (ODA) for developing new treatments for rare diseases. Congress passed the ODA in 1983 to encourage companies to develop orphan drugs when existing market incentives have historically been insufficient to encourage investments, due to small patient populations, significant R&D challenges, and limited probabilities of success relative to other therapeutic areas. Since enactment, more than 600 orphan drugs and biologics have been approved in the US compared to just 10 in the decade before passage.[67] While the IRA provides a specific exemption from price setting for medicines with a

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[62] Partnership for Health Analytic Research. (June 2023). Implications of the Inflation Reduction Act Price Setting Provisions on Post-approval Indications for Small Molecule Medicines. Available at: https://www.pharllc.com/publication/implications-of-the-ira-price-setting-provisions-on-post-approval-indications-for-small-molecule-medicines/

[63] Ibid.

[64] PhRMA. (July 2023). Emerging Value in Oncology: How Ongoing Research Expands the Benefits of Oncology Medicines. Available at: https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Org/PDF/PhRMA_Emerging-Value-Report/PhRMA_Emerging-Value-Report_FIN-web_July2023_v2.pdf

[65] Grabowski H., Long G. (March 18, 2024). Post-Approval Indications and Clinical Trials for Cardiovascular Drugs: Some Implications of the US Inflation Reduction Act. Journal of Medical Economics. Available at: https://www.tandfonline.com/doi/full/10.1080/13696998.2024.2323903

[66] Philipson T.J., Ling Y., Chang R. et al. (August 25, 2023). Policy Brief: The Potentially Larger Than Predicted Impact of the IRA on Small Molecule R&D and Patient Health. The University of Chicago. Available at: https://ecchc.economics.uchicago.edu/project/policy-brief-the-potentially-larger-than-predicted-impact-of-the-ira-on-small-molecule-rd-and-patient-health/

[67] FDA. (May 12, 2022). Developing Products for Rare Diseases & Conditions. Available at: http://www.fda.gov/ForIndustry/DevelopingProductsforRareDiseasesConditions/default.htm

single orphan designation (and indications only within that designation), the exemption is far too narrow and is expected to shift R&D incentives and negatively impact orphan drug development. To make matters worse, CMS' careless implementation of the Program and disregard for the critical incentives driving orphan drug development is further evidenced by its explicit removal of a statement in this year's Guidance—noting that CMS would consider additional actions it can take in implementing the "Negotiation Program to best support orphan drug development."

Market incentives prior to the enactment of the IRA incentivized biopharmaceutical companies to choose to launch first in small populations such as rare diseases, because they could earn revenues while conducting R&D on additional patient populations. Now, based on CMS' interpretation of the orphan-drug exclusion, companies across the market must grapple with difficult decisions about whether to choose early indications with the greatest economic value. Specifically, even where a drug's initial approval qualifies for the orphan-drug exclusion, CMS has elected to "use the date of the earliest approval of the drug or licensure of the biological product" to determine whether a drug may be selected for price setting, even if the exclusion is lost years later. As a result, promising drugs may be delayed in getting to market as companies may have an incentive to start the clock first with indications impacting larger population sizes. But importantly, it also means in many cases rare disease patient populations will have to wait for post-approval indications to treat their illness or these indications ultimately may never be realized given shortened timelines to conduct R&D after initial approval. To put a finer point on this disincentive, while the IRA provided a limited exemption for orphan drugs approved to treat a single rare disease, the exemption does not eliminate the disincentives imposed by the IRA and the Program's broader price setting framework which discourages companies from conducting R&D after initial approval, and CMS' Guidance exacerbates this concern.

Historically, post-approval R&D has been critical to advancing treatments for rare diseases. In fact, a total of 35 percent of orphan drugs had multiple indications between 1990 and 2022 (20 percent were approved for rare and common diseases, and 15 percent were approved for just orphan conditions). Half of all subsequent approvals for orphan drugs came five years after initial approval.[68] As noted by a researcher at Columbia University, "The likely result [of the IRA] will be fewer orphan-first launches and, without such launches, riskier trials for broader indications."[69] For our recommendations for improving implementation of the Orphan Drug Exclusion to mitigate against R&D disincentives for patients with rare diseases see Appendix A (Drug Selection).

CMS' treatment of medicines containing the same active ingredient or moiety as one drug under the Program discourages the post-approval R&D that results in new drugs and biological products.

CMS' interpretation of QSSD for the purposes of price setting under the IRA is untethered from the statute and will stifle the development of innovative and lifesaving treatments. CMS' overbroad approach treats new dosage forms and formulations containing the same active ingredient or moiety as the same drug, even if the drug was approved under a different marketing application. As a result, biopharmaceutical companies will have to reconsider the economic feasibility of investing in new drug or biological products that could provide meaningful new treatment options for different diseases or patient populations, or provide a new method of administration, jeopardizing the development of these critical treatments moving forward. As noted by a former FDA official, CMS' broad definition of QSSD will undoubtedly discourage post-approval R&D.[70]

Whether improving adherence for vulnerable patient populations or providing new treatment options for an entirely different disease or patient population, post approval R&D that leads to new drugs and biological products provide meaningful treatment advances for patients. For example, long-acting injectable formulations of antipsychotics have significantly improved patient adherence and treatment outcomes. These medications have

[68] Miller, K.L., Lanthier M. (January 2024). Orphan Drug Label Expansions: Analysis Of Subsequent Rare And Common Indication Approvals. Health Affairs. Available at: https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2023.00219.
[69] Masia N. (2024). Will Potential IRA Price Limits Delay Drug Launches? Health Capital Group. Available at: https://www.ispor.org/docs/default-source/intl2024/ispor24masiapt4poster138000-pdf.pdf?sfvrsn=2450c107_0
[70] Lumanity. Potential Impact of the IRA on the Generic Drug Market. Available at: https://lumanity.com/perspectives/potential-impact-of-the-ira-on-the-generic-drug-market/

been available for many years and were initially made available in oral dosage forms that patients were required to self-administer daily. Unfortunately, non-adherence rates to antipsychotic medications are relatively high among those with schizophrenia, ranging from 34 percent to 81 percent.[71] [72] [73] Poor adherence is associated with severe consequences, including greater risk of relapse, hospitalization, and suicide.[74] [75] [76] [77] Today, many of these medications are available as long-acting injectables (LAIs) that can be administered every two weeks to as little as every 6 months, depending on the drug. Real world use studies have shown that LAI antipsychotics improve medication adherence and patient outcomes leading to lower odds of hospitalization and fewer emergency room visits. Among Medicaid beneficiaries with schizophrenia, improved adherence due to LAI antipsychotics generated annual net savings of up to $3.3 billion, or $1,580 per patient per year, driven by lower hospitalizations, outpatient care, and criminal justice system involvement.[78] [79]

Unfortunately, the first set of drugs selected for price setting demonstrates CMS' disregard for the value these medicines provide and for the patient populations that rely on these treatment advances. While CMS was permitted to select 10 drugs for price setting, CMS adopted an overly broad interpretation of QSSD to sweep in a broad range of dosage forms and formulations, including those submitted under entirely different marketing applications. The selection of these drugs and biological products, for which the government-set price will go into effect in 2026, sends a clear signal discouraging any future research on improved dosage forms and formulations to meet unmet needs for various patient populations, including patients outside of Medicare. For example, one selected cancer medicine was originally approved for adults with a form of chronic leukemia. Many years later it was approved for use in a new dosage form for an entirely different disease for pediatric patients: graft versus host disease. The new oral suspension form for this patient population provided an important option for those with difficulties swallowing. While this new dosage form was also approved under an entirely different drug application in 2022, for an entirely different disease and patient population, the drug will nonetheless be treated as the same QSSD and subject to price setting just a year after the drug was approved by the FDA.[80]

Given the IRA's price setting framework and CMS' treatment of new dosage forms and formulations under the framework, the economic incentives driving investment in these types of drugs and biological products will be significantly limited moving forward given they may be swept into government price setting shortly after reaching the market. For our recommendations on how to appropriately identify QSSDs in line with the IRA and mitigate

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[71] Lacro J.P., Dunn L.B., Dolder C.R., et al. (October 2022). Prevalence of and Risk Factors for Medication Nonadherence in Patients with Schizophrenia: A Comprehensive Review of Recent Literature. Journal of Clinical Psychiatry. Available at: https://pubmed.ncbi.nlm.nih.gov/12416599/

[72] Lafeuille M.H., Frois C., Cloutier M., et al. (October 2016). Factors Associated with Adherence to the HEDIS Quality Measure in Medicaid Patients with Schizophrenia. American Health & Drug Benefits. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5123648/

[73] Greene M., Yan T., Chang E., et al. (February 2018). Medication Adherence and Discontinuation of Long-Acting Injectable Versus Oral Antipsychotics in Patients with Schizophrenia or Bipolar Disorder. Journal of Medical Economics. Available at: https://pubmed.ncbi.nlm.nih.gov/28895758/

[74] Sher L., Kahn R.S. (July 10, 2019). Suicide in Schizophrenia: An Educational Overview. Medicina (Mex). Available at: https://www.mdpi.com/1648-9144/55/7/361

[75] Ventriglio A., Gentile A., Bonfitto I., et al. (June 27, 2016). Suicide in the Early Stage of Schizophrenia. Front Psychiatry. Available at: https://pubmed.ncbi.nlm.nih.gov/27445872/

[76] Albert M., McCaig L.F. (September 2015). Emergency Department Visits Related to Schizophrenia Among Adults Aged 18-64: United States, 2009-2011. National Center for Health Statistics. Available at: https://www.cdc.gov/nchs/products/databriefs/db215.htm

[77] Higashi K., Medic G., Littlewood K.J., et al. (August 2013). Medication Adherence in Schizophrenia: Factors Influencing Adherence and Consequences of Nonadherence, a Systematic Literature Review. Therapeutic Advances in Psychopharmacology. Available at: https://pubmed.ncbi.nlm.nih.gov/24167693/

[78] Predmore Z.S., Mattke S., Horvitz-Lennon M. (April 1, 2015). Improving Antipsychotic Adherence Among Patients With Schizophrenia: Savings for States. Psychiatric Services. Available at: https://pubmed.ncbi.nlm.nih.gov/25555222/

[79] Bera R., Offord S., Zubek D., et al. (February 2014). Hospitalization Resource Utilization and Costs Among Medicaid Insured Patients With Schizophrenia With Different Treatment Durations of Long-Acting Injectable Antipsychotic Therapy. Journal of Clinical Psychopharmacology. Available at: https://pubmed.ncbi.nlm.nih.gov/24135840/

[80] Analysis of FDA labels of products on selected drug list. Drugs@FDA. Available at: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm

against the disincentives described here see Appendix A (Drug Selection).

