This file contains 122 unique comment letters received on the Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191-1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028. For comment letters from individuals not representing organizations, CMS has removed the name, address, and contact information of the individual for privacy purposes. Any organization or academic institution has not been de-identified.

June 26, 2025

Submitted via: IRARebateandNegotiation@cms.hhs.gov
(put in subject line of email)
Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave, SW
Washington, DC 20201

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191-1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Dr. Oz:

340B Health is submitting these comments on the Draft Guidance proposed on May 12, 2025 pertaining to manufacturer effectuation of the maximum fair price (MFP) in 2026, 2027, and 2028 under the Medicare Drug Price Negotiation Program. 340B Health represents over 1,600 hospitals that participate in the 340B Drug Pricing Program. 340B hospitals are the backbone of the nation's safety net, providing 77% of the hospital care provided to Medicaid patients[1] and 67% of all hospital uncompensated care while having extremely tight operating margins.[2] These hospitals serve a greater share of Medicare patients who are low income or disabled,[3] which have a higher burden of illness and associated costs.[4] Seventy-one percent of rural hospitals rely on 340B, which helps maintain services in areas that have seen a growing number of hospital closures.[5]

340B Health appreciates the steps that CMS has taken to address concerns raised by 340B providers about the retrospective refund process for effectuating the MFP. That said, we remain extremely concerned about the likelihood of significant harm to 340B covered entities under this Draft Guidance. We urge CMS to require that the MTF receive 340B claims data from covered entities and remove that data from being submitted to manufacturers to prevent, require manufacturers to provide a 340B refund within a specific timeframe for drugs sold at MFP, make

[1] Dobson DaVanzo, 340B DSH Hospitals Serve Higher Share of Patients with Low Incomes 12 (Sep. 26 2022), https://www.340bhealth.org/files/340B_and_Low_Income_Populations_Report_2022_FINAL.pdf.
[2] Dobson DaVanzo, 340B DSH Hospitals Increased Uncompensated Care in 2020 Despite Significant Financial Stress 4 (July 2020), https://www.340bhealth.org/files/Dobson_DaVanzo_Op_Margins_and_UC_FINAL.pdf.
[3] L&M Policy Research, Examination of Medicare Patient Demographic Characteristics for 340B and Non-340B Hospitals and Physician Offices 3-4 (July 28, 2022), https://www.340bhealth.org/files/LM-340B-Health-Demographic-Report-07-28-2022_FINAL.pdf.
[4] *Id.* at 4.
[5] The Cecil G. Sheps Center for Health Services Research, Rural Hospital Closures, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

manufacturer 340B deduplication policies available to covered entities, and clarify that the refund adjustment applies to claims initially determined to be 340B.

1. **Allow MTF to Remove 340B Claims from Data Submitted to Manufactures**

We appreciate that CMS continues to explore the feasibility of incorporating 340B related transactional data from 340B covered entities into its MTF process, and urge CMS to quickly move forward with allowing the Medicare Transaction Facilitator – Data Module (MTF DM) to identify 340B claims and remove them from the data submitted to manufacturers for purposes of effectuating the Medicare Fair Price (MFP). This process has been used to deduplicate 340B and Medicaid managed claims in Oregon for over a decade. The Oregon plan is extremely efficient, requiring only six data points to be shared with the state's Medicaid rebate vendor in order to match and remove those 340B claims from Medicaid rebate requests submitted to manufacturers. Because the data submitted is shared with only one government entity, data privacy is protected, as the Medicaid agency already has access to the patients' data in its systems.

It is easy to see the improved efficiencies if this model were adopted by CMS. Under the Draft Guidance, hundreds of manufacturers receive claims data from the MTF DM and each manufacturer is charged with developing its own mechanisms for identifying 340B claims so that they can refrain from reimbursing the MFP refund for such claims. CMS encourages manufacturers, covered entities, and wholesalers to work together to address this issue. But this process could potentially require thousands of covered entities to submit data to hundreds of different manufacturers, all of which could have different requirements. In contrast, CMS could deputize the MTF DM to receive covered entity data, match it with the PDE records, and pull the 340B claims out of the data sent to manufacturers. Instead of hundreds of manufacturers working with thousands of covered entities, sending and receiving data and developing mechanisms to identify 340B claims, covered entities would send data to a single source - the MTF DM – which would remove the claims from those sent to manufacturers, thus relieving hundreds of manufacturers from having to develop their own mechanism to deduplicate claims, and potential for incurring penalties prescribed under the statute. This process would have the added benefit of having a single repository of data, thus allowing for simplified auditing. Knowing of CMS's concerns regarding mandating that covered entities report data, CMS could make submission voluntary for covered entities, which would be similar to how CMS makes it optional to participate in the MTF PM for the purpose of streamlining payments.

We appreciate that CMS made clear in its October 2, 2024 final guidance that manufacturers may not effectuate deduplication policies by unilaterally changing the 340B program from an up-front discount to a back-end rebate program, absent permission from the Health Resources and Services Administration (HRSA). Several manufacturers are continuing to pursue such efforts and it is clear that their data submission requests for covered entities are extensive, involving several times more data than would be required for the MTF DM to match to the PDE data, or required under the Oregon deduplication model for Medicaid and 340B. Moreover, the data required varies by manufacturer, further complicating an already extremely burdensome process for covered entities. 340B hospitals participate in 340B only if they are able to show that they serve a disproportionate share of low-income patients and that their operating margins are

generally much lower than those of non-340B hospitals. The potential for extremely burdensome complication could have a significant financial impact on 340B hospitals, potentially limiting their ability to provide their existing level of services to their vulnerable patients.

2. **Require and Establish a Timeframe for 340B Refunds for Sales Made at MFP**

CMS clarified in the Draft Guidance that manufacturers could prospectively sell at the MFP, and use virtual inventory systems and wholesaler chargebacks, where applicable, to ensure that the MFP is made available timely. This system could also be used to effectuate deduplication between the MFP and the 340B price. 340B hospitals have a long history of managing virtual inventory systems, since they must ensure that 340B priced drugs are used only for outpatients, not for hospital inpatients. 340B hospitals may also dispense to individuals that do not qualify for 340B or are dually eligible for Medicaid and the hospital has chosen to carve 340B out of Medicaid. Further, some types of 340B hospitals are permitted to choose, on a per dispense basis, whether to use 340B priced drugs or non-340B and non-WAC prices for their outpatients. By making the MFP available at time of purchase, 340B entities could use their existing virtual inventory system to accumulate MFP priced drugs and 340B priced drugs, as dispensed, and maintain auditable records documenting that the drugs were used only for eligible patients.

We further recommend that CMS impose a 14-day window for issuance of 340B refunds (the difference between the MFP and the 340B ceiling price) in the event that manufacturers seek to meet their deduplication requirements by selling drugs at MFP to 340B entities. The draft guidance has no mechanism for manufacturers to report that they effectuated the 340B price if it is lower than the MFP. CMS comments that effectuating the 340B price falls under HRSA's purview, not CMS, but that should not apply in situations involving refunds to effectuate 340B for drugs purchased at MFP, since the entire MFP system is outside of HRSA's purview.

3. **Make Manufacturer 340B Deduplication Policies Available to Covered Entities; "Reasonable Belief" Standard Could Cause Significant Harm**

340B Health remains concerned about several aspects of CMS's proposed process for effectuation of deduplication. The Draft Guidance would allow manufacturers to refrain from paying the MFP refund if they have a "reasonable belief" that a claim is 340B based on claims data elements received from the MTF DM. That data includes the NPI for prescribers and hospitals. While CMS makes clear that using an NPI on its own would be insufficient to identify a claim as 340B, it is unclear in the guidance whether using both NPIs in combination would be sufficient for concluding that a claim was 340B. 340B Health strongly opposes identification of 340B eligibility based on a combination of NPIs. Many types of 340B hospitals may use 340B or another price to purchase drugs dispensed to their outpatients, making use of multiple NPIs useless in determining whether 340B was used for a specific claim. Further, as noted in the guidance, 340B hospitals' retail pharmacies may dispense to both 340B eligible and non-eligible patients, making decisions based solely on combined NPIs extremely unreliable.

340B Health is extremely concerned that manufacturers' 340B deduplication policies will not be shared with covered entities. Manufacturers' policies could cause significant harm to covered

entities if they over-identify claims as 340B and fail to issue the MFP refunds owed. We recognize that manufacturers can be subject to civil money penalties for failure to issue MFP refunds, however, there could be a long process before getting to that point that could be significantly harmful to covered entities, that already operate on thin margins. Covered entities should be able to review manufacturer policies so that they may share any concerns with the manufacturers in advance. Covered entities would also be equipped to more effectively track claims that would be subject to the policies so that they can identify quickly inappropriate determinations. Effectuation policies should not be implemented in a manner where they are rectified only after causing significant harm. We urge CMS to make manufacturers' 340B nonduplication polices accessible to covered entities.

4. **Clarify that Refund Adjustments May Require Payment of MFP for Claims Previously Identified as 340B**

We appreciate the Draft Guidance's discussion of the process to adjust refund amounts due to claim amendments, such as claim reversals, adjustments, or determinations that a claim is not MFP eligible after MTF refund was paid. We understand this to include situations where a manufacturer paid an MFP refund, and it was subsequently determined by the covered entity that the drug was 340B eligible as well as situations where the manufacturer did not pay an MFP refund because the claim was presumed to be 340B, but the patient was subsequently determined to not be eligible for 340B. In the latter case, the manufacturer should be required to pay the MFP refund within 14 days of receiving the claim amendments. We recommend clarification on this point in the final guidance.

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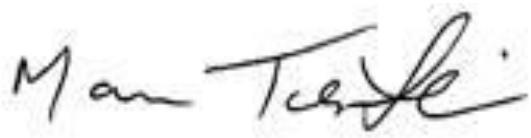
Thank you for considering our comments. Please contact me at maureen.testoni@340bhealth.org if you have questions or would like to discuss our comments.

Sincerely,



Maureen Testoni
President and Chief Executive Officer
340B Health

American Academy of
Allergy Asthma & Immunology

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June 26, 2025

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Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program Draft Guidance - Initial Price Applicability Year 2028

Dear Administrator Oz:

Established in 1943, the American Academy of Allergy, Asthma & Immunology (AAAAI) is a professional organization with more than 6,700 members in the United States, Canada and 72 other countries. This membership includes allergist/immunologists (A/I), other medical specialists, allied health and related healthcare professionals—all with a special interest in the research and treatment of patients with allergic and immunologic diseases. In the paragraphs that follow, we provide feedback on key proposals and policies in the aforementioned draft guidance.

Influence of MFP on ASP

Part B medications are essential, indeed often life-saving, for patients with allergy and immunology-related conditions, including allergies, asthma, and immuno-deficiency diseases. Many A/I patients will require medications for their entire life to manage their illness. These Part B medications are directly administered to the patient by their healthcare provider, who is reimbursed based on the average sales price (ASP), plus an add-on payment of 6-8%, which accounts for acquisition costs. These complex drugs or biologic agents may require oversight by physicians and other advanced practice training professionals due to the potential for severe adverse reactions during infusions. The add-on payment provides for these services to ensure the safety of these critical medications.

(More)

The draft guidance suggests that the 2028 Part B Maximum Fair Price (MFP) drug prices for negotiated drugs will be factored into the ASP. The addition of these MFP negotiated prices will cause the ASP to drop precipitously, and may cause the add-on payment to drop below practice costs. Meanwhile, the cost of administration continues to grow with inflation. Such a significant drop in the add-on payment will make it extremely difficult for the A/I providers, and especially independent practice small businesses, to maintain operations and provide critical care to our patients. The AAAAI urges CMS to exclude the MFP from ASP calculations, and to ensure that the add-on payment adequately reimburses health care providers for the cost of administration.

Provider Access to the MFP

CMS has suggested two proposed pathways through the draft guidance for Part B providers to access the MFP for Part B drugs from the primary manufacturer. This includes both a prospective pathway and a retrospective pathway. AAAAI has serious concerns regarding the retrospective pathway in which the manufacturer would provide reimbursement for the difference between the Part B provider's acquisition cost and the MFP. This pathway would be financially onerous for medical practices as they carry the difference until adequately reimbursed by the manufacturer. It could destroy the ability of small practices to provide buy-and-bill Part B medications, resulting in the loss of access for some patients, including those with immunodeficiencies. Many A/I patients rely on in-office administration for the ongoing management of their conditions and loss of access to these services due would be extremely disruptive to their continuous care. AAAAI strongly discourages CMS from pursuing a retrospective pathway for provider access to the MFP.

PBM Utilization Management Barriers

While drug coverage is required under statute, AAAAI is concerned by CMS statements that indicate that the agency does not intend to hold Medicare Advantage health plans and their pharmacy benefit managers (PBMS) accountable for tiering and utilization management protocols that may limit access to drugs negotiated through the Medicare Drug Price Negotiation Program. PBMs utilize opaque and often nonsensical formularies and utilization management strategies to reduce expenditures by the insurers within the same corporate umbrella or ownership structure. Much of what is referred to as "utilization management" is more aptly characterized as utilization delay or denial.

In practice, utilization management is frequently not about meaningful reviews of clinical utility but about delaying medical expenditures for as long as possible, when the main goal of outright denial cannot be justified. With each passing year, physicians – including allergists and immunologists – spend more time overcoming barriers established by payers, leaving less time for patient care. The AAAAI has consistently raised concerns regarding the detrimental impact of utilization management (UM) practices, including prior authorization (PA) and step therapy, on patients with complex conditions. These practices disproportionally impact underserved populations, which is a significant proportion of our patients given allergic and immunologic diseases are more prevalent in those communities.[1]

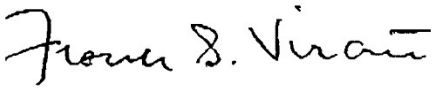
Furthermore, PBM formulary design, or tiering, is the direct result of negotiations between drug companies and the PBMs, triggering treatment interruptions when medications change coverage tiers from one year to the next with no basis in safety or efficacy of the products. PBMs consistently put medications with higher list prices over therapeutic equivalents with lower net costs because the higher list prices provide more generous price concessions for the PBM. This

[1] https://pubmed.ncbi.nlm.nih.gov/33713767/

gaming of the system to maximize overall profits causes inconsistency in coverage and interruptions in access to preferred medications, which can be extremely dangerous, particularly for our patients with immune deficiencies. The AAAAI has repeatedly raised concerns regarding CMS's 2018 memorandum permitting step therapy, and we urge CMS to take action to prevent PBM tiering manipulation and ensure these utilization management barriers cannot be used to block access to Part B negotiated drugs.

We appreciate the opportunity to provide comments on the aforementioned issues of importance to our members. Should you have any questions, please contact Sheila Heitzig, Director of Practice and Policy, at sheitzig@aaaai.org or (414) 272-6071.

Sincerely,



Frank S. Virant, MD FAAAAI
President, American Academy of Allergy, Asthma & Immunology

June 26, 2025

The Honorable Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Submitted electronically to IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Dr. Oz:

AARP, which advocates for the more than 100 million Americans age 50 and over, appreciates the opportunity to comment on the May 12, 2025, draft guidance pertaining to the third year of the Medicare Drug Price Negotiation Program (Negotiation Program) as part of the Inflation Reduction Act (IRA) of 2022. AARP strongly supported giving Medicare the authority to negotiate lower prescription drug prices for older Americans and the multitude of other provisions in the law that will help address high drug prices and related costs. We appreciate President Trump's continued commitment to lower prescription drug prices and the Administration's work to get a better deal for Americans, including through aggressively negotiating drug prices. We share that goal and want the Negotiation Program to be as strong and effective as possible so that millions of older Americans can finally afford their prescription drugs. Our comments on this third round of Negotiation Program guidance augment our 2023 comments on the initial guidance, and our 2024 comments on the second round guidance.

AARP commends CMS for soliciting input from the public on this guidance and appreciates its continued efforts to ensure that patients, caregivers, and health care providers have a voice in the Medicare drug price negotiation process. AARP strongly believes that the needs of Medicare beneficiaries should remain paramount as the agency implements the Negotiation Program. To realize the promised savings and benefits to older Americans, we encourage CMS to ensure that the negotiation process achieves the lowest possible maximum fair price (MFP) for each selected drug. It is also important for the agency to provide as much transparency as possible to help ensure that the public has confidence that MFPs are in fact fair and appropriate. CMS should place a high priority on conducting robust outreach and education for Medicare beneficiaries and health care providers to ensure that they are aware of the MFPs for selected drugs. These efforts should include clear, consumer-friendly reporting, and grievance and appeals processes (with timely resolution) for when an MFP is not provided as required under the law.

AARP also strongly supports the collection and consideration of appropriate clinical evidence, including unbiased drug value assessments, to inform CMS' evaluations of selected drugs. We also support efforts to help ensure program integrity and reduce opportunities for drug companies to game the system.

While the statute that created the Negotiation Program is broadly prescriptive, the agency is tasked with developing many specific details for the operation of the Negotiation Program in a number of important areas. Below we offer more specific comments in response to the current guidance.[1]

Identification of Selected Drugs for Initial Price Applicability Year 2028 (Section 30)

AARP reiterates its previous support for CMS' consistent application of the statutory definition of "qualifying single-source drug" by using all dosage forms and strengths of drugs and biological products in identifying potential qualifying single-source drugs. We also appreciate the agency's clear explanation of the statutory requirements for satisfying the definition of the term and the steps taken by the agency in accordance with those statutory requirements. We support strong program integrity protections for the Negotiation Program and seek to ensure that, consistent with statute, the negotiation process captures as many high-cost drugs as possible. Equally important, AARP believes that CMS' approach will limit opportunities for drug companies to find ways to inappropriately exclude drugs that would otherwise be eligible for the Negotiation Program. This is essential for the many Medicare beneficiaries who rely on these drugs and have already faced excessively high prices for far too long.

AARP supports adding Part B drugs to the Negotiation Program and CMS' proposal to utilize fee-for-service claims data to identify high-spend drugs. As the agency pursues this, we strongly believe that CMS should continue to evaluate alternative approaches to ensure that all program spending on Part B drugs – including the share of spending attributable to the Medicare Advantage program – is reflected in the calculations used to determine eligibility for the Negotiation Program. Medicare Advantage now accounts for over 50 percent of eligible Medicare beneficiaries. Not taking this spending into account will substantially understate Medicare spending for Part B drugs, making it less likely that these drugs will be selected for the Negotiation Program. Until the passage of the 2022 prescription drug law, Medicare spending for Part B drugs had grown by an average of nearly 10 percent per year for over a decade, spending largely driven by price increases. Meanwhile, Medicare beneficiaries are responsible for 20 percent of the cost of their Part B drugs. It is imperative that the Negotiation Program appropriately and accurately identifies high-spend drugs under both Part B and Part D to ensure that Medicare beneficiaries obtain the savings that were intended.

Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028 (Section 30.1)

In this guidance document, CMS indicates that if a drug is a fixed-combination drug (as defined at 21 C.F.R. §300.50) with two or more active moieties / active ingredients, the distinct combination of active moieties / active ingredients will be considered as one active moiety / active ingredient for the purpose of identifying potential qualifying single source drugs.

[1] AARP appreciates CMS' efforts to refine the negotiation process via the additional detail provided in this guidance document. However, we urge the agency – as it has been in this guidance - to be cautious in advancing a formal methodology/formula beyond the statutory requirements governing the Negotiation Program because such actions could introduce additional legal challenges to the Program given the Supreme Court's 2024 decision in Loper Bright Enterprises *et al*. *v*. Raimondo *et al*. (https://www.supremecourt.gov/opinions/23pdf/22-451_7m58.pdf)

However, CMS acknowledges that there may exist fixed-combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference. Therefore, CMS is soliciting comments on how the agency might consider grouping such fixed-combination drug products with products containing at least one but not all of the active moiety(ies) / active ingredient(s) into the same potential qualifying single-source drug for both drugs payable under Part B and/or covered under Part D, including input on terminology that could facilitate the effectuation of such a policy.

AARP supports CMS' stated approach for classifying fixed-combination drugs for purposes of identifying single-source drugs for Initial Price Applicability Year 2028. We believe this approach will help ensure that drug manufacturers cannot utilize minor or modest reformulations that do not result in clinically meaningful differences to avoid being selected for the Negotiation Program.

Delay in the Selection and Negotiation of Certain Biological Products with High Likelihood of Biosimilar Market Entry (30.3.1)

AARP continues to support CMS' approach to temporarily delay the selection of certain brand name biologic drugs for the Negotiation Program to protect against potential gaming of the selection process by drug companies, consistent with Section 1192(f) of the Act. AARP also appreciates that brand name biologic drug companies that enter into agreements with biosimilar drug companies that require or incentivize them to submit a delay request to CMS or restricts the quantity of the biosimilar that may be sold will not be able to benefit from this exemption. Similar "pay for delay" gaming is well-known for its harmful impact on competition and helping to artificially maintain high prescription drug prices. AARP believes that the detailed process requirements outlined in the current guidance document will be extremely effective in ensuring that this delay process is not abused.

Publication of the Selected Drug List (Section 30.4)

AARP supports and strongly encourages transparency to the greatest extent possible in all aspects of the Program and especially throughout the drug price negotiation process.

To that end, we support CMS's proposal to publish a list of the up to 50 top negotiation-eligible drugs (including the up to 15 selected drugs) ranked by combined Total Expenditures under Part B and Part D. We believe that this enhanced information will be helpful to a wide variety of stakeholders, including drug manufacturers and consumers, by providing insights into which products could be selected for Medicare drug price negotiation in future years.

To avoid confusion, AARP recommends that CMS clearly state that such lists are informational, and any products beyond those definitively selected for the Negotiation Program may not necessarily be selected in subsequent years.

Confidentiality of Proprietary Information (Section 40.2.1)

AARP continues to support and strongly encourage meaningful and appropriate transparency in all aspects of the Negotiation Program and especially throughout the negotiation process. AARP appreciates CMS' stated goals of protecting the proprietary information of manufacturers and ensuring that manufacturers submit the information that is needed for the Negotiation Program, while also avoiding treating information that does not qualify for such protection as proprietary.

Ensuring that the public has sufficient information about the derivation of Maximum Fair Prices (MFP) under the Negotiation Program will also help ensure confidence in both the process and the resulting prices for drugs subject to Medicare drug price negotiation. Going forward, we urge CMS to continue to refine its approach to transparency with respect to how it handles proprietary and non-proprietary information. In instances where the statute is silent with respect to the status of certain information, we ask CMS to lean toward disclosure to the maximum extent possible. Where necessary, CMS could solicit stakeholder comments regarding the data elements in question to gauge the benefits of such disclosure relative to the risks of conveying potentially sensitive market information.

AARP also encourages the agency to consider, within the confines of the law, what is in the best interest of the Negotiation Program and the public when determining which information is proprietary and to favor making relevant information publicly available whenever possible. This is especially important when the agency posts the MFP negotiated for a selected drug and its justification, where a high level of transparency will help instill confidence that the MFP represents the lowest price that the agency can reasonably obtain.

Dispensing Entity Enrollment in the MTF DM (Section 40.4.2.2)

AARP appreciates CMS' responsiveness to concerns that some pharmacies could face cashflow pressures due to the shift from payment by the Part D plan sponsor to a combination of Part D plan sponsor payment plus a refund for drugs that have a Medicare-negotiated price.

CMS should closely monitor transition periods when new maximum fair prices first become available early in the year and be willing to make changes to the reimbursement process as necessary to ensure beneficiary access to prescription drugs selected for the Negotiation Program.

Manufacturer-Specific Data (Section 50.1)

CMS inventories the data that manufacturers are required to submit to facilitate the negotiation (and renegotiation) process pursuant to Sections 1194(c), (d), (e), and (f) of the Social Security Act. Beyond these data, CMS solicits comment on the collection of additional, forward-looking "market data" for selected drug(s) that pertain to periods that overlap with the negotiation period and/or the price applicability period. CMS suggests this data could include, for example, forecasted net revenue and volume data for the selected drug(s) for these future periods.

AARP supports CMS' proposal to collect data on forecasted volume and sales at the beginning of the negotiation process, at least until its usefulness can be determined, consistent with our

overall orientation that more, and more transparent, data will better inform the negotiation process and give all stakeholders greater confidence in the outcomes.

Evidence About Therapeutic Alternatives for the Selected Drug (Section 50.2)

AARP appreciates that CMS can solicit, and use, a broad range of comparative clinical effectiveness information to help inform the Medicare drug price negotiation process. We believe the consideration of comprehensive data is necessary to develop an appropriate MFP for a selected drug.

AARP also supports CMS' decision to allow any interested party to submit data and evidence to CMS about therapeutic alternatives to drugs selected for negotiation. AARP agrees that information from members of the public, including manufacturers, Medicare beneficiaries, their caregivers, academic experts, clinicians, and other interested parties, can play an important role in informing the agency's negotiating position.

AARP continues to recognize and support the statutory prohibition against using evidence from certain cost-effectiveness research that treats extending the life of 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. However, AARP believes that there are health measures that do not violate this prohibition and that these drug value assessments are an extremely valuable source of information and supports using as much of such research as possible in the negotiation process. AARP also strongly supports CMS' intent to consider studies that clearly separate prohibited evidence from other evidence that is relevant to the negotiation process, as well as its decision to remove information submission requirements that may have created obstacles for respondents who are not familiar with cost-effectiveness measures.

In addition, AARP continues to strongly support CMS' decision to consider research on real-world evidence in Medicare populations. AARP is aware that many prescription drugs are not tested under real-world conditions prior to FDA approval and appreciates the potential usefulness of this data in the negotiation process. We also note that CMS' interest could help encourage more drug companies to engage in such research.

AARP strongly encourages CMS to continue to refine the information that is requested and submitted, potentially informed by best practices used by other health authorities, to help ensure that such input is meaningful and useful to the process.

Identifying Indications for the Selected Drug and Therapeutic Alternatives for Each Indication (Section 60.3.1)

AARP supports CMS' proposal to identify each FDA-approved indication for selected drugs and to identify therapeutic alternative(s) for each indication of the selected drug. We also agree that indications for therapeutic alternative(s) should include both FDA-approved indications and off-label uses that are supported by appropriate clinical evidence.

In this guidance document, CMS is soliciting comments on the possibility and feasibility of considering health care services payable under Medicare Part A or Part B as potential therapeutic

alternatives to the selected drug for future rulemaking. The Agency is interested in whether there are specific cases where a health care service could be a relevant therapeutic alternative to a selected drug consistent with section 1194(e)(2) of the Act as well as what factors could be used to determine if a health care service could be considered a therapeutic alternative or not.

As we have noted in previous correspondence related to the Negotiation Program, AARP supports the collection of a broad array of information on therapeutic alternatives, and we believe CMS should consider non-drug treatments that are supported by widely accepted clinical evidence or guidelines to the extent possible. For example, CMS could consider the costs and benefits of physical therapy in the evaluation of a product used to treat chronic pain.

Engagement with Primary Manufacturers and Interested Parties Prior to Initial Offers (Section 60.4.1)

CMS indicates that after the submission of the section 1194(e) data by Primary Manufacturers and other interested parties by March 1, 2026, the Agency will host meetings with Primary Manufacturers of selected drugs that have submitted section 1194(e) data. CMS also states that it will host public engagement events to seek input from patients and other interested parties.

AARP wholeheartedly supports CMS' stated direction with respect to stakeholder input, especially from patients and caregivers. We particularly support the inclusion of caregiver perspectives, who may be uniquely positioned to convey real world evidence. As we noted in our July 1, 2024 comments on CMS' 2nd round guidance on the Negotiation Program, AARP's research continues to highlight the importance of family caregivers and the challenges, including financial, they face in caring for the older adults in their lives. We applaud CMS acknowledging the role of caregivers in the guidance, in which it proposes to add that the agency "may also consider the caregiver perspective to the extent that it reflects directly upon the experience or relevant outcomes of the patient taking the selected drug."

AARP applauds CMS for hosting up to 15 patient-focused roundtable events, which will be open to patients, patient advocacy organizations, and caregivers and will allow for discussion among speakers. We believe that this more interactive approach will help CMS better contextualize the selected drugs in ways that are important to patients, providers, pharmacists, and caregivers.

AARP also strongly supports CMS' decision to host a town hall meeting for all selected drugs for practicing clinicians, researchers, and other interested parties. AARP believes that this form of public engagement will be particularly informative and strongly encourages CMS to consider hosting more than one event of this nature each year.

Monitoring for Bona Fide Marketing of Generic or Biosimilar (section 90.4)

AARP continues to support CMS' proposals to verify "bona fide marketing" of generic drugs and biosimilar products before a drug is removed from the selected drug list. AARP shares CMS' concern that marketing or other agreements between drug manufacturers may limit the availability of generic or biosimilar products, creating the illusion of a competitive market.

AARP appreciates CMS' intent to utilize a holistic approach to determine when a selected drug is subject to meaningful competition, as well as the provision of illustrative examples of when and how it would determine that bona fide marketing is occurring. For drugs that are removed from the selected drug list, we also urge CMS to continue to engage in regular oversight to ensure that not only does the competitor product remain available but that the manufacturer is in fact marketing the drug and beneficiaries have ready access to it.

Renegotiation of a Maximum Fair Price for Initial Price Applicability Year 2028 (Section 130)

Section 1194(f) of the Act establishes the requirements governing the identification of renegotiation-eligible drugs, the selection of drugs for renegotiation, and the renegotiation process.

Section 1194(f)(2) of the Act establishes the definition of a "renegotiation-eligible drug" as a selected drug for which (1) a new indication is added to the drug; (2) the drug monopoly status was not that of an extended-monopoly or a long-monopoly drug and changes to that of an extended-monopoly drug; (3) the drug monopoly status was not that of a long-monopoly drug; and changes to that of a long-monopoly drug; or (4) the Secretary determines there has been a material change to any section 1194(e)(1)[2] or (e)(2)[3] factor. CMS provides illustrative examples of the kinds of changes in these factors that could be considered "material" and which would potentially trigger a renegotiation process in Table 11 of this guidance document. CMS indicates that it will select renegotiation-eligible drugs if a change in any of the 1194(e) factors is "likely to result in a significant change" in the maximum fair price, which the agency here defines as a change of 15 percent or more.

AARP supports both the general parameters of CMS' renegotiation process, and the agency's proposition to initiate the renegotiation process if it is likely to result in a change in MFP of at least 15 percent (although we recognize that other thresholds could be considered) in an effort to conserve CMS resources.

[2] Section 1194(e)(1) factors are: (1) R&D costs of the manufacturer for the drug and the extent to which the manufacturer has recouped R&D costs; (2) Current unit costs of production and distribution of the drug; (3) Prior Federal financial support for novel therapeutic discovery and development with respect to the drug; (4) Data on pending and approved patent applications or exclusivities recognized by the FDA, and applications and approvals under section 505(c) of the FD&C Act or section 351(a) of the PHS Act for the drug; and (5) Market data and revenue and sales volume data for the drug in the United States.