The IRA and CMS' implementation of the Program will jeopardize our ability to bend the cost curve and reduce health disparities in the years ahead.

Six in ten Americans have one or more chronic conditions and 42 percent have 2 or more.[81] Chronic conditions, including mental illness, are the largest drivers of healthcare costs accounting for 90 percent of the $4.5 trillion spent on health care each year.[82] In the years ahead, the number of individuals with 3 or more chronic conditions is projected to nearly double by 2030, greatly increasing the burden of these illnesses and pressures on public programs. Much of this impact is expected to disproportionately affect underserved and marginalized populations, leading to widening health disparities.[83,84,85,86,87]

Better disease management achieved through use of medicines has long been credited with avoiding health complications and spending on other costly health care services. These features in turn have been shown to have the effect of curbing overall Medicare spending growth. For example, between 1999 and 2012, there was a significant reduction in Medicare spending growth for cardiovascular disease, one quarter of which was due to greater use of cardiovascular medicines over this period.[88]

Yet, just as chronic illness is expected to impose an increasing burden on our health care system and public programs, CMS' implementation of the Program is moving our healthcare system in the opposite direction by discouraging investment in chronic disease medicines which offer the best opportunity to reduce healthcare spending. CMS' initial list of drugs eligible for price setting illustrates this disincentive in action as the entire list is comprised of medicines to treat common chronic illnesses such as heart disease, diabetes, cancer and autoimmune diseases.[89] Moreover, CMS is expected to continue to select medicines that treat chronic disease for price setting in the years ahead—ironically due in large part to the high burden chronic illness imposes on the Medicare population.

Research shows these types of shortsighted policies can be expected to reduce the number of medicines developed in the future, including those that offer potential to reduce or eliminate spending on other costly medical care. One study from economists at the University of Chicago estimated that IRA price setting policies would increase overall healthcare spending by $50.8 billion over a 20-year period due to the lost opportunity to realize savings in

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[81] Benavidez GA, Zahnd WE, Hung P, Eberth JM. (February 29, 2024). Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area. Preventing Chronic Disease. Available at: https://www.cdc.gov/pcd/issues/2024/23_0267.htm

[82] CDC. (May 2023). Fast Facts: Health and Economic Costs of Chronic Conditions. Available at: https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html#:~:text=The%20impact%20of%20chronic%20diseases,significant%20health%20and%20economic%20benefits.

[83] Partnership to Fight Chronic Disease. What Is the Impact of Chronic Disease on America? Available at: https://www.fightchronicdisease.org/sites/default/files/pfcd_blocks/PFCD_US.FactSheet_FINAL1%20%282%29.pdf

[84] Buttorff C., Ruder T., Bauman M. (May 26, 2017). Multiple Chronic Conditions in the United States. Rand Corporation. Available at: https://www.rand.org/pubs/tools/TL221.html

[85] U.S. Department of Health and Human Services, Office of Minority Health. Heart Disease and African Americans and Hispanic Americans, Diabetes and African Americans and Hispanic Americans, Obesity and African Americans and Hispanic Americans, Asthma and African Americans and Hispanic Americans, Cancer and African Americans and Hispanic Americans.

[86] Ndugga N., Hill L., Artiga S. (June 11, 2024). . KFF. Available at: https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/Key Data on Health and Health Care by Race and Ethnicity. KFF. Available at: https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/

[87] Partnership to Fight Chronic Disease. (November 2, 2022). Advancing Health Equity, Improving Health Outcomes for All Could Save U.S. $3.8 Trillion. Available at: https://www.fightchronicdisease.org/latest-news/advancing-health-equity-improving-health-outcomes-all-could-save-us-38-trillion

[88] Cutler D.M., Ghosh K., Messer K.L., et al. (February 2019). Explaining the Slowdown in Medical Spending Growth Among the Elderly. Health Affairs. Available at: https://pubmed.ncbi.nlm.nih.gov/30715965/

[89] HHS. (August 29, 2023). HHS Selects the First Drugs for Medicare Drug Price Negotiation. Available at: https://www.hhs.gov/about/news/2023/08/29/hhs-selects-the-first-drugs-for-medicare-drug-price-negotiation.html

medical care that medicines generate.[90] Unfortunately, the IRA undermines the most effective tool we have to bend the cost curve and reduce health disparities in Medicare moving forward.

V. CMS has failed to implement proper safeguards to protect patients and clinicians in its implementation of the Program.

CMS has failed to meaningfully include key stakeholders, such as physicians and clinicians, in the price setting process.

We appreciate CMS' acknowledgement in the Guidance that it must revisit its approach to engaging stakeholders. It is clear to many that CMS' efforts to solicit and incorporate feedback on both the Program itself, as well as on the selected drugs for IPAY 2026 of the Program, have been seriously deficient. CMS offered two primary opportunities for stakeholders to engage and provide input into the price setting process in IPAY 2026: the Negotiation Data Elements Information Collection Request (ICR), and the Stakeholder Listening Sessions. Both were riddled with fundamental substantive, as well as operational, issues. CMS efforts likely led to the opposite effect of what CMS intended – *discouraging* rather than encouraging a diverse group of stakeholders with robust subject matter expertise from engaging in the IPAY 2026 process.

First, the Data Elements ICR was not an appropriate or complete mechanism to solicit input from patients, clinicians, or caregivers on the factors CMS must consider in determining prices for selected drugs. CMS asked for a significant amount of highly complex and technical data that posed a significant burden on patients and other key stakeholders – especially those from underrepresented or disadvantaged communities. To simply submit data to the Agency, these stakeholders needed to learn how to navigate a structurally complex form, decipher and answer highly technical questions in writing, and collect and provide data on the selected drug and potential therapeutic alternatives all within 30 days. Even worse, CMS declined to meaningfully solicit feedback on topics that are important to patients, clinicians, and caregivers – including clearly asking for their experience with a selected drug and the potential therapeutic alternative(s)[91] – while also imposing arduous word limits on the responses CMS did solicit. Together, these factors impeded a patient's, clinician's, or caregiver's ability to relay a complete narrative regarding their experience with a selected drug or therapeutic alternative.

Second, the Stakeholder Listening Sessions hosted by CMS for IPAY 2026 selected drugs, while perhaps well intended, were ill-conceived and poorly executed. This has been noted not only by patients themselves, but by experts in the field of patient engagement.[92] Issues highlighted by PhRMA and other stakeholders (including participants) include:

- **Lack of transparency into participant selection.** For each session, participation was limited to 20 speakers, though it was unclear to participants and the public how the speakers were selected, whether at random or based on certain criteria and each session only featured an average of 11 speakers per drug.[93]

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[90] Philipson T.J., Di Cera G. Issue Brief: The Impact of Biopharmaceutical Innovation on Health Care Spending. The University of Chicago. Available at: https://ecchc.economics.uchicago.edu/2022/08/03/the-impact-of-biopharmaceutical-innovation-on-health-care-spending/

[91] While CMS included new questions on the patient and caregiver experience in the revised ICR, the questions in Section H of the revised ICR were unnecessarily narrow and worded in a way that may have made it difficult for patients to clearly understand what specifically CMS was seeking in each question. For example, when defining "Therapeutic Alternative" in Questions 27 and 28, CMS used terms such as "drug class," "chemical class," and "therapeutic class," without defining these terms.

[92] Vandigo J., Edwards H.A., Flanagan J.H., Mattingly T.J. (June 24, 2024). Three Ways To Improve The Patient-Focused Listening Sessions In The Medicare Drug Price Negotiation Program. Health Affairs. Available at: https://www.healthaffairs.org/content/forefront/three-ways-improve-patient-focused-listening-sessions-medicare-drug-price-negotiation

[93] Patterson J., Wagner T.D., Campbell J. (November 2023). Three Takeaways from CMS's Patient-Focused Listening Sessions: Toward Improved Patient Engagement. National Pharmaceutical Council. Available at: https://www.npcnow.org/resources/three-takeaways-cmss-patient-focused-listening-sessions-toward-improved-patient

This is disappointing as the selected speakers were primarily white (88 percent) and below the age of 65 (63 percent) which may have obscured the views of Medicare patients and those from underserved or traditionally underrepresented communities.[94] CMS has provided no clarity into if these sessions were smaller than expected because of limited response or interest, or resulting from a decision by the Agency.

- **No meaningful dialogue between the Agency and the participants.** Staff remained in listening mode the entire time and did not provide information for participants to respond to or ask questions or provide feedback after participants spoke. CMS even asked at least one speaker to "reconsider" their statements on the IRA's impact to innovation the week of their listening session,[95] signaling that it may have even been trying to prevent any discussion on the flaws of the IRA.

- **Lack of clarity into conflict-of-interest disclosures.** CMS required participants to disclose "conflicts," though the purpose of those disclosures and what should be disclosed was unclear. Although funding from pharmaceutical companies was named as a potential "conflict," funding from other interested or biased parties – including payers, pharmacy benefit managers (PBMs) or other stakeholders with a vested interest in profiting off lowered drug prices – was not. This could have discouraged participation and confused the audience about participants' potential conflicts (or lack thereof).

- **Lack of accommodation of persons with disabilities.** In general, there were few apparent accommodations of persons with disabilities. At one point, CMS staff appeared to cut off a speaker with a speech impediment because the three-minute time limit had been reached.[96]

CMS has also failed to engage (or publicly disclose how they plan to engage) clinicians at critical junctures in the process. As PhRMA discussed at length in our comments on the IPAY 2026 Guidance, clinicians can offer valuable, real-world experience and insight into the selected drugs and key CMS decision points, including but not limited to identification of therapeutic alternatives, whether a selected drug or therapeutic alternative represents a therapeutic advance or meets an unmet need, and key subpopulations for selected drugs. As noted by physicians, CMS' failure in this regard could have very real consequences for patient access to treatment. Physicians are also in the best position to minimize the negative consequences Program implementation might have on formulary access. A structured process for receiving their input can ensure appropriate clinical reviews are considered in both evidence gathering and evaluation as well as monitoring the extent to which selected drugs and their competitors are appropriately covered on formularies.[97] As one physician has stated, "The [A]gency is required to consider a drug's clinical benefit, whether the drug addresses unmet needs, and what alternative treatments exist. But it's hard to make these determinations without a deep dive into the kind of observations and clinical evidence that physicians acquire from extensive, everyday experience."[98]

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[94] Patterson J., Wagner T.D., Salih R., Shabazz G., Campbell J. (June 2024). Breadth of Patient and Stakeholder Input in CMS's Drug Price Negotiation Program: A Content Analysis of the 2023 Patient-Focused Listening Sessions. Value in Health, Volume 27, Issue 6, S1. Available at: https://www.ispor.org/heor-resources/presentations-database/presentation/intl2024-3898/137099

[95] Czwartacki J.(November 30, 2023). After Participating in CMS's IRA Listening Sessions, I Remain Skeptical of IRA Implementation. RealClearHealth. Available at: https://www.realclearhealth.com/blog/2023/11/30/after_participating_in_cmss_ira_listening_sessions_i_remain_skeptical_of_ira_implementation_995832.html

[96] CMS cut off multiple patients throughout the sessions. For an example, please see the redacted transcript for "Speaker 3" during the Eliquis listening session on October 30th. Available at: https://www.cms.gov/files/document/eliquis-transcript-103023.pdf

[97] Fendrick A.M. (December 14, 2023). CMS Must Obtain Clinician Input Today to Prevent Part D Access Barriers Tomorrow. Health Affairs. Available at: https://www.healthaffairs.org/content/forefront/cms-must-obtain-clinician-input-today-prevent-part-d-access-barriers-tomorrow

[98] Fonseca R. (July 2, 2024). Without Doctor Input, the IRA Could Hurt Patients and Cost Them More. RealClearHealth. Available at: https://www.realclearhealth.com/blog/2024/07/02/without_doctor_input_the_ira_could_hurt_patients_and_cost_them_more_1041650.html.

CMS' lack of engagement is certainly not due to lack of feedback or ideas from stakeholders for how best to engage. To the contrary, principles to conduct patient-centered research have existed for years[99] and there is a wide range of academic and thought leader research[100] on methods to better understand and collect patient and caregiver feedback. In response to CMS' implementation of the IRA, experts in patient engagement, including both academics and patients themselves, have been increasingly vocal and concrete regarding how CMS should best receive information from patients, clinicians, and caregivers, and how they should use that information. [101] For example, NHC hosted a roundtable and subsequently released detailed, actionable recommendations to CMS on how to improve engagement with patients; these recommendations were developed in concert with over thirty different stakeholder groups. Because CMS received such thoughtful input, it is even more deeply disappointing that the Agency did not include a detailed engagement roadmap in the Guidance. Instead, it appears CMS will simply finalize a strategy (a strategy which will hopefully be based on feedback received from stakeholders in response to this Guidance) and move forward. Before that happens, PhRMA strongly encourages CMS to speak with stakeholders who should remain at the center of this process – patients, clinicians, and caregivers.

CMS has failed to articulate a patient-centered approach to setting prices or implement the few patient protections that were included in the IRA.

As previously noted, PhRMA strongly believes that CMS has an obligation to mitigate the potential harm to patients caused by the IRA. One way CMS can do this is by ensuring that all aspects of its price setting methodology are centered on the needs of patients. This includes adhering to the few explicit patient protections in the IRA. Unfortunately, there is very little evidence in the Guidance that CMS has taken that important step.

As previously mentioned in Section I of this letter, CMS is required by the IRA to develop a consistent methodology for determining prices for selected drugs. It is safe to assume that development of such a methodology would include, at a minimum, public release of certain aspects of the Agency's decision making. However, CMS has failed to disclose to the public (including in the "negotiations" with manufacturers) sufficient detail surrounding many aspects of its methodology.

CMS' apparent failure to adhere to the requirement that it develop a "consistent methodology" is concerning for a number of reasons, but primarily because it is unclear whether the evidence CMS is relying upon or generating, the manner in which CMS is interpreting the factors, or the methodology itself is centered on the perspective of patients, caregivers and society. If CMS is truly committed to a patient-centered approach, at minimum, the Agency needs to transparently articulate how the feedback gathered from the ICR process, the listening-sessions, and any other form of engagement is being used directly and quantitatively in setting the MFP. Without a formalized methodology, any improvements to data collection will fall flat and prices for selected drugs will not reflect the inherent value patients derive from the selected drugs. A failure to emphasize the needs of patients

[99] For examples, please see principles from the National Health Council (available at: https://nationalhealthcouncil.org/blog/the-nhcs-new-value-classroom-tools-to-help-patient-group-staff-engage-on-a-value-assessment/), the National Pharmaceutical Council (available at: https://www.npcnow.org/sites/default/files/2021-04/npc-guiding-practices-for-patient-centered-value-assessment.pdf), the Patient-Centered Outcomes Research Institute (available at: https://www.pcori.org/engagement/engagement-resources), and PhRMA (available at: https://phrma.org/en/resource-center/Topics/Cost-and-Value/Principles-for-Value-Assessment-Frameworks#:~:text=Clearly%20state%20the%20intended%20use,and%20reporting%20costs%20and%20economic)

[100] Examples of patient engagement research CMS should reference include: dosReis S., Butler B., Caicedo J., et al. (October 2020). Stakeholder-Engaged Derivation of Patient-Informed Value Elements. Patient. Available at: https://pubmed.ncbi.nlm.nih.gov/32676998/. See also: Slejko J.F., Hong Y.D., Sullivan J.L., et al. (September 2021). Prioritization and Refinement of Patient-Informed Value Elements as Attributes for Chronic Obstructive Pulmonary Disease Treatment Preferences. Patient. Available at: https://pubmed.ncbi.nlm.nih.gov/33554310/

[101] Vandigo J., Edwards H.A., Flanagan J.H., Mattingly T.J. (Jume 24, 2024). Three Ways To Improve The Patient-Focused Listening Sessions In The Medicare Drug Price Negotiation Program. Health Affairs. Available at: https://www.healthaffairs.org/content/forefront/three-ways-improve-patient-focused-listening-sessions-medicare-drug-price-negotiation

could lead to significant consequences to patient access to drugs in Medicare Part D, or the ongoing development of future treatments, as discussed earlier in this letter.

Another issue on which CMS has remained silent is how it intends to weigh the two sets of factors against each other. Per the IRA, CMS must consider two sets of factors when setting prices for selected drugs. An emphasis on the factors in Section 1192(e)(2) (related more closely to the value a selected medicine brings to patients) may somewhat mitigate inherent disincentives for continued innovation.[102] However, if CMS places too much importance on factors in Section 1194(e)(1) (related to "manufacturer-specific data"), the result could be a price that entirely disregards the value that medicines bring to patients, and have catastrophic consequences for both patient access and innovation. In the Guidance, CMS has declined to discuss the issue entirely, creating considerable uncertainty for manufacturers and jeopardizing patient access to current and future treatments.

One issue CMS does discuss in Guidance, but only superficially, is the use of cost effectiveness analysis (CEA) methodologies to arrive at prices for selected drugs. Given that the protection against use of discriminatory value metrics is one of the few explicit patient safeguards contained in the IRA, CMS' failure to fully explain how it intends to implement the safeguard is disappointing. CMS states that, "CMS will review cost-effectiveness measures used in studies relevant to a selected drug to determine whether the measure used is permitted in accordance with Section 1194(e)(2), as well as with Section 1182(e) of Title XI of the Act. CMS may use content in a study that uses a cost effectiveness-measure if it determines that the cost-effectiveness measure used is permitted in accordance with the law." However, CMS does not elaborate on specifically what specific methodologies it is considering. Transparency regarding specific methodologies is critical – the issue of what qualifies as discriminatory is currently not only a subject of debate among stakeholders, but also the subject of recent rulemaking within HHS' Office of Civil Rights.[103] And as noted in PhRMA's comments on the IPAY 2026 Initial Guidance, regardless of the specific approach taken, reliance on CEA, whether it is rooted in the quality-adjusted life year (QALY) or another similar metric, as the basis for policy decisions risks further discriminating against the elderly, the disabled, and underserved and underrepresented people of color who are already at higher risk of not receiving the care they need.

* * *

PhRMA appreciates your consideration of these comments. Please feel free to contact Elizabeth Carpenter (ecarpenter@phrma.org) and Jim Stansel (jstansel@phrma.org) if there is any further information we can provide or if you have any questions about our comments.

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Elizabeth Carpenter
Executive Vice President
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-----s-------

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Executive Vice President and General Counsel
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[102] We note, however, that the mitigation is limited by the fact that the statutory ceiling price applies even when a higher price would be set based on the factors related to the therapeutic benefits medicines offer to patients.

[103] HHS Final Rule, 89 Fed. Reg. 40066 (May 9, 2024) (value assessment prohibition codified at 45 CFR 84.57); HHS Final Rule, 89 Fed. Reg. 37522 (May 6, 2024).

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September 3, 2024

VIA ELECTRONIC FILING - REGULATIONS.GOV

Meena Seshamani, M.D., Ph.D.
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
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Attention: PO Box 8016

Re: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) (CMS-10849, OMB 0938-1452)

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) *Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request* (ICR or the ICR), including the Federal Register Notice, Supporting Statement – Part A, ICR Form (CMS-10849, OMB, 0938-1452).[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 $1.2 trillion in the search for new treatments and cures, including $100.8 billion in 2022 alone.[2] The biopharmaceutical industry is committed to working every day to discover and develop new treatments for patients with complex and debilitating diseases such as cancer, heart disease, rare genetic disorders, and many more.

In advance of Initial Price Applicability Year (IPAY) 2026, despite our concerns regarding government price setting of medicines, PhRMA articulated concrete, actionable recommendations for CMS on implementation and application of both the negotiation data elements ICR (data elements ICR) and drug price negotiation process ICR (counteroffer ICR). Unfortunately, as it did with most comments, CMS disregarded these recommendations. We strongly recommend the Agency revisit these decisions and pave an alternative path forward. Rather than reiterate our concerns on the mostly unchanged ICRs, we are attaching these recommendations as Appendices. PhRMA is attaching:

- Our comments on CMS' draft guidance for Initial Price Applicability Year (IPAY) 2027 as Appendix A;
- Our comments to CMS in response to the draft and revised IPAY 2026 "Negotiation Data Elements" ICR as Appendixes B and C, respectively; and

[1]Available for viewing at: https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849.
[2] PhRMA. (2023). 2023 PhRMA Annual Membership Survey. https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Refresh/Report-PDFs/A-C/PhRMA_membership-survey_single-page_70523_es_digital.pdf.

- Our comments to CMS in response to the draft and revised IPAY 2026 "Negotiation Data Exchange" ICR as Appendix D and E, respectively.

Unfortunately, CMS' changes to the ICR forms fail to address the vast majority of our prior comments, which focused on key considerations under the Paperwork Reduction Act (PRA). CMS now has a year of experience with this process and has still declined to make any significant changes to either the ICR form or the burden estimates. PhRMA members also have concrete experience with the process that validates the concerns we raised in our prior comments. A survey of members demonstrated that companies – operating under the assumption of selection – spent a minimum of six months of high-intensity effort to comply with CMS' data request. These efforts required complex coordination across many business functions, requiring new methods, and extensive sourcing, reviewing, fact-checking, and developing data – much of which is old and/or not readily available – under compliance pressure. Most importantly, the data elements required by CMS in the ICR reflect a fundamental misunderstanding and mischaracterization of how research and development (R&D) works. This fatally flawed approach, coupled with a very poor data collection system,[3] a poor user interface and lack of functionality necessitates a change in approach.