[3] Section 1194(e)(2) factors are: (1) The extent to which the selected drug represents a therapeutic advance compared to existing therapeutic alternatives for the selected drug and the costs of such existing therapeutic alternatives; (2) FDA-approved prescribing information for the selected drug and its therapeutic alternatives; (3) Comparative effectiveness of the selected drug and its therapeutic alternatives, including the effects of the selected drug and its therapeutic alternatives on specific populations (including individuals with disabilities, the elderly, the terminally ill, children, and other patient populations, hereinafter the "specific populations"); and (4) The extent to which the selected drug and the therapeutic alternatives to the drug address unmet medical needs for a condition for which treatment or diagnosis is not addressed adequately by available therapy.

Finally, given CMS' extensive efforts to collect stakeholder input in the initial negotiation process, AARP strongly encourages CMS to consider creating opportunities for patients and other interested parties to offer input that may be relevant to the renegotiation process.

AARP thanks you for the opportunity to submit comments on the latest guidance for the Negotiation Program and look forward to working with CMS as implementation continues. For decades, Americans have paid the highest prices in the world for prescription drugs – often three times higher than people in comparable countries. Successful implementation of the Negotiation Program represents a major victory for Medicare beneficiaries who are struggling to afford their prescription drugs, as well as the millions of taxpayers who help fund the Medicare program. The comprehensive evaluations that inform the drug price negotiation process will also help encourage and appropriately reward the development of truly innovative products. AARP stands ready to assist in any way with these and other efforts to bring down prescription drug prices and help older Americans afford the medications and treatments they need.

If you have any questions, please do not hesitate to contact me, or have your staff contact Gidget Benitez at gbenitez@aarp.org on our Government Affairs team.

Sincerely,

Megan O'Reilly
Vice President, Health and Family
Government Affairs

June 26, 2025

VIA EMAIL (IRARebateandNegotiation@cms.hhs.gov)

Chris Klomp
Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1859

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028

Dear Mr. Klomp:

AbbVie Inc. ("AbbVie") appreciates the opportunity to submit comments regarding the Centers for Medicare & Medicaid Services' ("CMS") draft guidance on how it intends to implement the prescription drug price control provisions of sections 1191 – 1198 of the Social Security Act ("SSA"), as added by the Inflation Reduction Act ("IRA"), for initial price applicability year ("IPAY") 2028 and for manufacturer effectuation of the "maximum fair price" ("MFP") in 2026, 2027, and 2028 ("IPAY 2028 Draft Guidance" or "Draft Guidance").[1]

AbbVie is a biopharmaceutical company committed to discovering and delivering innovative medicines and solutions that solve serious health issues today and address the medical challenges of tomorrow. We strive to have a remarkable impact on people's lives across several key therapeutic areas including immunology, oncology, neuroscience, and eye care. AbbVie focuses on these areas to accelerate the development of innovative approaches to treat disease and to respond to unmet patient needs. AbbVie has a robust pipeline of potential new medicines, with the goal of finding solutions to address complex health issues and enhance people's lives.

Innovation is the lifeblood of our company—our investments in U.S. research and development ("R&D") reflect our commitment to innovation in this country across a wide array of pharmaceuticals and disease states. The IRA's unprecedented price-control provisions raise significant constitutional and rule-of-law concerns and threaten to impede AbbVie's investments and the Administration's own health care priorities with serious unintended consequences for the

[1] CMS, Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 [IPAY 2028 Draft Guidance] (May 12, 2025), https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

efforts to foster pharmaceutical innovation within the United States. In this context, it is especially important for CMS to remain within the bounds of authority prescribed by Congress and to implement the IRA's provisions with scrupulous regard for the limits of its authority and the bedrock requirements necessary to ensure reasoned decision-making and proper accountability. Unfortunately, CMS' IPAY 2028 Draft Guidance exacerbates many of the concerns from the IPAY 2026 and 2027 guidance that depart from the statute and pose the greatest risk for innovation. Our comments on specific provisions of CMS' Draft Guidance are set forth below. AbbVie is also reiterating and incorporating by reference our comments on CMS' IPAY 2026 and IPAY 2027 draft guidance, and we incorporate by reference other AbbVie correspondence to CMS regarding the "Medicare Drug Price Negotiation Program" ("DPNP"). The comments below focus on additional and new areas of concern and should be read to include the comments and correspondence AbbVie has previously provided. CMS has never adequately responded to many of our previous comments, and, despite recognizing concerns with the DPNP and the current Administration's recognition of a need for greater transparency in the DPNP,[2] CMS has not adequately modified its guidance to address the prior Administration's administrative overreach, lack of transparency, and operational missteps. We remain concerned that CMS is deviating from the statute and using guidance to impose requirements that are arbitrary and not adequately explained, and, in some cases, entirely outside the scope of CMS' authority or expertise. We respectfully urge CMS to reconsider the IPAY 2028 Draft Guidance and to respond meaningfully to comments submitted.

I. CMS Methodology for Developing an Initial Offer Lacks Transparency and Fails to Appropriately Credit Innovation in the Biopharmaceutical Industry

In President Trump's April 15, 2025 Executive Order, the White House established a clear directive for CMS' implementation of the IRA to "improve the transparency of the Medicare Drug Price Negotiation Program, prioritize the selection of prescription drugs with high costs to the Medicare program, and minimize any negative impacts of the maximum fair price on pharmaceutical innovation within the United States."[3]

AbbVie supports this Administration's goal of bringing transparency to the process. Unfortunately, however, AbbVie remains concerned that CMS has continued its opaque methodology for developing initial offers to manufacturers of selected drugs, repeating the prior

[2] CMS Press Release, CMS Statement on Lowering the Cost of Prescription Drugs (Jan. 29, 2025), https://www.cms.gov/newsroom/press-releases/cms-statement-lowering-cost-prescription-drugs; 90 Fed. Reg. 14273, Executive Order 14273: Lowering Drug Prices by Once Again Putting Americans First 90 Fed. Reg. 16441 (April 15, 2025).

[3] 90 Fed. Reg. at 16442 (Section 3); *see also* CMS Press Release, CMS Statement on Lowering the Cost of Prescription Drugs (Jan. 29, 2025), https://www.cms.gov/newsroom/press-releases/cms-statement-lowering-cost-prescription-drugs ("As the second cycle begins under the Trump Administration, CMS is committed to incorporating lessons learned to date from the program and to considering opportunities to bring greater transparency in the Negotiation Program.").

Administration's errors. For example, CMS has refused to provide relevant information on either the basis of the extra-statutory "starting point" for calculating its initial offers or on how each of the statutorily mandated factors impact that starting point. What is apparent, however, is that methodologies proposed and employed by CMS do not sufficiently consider innovation in the biopharmaceutical industry and fail to tie an initial offer to the only statutory benchmark on price—the statutory ceiling price.[4]

In establishing an initial offer, CMS should structure methodologies that are limited only by the statutory ceiling price. CMS should also appropriately incentivize biopharmaceutical innovation and be transparent about exactly how it calculates initial offers. AbbVie does not agree with the agency's results-oriented processes proposed in the IPAY 2028 Draft Guidance. Instead, CMS should appropriately credit selected drugs whose approval advanced the standard of care for a disease state to help ensure that an initial offer is not artificially depressed, and it should focus on clinical appropriateness rather than price in selecting therapeutic alternatives.

A. The "Starting Point" is an Extra-Statutory Construct that Artificially Depresses the Initial Offer

The IPAY 2028 Draft Guidance continues to build on CMS' extra-statutory construct of the "starting point" to artificially depress initial offers in arbitrary and inconsistent ways. As CMS continues to modify its approach to determining initial offers from year to year, with very little transparency, untethered to the statute, it is impossible for manufacturers to predict how CMS will determine initial offers for selected drugs. More importantly, it raises significant constitutional and rule-of-law concerns.[5]

AbbVie appreciates that CMS is considering reform, but any such reform must be consistent with the statute and tied to the statutorily established ceiling price, not create further, arbitrary data points to depress an initial offer further from the ceiling price. While CMS has "acknowledg[ed] that the therapeutic alternative(s) may not be priced to reflect the clinical benefit of the selected drug,"[6] instead of attempting to remedy this problem by making adjustments to reflect actual clinical benefit and innovation, CMS proposes to maintain an approach that uses therapeutic alternatives to determine the starting point of an initial offer rather than anchoring to the ceiling price calculations established in the statute as a key mechanism for balancing innovation.

B. The Potential Alternative Approaches to the Starting Point are Ill-defined and Inconsistent

The IPAY 2028 Draft Guidance solicits comment on "possible alternative approaches to

[4] SSA § 1194(c).
[5] *See* 5 U.S.C. § 706 (2).
[6] IPAY 2028 Draft Guidance § 60.3.2 (p. 130).

determine a starting point for a selected drug with one or more therapeutic alternatives," one of which would consider the statutory ceiling price, and the other of which would consider the selected drug's unit cost of production and distribution.[7] The statutory ceiling price is the only benchmark that is permitted under the statute.

Moreover, CMS continues to make "starting point" a moving target, which demonstrates the arbitrariness of CMS' determinations. For example, IPAY 2026 guidance stated that "CMS will use the Part D net price(s) ("net price(s)") and/or ASP(s) of the therapeutic alternative(s) (or a subset of the most clinically comparable therapeutic alternatives) for the selected drug, as applicable."[8] The next year, CMS revised that approach. The IPAY 2027 final guidance stated that the agency would consider for each therapeutic alternative covered under Part D, the lower of: (1) Part D total gross covered drug cost net of Direct and Indirect Remuneration and Coverage Gap Discount Program payments; or (2) the "maximum fair price" for IPAY 2026 selected drugs, if applicable.[9] CMS then granted itself broad latitude to choose a starting point "within that range" if there were multiple therapeutic alternatives.[10] Now, the IPAY 2028 Draft Guidance explains that CMS is considering "other domestic reference prices," the statutory ceiling price, and the unit cost of production and distribution. CMS' inability to land on a consistent process for determining a starting point, let alone an initial offer, exemplifies an arbitrary process and exacerbates the statute's lack of guiding principles for imposing MFPs.

AbbVie appreciates that CMS' Draft Guidance recognizes concerns with CMS' approach to date, leading to its request for comments on "possible alternative approaches."[11] But AbbVie disagrees with CMS' proposal to use the prices of supposed "therapeutic alternatives" or unit costs of production to determine a starting point for a selected drug. Both of these are subsets of factors CMS is required to "consider," per the statute. They are not benchmarks that CMS can use to depress an "initial offer" at the start. This approach is not supported by any statutory language or Congressional intent and continues to move the extra-statutory "starting point" construct further and further away from the Congressionally defined ceiling price.

To the extent CMS is also proposing to consider "other domestic reference prices" [12] to determine starting points, the Draft Guidance does not define "domestic reference prices," and it is unclear whether CMS is considering metrics that manufacturers report to the government, or whether the agency intends to fabricate even more new pricing metrics, like it has done with the manufacturer U.S. commercial average net unit price and the manufacturer net Medicare Part D average unit price, discussed below. Regardless, the IRA statute already determines how federal

[7] IPAY 2028 Draft Guidance § 60.3.2 (p. 131).
[8] IPAY 2026 guidance § 60.3.2.
[9] IPAY 2027 draft guidance § 60.3.2.
[10] *Id.*
[11] IPAY 2028 Draft Guidance § 60.3.2 (p. 131).
[12] IPAY 2028 Draft Guidance § 60.3.2 (p. 131).

government price metrics should be taken into account to determine the ceiling price, and AbbVie discourages CMS from continuing to explore new and different ways to incorporate CMS-constructed pricing metrics year over year when Congress has already spoken.

Moreover, because CMS has provided no details for us to understand the scope of such proposal, we are unable to assess the "domestic reference prices" that CMS is considering. We request that CMS provide additional detail—which at a minimum lists the "domestic reference prices" that CMS is considering—through notice-and-comment rulemaking, so stakeholders can provide meaningful comments on an actual proposal.

C. CMS' Dueling Definitions of "Indication" Are Unworkable, Internally Inconsistent and Inappropriately Devalue Critical, Patient-Focused Drug Development

The IPAY 2028 Draft Guidance maintains CMS' dueling and inconsistent definitions of the term "indication," explaining that, for some parts of the Draft Guidance, CMS will use the well-understood meaning of the word "indication" to mean FDA-approved use included in drug labeling, while, for other parts of the Draft Guidance, CMS will rewrite this term to instead mean a "condition or disease state."[13] CMS then proposes to use the latter of these two definitions to identify the therapeutic alternatives against which it will compare a selected drug.

This approach is internally inconsistent with other aspects of CMS' proposed approach for identifying therapeutic alternatives. CMS begins its own analysis of therapeutic alternatives by identifying the *FDA-approved indication(s)* of the selected drug—and the Draft Guidance explains that only under certain circumstances will CMS look outside of the FDA-approved indication to further off-label use.[14] Then, as the Draft Guidance further explains, the agency will focus on clinical comparability in assigning therapeutic alternatives and calculating the "starting point." But clinical use is specific to the patient population within a disease or condition. Many drugs are absorbed and metabolized differently in pediatric and adult patient populations with the same "condition or disease state," for example, leading to different pharmacokinetic profiles. Other drugs are contraindicated or limited for use by patients with a "condition or disease state" but varying co-morbidities. A fulsome analysis of clinical comparability simply cannot be done across disease states without assessing the unique clinical considerations of that disease state.

Additionally, CMS' proposed approach is inconsistent with the use of "indication" in the statute. The IRA uses the word "indication" twice—first to refer to "addition of a new indication" for purposes of renegotiation and second in section 1192(e)(3)(A). It is clear that the statutory reference in section 1192(e)(3)(A) has no requirement that such indication be for a new condition or disease state and any proposal by CMS to interpret the term "indication" otherwise creates a

[13] IPAY 2028 Draft Guidance § 60.3.1 (n. 99); *see* 21 U.S.C. § 355(d); 21 C.F.R. § 201.57(c).
[14] IPAY 2028 Draft Guidance § 60.3.1 (p. 128).

contradiction, by using the same word in two different ways, solely for the purpose of devaluing innovation.

In addition, the IPAY 2028 Draft Guidance states that the agency will consider a number of factors in identifying therapeutic alternatives—many of which can *only* be considered as they relate to a specific, FDA-approved indication. This includes the place in therapy based on evidence-based clinical practice guidelines, pharmacologic and therapeutic characteristics, utilization in the Medicare population, and the availability of direct and indirect comparative evidence relative to the selected drug. CMS likewise acknowledges that it will consult with the U.S. Food and Drug Administration ("FDA") to obtain additional information—but again, drug applications and FDA's review of those applications are specific to the drug's "proposed indications for use."[15] FDA approves a drug as safe and effective not for a disease or condition but for specific, proposed indications.[16]

Ultimately, the approach proposed in the Draft Guidance (as well as previous guidance) would result in a devaluing of treatments that are developed in a patient-focused way, with attention paid to the needs of specific patient populations. As Congress and this Administration have recognized, drug development should be targeted to the specific patient populations that need those medicines for treatment.[17] And doing this type of targeted, patient-focused drug development requires significant resources and investments of time and money—all of which will be washed away under CMS' "disease state" approach.