Despite stakeholders' experience with the process, the Agency continues to ask for an increasingly unreasonable amount of data from manufacturers, often requiring a lookback of one or more decades. This growing burden is compounded by the fact that the requested data is often inconsistent with business practices, operational definitions, and in many cases requires completely new processes to obtain. For example, the ICR requires collection of data that may be solely possessed by a "Secondary Manufacturer"[4] and thus particularly difficult for a Primary Manufacturer to obtain. On top of this already burdensome request, the ICR also requires the intensive process of quality- and fact-checking the compiled data (which can be nearly impossible if possessed solely by a "Secondary Manufacturer") within a one-month period. Perhaps most alarming is that the Agency has provided no transparency into how or if it even used the vast amounts of data collected during the IPAY 2026 price setting process, raising questions as to the goals behind the process. This underscores that not only are these ICRs fundamentally misaligned with the purposes and goals of the PRA, but that the Agency has made no effort to carefully consider the burden on stakeholders in alignment with its duties under the PRA.

Even despite feedback from the Office of Management and Budget (OMB),[5] CMS made only minimal changes to the ICR forms. Instead of refining the questions asked to be more relevant to the price setting process as PhRMA requested in previous comments, the IPAY 2027 ICR changes only increase the burden of data submissions and, in many cases, reduce the utility of the form. In fact, the data elements

[3] Specifically, CMS relied on the Health Plan Management System ("HPMS") for data entry, but HPMS is a form-based system that requires users to enter each text response in a separate field. The system does not include a functionality for users to automatically upload a spreadsheet into the form, requiring users to copy and paste or to manually enter each line item. If there are multiple NDCs listed, this entry can require cutting and pasting into hundreds or thousands of fields. In addition, HPMS did not provide a confirmation copy of submissions and significantly slowed in its processing when under the strain of multiple users.
[4] While PhRMA is not reiterating our comments on the "Primary" and "Secondary" manufacturer construct in this letter, we refer readers to PhRMA's comments on the IPAY 2026 and 2027 guidance and the IPAY 2026 negotiation data elements ICR.
[5] Please see: https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202306-0938-013 (requiring CMS to "provide an analysis of the 2026 negotiation data submissions from manufactures [sic] including, but not limited to, a meta-analysis of data from sections C: Research and Development Costs and Recoupment and D: Current Unit Costs of Production and Distribution. Also, in its 2027 ICR submission, CMS will address how it made improvements to the agency's ability to audit the manufacturers' data and improvements to the data collection more broadly from its analysis of the 2026 negotiation data."). CMS has not explained how it complies with this OMB request. CMS also appears to view the requirements of the PRA as perfunctory—ready to make the requisite certifications under the PRA without seriously evaluating whether the 2027 collection could reasonably be viewed as meeting such certifications. These include: certifying that each question in the collection is "necessary," "avoids unnecessary duplication," "reduces burden on small entities;" uses plain, coherent, and unambiguous language that is understandable to respondents;" is "consistent and compatible with current reporting and recordkeeping practices;" or informs respondents how the information was used previously so as to justify collection for another year of the IRA price-setting.

ICR now extends for 69 pages, with the majority of questions included in Sections A – I comprising of multiple subparts. Additionally, the form continues to require respondents to submit vast amounts of data with unreasonable speed -- in just 28 days post-selection -- despite the difficulty, such as the form's inconsistency with ordinary business record-keeping and the difficulty faced by Primary Manufacturers in obtaining this data from "Secondary Manufacturers". To compile, review, and certify the requested data in the given timeframe, Primary Manufacturers must either risk waiting for the selection announcement and then certify a submission it could not have compiled and fact checked in 28days or are forced to assume they will be selected and spend countless hours and extraordinary expense compiling this information – a process, which, in part it will have to repeat if it is ***not*** selected during that year's IPAY. Even operating under the assumption that it will be selected, manufacturers will still struggle to certify the accuracy of their submissions as in a number of cases, CMS asks for this data to cover the preceding three years including the "calendar year ending December 31, 2024"[6] – even though that data may not be complete and ready for submission within the two months required to meet the March 1, 2025 deadline.

It is clear that CMS itself does not truly view this process as "negotiation". Instead, CMS' proposal to continue requesting inordinate amounts of data – without even reporting on whether or how it used such data throughout the IPAY 2026 process – shows that the Agency believes manufacturers have little recourse but to adhere to the Agency's arbitrary demands. The data collection process is not only flawed but it requires a significant amount of time and financial investment, well beyond the Agency's unchanged estimate of 704.25 hours at a total cost of $85,184.13 across a biopharmaceutical manufacturer. In fact, PhRMA members reported estimates averaging over 7,700 hours of staff labor to comply, with approximately 21 business functions involved in responding, and a significant need to employ external consultants, such as outside counsel.[7] These excessive and unworkable demands for manufacturer-specific data place an undue burden on manufacturers of selected drugs, while ultimately appearing irrelevant to the Agency's determined price. Moreover, the fact that CMS already has access to much of the requested manufacturer-reported data raises the question of why the Agency even needs to request this data from manufacturers in the first place and further shows how the Agency is ignoring its duties under the PRA.

Unfortunately, patients and caregivers will ultimately bear the brunt of CMS' unworkable demands. CMS' approach to determining the Maximum Fair Price (MFP) for selected drugs has significant implications for patient access[8] and biopharmaceutical innovation.[9] Yet, instead of working with manufacturers and key stakeholders – like patients, clinicians, and caregivers – to mitigate these potential unintended consequences by considering the critical data on the clinical benefit that selected drugs can offer to patients, caregivers, and society, CMS instead focuses on collecting unnecessary and irrelevant data. Moreover, they do this while refusing to give any insight into how *and if* any of the data provided – including data submitted by these key stakeholders – was used in setting MFPs.

* * *

[6] Draft Questions 16, 20, 22.
[7] A company survey of experience indicates that the information collection process was extraordinarily more burdensome than CMS estimated despite the extensive recommendations PhRMA provided to CMS on how to more productively facilitate collection. CMS not only requested information that was almost impossible to collect but also in a manner that significantly differed from corporate record-keeping.
[8] Hayden Consulting Group. (Sep 2023). IRA: Patient Access to Therapeutic Options. Available at: https://haydencg.com/ira-patient-access-to-therapeutic-options/.
[9] Philipson TJ, Ling Y, Chang R. (Oct 2023). The Impact of Price Setting at 9 Years on Small Molecule Innovation Under the Inflation Reduction Act.* The University of Chicago. Available at: https://bpb-us-w2.wpmucdn.com/voices.uchicago.edu/dist/d/3128/files/2023/10/Small-Molecule-Paper-Final-Oct-5-2023.pdf.

I. Requirements of the PRA and CMS' Noncompliance with these Requirements

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

> (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."[10]

As noted previously, CMS continues to fail each element of this regulatory test.

First, 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 PRA compliance. The data requested is not the "least burdensome necessary" and CMS has not shown it is even considering the burden on respondents. The Agency has not fixed basic issues that increase burden, including in cases where the data elements will be impossible for the manufacturers to collect (e.g., cases where the original developer of a product no longer exists, or data cannot be reported at the level of precision requested by CMS given the incongruence with business practices for recording and accessing information) or fundamental issues with the Health Plan Management System (HPMS) portal that both PhRMA and its member companies raised in previous comments. In fact, the Agency has actually increased the length and the burden placed on the public through these forms and has not demonstrated that it is attempting to reduce the burden or seeking a way to be the "least burdensome necessary".

Second, the PRA requires agencies to ensure they do not demand already available data to avoid duplication. Yet, CMS has yet to offer a reasonable explanation for why it requires "publicly available" data, including fields like the "Federal Supply Schedule" and "Big Four Prices". CMS' explanation that a manufacturer could potentially have marginally more up-to-date data on such fields does not explain why the PRA would permit an agency to impose such a heavy burden on respondents in return for a hypothetical minimal benefit.

Finally, the Agency has not shown the data collected has any practical utility as there is no transparency in whether the submitted data is being used. There is no evidence that the vast amount of data sought by CMS actually informs the Agency's MFP decision-making. Indeed, in its draft guidance for IPAY 2027, CMS proposes exceedingly vague standards for how it will evaluate manufacturer-submitted data. CMS states that it will consider these data in "totality," and will use them to apply "upward," "downward" or "no" adjustments to the preliminary price. CMS states it will "consider each factor in isolation or in combination with other factors." In discussing each factor, CMS states that it "may" consider adjusting the preliminary price based on the data submitted, but then also states that its overall adjustment to price based on such data may "differ" from the examples it provides.[11] The collection process shifts

[10] 5 C.F.R. § 1320.5(d)(1)(i)-(iii).

[11] IPAY 2027 Draft Guidance at § 60.3.4. Note, PhRMA provided concrete recommendations on information collection in our comments to CMS in response to the draft and revised IPAY 2026 "Negotiation Data Elements" ICR. Please see Appendices B and C to this letter.

disproportionate costs and burden onto the public as the ICR seeks duplicative information and information that may not even be relevant to price setting.

To correct these shortcomings and comply with the PRA, PhRMA strongly suggests CMS review the suggestions in PhRMA's previous comments on reducing the burden posed by both ICR forms as well as the comments below.

II. General Comments and Recommendations

We continue to urge CMS to provide a format for data collection that facilitates flexibility, consistency, and compliance rather than unjustifiably increasing burdens on respondents and exposing them to potential liability. The below comments summarize some, but not all, of PhRMA's general concerns and recommendations to improve the ICR, to be considered in concert with our recommendations in our prior comments.

Burden Estimate:

Despite the increasing reporting burden relative to last year's ICR and numerous comments underscoring how CMS has underestimated this burden, the agency continues to report the same reporting burden estimate. Although the Agency states in the Supporting Statement that it is "considering design alternatives for Sections A, B, D, and G of the [data elements ICR] Form to reduce Primary Manufacturer data submission burden," these changes have not been implemented. In fact, CMS has only increased this burden with a drastic increase in the number of questions and length of the data elements ICR form. Yet, the Agency continues to unreasonably insist that manufacturers (across all team members working on a submission) will spend only 500 hours each (unchanged from IPAY 2026) to gather and submit the information CMS requires for the data elements ICR at a cost of about $52,720 per respondent (only slightly increased from IPAY 2026's estimate of about $51,600 per respondent). CMS also estimates that it will only take respondents 204.25 hours (unchanged from IPAY 2026) at a cost of approximately $32,460 per respondent (slightly *decreased* from IPAY 2026's estimate of approximately $32,730 per respondent) to develop and submit the information required by the counteroffer ICR. Such estimates are unreasonable on their face, but especially given CMS' estimate that the Agency will spend more than this amount for its own work (e.g., the Agency estimates it will cost approximately $1,118,600 to review the Section 1194(e) data submissions from Primary Manufacturers and the public and modify the HPMS system across the 15 selected drugs (approximately $74,570 per product)).

Timeline Considerations:

CMS' approach to the data elements ICR is fundamentally flawed. CMS' process requires submitters to consider every possible scenario with no bounds on the potential universe of products in just 28 days. As noted in previous comments, PhRMA believes that CMS must publicly identify the therapeutic alternative(s) or the therapeutic alternative(s) under consideration, along with any resources (e.g., manufacturer feedback, clinical guidelines, advisory panels, etc.) prior to the data submission. CMS could accomplish this and alleviate some of these issues by creating a scoping process in advance of the drug selection announcement to help determine potential therapeutic alternative(s) under consideration. Otherwise, not only will manufacturers of *potential* therapeutic alternatives feel compelled to submit potentially irrelevant data, but the data CMS receives from the public through Section I will be more likely to contain irrelevant and unnecessary data. While we appreciate CMS including the option to submit a dossier in Question 36 to support more narrative answers to Questions 30 through 35 and Question 37, it does not significantly reduce the burden on manufacturer data submitters given the universe of potential scenarios.

Additionally, as stated in prior comments, requiring all data to be collected, certified, and submitted, without an opportunity to supplement, in less than one month is unreasonable given the substantial amount of information requested. Furthermore, it disadvantages patients, caregivers, and other key

respondents from traditionally underrepresented or underserved communities who may not be as well-funded or able to pull together this data on such short notice. To mitigate these issues CMS should consider: (a) reducing the burden of the data collected; (b) allowing all respondents to supplement data submissions; and (c) extending data collection deadlines wherever possible. CMS should seek the most accurate and complete picture possible when setting prices that can have serious implications and consequences for America's seniors and disabled individuals enrolled in Medicare. In addition, a supplemental response may not always be necessary, and manufacturers should not be penalized should they choose not to submit a dossier if the answers are otherwise sufficient.

Lack of Substantial Changes to the Manufacturer Data Elements:

The Manufacturer Data Elements continue to be flawed and incongruent with current business practices. As stated above, many of the questions in this section also violate the PRA in terms of both utility and necessity. For example, CMS continues to break R&D costs into five categories. As we have previously explained, this subdivision is well beyond how manufacturers report such data in other contexts, how they organize data, and potentially contravenes manufacturers' document retention policies.[12] Furthermore, the breadth of R&D cost data required to be submitted in order for CMS to determine if these costs have been "recouped" is unnecessary and based on a fundamentally flawed concept of "recoupment". As PhRMA and others have continually noted, very few drug candidates among those entering clinical trials are ultimately successful in reaching approval by the FDA—in fact, just 12 percent.[13] Companies account for these odds when they plan their R&D programs across portfolios and ultimately rely on the revenues from a few successful medicines to discover new medicines and to help recoup costs of the many failures across their entire portfolio of medicines. Therefore, not only is this information nearly impossible to collect in the manner in which CMS requests it, given the nature by which R&D investment occurs, but it serves no practical utility as the question of recoupment could be simply answered via a checkbox (e.g., if the product has "recouped" its investment or not). Moreover, CMS relies on flawed logic for the purposes of assessing recoupment by comparing some of the costs associated with selected medicines to global, total lifetime manufacturer revenue figures, clearly violating accounting matching principles. For these reasons, we continue to reiterate prior comments recommending CMS amend the ICR to allow a single global response for all manufacturer's R&D costs across all development programs, similar to a Form 10k for Securities and Exchange Commission filing, and a single attestation (YES/NO) for recoupment.

Furthermore, much of the data CMS requests is duplicative of data CMS already has access to and which is already publicly available. For example, CMS continues to demand expansive and burdensome data – such as "any patents that are, have been, or may be listed for the selected drug in the FDA Orange Book or Purple Book; utility patents that claim the drug product (formulation or composition), drug substance (active ingredient), metabolites or intermediaries of a selected drug, method(s) of using the drug, or method(s) of manufacturing the drug; and design patents that, for example, claim a design on the packaging of the selected drug". We continue to urge CMS to procure information on approved patent applications from the FDA's Orange Book and Purple Book listing and relevant drug information regarding approved drug applications under the FDCA and PHSA from Drugs@FDA as these are publicly available data sources. Likewise, the expanded patent information requested this year is also available from the USPTO using the patent public search tool. Similar to prior comments, we continue to recommend that 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.

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[12] Note: On p. 11 of the supporting statement, CMS says: "There are no special circumstances that would require information collection for the [data elements and counter-offer] forms . . . to be conducted in a manner that requires respondents to [among other things] … Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years." CMS should confirm this certification.

[13] DiMasi JA, Grabowski HG, Hansen RW. (Feb 2016). Innovation in the pharmaceutical industry: New estimates of R&D costs. J Health Econ. 47:20-33. DOI: 10.1016/j.jhealeco.2016.01.012. Available at: https://pubmed.ncbi.nlm.nih.gov/26928437/

It is CMS' responsibility under the PRA to not only be committed to reducing burden whenever possible but also provide justification for each element of data. If these elements cannot be justified as they do not directly influence CMS' MFP decision-making, CMS must reformulate its request to reduce the associated burden.

Lack of Clarity:

CMS has not provided any insight or clarity into how the data will be used or even if the data will be used in the Agency's decision-making. This includes, but is not limited to, any information or structure around how the different sections will be weighted (i.e., if -- as suggested by PhRMA and other key stakeholders[14] -- CMS will assign a greater weight to the Section I factors that actually reflect the benefit the selected drug brings to patients, caregivers, and society), and Section G asking for the "Manufacturer Net Medicare Part D price," inclusive of coverage gap discounts "and other supply chain concessions (e.g., wholesale discounts) not reflected in the sum of the plan-specific enrollment weighted amounts calculation," reported at the NDC-11 level.[15] As noted by PhRMA in our comments on the IPAY 2027 initial guidance, the terms "other supply chain concessions" and "wholesale discounts" are poorly defined and overly broad. Furthermore, CMS is suggesting that manufacturers report aggregate price concessions for supply chain entities across the pharmaceutical supply chain, but this calculation would not accurately reflect the net price to Medicare Part D plans at the NDC-11 level as price concessions for supply chain entities are not net prices available to Part D plans. As such, this calculation is not only an inaccurate accumulation of discounts for CMS to require but represents significant burden upon Primary Manufacturers that would be required to track and aggregate these price concessions at the NDC-11 level, which would go well beyond the burden permitted under the PRA.

Furthermore, PhRMA commented in response to CMS' IPAY 2027 Draft Guidance that the proposal to net out coverage gap discounts (or manufacturer discounts) as part of establishing the starting point for developing an initial offer for a selected drug circumvents Congress' directive to exempt selected drugs from being subject to such discounts.[16]

CMS has also not provided any clarity or articulated a process for arriving at one MFP across multiple indications or multiple products containing the same active ingredient or moiety. This is particularly concerning given CMS' overbroad interpretation of qualifying single source drug, which improperly treats new dosage forms and formulations containing the same active ingredient or moiety as the same drug, even if the drug was approved under a different marketing application. As a result, biopharmaceutical companies are already reconsidering the economic feasibility of investing in post-approval R&D, including whether to bring new drug or biological products to market that could provide valuable new treatment options for different diseases or patient populations, or provide a new method of administration. We are concerned that the granularity of the data and the questions included in the ICR suggest CMS may be exploring a prevalence or volume weighted approach to setting the price, without any explanation in guidance or this ICR of how these data will be used. This will devalue drugs with multiple indications in the price setting process and thereby further discourage post-approval R&D. We urge CMS to consider the compounded effect this approach may have on R&D investments to bring forward these critical treatment advances to meet unmet patient need.

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[14] McElwee F., Cole A., Garrison L.P., Towse A. (Jun 2024). Federal Support Should Not Be A Factor In Determining Pharmaceutical Prices Under The IRA. Health Affairs Forefront. DOI: 10.1377/forefront.20240613.956455 Available at: https://www.healthaffairs.org/content/forefront/federal-support-should-not-factor-determining-pharmaceutical-prices-under-ira.

[15] Although PhRMA disagrees that the Agency should use coverage gap discounts at all in the price-setting, we note that the Agency already has access to these data.

[16] PhRMA comments IPAY 2027 draft guidance, note 18. Specifically, the IRA exempts selected drugs from the Manufacturer Part D discount program that begins in 2025, and which is the successor to the Coverage Gap Discount Program.

Lack of Transparency:

As stated above, it is clear from CMS' approach to the ICR that CMS believes manufacturers have little recourse but to adhere to the agency's arbitrary demands – even when they violate the spirit and standards of the PRA. CMS has not made adequate attempts to reduce the burden placed on manufacturers and it is not clear if CMS is even utilizing the massive amounts of data requested from manufacturers. It is not apparent if CMS even knows what information it needs, as the Agency to date has not explained precisely how it uses manufacturer- and stakeholder-submitted information to develop a replicable MFP or the "clear and consistent" methodology required by statute.

CMS' lack of transparency may also have the unintended consequence of "chilling" participation from patients, caregivers, clinicians, and other key stakeholders. Unless CMS provides some form of insight into how it is using the data these stakeholders take the time to provide, potential data submitters may not feel that their investment is worth the time or the effort. To avoid this, CMS must transparently demonstrate that it is carefully considering the data provided both through the ICR process and the stakeholder listening sessions by releasing information on what information the Agency considered and what types of stakeholders (e.g., patient, academic researcher, biopharmaceutical manufacturer) the data originated from.

Lack of Context:

CMS continues to ask questions that fall far short of capturing the full context surrounding the requested data. We support CMS' goal of prioritizing patient perspectives in its decision-making, and as such, continue to ask CMS to ensure that its data collection seeks to fully understand the market and any unintended consequences from price setting. For example, Section C splits R&D costs in artificial ways which provides no vehicle to adequately describe the full innovation story of a selected drug and the non-linear process pharmaceutical innovation usually takes, with many starts, stops, and dead ends, all of which entail significant costs. Additionally, the value of a drug must be considered across the product's lifecycle, not just at the time of selection which may be years after a drug was approved to address a specific need or gap. Thus, some of the language used by CMS in Section I, such as that the Agency will consider whether a selected drug is "currently meeting an unmet need" [emphasis added], misses much of this context and should be reframed to capture whether patients, clinicians, and other key stakeholders believe the selected drug has met an unmet need *from launch*. Finally, Section D also does not explicitly consider certain supply chain costs (e.g., wholesaler fees, other distribution costs) that are critical to CMS understanding the true "current unit costs of production and distribution" that a manufacturer incurs for the drug. MFPs rooted in data that lack context, such as the examples described above, fail to appreciate the full value of selected drugs which could have real consequences for patients including, but not limited to, potential access barriers.