D. CMS Should Not Consider the Part D Net Price or the MFP of Therapeutic Alternatives When Establishing the Starting Point

The Draft Guidance provides that, for selected drugs in IPAY 2028, when assessing therapeutic alternative(s) covered under Part D to determine the starting point for a selected drug's initial offer, CMS intends to use the lower of either: "(1) the Net Part D Plan Payment and Beneficiary Liability, which reflects [the Total Gross Covered Drug Cost (TGCDC)] net of [Direct and Indirect Remuneration (DIR)] and [Coverage Gap Discount Program (CGDP)] or Manufacturer Discount Program payments, as applicable; or (2) the MFP for selected drugs for a prior initial price applicability year, if applicable."[18] In parallel, CMS requires manufacturers to submit data on the "manufacturer net Medicare Part D average unit price"[19] as part of its response to the Data Elements information collection request. The "manufacturer net Medicare Part D average unit price" metric includes "coverage gap discounts . . . and discounts under the

[15] 21 C.F.R. § 314.50(a)(1); 21 U.S.C. § 355(b)(1)(A).
[16] 21 U.S.C. § 355(d)(1), (2), (4), (5); 21 C.F.R. § 314.125(b).
[17] A new drug application must specifically identify the drug's "proposed indications for use," which are the specific conditions of use that FDA reviews and approves. 21 C.F.R. § 314.50(a)(1); 21 U.S.C. § 355(b)(1)(A); *id*. at. § 355(d)(1), (2), (4), (5); 21 C.F.R. § 314.125(b).
[18] IPAY 2028 Draft Guidance § 60.3 (p. 130).
[19] IPAY 2028 Draft Guidance, Appendix A (p. 213).

Manufacturer Discount Program" as well as "other supply chain concessions."[20]

CMS' proposed approach to consider statutorily mandated discounts when determining the starting point for a selected drug's initial offer is inconsistent with the statute's direction for calculating the MFP ceiling for a Part D selected drug. AbbVie strongly opposes the inclusion of these discounts both as part of the starting point for a selected drug's initial offer and as a component of the Market Data and Revenue and Sales Volume data manufacturer reporting requirements.

Congress did not intend for CMS to consider manufacturer or coverage gap discounts in setting an MFP. To the contrary, the IRA specifically excludes selected drugs from the definition of "applicable drugs" subject to the manufacturer discount in Part D.[21] CMS' use of manufacturer or coverage gap discounts of therapeutic alternatives in establishing a starting point for an initial offer circumvents Congress' intent. In effect, CMS would be reincorporating such discounts into the MFP starting point, when Congress explicitly required that manufacturers of selected drugs are exempt from these discounts. Moreover, there is absolutely no statutory basis for considering the MFP of therapeutic alternatives when determining an initial offer. This approach risks creating a reference price system anchored to a single alternative versus the breadth of therapeutic alternatives the statute instructs CMS to consider,[22] anchoring one manufacturer to the results of another manufacturer's "negotiation," regardless of the monopoly status of the respective selected drugs.

With respect to the net Part D data reporting requirements, the CMS-constructed Part D pricing metric "manufacturer net Medicare Part D average unit price" is not contemplated as information the manufacturer must submit under the statute. This metric cannot be considered "market data" as it does not reflect a price in the market or align with any existing reporting requirements or accounting procedures. This constructed metric inclusive of statutorily mandated manufacturer discounts for a selected drug undermines the Congressional intent that selected drugs should be subject to *either* an MFP *or* statutorily mandated discounts—not both. The manufacturer and coverage gap discounts are part of the Medicare Part D benefit structure, like the deductible or the government contribution. These statutorily mandated discounts are not part of the price of the drug from the manufacturer to the Medicare Part D plan or any other customer.

As AbbVie has stated in prior comments to the agency, CMS should clarify that, with respect to the determination of a starting point for a selected drug's initial offer, the selection of therapeutic alternatives will be based exclusively on clinical appropriateness within the same class and mechanism of action, and will not take into account the costs of therapy, including the net Part

[20] IPAY 2028 Draft Guidance, Appendix A (page 213).
[21] SSA § 1860D-14C(g)(2)(B).
[22] SSA § 1194(e)(2).

D price or the MFP of therapeutic alternatives.

E. CMS' Guidance on Identifying Therapeutic Alternatives Does Not Provide Clarity and Does Not Align with Real-World Practice

To the extent CMS continues with its extra-statutory "starting point" analysis, CMS needs to provide clear and predictable guidance regarding how it intends to identify appropriate therapeutic alternatives to the selected drug. The only therapeutic alternatives that can be consistently identified, while aligning with real-world practice, are other branded innovative medicines having the same mechanism of action as the selected drug. CMS should be particularly cautious when identifying therapeutic alternatives to selected drugs in the "six protected classes" where seemingly similar, but particularly vulnerable, patients often respond differently to the same drug and need access to the medications that are most effective in treating their condition.

1. Therapeutic Alternatives Should be Most Clinically Comparable and Have the Same Mechanism of Action as the Selected Drug

In the Draft Guidance, CMS has stated that a "'therapeutic alternative' may refer to one or more therapeutic alternative(s) or a subset of therapeutic alternatives that are *clinically comparable.*"[23] But CMS fails to define what "clinically comparable" means, leaving it a guessing game that risks inclusion of too broad a set of appropriate therapeutic alternatives. It is imperative that CMS adopt a definition that ensures that a true clinical equivalent to the selected drug is chosen, if one exists. Specifically, to be "clinically comparable" to a selected drug, a therapeutic alternative must be a branded therapy that shares the same mechanism of action and is medically appropriate for the same group of patients in each of the FDA-approved indications as the selected drug. The differences in efficacy and safety outcomes between the selected drug and a therapeutic alternative treatment should be small and not clinically meaningful. In fact, in its IPAY2026 guidance, CMS recognized the importance of finding a truly comparable alternative by inserting the word "most": a therapeutic alternative "may refer to one or more therapeutic alternative(s) or a subset of the *most clinically comparable* therapeutic alternatives."[24] The deliberate and persistent removal of "most" from the IPAY 2027 guidance and this Draft Guidance is telling. CMS has inappropriately strayed away from a correct reading of what a therapeutic alternative should be and pointedly has chosen to hide behind an increasingly opaque phrase without a definition. CMS should revise the Draft Guidance to, (i) revert to the inclusion of "most" when identifying clinically comparable therapeutic alternatives, and (ii) adopt a specific definition of "clinically comparable" (as recommended above) that pinpoints the "most" clinically comparable therapeutic alternative(s) to the selected drug. CMS should also be transparent about the data, information, and resources it uses to select "clinically comparable" therapeutic alternatives.

[23] IPAY 2028 Draft Guidance § 60.3.1 (p. 128) (emphasis added).
[24] IPAY 2026 guidance § 60.3.1 (p. 145) (emphasis added).

CMS has stated that it will use a variety of public and private sources to identify potential therapeutic alternatives.[25] In particular, "CMS will begin by identifying potential therapeutic alternatives within the same pharmacologic class as the selected drug based on properties such as chemical class, therapeutic class, or mechanism of action and then also consider therapeutic alternatives in different pharmacologic classes based on CMS' review" of those sources.[26] But CMS' identification of such a broad collection of disparate sources provides no consistent standards and no meaningful guidance for manufacturers to predict what CMS may identify as therapeutic alternatives. This ultimately renders CMS' starting point an opaque black box. Since the identification of therapeutic alternatives is the foundation of CMS' starting point analysis, albeit erroneous, clarity as to what public sources define a therapeutic alternative is necessary.

FDA's determination of a selected drug's mechanism of action, as reported in its prescribing information, provides a definitive public source to identify its therapeutic alternatives. Per FDA regulation, the prescribing information for drugs and biological products must include a summary of their mechanism of action, which generally provides information about how the active ingredient contributes to the therapeutic effect of the drug and any associated adverse events.[27] Drugs that operate through the same biological pathway are more likely to exhibit similar therapeutic effects and have comparable side effect profiles. Patients are more likely to switch to medicines having the same mechanism of action, if they need to change drugs but still require the same therapeutic approach. By contrast, patients who fail or have an inadequate response to prior treatment are more likely to switch to a different mechanism of action. Earlier lines of treatment that must be stepped-through for prescription of the selected drug are not appropriate therapeutic alternatives. Similarly, for selected drugs that are most often prescribed as adjunctive therapy to a primary treatment, the primary treatment can hardly be deemed as an appropriate therapeutic alternative. Accordingly, CMS should define therapeutic alternatives by mechanism of action, as opposed to its current proposal to reference any drug approved by FDA or used off-label to treat the same condition.

2. Basing Therapeutic Alternatives on Generic and Biosimilar Products Contradicts the IRA

Under CMS' scheme for identifying a starting point for a selected drug's MFP, CMS has stated that "in addition to brand name drugs and biological products, CMS intends to consider generic drugs and biosimilars."[28] This approach runs entirely counter to the IRA's intent. The IRA

[25] IPAY 2028 Draft Guidance § 60.3.1 (pp. 128-29) (listing potential sources as including "data submitted by the Primary Manufacturer and the public, prescribing information approved by the FDA, drug classification systems commonly used in the public and private sector for formulary development, CMS-recognized Part D compendia, widely accepted clinical guidelines, evidence identified through the CMS-led literature review, published drug or drug class reviews, peer-reviewed studies, and Medicare claims or other data sets").
[26] *Id.* § 60.3.1 (p. 129).
[27] 21 C.F.R. § 201.57(c)(13)(i)(A).
[28] IPAY 2028 Draft Guidance § 60.3.1 (p. 128).

clearly distinguishes between innovator medicines and generic and biosimilar products. Indeed, per the statute, only innovator drugs and biological products may be selected for the DPNP,[29] and innovator medicines that form the basis of approval of a marketed generic or biosimilar product are disqualified as multisource from being selected for the DPNP.[30] As AbbVie has previously commented, it is inappropriate and inconsistent with the IRA's statutory history to use the price of a follow-on product to value an innovative medicine, either within or especially outside of the class of products.

In addition, this approach will negatively impact biopharmaceutical innovation in the United States. The IRA treats innovator medicines differently than generic and biosimilar products for good reason—their risks and rewards are completely incomparable. Novel drug discovery is resource intensive and fraught with risk. Innovative medicine manufacturers need to conduct basic research to understand the causes of diseases, undertake drug discovery programs to find the successes among the failed attempts, engage in robust clinical trials to prove the safety and effectiveness of medicines, and invest in countless other initiatives that bring new therapies to patients and physicians. By contrast, manufacturers of generic and biosimilar drugs forgo the substantial risks and investments associated with developing a new drug by leveraging the work of the innovator manufacturer that came before them. Innovative medicines must be priced differently than generic and biosimilar products, in the limited time before the market becomes genericized, to recover their exorbitant investments and continue funding essential research and development to advance patient care.

CMS should not devalue innovation by benchmarking a selected drug's starting point based on the pricing of generic and biosimilar products that have not undertaken such risks and have no role in discovering new medicines. While AbbVie maintains that initial offers should be calculated based on the ceiling price, if CMS is to use a "starting point" construct, the only appropriate comparison for establishing that starting point is the pricing of innovator therapeutic alternatives.

F. CMS Must Credit Selected Drugs Whose Approval Advanced the Standard of Care

After identifying the selected drug's therapeutic alternatives, CMS states that it will use the section 1194(e)(2) factors on "alternative treatments" to adjust the starting point to determine the preliminary price.[31] Presently, CMS will credit only those selected drugs that represent a therapeutic advance over their therapeutic alternatives available at the time the section 1194(e)(2) data is submitted.[32] But this approach is contrary to the statute and unfairly ignores the scientific breakthroughs a selected drug represented when it was approved. In the interest of transparency,

[29] SSA § 1192(e)(1).
[30] *Id.*
[31] IPAY 2028 Draft Guidance § 60.3.3 (pp. 132-33).
[32] IPAY 2028 Draft Guidance § 60.3.3.1 (p.134).

AbbVie encourages CMS to clarify how it intends to evaluate each of the section 1194(e)(2) factors and to reassess how it plans to apply the "therapeutic advance" factor.

1. The Current Methodology of Evaluating the Section 1194(e)(2) Factors is Unclear and Causes the Factors to Collapse

The IRA explicitly delineates four discrete "factors" about alternative treatments that CMS "shall" consider for determining its offers and counteroffers.[33] Those individual factors are:

> (A) The extent to which such drug represents a therapeutic advance as compared to existing therapeutic alternatives and the costs of such existing therapeutic alternatives.
>
> (B) Prescribing information approved by the Food and Drug Administration for such drug and therapeutic alternatives to such drug.
>
> (C) Comparative effectiveness of such drug and therapeutic alternatives to such drug, taking into consideration the effects of such drug and therapeutic alternatives to such drug on specific populations, such as individuals with disabilities, the elderly, the terminally ill, children, and other patient populations.
>
> (D) The extent to which such drug and therapeutic alternatives to such drug address unmet medical needs for a condition for which treatment or diagnosis is not addressed adequately by available therapy.[34]

Although each of factors (A) through (D) must be considered and factored into offers, CMS' guidance does not clearly delineate how it intends to evaluate each factor. For instance, CMS' guidance is silent as to what conditions would cause each section 1194(e)(2) factor to upwardly or downwardly adjust the starting point.[35] And conspicuously absent from CMS' guidance is any discussion of how CMS intends to weigh factor (B) for "prescribing information" to determine the preliminary price.

Further, CMS' approach causes factors (A) and (C) to collapse into a singular analysis of comparative effectiveness of the selected drug relative to the currently available therapeutic alternatives. Specifically, with reference to factor (C), CMS states that "to consider the comparative effectiveness of a selected drug and its therapeutic alternative(s), CMS will identify outcomes to evaluate for each identified indication of the selected drug."[36] These outcomes would

[33] SSA § 1194(e).
[34] SSA § 1194(e)(2).
[35] *See* IPAY 2028 Draft Guidance § 60.3.3.1 (pp. 133-34).
[36] *Id.*

be used to review "the clinical benefit of the selected drug and its therapeutic alternative(s) for those indications."[37] Similarly, with reference to factor (A), CMS states that it "will examine improvements in outcomes to determine the extent to which a selected drug represents a therapeutic advance as compared to its therapeutic alternative(s)."[38] It remains opaque how CMS intends for the comparison of clinical benefit under factor (C) to differ from the comparison of improvements in outcomes under factor (A), particularly considering that CMS has decided to evaluate both comparisons relative to the therapeutic alternatives available "at the time the section 1194(e)(2) data is submitted."[39] Because CMS views both factors from the same vantage point, this essentially results in the same comparative analysis under both factors.

CMS should revise its guidance to clarify how it intends to individually assess each section 1194(e)(2) factor to adjust the starting point to determine the preliminary price.

2. Therapeutic Advance Must Be Evaluated at the Time of Approval to Appropriately Credit Innovation

Pioneering medicines that validate a novel mechanism of action to treat a disease not only advance patient care but also blaze the trail for the development of follow-on innovator medicines. Factor (C) already credits ***best-in-class therapies*** that offer greater clinical effectiveness relative to today's therapeutic alternatives. As a matter of policy, CMS should also reward ***first-in-class therapies*** that therapeutically advanced the standard of care as compared to the existing therapeutic alternatives at the time of their approval.

Indeed, Congress codified recognition of both achievements in the section 1194(e)(2) factors. The IRA requires CMS to consider both "the extent to which such drug represents a therapeutic advance as compared to ***existing*** therapeutic alternatives" and the "comparative effectiveness of such drug and therapeutic alternatives to such drug."[40] Congress' reference to those existing therapeutic alternatives at the time of the therapeutic advance is significant. This temporal modifier is meant to recognize the improvements in outcomes that came about as a result of the selected drug.

CMS should not read the statute in a way to render the phrase "existing therapeutic alternatives" superfluous by collapsing this factor into the comparative effectiveness factor.[41] Yet, CMS' flawed approach does just that. CMS suggests it will consider "other drugs [that] have

[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] SSA § 1194(e)(2)(A), (C) (emphasis added).
[41] *TRW Inc. v. Andrews*, 534 U.S. 19, 31 (2001); *see also Elwell v. Oklahoma ex rel. Bd. of Regents of Univ. of Oklahoma*, 693 F.3d 1303, 1307 (10th Cir. 2012) ("[W]e are always hesitant to assume Congress included pointless language in its statutory handiwork."); *Sec. & Exch. Comm'n v. Stubos*, 634 F. Supp. 3d 174, 195 (S.D.N.Y. 2022) (rejecting interpretation that would require the court "to presume that Congress added the word 'pending' for no reason").

become available since the selected drug's initial approval,"[42] instead of considering alternatives that were "existing" at the time of approval. By only considering therapeutic advance at the time the section 1194(e)(2) data is submitted, CMS' approach undermines Congress' intent to encourage and reward "therapeutic advance" in the context of scientific breakthroughs for "new, truly valuable treatments," such as the discovery of first-in-class drugs.[43] To give effect to the word "existing," CMS must interpret "existing therapeutic alternatives" to refer to those therapeutic alternatives that existed at the time of the selected drug's approval. Accordingly, those selected drugs whose approval therapeutically advanced the standard of care merit an upward adjustment of the starting point.

II. CMS Should Adjust Its Proposed Approach to Considering Manufacturer Specific-Factors to Be Objective and Accurate, not Results Oriented

Following the determination of a selected drug's preliminary price, CMS states that it will consider the section 1194(e)(1) factors for "Manufacturer-Specific Data" to adjust the preliminary price and determine CMS' initial offer.[44] CMS reserves discretion for itself to determine whether or not to adjust for each factor, and if so by how much, insisting that it "may" (or may not) adjust, even when the criteria for adjustment clearly are met.[45] CMS retains this discretion with no reasoned or consistent standard in applying that discretion, nor any transparency as to how or when it is applied year over year. Indeed, it seems very possible the same criteria, with the same underlying facts, could be applied on a radically different scale from year to year, with no transparency into the agency's decision making.

Further, instead of objectively considering each factor, the IPAY 2028 Draft Guidance proposes to inappropriately reinterpret the manufacturer-specific factors set forth in section 1194(e)(1) with the sole objective of driving down the initial offer.[46] For example, the Draft Guidance continues to disregard data on pending and approved patent applications and FDA exclusivities, applications, and approvals even though they are strongly probative of clinical benefit and should be heavily weighted. Additionally, the Draft Guidance proposes to narrow CMS' consideration of R&D costs by excluding costs associated with acquisition, an arbitrary and inconsistent divergence from previous guidance. And CMS proposes to expand the scope of manufacturer-specific data outside the limits of the statute, proposing manufacturers provide speculative forward-looking market data. These reinterpretations of the manufacturer-specific data

[42] IPAY 2028 Draft Guidance § 60.3.3.1 (p. 134).
[43] Ron Wyden (Senate Finance Committee), *Principles for Drug Pricing Reform* (June 22, 2021) (emphasis added), https://www.finance.senate.gov/imo/media/doc/062221%20SFC%20Drug%20Pricing%20Principles.pdf.
[44] IPAY 2028 Draft Guidance § 60.3.4 (pp. 135-37).
[45] CMS states that it "will consider the five factors outlined in section 1194(e)(1) of the Act in totality and apply an upward adjustment, downward adjustment, or no adjustment," but fails to provide manufacturers transparency into how each factor was assessed. IPAY 2028 Draft Guidance § 60.3.4 (p. 136).
[46] IPAY 2028 Draft Guidance § 60.3.4 (pp. 135-37). AbbVie comments on the manufacturer specific-factor data elements based on the limited information set forth in the IPAY 2028 Draft Guidance. As of the date of this letter, CMS has not issued the IPAY 2028 Information Collection Request for the data elements submission.

appear designed to skew toward a lower initial offer for imposing an MFP. But CMS' approach in considering the manufacturer-specific factors should be objective and based on accurate data. Results-oriented data requirements and reviews exacerbate the lack of clear standards in the statute and are a far cry from the statute's mandate that CMS use a "consistent methodology and process"[47] in setting prices.

A. CMS Cannot Disregard Pending and Approved Patent Applications and FDA Exclusivities, Applications, and Approvals

Section 1194(e)(1) of the IRA lists five discrete factors of "Manufacturer-Specific Data" that CMS must consider.[48] Among the section 1194(e)(1) factors, data on pending and approved patent applications and FDA exclusivities, applications, and approvals are strongly probative of clinical benefit and should be heavily weighted.

Yet, CMS' guidance contravenes the statute by using these data only to inform its understanding of the other section 1194(e)(1) and (e)(2) factors.[49] CMS should assess this factor on its own merits, and U.S. Patent and Trademark Office ("PTO") and FDA recognitions should upwardly adjust the preliminary price.

1. As With All Other Manufacturer-Specific Data, Patents and FDA Recognitions Deserve Independent Consideration

The United States has long been the leader in innovation in the biopharmaceutical industry through comprehensive policies that support exclusivities, applications, and approvals before the FDA and patents and applications before the PTO. In enacting the IRA, Congress intended for CMS to preserve these incentives for developing "new, truly valuable treatments" for patients.[50] Specifically, recognizing the importance of innovation, the IRA mandates that CMS appropriately assess each manufacturer's "[d]ata on pending and approved patent applications, exclusivities recognized by [FDA], and applications and approvals under section 505(c) of the [FDCA] or section 351 (a) of the [PHSA]" for the selected drug.[51]

Inexplicably, CMS does not give this factor any independent weight. Unlike all other factors that CMS assesses individually, CMS will use information regarding "patent applications, exclusivities, and applications and approvals for the selected drug" to "support CMS' consideration of the 1194(e)(1) and 1194(e)(2) factors."[52] Among the manufacturer-specific data factors, this is the only factor for which CMS provides no illustrative examples of how it may

[47] SSA § 1194(b).
[48] SSA § 1194(e)(1).
[49] IPAY 2028 Draft Guidance § 60.3.4 (p. 136).
[50] Ron Wyden, *Principles for Drug Pricing Reform* (June 22, 2021).
[51] SSA § 1194(e)(1)(D).
[52] IPAY 2028 Guidance § 60.3.4 (p. 136).

impact adjustment of the preliminary price. In effect, CMS reads this factor out of the IRA.

Transparency over how CMS intends to use this factor to inform its determination of an initial offer is necessary. As set forth below, AbbVie encourages CMS to rely upon (1) PTO's technical knowledge in reviewing and awarding patents; and (2) FDA's scientific and medical expertise in awarding exclusivities, reviewing applications, and granting approvals. CMS should make clear that it supports innovation in the biopharmaceutical industry by adopting policies that PTO and FDA recognitions should upwardly adjust a selected drug's preliminary price.

2. Patents Reflect Innovative R&D That Should be Rewarded

Innovative medicines are the culmination of many distinct inventions. Scientific breakthroughs often occur with the discovery of novel active ingredients that are found to be effective in treating diseases. Innovative research and development continue even after the initial discovery of the active ingredient itself—for example, with the development of a new drug formulation to achieve the target product profile, the design of innovative clinical trials to prove safety and efficacy, and the clinical trial program to obtain FDA approval for new indications. These are only a few illustrative examples of the many discoveries essential to the development of innovative medicines. And, if these breakthroughs are deemed worthy under the PTO's statutorily-prescribed requirements for patentability, the PTO will award a patent. These patented innovations should be recognized with an upward adjustment of the preliminary price.

CMS states that "patents and exclusivities may inform CMS' understanding of therapeutic alternatives and other available therapy for the purposes of adjusting for clinical benefit, including consideration of the extent to which the selected drug represents a therapeutic advance or the extent to which the selected drug addresses an unmet medical need."[53] AbbVie agrees that patents can be highly probative of therapeutic advance and fulfilling unmet medical needs. But patents are a snapshot in time of past innovation. Since therapeutic advance and unmet medical need under CMS' approach may only be assessed as of today, patents' retrospective analysis of innovation over the then-existing state of the art has limited utility under CMS' framework. By inappropriately limiting its analysis of the impact of patents on the other section 1194(e)(1) and (e)(2) factors as of today, CMS has improperly excised from the IRA any recognition of exceptional innovation.

CMS further undervalues innovation when it fails to credit strong patents that have survived serial challenges by generics and biosimilars. Under the Hatch-Waxman Act and BPCIA, biopharmaceutical patents are routinely challenged by generic and biosimilar manufacturers to obtain clearance for market entry prior to patent expiry. For innovators that have successfully defended against these rigorous patent challenges—whether by court judgment or acknowledgement of infringement and validity by the patent challenger—these wins are a testament to the quality of their patents. In these situations, innovators should be awarded an

[53] IPAY 2028 Guidance § 60.3.4 (p. 136).

upward adjustment of the preliminary price for the quality of their intellectual property.

3. FDA Exclusivities, Applications, and Approvals Reflect Advancements in Patient Treatments That Must Be Protected

Long before the IRA, Congress incentivized innovators to promote new drug development in areas of significant medical need. FDA periods of regulatory exclusivity recognize the substantial research and development required to bring new therapies to patients. FDA also grants regulatory designations that expedite a drug application's development and review pathway to speed the approval of drugs that address unmet medical needs and/or treat special patient populations. Examples of such FDA exclusivities and designations include the following:

EXCLUSIVITIES
New Chemical Entity (NCE) Exclusivity: Awarded for approval for a drug that contains a new chemical entity for which no other drug has been approved.
Reference Product Exclusivity: Awarded for approval for a new biological product.
Orphan Drug Exclusivity (ODE): Awarded for approval for an orphan-designated new drug that is intended to treat a rare disease or condition.
Generating Antibiotic Incentives Now (GAIN) Exclusivity: Awarded for approval of certain antibacterial or antifungal drugs designated as Qualified Infectious Disease Product (QIDP) intended to treat serious or life-threatening infections.
New Clinical Investigation Exclusivity: Awarded for completion of additional clinical studies that are essential to the approval of a drug application.
Pediatric Exclusivity: Awarded for completion of additional clinical studies of a drug or biological product at FDA's request that may produce health benefits in a pediatric population.

DESIGNATIONS AND CLASSIFICATIONS
First-in-Class: Recognition for a drug that presents a new and unique mechanism for treating a medical condition.
Orphan: Awarded to drugs intended to treat patients with rare (small population) diseases.
QIDP: Awarded to an antibacterial or antifungal drug that treats a serious or life-threatening infection caused by an antibacterial or antifungal resistant pathogen.

Fast Track Review: Recognition for a drug intended to treat a serious condition if data demonstrates the potential to address unmet medical need
Breakthrough Therapy: Recognition for a drug intended to treat a serious condition and preliminary clinical evidence indicates the drug may demonstrate substantial improvement on clinically significant endpoint(s) over available therapies
Priority Review: Recognition for a drug that treats a serious condition and, if approved, would provide a significant improvement in safety or effectiveness, proposes a labeling change pursuant to a requested pediatric study, or that has been designated as a qualified infectious disease product
Accelerated Approval: Awarded to drugs that treat a serious condition, provide a meaningful advantage over available therapies, and demonstrates an effect on a surrogate endpoint reasonably likely to predict clinical benefit

These FDA exclusivities and designations encourage continued research and development of new biopharmaceutical products, which contributes to why the United States has led development of innovative medicines. Now, the IRA upsets the careful framework Congress created by imposing price controls that undercut the hard-earned exclusivities and designations rewarded by FDA. To rehabilitate the incentives FDA intended with the award of these exclusivities and designations, CMS should upwardly adjust the preliminary price of selected drugs through factor 1194(e)(1)(D).

First, AbbVie is concerned that CMS has adopted an approach that not only fails to credit FDA exclusivities—but instead penalizes them. CMS' only guidance with respect to how it plans to assess FDA exclusivities states that:

> [I]n light of exclusivities, there may be no other available therapy aside from the selected drug that adequately addresses treatment or diagnosis of a disease or condition, and consideration of such information would be relevant to CMS' consideration of the extent to which the selected drug addresses an unmet medical need for that disease or condition.[54]

To the extent that CMS suggests that FDA exclusivities stymie drug development—instead of incentivizing the creation of drugs that would address an unmet medical need—this reflects a fundamental misunderstanding of the purpose and effect of exclusivities that contravenes established FDA policy.

As just one example, orphan drug exclusivity has been successful in focusing research and development efforts into rare diseases and conditions that are not adequately addressed by other therapies. Congress created orphan drug exclusivity after finding that "adequate drugs for many [rare] diseases and conditions have not been developed," and "it is in the public interest to provide [changes to reduce the costs of developing such drugs] and incentives for the development of

[54] IPAY 2028 Draft Guidance § 60.3.4 (p. 136).

orphan drugs."[55] Considering Congress already established a balanced incentive structure for orphan drug development, it would be perverse for CMS to penalize manufacturers for these efforts. Rather, CMS should deem that orphan drug exclusivity and all other FDA exclusivities merit an upward adjustment of the preliminary price.

Second, CMS' guidance provides no explanation of how it intends to evaluate the impact of FDA applications and approvals on the preliminary price. CMS' policies should support manufacturers investing in clinical research and development to obtain FDA approval in any additional indications for which the selected drug is proven safe and effective. However, under CMS' current methodology, if a selected drug obtains approval for a new indication that has lower-priced therapeutic alternatives, this will depress CMS' starting point. AbbVie remains concerned that CMS will penalize manufacturers that seek new and expanded approvals for a selected drug with a lower initial offer. The DPNP should not put manufacturers in a worse position for obtaining new FDA approvals to treat different diseases. Thus, AbbVie urges CMS to ensure that additional FDA applications and approvals would only *increase* CMS' initial offer.

Third, CMS should not limit its consideration of FDA exclusivities, applications, and approvals solely to the extent they reflect upon therapeutic advance and unmet medical need relative to today's available therapeutic alternatives.[56] FDA exclusivities, applications, and approvals are certainly relevant to therapeutic advance and unmet medical need, but they are assessed relative to the then-existing therapies at the time of the award. For example, FDA's four "expedited programs" for serious conditions—fast track review, breakthrough therapy, priority review, and accelerated approval—are awarded based on FDA's express finding that the drug can therapeutically advance the standard of care or address a previously unmet medical need.[57] To qualify for these expedited programs, the drug must be intended to treat a "serious condition" that is associated with morbidity that has a substantial impact on day-to-day functioning.[58] The drug should further "have an effect on a serious condition or a serious aspect of a condition, such as a direct effect on a serious manifestation or symptom of a condition or other intended effects."[59] The FDA will consider whether the product is intended "to mitigate or prevent a serious treatment-related side effect," "to avoid or diminish a serious adverse event associated with available therapy for a serious condition," or "to prevent a serious condition or reduce the likelihood that the condition will progress to a more serious condition or a more advanced stage of disease."[60] These are fact-intensive scientific inquiries conducted by FDA to determine whether a drug merits these recognitions as compared to the then-existing therapies. CMS should defer to FDA's scientific

[55] Orphan Drug Act, Public Law 97-414, § 1.
[56] IPAY 2028 Draft Guidance § 60.3.4 (p. 136).
[57] FDA, Guidance for Industry, *Expedited Programs for Serious Conditions—Drugs and Biologics* (May 2014), https://www.fda.gov/media/86377/download.
[58] *Id.* at 2, 7.
[59] *Id.*
[60] *Id.*

expertise when determining if a selected drug has therapeutically advanced the standard of care or addressed a previously unmet medical need.