Unnecessary Character and Citation Limits:

As PhRMA has previously noted, CMS' arbitrary word and citation limits negatively impact the ability of all data submitters, including patients, caregivers, and manufacturers, to provide the narrative explanations CMS seeks. Especially given the various scenarios that must be accounted for – as CMS does not announce or supply the therapeutic alternative(s) under consideration prior to the data submission deadline – CMS is depriving respondents of the ability to provide important contextual and narrative information on the selected drug and its therapeutic alternative(s). Instead of making strides to fix this oversight, CMS doubled down on limiting respondents' freedom to answer questions comprehensively by replacing word limits with character limits. Considering that many of the questions ask for scientific or technical answers – both of which require long and technical terminology – CMS' change may actually shorten the answers data submitters are allowed to provide.

Protection of Proprietary Information:

While we appreciate CMS adding questions 28 and 64 to allow respondents to identify information that should be withheld by CMS under FOIA Exemption 3 and/or 4,[17] this is only a first step as there are other proprietary/confidential commercial information concerns that go beyond FOIA.

First, Congress drafted the IRA to impose on CMS an obligation to vigorously protect manufacturer-submitted proprietary data – a protection that extends beyond simply withholding it from FOIA releases. Such information shall be "used only by the Secretary or disclosed to and used by the Comptroller General of the United States for purposes of carrying out this part [Part E of Title XI of the Social Security Act]".[18] CMS should recognize this limitation in its form(s) and explain how it will ensure information is used only to carry out the price-setting provisions of the IRA (as well as whether the agency will establish a process similar to the "reverse FOIA" process to allow submitters to be notified of and possibly contest any "use" of submitted data for purposes other than carrying out the IRA price-setting provisions).

In addition, CMS should amend the ICR to be clear that the agency continues to be bound by regulations at 45 CFR Part 5, including (1) the requirement that CMS allow submitters to designate information as confidential commercial information *after* submitting it; and (2) requiring CMS to engage in a pre-disclosure notification process, including in cases where a submitter did not designate information as confidential-commercial and the government has "substantial reason to believe that information . . . could reasonably be considered exempt . . . as [confidential commercial information]". [19]

CMS also should remove all character/word limits for explanations, so entities are not limited in describing the confidential commercial or proprietary nature of the submission.

Finally, as stated in previous comments, CMS needs a robust security protocol for protecting manufacturer proprietary information. In IPAY 2026 draft guidance comments, PhRMA already provided comments and recommendations on how CMS could create a robust confidentiality and data security protocol.

Section H. Certification:

PhRMA reiterates comments on the significant issues associated with the required certification included in this Section. Please refer to our 2026 comments.

Section I Data Submission Affiliations:

PhRMA continues to have serious concerns over the definition of "affiliated with the manufacturer of the selected drug" as used in Question 29. This shortsighted definition goes beyond other definitions of affiliations to include non-financial relationships. Additionally, although unclear on this point, the draft ICR could be read to request a response not just from researchers (as was the case for IPAY 2026) but from all respondents, including patients and caregivers. This could chill participation as some stakeholders may engage with manufacturers but do not have a conflict of interest as that term is commonly understood. Indeed, labeling such relationships as "conflicts" does a disservice to the patients and caregivers who may seek out relationships with manufacturers precisely because these manufacturers' products provide important therapeutic benefits for their or a loved one's condition. Finally, CMS ignores all other conflicts of interest, including from payers or pharmacy benefit managers that have a vested interest in profiting off drug prices with no countervailing interest in ensuring continued development of new medicines for patients.

[17] 5 U.S.C. § 552(b)(3), (4)
[18] Social Security Act § 1193(c)
[19] 45 C.F.R. §§ 5.41-5.42

Changes to Section I

While PhRMA appreciates many of the changes made to Section I, including splitting the questions into relevant sections and writing the "Patient- or Caregiver-Focused Input" section in a more lay-friendly way, we continue to have concerns with the information sought by the Agency. Some of the questions (e.g., Questions 33A, 33B, 56A, 56B) seek information that CMS should already be able to access. Furthermore, these new questions seem to discount the importance of meaningful engagement with patients and caregivers, who are often experts with lived experiences and opinions critical to CMS' decision-making.[20] For example, the patient and caregiver section (Questions 38 – 44) does not include a question asking respondents for their thoughts on potential therapeutic alternatives despite directly asking researchers (Question 53) and clinicians (Question 47c) for their thoughts. Furthermore, CMS fails to ask patients and caregivers for what they consider to be patient-important or centered outcomes the Agency should consider, although it asks academics for clinical outcomes (Question 54b) and clinicians for outcomes they use to "assess improvement or treatment response (Question 46b).

Equity Considerations:

To fully include and incorporate voices from diverse and potentially medically underserved populations in its analyses, CMS should actively seek out the viewpoints and lived experiences of communities most impacted by the therapeutic areas treated by the selected drugs. While we cannot comment on the stakeholders who submitted and had data considered by CMS, as the Agency has provided no transparency into that process, observers have noted that speakers at listening sessions were primarily white and under the age of 65.[21] This is not necessarily reflective of the populations that will be most impacted by CMS' price-setting. As stated earlier in this letter, the ICR process and timeline inherently disadvantages those from under-resourced communities. Furthermore, the manner in which the Agency is seeking input on research metrics (e.g., only asking researchers questions on methodologies via Question 54A) raises questions on how CMS is considering metrics related to equity. In fact, the Agency's willingness to potentially consider cost-effectiveness measures so long as they do not discriminate against someone "who is elderly, disabled, or terminally ill" raises concern that CMS may rely on metrics known to undervalue communities of color.[22,23]

Separately, PhRMA appreciates the step forward the Agency took to attempt to collect demographic information from patient and caregiver respondents. This information can help CMS ensure that it is considering data and information that reflects the populations treated by a selected drug. To this end, PhRMA suggests the Agency collect this information from all non-manufacturer respondents. This includes collecting information from clinician respondents on approximately how many days per month a clinician sees patients and basic information on the population treated (e.g., percent of patients treated taking the selected drug, practice zip code) to make sure the Agency prioritizes data from providers working with and reflecting the views of the populations most likely to be impacted by CMS' price setting decisions. To hold itself responsible for meeting these goals and creating a more patient-centric process, CMS also must commit itself to transparency. This includes releasing summarized information

[20] Oehrlein E.M., Edwards H.A., Howarth T.J., Vandigo J. (Nov 2023). Listening Sessions Can Help CMS Become More Patient-Centered. Here's How The Sessions Could Be More Effective. Health Affairs Forefront. DOI: 10.1377/forefront.20231031.623114. Available at: https://www.healthaffairs.org/content/forefront/listening-sessions-can-help-cms-become-more-patient-centered-here-s-sessions-could-more.

[21] Patterson J. (May 2024). Breadth of Patient and Stakeholder Input in CMS's Drug Price Negotiation Program: A Content Analysis of the 2023 Patient-Focused Listening Sessions. National Pharmaceutical Council. Available at: https://www.npcnow.org/resources/breadth-patient-and-stakeholder-input-cmss-drug-price-negotiation-program-content.

[22] Stetler P. (Mar 2023). The Eugenic Roots of 'Quality Adjusted Life Years,' and Why They Matter. Washington Post. Available at: https://www.washingtonpost.com/made-by-history/2023/03/08/qlay-disabilities/.

[23] Andrade G. (Jan 2024). Ethical Shortcomings of QALY: Discrimination Against Minorities in Public Health. Cambridge Quarterly of Healthcare Ethics. 1-8. doi:10.1017/S0963180123000580. Available at: https://www.cambridge.org/core/journals/cambridge-quarterly-of-healthcare-ethics/article/abs/ethical-shortcomings-of-qaly-discrimination-against-minorities-in-public-health/04012151EAB7F9629D55D672EEA4CB22.

on the demographic information of respondents participating in the data collection process, the number and types (e.g., patient, clinician, academic) of respondents that submitted data, participated in listening sessions, and had data used by CMS in its MFP calculation to ensure the Agency considers information from a wide range of diverse stakeholders.

Quality-Adjusted Life Years and Similar Cost-Effectiveness Metrics:

As stated in PhRMA's prior comments, CMS' decision to rely on flawed cost-effectiveness standards in MFP decision-making is both misguided and unnecessary. Reliance on cost-effectiveness measures, whether it is rooted in the quality-adjusted life year (QALY) or another similar metric, as the basis for policy decisions risks further discriminating against the elderly, the disabled, and underserved and underrepresented people of color who are already at higher risk of not receiving the care they need.

CMS should not consider cost-effectiveness metrics, even if the data submitter claims they do not believe their submission discriminates against the elderly, the disabled, or the terminally ill. The Agency has a duty to make sure it relies on the best data possible to make sure its MFP decision-making does not exacerbate any existing health disparities and considers (to the degree feasible in CMS policy decision-making) the differing needs of individual patients and sub-populations. As such, to ensure CMS does not use any cost-effectiveness measures in its decision-making – in accordance with Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act – the Agency must, at the very minimum, make clear that Question 63 is mandatory for all respondents and that CMS will not consider cost-effectiveness measures in its decision-making. Furthermore, Question 56c is the only question that contains a reminder that CMS will not use the QALY or evidence that potentially discriminates against the selected (elderly, disabled, or terminally ill) populations despite asking for methodologies. Yet in the same section, CMS asks for potential frameworks to consider in Questions 54a, and questions on evidence in Questions 54c and 57. Any time that CMS asks a question in which the respondent could respond with evidence generated via a QALY or other similar cost-effectiveness measures, it must contain a reminder that respondents should not submit this evidence as CMS will not consider it or use it in its decision-making.

Technical Improvements

In addition to the comments above, PhRMA noted a few technical discrepancies the Agency should consider for improving the functionality of the ICR forms. This includes renaming the "Patient-Focused Experience" header to be more inclusive of respondent types and to match the description in the instructions that calls the section "Patient- or Caregiver-Focused Input". Furthermore, there are small typographical errors the Agency should fix including in Question 39A where it asks "How do the condition(s) you listed in Question 39 impact your daily life and well-being or the daily life and well-being of someone you provide care for?" This question should refer back to Question 38 instead of 39. Additionally, despite asking for different information, Questions 46 and 47 are both confusingly titled "Treatment-related Questions". Finally, CMS should consider the readability and navigation of Section I for public respondents, especially if seeking information from those actually enrolled in Medicare. This includes ensuring the form is both easily accessible, without a large number of "clicks" to navigate to the form from CMS' homepage, and easily navigable, so respondents can readily find required questions and navigate to the desired section(s).