CMS should further recognize that FDA exclusivities and designations are granted many years prior to IRA drug selection. If therapeutic advance and unmet medical needs under section 1194(e)(2) factors are to be judged only relative to today's available therapies, as CMS suggests, then these FDA exclusivities and designations would have no use in informing CMS' evaluation of these factors. Instead, CMS should recognize that FDA exclusivities and designations are awarded for innovative research that has materially advanced patient health over the then-existing therapies, and as a matter of policy, CMS should protect such innovative research awarded FDA exclusivities and designations by upwardly adjusting the preliminary price.

B. Excluding Acquisition Cost from R&D Cost Analysis Is Arbitrary and Inconsistent, and Improperly Narrow CMS' Already-Restrictive Conception of R&D Costs

In imposing an MFP, the IRA requires CMS to consider "[r]esearch and development costs of the manufacturer for the [selected] drug and the extent to which the manufacturer has recouped research and development costs."[61] In IPAY 2026 and 2027 guidance, rather than allowing the manufacturer to submit commonsense information showing its research and development costs, CMS transformed the statutory requirement into six unique sub-elements (e.g., "R&D: Basic Pre-Clinical Research Costs"), each of which included additional definitions, instructions, and de-facto sub-requirements.

At the same time, CMS has prevented manufacturers from submitting other information about the costs they incurred in developing and bringing a product to market, instead adopting an overly narrow definition of R&D costs that disregards legitimate and unavoidable manufacturer-specific costs. For example, relying on its extra-statutory "Primary Manufacturer" construct, CMS limited reportable R&D costs to those incurred by the Primary Manufacturer, disregarding substantial research and development costs incurred by Secondary Manufacturers, including commercialization and manufacturing partners.

CMS' limits on reportable R&D costs already put manufacturers of selected drugs at a stark disadvantage in the price-setting process, making it more likely that the agency will determine that the manufacturer "has recouped its R&D costs"—which will result in CMS "adjusting the preliminary price downward or apply[ing] no adjustment"[62]—when, in fact, costs have not been recouped.

Against that backdrop, AbbVie has significant concerns that now, in its IPAY 2028 Draft

[61] SSA § 1194(e)(1)(A).
[62] IPAY 2028 Draft Guidance § 60.3.4 (p. 136).

Guidance, CMS appears poised to exacerbate the limits on R&D cost considerations in IPAY 2028 by prohibiting manufacturers from reporting acquisition costs.[63] The Draft Guidance explains that the agency views "that acquisitions [sic] costs are generally driven by the estimated net of the present value that is assessed based on the future revenue expectations for a drug, and that acquisition costs are not driven by R&D."[64] That is incorrect. The cost of acquiring a biotech incubator may be assessed based on the future potential value for the product, but acquisition costs are absolutely still driven by R&D. Pharmaceutical companies of all sizes have always relied on acquiring start-up businesses or rights to individual R&D streams to further the main company's R&D objectives.[65] In fact, of 323 new drug approvals between 2015 and 2021, sixty-five (65) percent originated from external sources.[66]

Acquisition costs are therefore an essential part of all pharmaceutical R&D. Discounting that cost contravenes the statute and is an arbitrary departure from previous guidance. If CMS moves forward with this proposal, it will produce a chilling effect across the industry that will ultimately stall innovation for years to come.

C. CMS Cannot Compel Manufacturers to Provide Speculative "Forward-Looking" Market Data or Use this Data as a Basis for MFPs

AbbVie opposes CMS' suggestion that it may collect and consider "forward-looking" market data when setting MFPs. Although the scope of forward-looking information that CMS intends to collect is unclear,[67] at a fundamental level, the statute does not permit CMS to compel manufacturers to report this information. Moreover, it would be inappropriate for CMS to rely on speculations of future market conditions that may never occur when imposing MFPs.

The statute enumerates specific types of information that CMS must consider as part of the MFP-setting process,[68] and these factors do not include the submission of forward-looking market

[63] IPAY 2028 Draft Guidance § Appendix A (p. 206) ("Acquisition costs are excluded from R&D costs.").
[64] IPAY 2028 Draft Guidance § Appendix A (p. 204), n. 128.
[65] For example, a May 2022 report conducted by McKinsey found that as of 2020, "no less than 45 percent of the drugs in the pipelines of the 20 biopharmaceutical companies with the biggest R&D budgets were sourced externally, and in 2021, 66 percent of the entire industry's pipeline revenues were generated from such drugs." Lotte Berghauser Pont et al., *Innovation sourcing in biopharma: Four practices to maximize success* (May 31. 2022), https://www.mckinsey.com/industries/life-sciences/our-insights/innovation-sourcing-in-biopharma-four-practices-to-maximize-success.
[66] *See* A. Schuhmacher et al., *Investigating the origins of recent pharmaceutical innovation* 22 NATURE REVIEWS DRUG DISCOVERY 781-782 (Oct. 2023).
[67] Presumably, requests for forward-looking information will be included in the IPAY 2028 Data Elements information collection request, which CMS has not yet released. In the IPAY 2028 draft guidance, CMS describes examples of potential forward-looking market data in the IPAY 2028 draft guidance, which could include: "(1) the manufacturer's annual forecast of U.S. net revenue, volume by indication, and net pricing for the selected drug itemized by the relevant market channel (e.g., Medicare, Medicaid, commercial or other); and (2) an annual gross-to-net ratio trend for the selected drug across all market channels and market share percentages and volume, by indication." IPAY 2028 Draft Guidance § 50.1 (p. 104).
[68] SSA § 1194(e)(1).

data. In relevant part, the IRA authorizes CMS to collect from manufacturers of selected drugs "[m]arket data and revenue and sales volume data for the drug in the United States."[69] Market data does *not* include internal company projections about future revenues or sales volumes. This information is an estimate of conditions that may never actually occur. Congress clearly limited CMS to considering "market data," rather than projections. Given the uncertain nature of forward-looking market information, it would be entirely inappropriate for CMS to use this information as a basis for the price that manufacturers must offer to Medicare beneficiaries.[70]

Moreover, the legislative history of the IRA makes clear that Congress was well aware of the existence of forward-looking data and chose not to include it in the manufacturer-specific factors considered. Indeed, Congress considered incorporating "projected future revenues" into the market data that would be submitted by a manufacturer under section 1194(e)(1) in predecessor legislation to the IRA.[71] But, that language was removed in the very next version.[72] Thus, Congress made a deliberate choice to exclude any such information, likely recognizing the strong policy arguments against any such inclusion.

Importantly, manufacturers must not be compelled to provide highly confidential forward-looking statements as part of a submission that CMS has historically asserted could "give rise to liability, including under the False Claims Act."[73] By its nature, these forecast and trend projections are subject to change, and the accuracy of this information would inevitably be impacted by events outside of a manufacturer's control—due to, for example, federal and state regulatory schemes that impact drug pricing and marketing and competitor activities. Moreover, the disclosure of manufacturer forward-looking market data to CMS may implicate the securities laws and trigger disclosure obligations to shareholders. This raises questions about how CMS or other regulators would respond if a manufacturer's projections ultimately do not occur either due to changes in business strategy or events outside of the manufacturer's control.

III. CMS' New Position on Fixed Combination Drugs is Unsupportable under the Statute and Inconsistent with Federal Regulations and Long-Standing FDA Precedent and Approvals

A. CMS Has No Authority to Bundle Drugs Containing Two Drugs or Biological Products with "a drug" or "a biological product" for QSSD Purposes

The terms "active moiety" and "active ingredient" do not appear in the statute. As described

[69] SSA § 1194(e)(1)(E) (emphasis added).
[70] CMS, Medicare Monthly Enrollment, https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment.
[71] *See, e.g.*, Elijah E. Cummings Lower Drug Costs Now Act, H.R. 3, 117th Cong. § 1194(d)(1)(B) (2021).
[72] Build Back Better Act, H.R. 5376, 117th Cong. (2021).
[73] 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) Forms (CMS-10849, OMB 0938-1452), § H.

in AbbVie's prior comments to CMS IRA guidance, the IRA's definition of a qualifying single source drug ("QSSD") does not contemplate bundling different drug products as a single QSSD. Nonetheless, CMS has adopted an "active ingredient" / "active moiety" assessment for identifying QSSDs that goes well beyond a plain reading of the statute.

Within that framework, CMS has repeatedly adopted the definition of fixed combination product contained in 21 C.F.R. § 300.50[74] and has stated in its guidance that a fixed combination drug containing two or more active moieties / ingredients would be treated as its own QSSD: "If a drug is a fixed combination drug with two or more active moieties / active ingredients, the distinct combination of active moieties / active ingredients will be considered as one active moiety / active ingredient for the purpose of identifying potential qualifying single source drugs."[75]

However, in the IPAY 2028 Draft Guidance, CMS introduces a new standard for certain fixed combination products: "CMS acknowledges that there may exist fixed combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference."[76] CMS then provides an example: "An example might include the addition of active moiety / active ingredient X to a different active moiety / active ingredient Y, where active moiety / active ingredient X affects the bioavailability of active moiety / active ingredient Y but is not therapeutically active against the disease state that active moiety / active ingredient Y is indicated for. In this example, the addition of active moiety / active ingredient X does not result in a clinically meaningful difference."[77]

In direct conflict with the cited FDA regulation and CMS' established guidance, CMS asserts that "a drug" or "a biological product" for QSSD purposes not only includes all products from an individual sponsor containing the same "active moiety" or "active ingredient" but can also include some (but not all) fixed combination drugs that contain multiple distinct active moieties and active ingredients. CMS, in other words, has inappropriately expanded the clear statutory reference to "a drug" or "a biological product" (interpreted by CMS to mean a single active moiety/active ingredient) to now include a drug/biologic product that consists of "two or more drugs" (two different active moieties/active ingredients). Accordingly, any MFP applied to a fixed combination product where only one component is a selected drug exceeds CMS' authority, raises

[74] 21 C.F.R. § 300.50 identifies a fixed combination product where "Two or more drugs may be combined in a single dosage form when each component makes a contribution to the claimed effects and the dosage of each component (amount, frequency, duration) is such that the combination is safe and effective for a significant patient population requiring such concurrent therapy as defined in the labeling for the drug. Special cases of this general rule are where a component is added:
(1) To enhance the safety or effectiveness of the principal active component; and
(2) To minimize the potential for abuse of the principal active component."
[75] IPAY 2027 guidance § 30.1 (p. 169); IPAY 2026 guidance § 30.1 (p. 100).
[76] IPAY 2028 Draft Guidance § 30.1 (p. 13).
[77] IPAY 2028 Draft Guidance § 30.1 (p. 13).

significant constitutional and rule-of-law concerns and wholly disincentivizes the discovery of novel fixed combination therapies.

B. CMS Deviates from FDA's Fixed Combination Standard, Which Leads to Unpredictable and Inappropriate Outcomes

Departing from its IPAY2026 and IPAY2027 position, CMS introduces more ambiguity to its impermissible QSSD bundling policy by proposing a new set of rules for certain fixed combination drugs where one active moiety/ingredient affects the bioavailability of other active(s) but "is not biologically active against the disease state(s) the drug is indicated for." [78] CMS summarily concludes that these combinations "do[] not result in a clinically meaningful difference" without any examples or reasoned basis.[79] Such conclusion fundamentally misunderstands FDA's data and approval requirements for fixed combination drugs.

The FDC Regulation states that "[t]wo or more drugs may be combined in a single dosage form when *each component makes a contribution to the claimed effects* and the dosage of each component (amount, frequency, duration) is such that *the combination is safe and effective for a significant patient population requiring such concurrent therapy* as defined in the labeling for the drug."[80] In addition, the FDC Regulation includes "special cases" to this general rule when a secondary component contributes to a product's overall therapeutic effect through, for example, "enhanc[ing] the safety or effectiveness of the principal active component" or "minimiz[ing] the potential for abuse of the principal active component."[81] Accordingly, FDA's policy and practice on fixed combination drugs is grounded in the belief that the sponsor must prove that the combination of active ingredients offers a benefit greater than each active ingredient used alone at therapeutic doses but does not require each active component to be biologically active in the disease state.[82] Thus, each approved fixed combination drug, regardless of the mechanism of action

[78] IPAY 2028 Draft Guidance § 30.1 (p. 13). This phrase is ambiguous, especially in instances where the proposed combination treats a different indication than the single actives as separate monotherapies. Does CMS mean that the single active must be biologically active against the indicated disease as a monotherapy, or that the single active must be biologically active against the indicated disease proposed to be treated with the combination?
[79] IPAY 2028 Draft Guidance § 30.1 (p. 13).
[80] 21 C.F.R. § 300.50 (emphasis added) ("FDC Regulation"); *see also United States v. An article of drug*, 441 F. Supp. 105, 111 (D. Colo. 1977) ("The rationale for special treatment of combination drugs is that a single component of a drug may affect the other components, react with them, and enhance or reduce the total effect of the drug. Also, a combination of two generally recognized drugs may produce unexpected side effects thereby affecting the safety of the combination").
[81] 21 C.F.R. § 300.50; *see also* 80 Fed. Reg. 79776, 29786 *Fixed-Combination and Co-Packaged Drugs: Applications for Approval and Combinations of Active Ingredientd Under Consideration for Inclusion in an Over-the-Counter Monograph* (Dec. 23, 2015) [2015 Proposed Rule] (providing examples of special cases to include where one active ingredient is intended to "(1) Provide a direct effect that either potentiates or makes another active ingredient more tolerable, (2) minimize an adverse reaction associated with another active ingredient, or (3) reduce the abuse potential associated with another active ingredient").
[82] 2015 Proposed Rule at 79778; *see also Gillis v. QRX Pharma Ltd.*, 197 F. Supp. 3d 557 (Jul. 6, 2016) (FDA policy is to reject fixed combination drug products that do not offer some advantage over the single ingredients in terms of enhanced effectiveness, safety, patient acceptance, or quality of formulation).

of its active components, reflects FDA's determination that each active ingredient contributes a clinically meaningful benefit to the overall combination.[83]

CMS' new standard creates misalignment between how FDA classifies and approves fixed combination drugs and how they will be treated under the IRA. Representative examples of FDA approved fixed combination products that would not meet CMS' new criteria include:

- Ritonavir Combination Products: Protease inhibitors are a class of antiretroviral drugs used to treat viral infections by blocking protease activity and preventing the virus from maturing. AbbVie discovered that ritonavir increases the bioavailability of other antiretroviral drugs by inhibiting an enzyme (CYP3A) that can metabolize and render inactive protease inhibitors.[84] As a result, ritonavir is often co-administered to increase plasma concentration (e.g., enhance the pharmacokinetics) of the other active ingredient(s), ultimately providing a boosting effect of the principal active ingredient that is responsible for the antiviral effect. More specifically, ritonavir has been shown to be an essential component in combination products that treat a range of viruses including hepatitis C (TECHNIVIE, VIEKIRA XR, VIEKIRA PAK), and mild-to moderate COVID-19 (PAXLOVID).[85]

- Carbidopa Combination Products: Parkinson's disease is characterized by a deficiency of dopamine in the brain, particularly in the areas that control body movement. Levodopa is a dopamine precursor that can traverse the blood-brain barrier to deliver dopamine to the brain. But levodopa is quickly metabolized in the body, leaving only a small fraction available for transport to the brain. As a result, higher doses of levodopa are necessary for adequate therapeutic effect, which can lead to increased side effects such as nausea. Carbidopa inhibits levodopa from being converted to dopamine outside the brain, which reduces the amount of levodopa that must be administered to patients. Since the 1970s, carbidopa has been commonly approved in fixed dose combinations to potentiate levodopa's activity

[83] *See e.g.,* FDA, Guidance for Industry, *New Chemical Entity Exclusivity Determinations for Certain Fixed-Combination Drug Products* at 1 (Oct. 2014) (recognizing fixed-combination products "play an important role in optimizing adherence to dosing regimens and improving patient outcomes"); *see also* 2015 Proposed Rule at 79779 (FDA noting that fixed-combination drugs can, among other things, provide more convenience for patients, facilitate compliance with a prescribed regimen, and offer therapeutic benefits).

[84] *See* KALETRA Prescribing Information § 11 (Rev. 10/2020) ("KALETRA is a co-formulation of lopinavir and ritonavir. Lopinavir is an inhibitor of the HIV-1 protease. As co-formulated in KALETRA, ritonavir inhibits the CYP3A-mediated metabolism of lopinavir, thereby providing increased plasma levels of lopinavir.")

[85] *See e.g.*, TECHNIVIE Prescribing Information § 11 (Rev. 12/2019) ("TECHNIVIE is a fixed-dose combination tablet containing ombitasvir, paritaprevir, and ritonavir for oral administration…[consisting of] a CYP3A inhibitor (ritonavir) that inhibits CYP3A mediated metabolism of paritaprevir, thereby providing increased plasma concentration of paritaprevir."); PAXLOVID Prescribing Information § 12.1 (Rev. 10/2020) ("Nirmatrelvir is a severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) antiviral drug. Ritonavir is an HIV-1 protease inhibitor but is not active against SARS-CoV-2. Ritonavir inhibits the CYP3A-mediated metabolism of nirmatrelvir, resulting in increased plasma concentrations of nirmatrelvir.").

and make levodopa drugs more tolerable.[86] Although FDA has approved carbidopa alone, the approved labeling for this product states "LODOSYN (carbidopa) has no antiparkinsonian effect when given alone. It is indicated for use with carbidopa-levodopa or levodopa."[87]

- Trospium Combination Product: When dosed as a monotherapy, xanomeline is associated with significant adverse events due to its intolerable muscarinic effects.[88] FDA, however, recently approved the fixed dose combination of xanomeline tartrate and trospium chloride for the treatment schizophrenia.[89] FDA notes that "trospium has no known efficacy in schizophrenia and was added to attenuate the intolerable muscarinic effects reported in previous clinical trials of xanomeline alone."[90] FDA further states that "the combination of xanomeline and trospium has fewer anticholinergic adverse events than xanomeline alone, thus meeting the requirements of 21 CFR § 300.50 (fixed-combination prescription drugs for humans)."[91]

- Naloxone Combination Products: Buprenorphine, a partial opioid agonist, reduces craving and withdrawal symptoms associated with opioid dependence by activating opioid receptors in the brain to a lesser degree than full agonists like heroin or methadone. Naloxone, an opioid receptor antagonist, is used in combination with buprenorphine to reduce the abuse potential of buprenorphine following manipulation for purposes of abuse. As FDA has observed, "naloxone is intended to be inactive when the product is used as intended, sublingually….[but] naloxone is intended to produce aversive symptoms if the product is crushed and injected [to reduce the abuse potential of buprenorphine]."[92]

CMS should continue to defer to FDA's determination that each active component in an approved fixed combination drug has demonstrated its contribution to the drug product's claimed

[86] 2015 Proposed Rule at 79786.
[87] LODOSYN Prescribing Information (Rev. 2/2014).
[88] COBENFY (xanomeline tartrate and trospium chloride), NDA 216158, Integrated Review at 4 (Sept. 26, 2024) (where adverse events include nausea, vomiting, diarrhea, sweating, and excess salivation).
[89] COBENFY Prescribing Information § 12.1 (Rev. 9/2024) (The "efficacy [of xanomeline] is thought to be due to its agonist activity at M1 and M4 muscarinic acetylcholine receptors in the central nervous system. Trospium chloride is a muscarinic antagonist. Trospium chloride antagonizes the muscarinic receptors primarily in the peripheral tissues.").
[90] *Id.* at 15.
[91] *Id.* at 4.
[92] *See e.g.,* ZUBSOLV (buprenorphine hydrochloride; naloxone hydrochloride), NDA 204242, Cross Discipline Team Leader Review at 3 (June 12, 2013); *see also* SUBOXONE, NDA 20733, Division Director's Review of NDA and Basis of Action, at 6 ("It is permissible that a component be added to minimize the potential for abuse of the principal active component. In order to satisfy the requirements of the combination rule, approval under 21 CFR 300.50(a)(2) the naloxone component of SUBOXONE must be shown to minimize the abuse potential of the buprenorphine when intentionally self-administered intravenously").

effects. FDA is best positioned to conduct this assessment as it is engaged throughout the course of a product's lifecycle and reviews clinical data to determine that the combination is clinically meaningful to patients, and has patient benefits over-and-above each of the component drug parts alone.

CMS' new standard will result in substantial confusion around fixed combination drugs approved to-date. For example, it is unclear how CMS policy would align with FDA's orphan drug designation ("ODD") framework, which grants orphan designations based on the active moiety/ingredients. A fixed combination drug would have a separate ODD from any designation assigned to individual component parts, even if designated for the same rare disease or condition. Under CMS' new proposed policy, it is not clear if the combination and monotherapy products would qualify for the orphan drug exemption under the IRA given the multiple orphan designations.

In addition, CMS should apply FDA's standard equally to Part D and Part B drugs regardless of their reimbursement scheme. There is simply no basis to have different outcomes depending on whether a product is administered by a patient or a physician.

Finally, adopting CMS' ambiguous standard for the term "fixed dose combination" would significantly hinder drug product innovation. This is precisely what the current Administration has asked CMS to avoid when it ordered that CMS' guidance shall "minimize any negative impacts of the maximum fair price on pharmaceutical innovation with the United States."[93] Companies would be disincentivized from making new medicines or improving on existing ones, if one part of a subsequent novel drug combination containing two previously-approved active moieties is deemed by CMS not to be "biologically active against the disease state(s) the drug is indicated for" and thus does not result in a "clinically meaningful difference." The impact would be devastating for patients. As noted above, there are several examples of combination products approved today that would not meet CMS' standard for a distinct QSSD. This is particularly the case if one of the actives is approved more than 7 (small molecule) or 11 (biologic) years prior to launch of the combination—the result is that the otherwise novel combination would be immediately subject to the MFP of the drug with the single active, thereby wiping out any incentive to bring patient-centric products to market.

IV. CMS Approach to Manufacturer Meetings Is Arbitrary

CMS continues to apply arbitrary and inconsistent limits to manufacturer DPNP meetings. CMS has again fallen short in its Draft Guidance of establishing any semblance of a genuine negotiation process. The format and content of any meetings continue to be made at CMS' discretion, including for example, how many pages of materials may be shared, the number of people allowed to attend, and the limited two-hour length of each meeting. CMS appears to be

[93] 90 Fed. Reg. at 16442 (Section 3).

moving even further away from a meaningful process or affording manufacturers adequate procedures. In a process in which manufacturers already lack visibility to CMS' standards, methodologies and applications in making pricing determinations, the continuation of one-sided discretionary terms for meetings, with no manufacturer input, only reinforces that the contract CMS seeks to impose is akin to a contract of adhesion that lacks even the most basic accommodations for manufacturers' reasonable requests.

V. CMS Should Reconsider its Proposal to Publish the List of Negotiation-Eligible Drugs

The IRA requires CMS to publish a list of the selected drugs by "February 1 of the year that begins 2 years prior to" the start of each IPAY.[94] In a departure from that statutory requirement and CMS' practice with respect to previous IPAYs, the IPAY 2028 Draft Guidance states that CMS intends to publish "a list of the up to 50 top negotiation-eligible drugs (including the up to 15 selected drugs) ranked by combined Total Expenditures under Part B and Part D."[95] CMS should reverse course on this proposed publication. First, the IRA directs the publication only of those drugs that *have been selected* rather than the full list of drugs considered "negotiation-eligible." CMS does not suggest there is any ambiguity in the statutory provision directing publication of only selected drugs, and CMS identifies no justification for departing from the plain language of the statute.

Notwithstanding the lack of statutory authority for publishing a list of up to 50 top negotiation-eligible drugs, there are other considerations that are threatened by premature publication. Most importantly, publication could negatively impact patient access to those medications by spurring Part D plans to consider shifting patients off drugs anticipated for selection in future years. Indeed, as noted below, AbbVie is aware of Part D plans that are already considering such shifts for next year (CY 2026) for drugs that are selected for IPAY 2027.

Early publication of negotiation-eligible drug lists also threatens to put a finger on the scale for selection in future years, subjecting drugs to MFPs that may otherwise not have been captured. There will be particular pressure to select in a future price applicability year those products that have appeared publicly on a negotiation-eligible drugs list, regardless of whether the publicized list remains accurate or is relevant in future years, for example, given changes in market data or eligibility. This is particularly the case because generic drugs and biosimilars that reference those innovator products will be less likely to come to market.[96] CMS' premature publication of up to 50 drugs will inevitably deprive those drugs of both the opportunity to exit the DPNP based on generic and biosimilar competition and the opportunity to have selection delayed based on a delay

[94] SSA § 1191(b)(3).
[95] IPAY 2028 Draft Guidance § 30 (p. 9).
[96] *See* IQVIA *Assessing the Biosimilar Void in the U.S.* at 17 (Feb. 3, 2025), https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/assessing-the-biosimilar-void-in-the-us.

under the Special Rule to Delay Selection and Negotiation of Biologics for Biosimilar Market Entry. Indeed, Congress has consistently recognized the importance of generic and biosimilar competition in providing access to lower-priced follow-on products and increased competition and has sought to incentivize development and marketing of those products, including through regulatory exclusivities for first-to-market generic drugs and interchangeable biosimilars.

AbbVie encourages CMS to recognize the important policy considerations that counsel against premature publication of a list of negotiation-eligible drugs. Congress specifically directed that CMS publish drugs that *had been selected*—not those that might be in the future; CMS should heed Congress' direction.

VI. CMS Is Not Properly Accounting for the Unique Challenges of Adding Part B Drugs to the IRA

The IPAY 2028 Draft Guidance does not properly account for the unique challenges of adding Part B drugs to the DPNP. Part B and Part D drugs are often fundamentally different types of products and claims for Part B and Part D drugs are entirely different and difficult to reconcile. CMS should take care that its inclusion of Part B drugs in the DPNP considers the distinctive attributes of Part B drugs, including how such drugs are billed and reimbursed. For instance, many Part B drugs have unique attributes that CMS should consider when determining their pricing or other metrics under the IRA. Importantly, Part B drug utilization and adherence is also fundamentally inherent in claims data, where it is not for a Part D drug. AbbVie requests that CMS conduct a drug-specific analysis, which at a minimum considers a drug's prescribing information, treatment landscape, and the appropriate timeline to fully and accurately capture utilization trends. For example, some Part B products could require multiple years of data to properly assess the onboarding, titration, and maintenance phases of treatment, in order to accurately compare the drug to potential therapeutic alternatives.

AbbVie urges CMS to carefully consider the operational complexities of adding Part B drugs to the DPNP and provides specific recommendations below.

A. The Draft Guidance Does Not Propose a Robust Methodology to Calculate a 30-day Supply Equivalent, Particularly for Part B Drugs

AbbVie appreciates that the Draft Guidance recognizes there are "drugs for which a 30-days' supply is not representative of the typical use of such drug," and requests comments on an "alternative approach to negotiating a single price for the selected drug. [97] However, the issue is not limited to just drugs for which a 30-day supply is not representative, but also impacts comparisons between Part B and Part D drugs, for which the Draft Guidance fails to provide an appropriate methodology, particularly for Part B drugs. As CMS is aware, the 30-day supply

[97] IPAY 2028 Draft Guidance § 60.1.

equivalent is a key part of the DPNP—used in calculating the initial offer (and counteroffers), the price of any therapeutic alternatives, and the ceiling price for a selected drug; thus, failure to provide a robust methodology severely impacts the process.

As a result, comparing the 30-day supply of Part B and Part D drugs in the way that CMS contemplates in section 60 of the IPAY 2028 Draft Guidance will distort the value that CMS calculates based on a 30-day supply of the drug.[98]

CMS has long recognized that Part B drugs are unique from Part D drugs. For example, a 2006 MLN Matters Article provides that Part B typically covers drugs that are not usually self-administered and are furnished and administered as part of a physician service.[99] Because Part B and Part D drugs are billed differently and have different claims data (i.e., Part B claims data versus Part D prescription drug event data), comparing the 30-day supply for each could lead to unequal comparisons, as well as significant operational complexities when combining data and calculating the initial offer and MFP for drugs that are administered both under Part B and Part D. For example, a drug might be billed under Part B while the patient is onboarding onto the drug (e.g., physician-administered at induction), but then administered under Part D during later stages (e.g., self-administered at maintenance), depending on the stage of the patient's journey. This will further complicate CMS' ability to calculate the 30-day supply used in setting the initial offers (and counteroffers), the price of therapeutic alternatives, and the ceiling price for a selected drug.

One of the key differences between Part B and Part D claims is that facilities bill Part B drugs according to the actual administration of those drugs, but for Part D drugs, a patient is dispensed the supply of drug by the pharmacy, and the patient takes the drug in accordance with his or her prescribed treatment regimen. For example, a patient may be administered their Part B drug that is typically administered on a weekly basis, but then due to, for example, traveling or experiencing an adverse effect, the patient may skip over a week and not receive their next dose of the Part B drug until two weeks later. In contrast, a delay or a skipped dose might not be apparent for a Part D drug, because the pharmacy bills when it dispenses—e.g., 30 pills—not each time a patient takes a pill. This would result in a situation where the patient had fewer administrations under Part B, distorting what constitutes a 30-day supply and thus undervaluing this Part B drug relative to a potential Part D counterpart.

Moreover, CMS provides that it will use the "days between service" amount calculated for each Part B claim to calculate the 30-day equivalent supply. If the "days between service" is less than or equal to 34, then the number of 30-day equivalent supplies will equal one. If the "days

[98] IPAY 2028 Draft Guidance at § 60.1 (p. 109), § 60.2.1 (p. 112), § 60.3.2 (p. 131), § 40.4 (p.153).
[99] CMS, Related MLN Matters Article # SE0652 (Aug. 8, 2006), https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA0652.pdf; *see also* Medicare, Prescription Drugs (Outpatient) (explaining that "[u]sually, Part B covers drugs you wouldn't typically give to yourself, like those you get at a doctor's office or in a hospital outpatient setting"), https://www.medicare.gov/coverage/prescription-drugs-outpatient.

between service" is greater than 34, then the number of 30-day equivalent supplies will be equal to the days between service divided by 30.[100] AbbVie believes this will inappropriately undervalue some drugs and overvalue others. Moreover, CMS' proposed methodology fails to provide clarity on how fixed treatment interval therapies will be evaluated in comparison to treat-to-progression therapies.

CMS has acknowledged the need to develop a methodology for calculating a 30-day supply equivalent for all formulations of selected drugs and therapeutic alternatives, but it has not developed a robust process for doing so. Any methodology should be flexible to accommodate the clinical disease state and treatment landscape, and account for differences in titration and onboarding versus maintenance dosing, as well as to account for treatment-free intervals.

B. CMS Should Limit the Impact of MFP on ASP

The IRA incorporates drugs payable under Part B into the DPNP starting for IPAY 2028, but the Draft Guidance remains silent on the impact—if any—of the MFP that CMS sets for a Part B selected drug on the selected drug's Average Sales Price ("ASP") calculation. The IRA itself is also silent on the impact of MFP on ASP calculation, and there are strong legal and public policy bases for not requiring manufacturers to include a selected drug's MFP in its ASP calculation, as we have previously explained in prior correspondence with CMS regarding the DPNP.