III. Conclusion

PhRMA appreciates the opportunity to submit comments in response to the *Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request.* We continue to urge CMS to limit the data that must be provided to elements essential to operation of the Program; leverage data already available to CMS as much as possible; and provide additional time for supplemental data

submission to the greatest extent possible. Please contact James Stansel (jstansel@phrma.org) and/or Elizabeth Carpenter (ecarpenter@phrma.org) if there is additional information we can provide or if you have any questions about our comments.

-----s-------
Elizabeth Carpenter
Executive Vice President
Policy & Research
PhRMA

-----s-------
James C. Stansel
Executive Vice President and General Counsel
PhRMA

VIA ELECTRONIC DELIVERY

September 3, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244–1850

RE: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 (CMS-10849)

Dear Administrator Brooks-LaSure:

The Protecting Innovation in Rare Cancers (PIRC) coalition appreciates the opportunity to submit feedback, including input from our patient communities, on the Centers for Medicare & Medicaid Services' (CMS') draft guidance for the Medicare Drug Price Negotiation Program (MDPNP) for initial price applicability year 2027 (the Draft Guidance).

PIRC is a collaborative, multi-stakeholder patient advocacy coalition committed to improving access to and affordability of existing treatments for all patients while preserving the incentives required to advance future innovations in rare cancers. The coalition seeks to fulfill an important role in exchanging information and collaborating toward educating both our rare cancer communities and policymakers on the impact the Inflation Reduction Act (IRA) might have on access to existing Part D drugs and development of new therapeutic options.

Medicare beneficiaries with rare cancers have faced significant challenges due to high out-of-pocket (OOP) costs and a limited set of treatment options. The Part D redesign provisions of the IRA will, for most patients, reduce the struggle to pay high OOP costs at the pharmacy. The MDPNP is, however, unlikely to reduce OOP costs for cancer treatments to below the $2,000 cap applicable for CY2025 and there appears to be as much of a chance that negotiated prices could lead to increased rather than decreased premiums. This is consistent with Congress' expectation that MDPNP savings would offset the estimated $30 billion increase in Medicare spending due to Part D benefit redesign.[1]

[1] Congressional Budget Office. Estimated budgetary effects of Public Law 117-169, to provide for reconciliation pursuant to Title II of S. Con. Res. 14. Published 2022. https://www.cbo.gov/system/files/2022-09/PL117-169_9-7-22.pdf

Our patient communities remain concerned that the MDPNP could reduce the number of new treatments that are brought to market, including new uses in multiple cancers and development of combination therapy regimens that could offer new hope for patients to live longer.

As more fully detailed below, PIRC appreciates that CMS proposes to implement stakeholder engagement opportunities that give patients and patient advocacy organizations a more robust opportunity to contribute information on the patient experience. As we stated in our comments to CMS' Guidance for IPAY2027 (attached), PIRC is concerned that the Agency has declined to reconsider key aspects of the MDPNP likely to deter research and development in rare cancers. Our comments include:

- Discussion of factors that put cancer treatments at a disadvantage within the context of the MDPNP.

- Support for CMS' efforts to improve its stakeholder engagement to include more meaningful patient participation.

- General feedback on the data elements for IPAY2027.

We continue to urge CMS to fully engage stakeholders so that its policy determinations and exercise of discretion will avoid disrupting incentives to scientific advances that have provided hope for blood cancer patients and their families.

CMS' implementation of the MDPNP has the potential to disadvantage rare cancer treatments.

Although just one cancer treatment was selection for negotiation in the first year of the MDPNP, it is likely that several could be selected for IPAY2027. Inclusion of Part B drugs will greatly increase the proportion of oncology agents subject to negotiated prices and create significant pressures on manufacturers and investors to rethink whether and how to allocate resources to developing cancer treatments. The IRA appears to give CMS discretion as it selects drugs for negotiation and we strongly urge the Agency to consider the factors below as it selects drugs and moves through the negotiation process.

- Cancers are complex illnesses that can be difficult to diagnose early, particularly if tumors are small in early stages and cause few symptoms. Rare cancers can be difficult to diagnose with specificity. This makes it difficult to enroll a sufficient number of participants to conduct clinical trials demonstrating clinical benefit.

- Rare cancers present heightened challenges to drug developers because they tend to have poorly understood natural histories, significant heterogeneity, and diverse clinical manifestations.

- A recent study noted that approximately 97% of oncology drugs studied for an indication never receive FDA approval for that indication.
    - Small molecules can have off-target toxicities
    - Misidentification of essential genes in cancer
    - Mischaracterization of target-specific inhibitors[2]

  Although CMS includes specific costs related to study failures in the research and development costs for selected drugs, the linkage between the cost of failures and successful drug candidates is more complex than reportable direct costs. The high failure rate presents a risk that is incorporated into the decision to pursue or abandon a research program. Changing the "upside" against which the risk is weighed (as the MDPNP does) can and likely will drive the set of new treatment options over the next decade and beyond.

- Approximately one-third of cancer drug approvals use the accelerated approval (AA) pathway, and over 80% of AA approvals are for cancer therapies. The AA program was created in 1992 to give patients early access to promising drugs for debilitating or fatal diseases.[3]

    - The AA program has come under scrutiny due to failures of some AA drugs to demonstrate clinical benefit over the standard of care in confirmatory studies.
    - A recent study[4] assessed the survival benefit from AA therapies in rare cancers, finding that 264,061 people treated with an orphan cancer treatment gained 145,413 life years. This was a 16.5% gain over the standard of care.

- Cancer treatments are far less likely to have generic competition than treatments for more common conditions. A recent study compared generic competition for oncologic drugs with that of cardiovascular treatments.

    - A smaller proportion of oncologic products had generics (49% vs. 80%).
    - For off-patent drugs, the median time from RLD approval to the first ANDA approval was longer for oncologic products compared to cardiovascular products (15.4 years versus 12.3 years).
    - The factors identified as impeding generic development in oncology were product dosage form and FDA recommendations requiring patient enrollment for bioequivalence studies for cancer treatments.

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[2] Ann Lin *et al.*, Off-target toxicity is a common mechanism of action of cancer drugs undergoing clinical trials.*Sci. Transl. Med.**11**,eaaw8412(2019).DOI:10.1126/scitranslmed.aaw8412*

[3] Trends in FDA-Approved Cancer Therapies (uspharmacist.com)

[4] Benedict, Á., Szabó, G., Marczell, K., Doherty, B., & Martin, S. (2024). Life Years Gained From the FDA Accelerated Approval Program in Oncology: A Portfolio Model. *Journal of the National Comprehensive Cancer Network*, *22*(6), 382-389. Retrieved Aug 26, 2024, from https://doi.org/10.6004/jnccn.2024.7010

PIRC appreciates CMS' efforts to improve its stakeholder engagement to include more meaningful patient participation.

Throughout CMS' implementation of the MDPNP for IPAY2026, patient advocacy organizations struggled with the constricted timeframes allotted to review drafts, assess the potential impact on the patient community, and incorporate learnings from patients into a cohesive document to inform CMS' next steps. This year, CMS' expanded timeframe to respond to the model documents for the Medicare Prescription Payment Program (MPPP) and Draft Guidance for IPAY2027 enabled our organizations to conduct the thorough review and patient outreach that is essential to our mission. We appreciate that CMS responded to feedback from stakeholders and extended its comment periods when it had discretion to do so.

PIRC and its participating organizations presented concerns with last year's patient engagement "listening sessions" as a mechanism for collecting patient experience information. We noted several observations from those sessions, including:

- The demographic of patients contributing during the listening sessions underrepresented nonwhite beneficiaries

- Several participants were not Medicare beneficiaries, and their input focused on their own high out-of-pocket costs. This may have been due to a lack of understanding that the negotiated prices are not applicable outside the Medicare program.

- The listening session format did not lend itself to the type of dialogue likely to result in meaningful information.

    - The lack of feedback from CMS appeared to make participants uncomfortable.
    - The time reminders gave an impression that CMS was more interested in keeping to a tight schedule than gaining information from the patient community. The sessions ended early, and it was unclear whether some individuals asked to participate and their request was declined.

- There was an overarching lack of clarity among patients and patient advocacy communities on the types of information CMS was interested in and how the information would be used in the negotiation process.

- Most participants believed that the savings from the negotiation would be passed on to Medicare patients using the drug in the form of reduced out-of-pocket costs. There was little awareness of the OOP cap.

- CMS' use of the Federal Register to inform stakeholders of the listening session dates and times was an ineffective outreach strategy.

PIRC urges CMS to expand its outreach and engagement beyond the listening session format with stakeholder engagement opportunities that enable meaningful dialogue among participants as well as between participants and CMS staff. We suggest that CMS:

- Consider "trusted messengers" such as patient advocacy organizations, community and church communities, and similar approaches to improve the diversity among participants.

- Provide informational material that clarifies both the information CMS seeks and how it expects to use that information.

- Enable small group discussions with patients, advocates, clinicians, and CMS staff that are set up by patient advocacy organizations.

- Allow participants and attendees to submit data and other information to CMS after the stakeholder engagement event.

General Feedback and Concerns

PIRC was disappointed to see that CMS declined to refine aspects of the MDPNP patients and patient organizations identified as either driving unnecessary burdens or presenting a risk of influencing research and development away from rare cancers and other areas with high unmet needs.

PIRC, once again, urges CMS to reconsider its decision to identify a qualifying single-source drug based on common active moiety (drugs) or common active ingredient (biologics). An approach that treats products as the same qualifying single-source drug only when they share an NDA or BLA is within the plain language of the statute, would reduce the burden on manufacturers, and would increase the utility of the collected information in identifying an MFP based on the statutory factors and considerations. We remain conerned that CMS' approach creates conflicts between the IRA's timeline from NDA/BLA approval to negotiation eligibility and the timeline applied under CMS' implementation of the MDPNP. More importantly, our patient communities are concerned that CMS' interpretation reduces the value of new indications to manufacturers, their investors and shareholders, and potential licensing partners.

We are also concerned that CMS' implementation approach, rather than the statute, necessitated creation of the Primary/Secondary Manufacturer construct. Manufacturers, particularly the smaller clinical stage compaies innovating in rare cancers, often develop drug candidates and license one or more indications to a partner. Research and development costs may be split across multiple entities and a manufacturer with data on costs may not have access to data on sales volume, revenue, and other data elements required within the ICR. PIRC expects that implementation of the MFP will present similar problems, particularly if one entity is fully responsible for ensuring access to the MFP through rebates on sales revenue that accrues to another, unrelated entity.

PIRC notes that there is a significant change in the conditions for which CMS will assess a selected drug and its alternative therapies for IPAY2027. Although patients are most confident that their treatment is appropriate when it is used according to the FDA-approved label, off-label use of FDA approved treatments is within the practice of medicine and an important part of cancer care. The Social Security Act specifically accounts for Medicare coverage of off-label uses that are compendia-listed or supported by peer-reviewed literature, deeming those uses as medically accepted. In addition, to the extent that there is less incentive to invest in follow-on indications, off-label use in rare cancers may represent the highest unmet need that a particular treatment addresses. Moreover, Part D expenditures accrue across medically accepted uses for cancer treatments and compendia-listed non-cancer treatments. If CMS ignores uses for which it incurs Part D costs, it will fail to identify a single MFP that fits CMS' policy of starting with the cost of alternative therapies for all uses of the selected drug. We urge CMS to collect information on all medically accepted uses of selected drugs and relevant therapeutic alternatives.

In addition, PIRC urges CMS to:

- Solicit and consider patient information that reflects the whole patient, including quality of life impacts not quantified in clinical studies, and other information that is important to patients.

- Include factors such as drug toxicity and side effect profiles in assessing unmet need.

- Consider the fact that rare cancer patients can have multiple treatments available and still have unmet need as they progress through lines of treatment.

- Reconsider imposing word count limits on stakeholder submissions.

Conclusion

PIRC appreciates the opportunity to contribute the perspectives of those within the rare cancer patient and caregiver community as CMS implements the drug price negotiation provisions of the IRA. We look forward to a continuing dialogue throughout the IRA implementation process and welcome the opportunity to discuss our comments or the experience of rare cancer patients generally.

Biomarker Collaborative
Cancer*Care*
Cutaneous Lymphoma Foundation
CLL Society
Desmoid Tumor Research Foundation
Exon 20 Group
The Healing NET Foundation
ICAN, International Cancer Advocacy Network
MET Crusaders
Ovarian Cancer Research Alliance (OCRA)
PD-L1 Amplifieds

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September 3, 2024

VIA ELECTRONIC DELIVERY

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244–1850

RE: Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 Information Collection Request Forms

The Biotechnology Innovation Organization (BIO) appreciates this opportunity to comment on the Negotiation Data Elements and Drug Price Negotiation Process for Initial Price Applicability Year 2027 under Sections 11001 and 11002 of the Inflation Reduction Act (IRA) Information Collection Request (ICR) Forms.

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, delay the onset of such diseases, or prevent them in the first place. As a result, our members' novel therapeutics, vaccines, and diagnostics not only have improved health outcomes but also have reduced health care expenditures due to fewer physician office visits, hospitalizations, and surgical interventions. BIO's members include biologic and vaccine manufacturers, which have worked closely with stakeholders across the spectrum, including the public health and patient advocacy communities, to support policies that help ensure access to innovative and life-saving medicines and vaccines for all individuals.

BIO and our members have previously expressed our concerns over the significant burden and inefficiencies inherent in the negotiation data elements and drug price negotiation process ICR forms ('Data Elements Forms'). The manual process has been unduly burdensome and time-consuming for manufacturers and particularly challenging given the large volumes of data requested within a limited time frame. The reporting process requires intensive manual data entry, which increases the potential for human error. CMS continues to underestimate this intensive burden and the amount of time it takes for manufacturers to complete the submission in the Paperwork Reduction Act Disclosure Statement. Not only is the method of submission extremely cumbersome, but the data elements themselves conflict with manufacturers' standard operational practices and bring little to no utility. Rather than refocusing the data elements to a more targeted set of valuable clinical information and the patient perspective, CMS has

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continued to impose additional burden on manufacturers with irrelevant cost-related factors and unrelated global revenue comparisons. BIO urges CMS to recognize the significant challenge imposed on manufacturers through this process and instead take reasonable steps to reduce manufacturer reporting burden and prioritize data elements driven by clinical guidelines and patient need rather than cost-related factors that do not reflect actual patient cost-sharing amounts.

Specifically, CMS may take reasonable steps to lessen manufacturer burden throughout the ICR and further the Agency's interests in transparency, efficiency, and informed decision-making by:

- Allowing manufacturers to use reasonable assumptions (with accompanying justifications) regarding the manufacturer-specific data that they submit
- Allowing manufacturers to submit an attestation of whether 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 the extent to which the costs were not recouped.
- Removing irrelevant and inappropriate information that adds to manufacturer burden while providing no patient value;
- Automating the process of inputting and updating data tables to replace the current manual process requiring line-by-line data entry;
- Providing relevant data to manufacturers in advance of the selected drug publication date, including updated Medicare expenditure data, the methodology used to weigh the various factors in developing the MFP, and a scoping process-- to the extent possible-- for stakeholders to gain a more comprehensive understanding of the list of therapeutic alternatives prior to negotiation.

Our more detailed comments are as follows.

Research and Development (R&D) Costs and Recoupment (Section C)

BIO remains concerned that CMS' treatment of R&D throughout Section C is inconsistent with the realities of research and precludes a full accounting of the true costs required to bring a new drug to market. CMS fails to consider the substantial challenges and complexity of navigating through a significant volume of data to respond to CMS' five distinct categories of information requests. The extensive request for information within these distinct categories, while providing little utility to the kinds of information that matter to patients and physicians, requires tremendous effort from manufacturers to quantify and attribute many components across multiple stages of research. These categories are also unnecessary given that they are not based on the price setting guidance itself. Historic data will be extremely challenging to track and quantify and may not even be accessible at all, particularly for products discovered several

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decades ago. Allocating all costs with the level of granularity that CMS requires may not be feasible, as costs may be shared across a disease area or across multiple projects. These concerns are compounded by the fact that CMS imposes an extremely narrow timeline, whereby manufacturers have only twenty-eight to thirty days from the date of NDC-11 list publication to compile all data, perform internal reviews, and input data into the system.

BIO also opposes CMS' request for the Primary Manufacturer's global and U.S. total lifetime net revenue. With CMS' request, the costs associated with the select medicine may be incurred over different periods than the revenue it generates, or different stages in the drug's life cycle, or may be shared or distributed across multiple products or activities. Thus, comparing these costs to total lifetime revenue would not account for the time and nature of the expenses relative to the revenue generated in specific periods, and could be significantly misleading.

Finally, as BIO has stated in previous comments, CMS' focus on "recoupment" of R&D costs is significantly misguided and not reflective of how innovation occurs within the biopharmaceutical sector. Not all companies conduct research and development in the same manner. Many companies invest in R&D within programs for a disease area with high unmet needs rather than simply targeting a distinct drug or biologic. Some programs may have many investigational compounds or molecules at different stages of development, and many of these R&D costs will never be "recouped". These nuances are not reflected in CMS' focus on R&D cost recoupment; accordingly, this could disadvantage companies that are developing new treatments in a way that is difficult to quantify and that is not considered by CMS' approach.

Market Data and Revenue and Sales Volume Data (Section G)

BIO opposes CMS' request for the Federal supply schedule (FSS) price, Big Four price, and other pricing data that is unrelated and does not reflect actual Medicare prices. Requesting such unrelated data only increases manufacturer burden without providing any additional patient or stakeholder value beyond what is already available to CMS. Likewise, CMS' request for the Manufacturer Net Part D price is also problematic, as it is not a standard price reporting metric used anywhere in federal price reporting. The statutory discount is part of the D structure, not a discount offered in the market to a customer – and drugs with MFPs will be exempt from the Statutory Discount. To avoid misinterpretation, CMS must narrow its reference to "other supply chain concessions" within the definition of Manufacturer Net Medicare Part D price, such that those discounts excluded within Medicaid Best Price should also be excluded in the definition of Manufacturer Net Medicare Part D price

In the IPAY 2027 Data Elements Forms, CMS provides clarification into what information will be treated as proprietary, stating, "CMS will treat research and development costs and recoupment, unit costs of production and distribution, pending patent applications, market data,

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revenue, and sales volume data as proprietary, unless the information that is provided to CMS is already publicly available." BIO appreciates this clarification and supports CMS' addition of Question 28 allowing manufacturers to flag confidential information.

Primary/ Secondary Manufacturer Construct (Section A-G)

BIO continues to be deeply concerned with CMS' insistence to hold Primary Manufacturer responsible for submitting applicable information concerning a Secondary Manufacturer. As we have stated in previous comments, the Primary Manufacturer has no inherent legal authority to compel a Secondary Manufacturer to act or not act, including to share highly sensitive information not otherwise accessible by the Primary Manufacture. While the fundamental concerns of requesting this information remain, BIO requests that, at a minimum, CMS allow for more time to submit NDCs from other entities that are unknown to the Primary Manufacturer.

Evidence About Alternative Treatments (Section I)

While BIO supports CMS' attempts to gather patient-centered data and solicit input from patients, beneficiaries, caregivers, and the broader community, it is essential that CMS reinforces a holistic understanding of patient needs and perspectives when measuring the value of drugs and therapeutic alternatives. The current process of imposing arbitrary word count limits and rigid responses makes it difficult for stakeholders to capture the true and holistic value of drugs and therapeutic alternatives for patients. A holistic understanding of value includes both clinical and non-clinical benefits, including a patient and caregiver's mental and social well-being and other long-term benefits to the broader ecosystem and society at large. While CMS appears to be receptive to broader views of value, it is evident that non-clinical benefits are not being sufficiently emphasized as CMS determines an MFP. Moreover, in the first round of negotiated MFPs for the 10 selected drugs, it remains unclear how or whether CMS has used the evidence gathered.

CMS must make significant changes to improve the data collection process so that the data elements meaningfully capture the drug and therapeutic alternatives' value and impact on patients. BIO recommends that CMS provide a more structured consultation process and conduct targeted beneficiary outreach to improve the quality and relevance of responses. CMS must also publicly state how the information it gathers will be used and evaluated.

BIO appreciates and supports CMS' confirmation that evidence that uses discriminatory approaches such as Quality Adjusted Life Years (QALYs) will not be considered.
BIO also appreciates and supports CMS' inclusion of Question 36 allowing manufacturers to submit a dossier to supplement responses. However, it is evident that a supplementary

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response may not always be necessary. Thus, we encourage CMS to clarify that manufacturers will not be penalized for choosing not to submit a dossier if the answers are otherwise sufficient.

Sincerely,

/s/
Crystal Kuntz
Senior Vice President, Health Policy & Research

/s/
Melody Calkins
Senior Manager, Healthcare Policy