Including MFP in ASP calculations would have sweeping, detrimental impacts on provider reimbursement and patient access to selected drugs, extending far beyond the Medicare fee-for-service program – including in the majority of Medicare Advantage and commercial health plans that use ASP-based reimbursement methodologies. According to a May 2025 Milliman report titled, "Impact of the Inflation Reduction Act on Provider Payment and Patient Access to Care," provider reimbursement for negotiated Part B drugs will decrease by $56.3 billion over 10 years.[101] Reducing patient access and creating even more untenable reimbursement situations for providers by factoring MFP into ASP, including outside of Medicare, undermines the very purpose of the IRA with respect to Medicare Part B selected drugs. Past precedent confirms that CMS has the authority to make clear that MFP is not included in ASP. CMS should amend the regulatory definition of a "unit" to clarify that MFP units are not included in the ASP calculation.[102] This clarification would be consistent with the statute and would avoid unintended consequences for patients and providers associated with market-wide reductions in reimbursement for selected drugs. CMS could also promulgate regulations in the CY 2026 Physician Fee Schedule rule or other anticipated rulemaking to bring much needed clarity to this issue as soon as possible. Finalizing rulemaking in 2025 to clarify that the MFP is not included in ASP would allow CMS

[100] IPAY 2028 Draft Guidance § 60.2.1.1 (p. 113).
[101] Katie Holcomb et al., *Milliman Report: Impact of the Inflation Reduction Act on Part B Provider Payment and Patient Access to Care* at 3 (May 2025).
[102] SSA § 1847A(b)(2)(B).

to consider the viewpoints of providers and other stakeholders regarding this critically important question with potentially far-reaching impacts. For the reasons set forth above, CMS should clarify in final IPAY 2028 guidance and the CY 2026 Physician Fee Schedule rule, or other anticipated 2025 rulemaking, that MFP is not included in ASP. An alternative interpretation would have damaging market-wide impacts on providers, patients, and the healthcare system as a whole.

C. CMS Should Explore Alternatives to the MTF for MFP Effectuation of Part B Selected Drugs

AbbVie opposes CMS' intent to carry over the flawed Medicare Transaction Facilitator ("MTF") construct to Part B selected drugs. As explained above, the addition of Part B drugs to the DPNP carries unique challenges that CMS is not properly accounting for. Indeed, stakeholders, including providers and patient groups, have expressed significant concerns with the entry of Part B drugs in the DPNP. For example, because Part B provider reimbursement will be tied to the MFP,[103] the dramatic reduction in reimbursement is expected to lead to "practice-ending shifts" that may make it financially impossible for independent physicians to provide Part B drugs, such as advanced cancer therapies, to patients in need.[104] If CMS were to carry over the MTF construct to Part B, providers would also face new administrative burdens and delays before they could access the MFP. Given these risks and the impact on patient access, there is strong support for federal legislation that would effectuate the Part B MFP by keeping provider payments at ASP + 6% and requiring manufacturers to pay a rebate to CMS instead of putting providers in the middle.[105]

Against this backdrop, AbbVie encourages CMS to explore alternatives to the MTF that could mitigate the IRA's impact on Part B providers and patients. For example, CMS could consider expanding the role of Medicare Administrative Contractors ("MACs"), which have administered Part B fee-for-service claims for decades. MACs have an established network and existing dataflows with CMS and Part B providers, obviating the need for new systems and agreements across the supply chain. CMS also could encourage the development of private market solutions, which could potentially facilitate MFP access for Part B drugs under fee-for-service and Medicare Advantage, at no added cost to the federal government.

Any MFP effectuation solution for Part B drugs—whether the MTF or an alternative—must also effectively prevent duplication of the MFP and the 340B ceiling price, consistent with the statute's explicit nonduplication requirement.[106] To the extent a rebate model (as discussed below) is not available, AbbVie requests that CMS leverage and expand on the "JG" and "TB"

[103] SSA § 1847A(b)(1)(B).
[104] AJMC, Community Oncology Bracing for IRA Impact (May 31, 2025), https://www.ajmc.com/view/community-oncology-bracing-for-ira-impact.
[105] Barrasso, Burgess Bill Protects Medicare Part B Patients (Sep. 13, 2023), https://www.barrasso.senate.gov/newsroom-news-releases-barrasso-burgess-bill-protects-medicare-part-b-patients/.
[106] SSA § 1193(d).

claim modifiers, which the agency uses to identify 340B units that are excluded from the Part B inflation rebate calculation.[107] However, given that the Part B inflation rebate is limited to fee-for-service, CMS should expand the 340B claim modifier requirement to extend to all MFP-eligible claims. Additionally, it is critically important that CMS use all available authorities to enforce use of 340B claim modifiers and ensure compliance with the 340B nonduplication requirement. Moreover, accurate and timely identification of 340B claims will benefit all stakeholders, as it will facilitate timely effectuation of the MFP and reduce the potential for disputes about whether the 340B price or MFP is due on a given claim.

D. Part B "Total Expenditures" Must be Limited to Expenditures Paid Under Part B

For Part B selected drugs, the IRA limits "total expenditures" to expenditures that are paid under Part B of the Title XVIII of the Social Security Act. Specifically, the IRA directs CMS to rank and select negotiation-eligible drugs based on their "total expenditures . . . under parts B and D of title XVIII."[108] Part B drugs "total expenditures" are further defined as follows:

> The term "total expenditures" excludes, in the case of expenditures with respect to part B of such title, expenditures for a drug or biological product that are bundled or packaged into the payment for another service.[109]

The IPAY 2028 Draft Guidance provides that "CMS will determine Total Expenditures by using Part B claims data to calculate total allowed charges (meaning the amount that is inclusive of the beneficiary coinsurance and Medicare payment for the covered Part B item or service)."[110] AbbVie interprets the Draft Guidance to mean that CMS will correctly determine Part B total expenditures using data from Part B fee-for-service claims. This is the only methodology that complies with the statute's limitations to expenditures that are paid "under[] Part B."[111]

If CMS were to include in Part B "total expenditures" drugs that are paid under Medicare Advantage, that approach would be in direct conflict with the statute, which permits the agency to consider only payments made "under Part B" for a selected drug, not payments made under Medicare Advantage plans, which is Part C of the Medicare statute. Section 1851(a)(1) of the SSA, the first provision in the Medicare Advantage statute, makes clear that Part B does not include Part C by clearly distinguishing Part B from the Medicare Advantage (previously called Medicare+Choice) Program. In relevant part, section 1851(a)(1) states that "each Medicare+Choice [MA] eligible individual… is entitled to elect to receive benefits… under this

[107] 42 C.F.R. § 427.303(b).
[108] SSA §§ 1192(d)(1), 1192(b)(1).
[109] SSA § 1191(c)(5) (emphasis added).
[110] IPAY 2028 Draft Guidance § 30 (p. 8), n. 6.
[111] SSA § 1192(b)(1).

title—(A) through the original [M]edicare fee-for-service program under parts A and B, or (B) through enrollment in a [MA] plan under this part [Part C]."[112]

Medicare Advantage units must be excluded from Part B "total expenditures" also because they are not separately payable, as the statutory definition of Part B total expenditures requires; rather, CMS makes capitated payments to Medicare Advantage plans on a per member per month basis to cover plan costs of reimbursement for the full range of inpatient, outpatient, and provider-based services covered under Part C. If Congress intended for "total expenditures" to include units of Part B drugs furnished to Medicare Advantage enrollees, it would have said so, the way that it did in the definition of MFP-eligible individuals.[113] In particular, the same statutory provision that defines "total expenditures"—section 1191(c) of the SSA— also defines the term "maximum fair price eligible individuals." So, although the statutory definition of "total expenditures" does not expressly address Medicare Advantage expenditures, the context and structure of the statute makes clear that a "maximum fair price eligible individual" "includes an individual who is enrolled in a [Medicare Advantage] plan under part C . . . if payment may be made under part B for such selected drug."[114] As evidenced by the inclusion of Medicare Advantage in the definition of an MFP-eligible individual—and the structure of the Medicare statute, more generally—Congress is explicit when it intends for references to Part B drugs to include when the drug is paid by a Medicare Advantage plan. CMS would be well outside its authority to include Medicare Advantage claims in Part B total expenditures. AbbVie encourages CMS to clarify in final guidance that Medicare Advantage claims are not included in Part B total expenditures.

VII. CMS Should Continue to Monitor Part D Formulary Inclusion of Selected Drugs

Since the Part D program's inception, CMS has required that Part D plans include "all or substantially all" drugs in the following six "protected classes:" immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics.[115] CMS instituted this policy because "it was necessary to ensure that Medicare beneficiaries reliant upon these drugs would not be substantially discouraged from enrolling in certain Part D plans, as well as to mitigate the risks and complications associated with an interruption of therapy for these vulnerable populations."[116] As CMS noted in the preamble to its 2019 final rule, this policy has

[112] SSA § 1851(a)(1) (emphasis added).
[113] SSA § 1191(c)(2)(B).
[114] *Id*.; *see also* IPAY 2028 Draft Guidance § 80 (p. 159).
[115] CMS, CMS Announces Course of Action To Identify Protected Classes of Prescription Drugs (Jan. 19, 2009), https://www.cms.gov/newsroom/press-releases/cms-announces-course-action-identify-protected-classes-prescription-drugs (referencing June 2005 policy).
[116] CMS, Medicare Prescription Drug Benefit Manual, Chapter 6, "Part D Drugs and Formulary Requirements," Section 30.2.5, https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/part-d-benefits-manual-chapter-6.pdf.

been codified in section 1860D–4(b)(3)(G) of the SSA.[117]

Under this policy, Part D plans are prohibited from imposing utilization management protocols, such as prior authorization and step therapy, with respect to a beneficiary's existing therapy that is a protected class drug.[118]For both existing and new beneficiaries, CMS prohibits Part D plans from "implement[ing] [prior authorization] or [step therapy] requirements that are intended to steer beneficiaries to preferred alternatives within these [protected] classes."[119] CMS reconsidered and affirmed this position in 2019, stating that "the risks associated with inappropriately interrupting therapy for stabilized patients receiving protected class drugs for protected class indications by potentially subjecting them to [prior authorization] or [step therapy] requirements outweighs the potential clinical benefits that some enrollees could gain from switching therapies that might be more appropriate and the potential cost savings that would accompany the additional formulary management flexibility."[120]

In March 2025, AbbVie submitted a letter to CMS noting our concerns that incentives created by the IRA are spurring Part D plans to consider attempting to violate longstanding six protected class policy. Such action violates longstanding bipartisan protected class policy, could drive wasteful utilization of the health care system, and most importantly, could be devastating for patients who rely on these therapies.

In the Draft Guidance, CMS has acknowledged concerns that Part D plan sponsors could broadly shift access with respect to a drug selected for the DPNP after the drug has been announced as a selected drug, and that CMS will continue to monitor trends in formulary placement for selected drugs beginning after drugs are selected for an initial price applicability year. We support that monitoring and encourage CMS to: (1) pay special attention to protected class drugs when reviewing plan formularies as noted above; and (2) explicitly state to Part D plans that CMS will not approve a formulary that violates protected class policy.

Additionally, AbbVie is concerned that the MFPs imposed via the DPNP could further circumvent access to therapies in these classes, despite access being required through the Part D protected class policy. In late October of last year, the National Community Pharmacists Association ("NCPA") released the results of its survey of roughly 4,135 independent pharmacy owners and managers and found that under the IRA's DPNP, pharmacies will likely be waiting over 30 days for the manufacturer MFP refund payments for dispensing selected drugs, and the average pharmacy will have to underwrite over $27,000 every month waiting to be made whole

[117] CMS, "Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses," Final Rule, 84 Fed. Reg. 23832, 23834 (May 23, 2019), https://www.govinfo.gov/content/pkg/FR-2019-05-23/pdf/2019-10521.pdf.
[118] 42 C.F.R. § 423.120(b)(2)(vi)(C).
[119] CMS, Medicare Prescription Drug Benefit Manual, Chapter 6, "Part D Drugs and Formulary Requirements," Section 30.2.5.
[120] 84 Fed. Reg. at 23840.

from manufacturer refund payments.[121] Fifty-one percent of respondents say they are strongly considering not stocking selected drugs, and an additional 40 percent are somewhat considering not stocking selected drugs.[122] This would result in not only an access issue for selected drugs in protected classes, but also dangerous non-medical switching for patients that have achieved stability on their protected class therapies; thus rendering the existing regulatory requirement that plans cover "all or substantially all" therapies in a protected class futile, because placement on formulary is meaningless if patients cannot obtain the drug at the pharmacy counter. Therefore, AbbVie encourages CMS to consider a selected drug's protected class status when determining the extent of price controls it will impose on that drug. CMS should account for the impact its price setting will have on patient access at the pharmacy counter, particularly for drugs in these protected classes treating vulnerable patients.

VIII. CMS' Arbitrary Proposed Methodology for Determining Renegotiation Eligibility Fails to Provide the Clear, Transparent Standard that Manufacturers Need to Adequately Prepare for Addressing Material Changes in Selected Drugs

Starting in IPAY 2028, the IRA requires CMS to select drugs for renegotiation if they transition monopoly drug status.[123] CMS also may select drugs for renegotiation if a new indication is added or if there is a "material change" in any of the section 1194(e) factors, provided that CMS determines that renegotiation is "likely to result in a significant change" in the MFP.[124] The Draft Guidance states that to determine whether a new indication or a material change to a section 1194(e) factor is "likely to result in a significant change" in the MFP, CMS will consider: (1) the likelihood that the new indication or material change would result in a renegotiated MFP that represents a 15 percent or greater change relative to the current MFP upon engaging in renegotiation with the Primary Manufacturer; and (2) whether such a change in the MFP for the renegotiation-eligible drug would have a significant impact on the Medicare program.[125]

CMS' proposed methodology for selecting renegotiation-eligible drugs sets up a process that would exacerbate the agency's lack of transparency. The agency does not provide a methodology for—nor even generally explain—how it intends to determine whether renegotiation would satisfy the 15 percent threshold or how it will determine whether there is a significant impact on the Medicare Program—nor how the agency would analyze a material change that would significantly impact the Medicare Program potentially in an amount just shy of 15 percent. And, importantly, the Draft Guidance does not explain how these materiality calculations can possibly be kept from infecting the eventual "renegotiation." If the agency has already definitively determined that there will be a 15 percent impact on the program, how is the "renegotiation" to

[121] NCPA, Report for Fall Survey of Independent Pharmacy Owners/Managers Executive Summary at 1 (Oct. 2024), https://ncpa.org/sites/default/files/2024-10/NCPA-FallSurvey2024-ExecSummary.pdf.
[122] *Id.*
[123] SSA § 1194(f)(3)(A)-(B).
[124] SSA § 1194(f)(3)(C).
[125] IPAY 2028 Draft Guidance § 130.2.1 (p. 194).

result in anything less than a 15 percent change?

AbbVie urges CMS to establish a transparent and clear standard for reaching the determination that a selected drug should be subject to discretionary renegotiation.

CMS provides "illustrative examples" of circumstances that would lead to selection of a renegotiation-eligible drug, but all of the examples presuppose that the 15 percent threshold inquiry has or has not been satisfied—none demonstrate *how* CMS is determining that percentage.[126] For example, Table 12 of the Draft Guidance states what CMS would do if it determines that a change in a factor would result in a "renegotiated MFP [that] would likely decrease by 15% or more" or if "the renegotiated MFP would likely increase by 15% or more."[127] Critically, the Draft Guidance does not explain *how* CMS would determine whether a change in the section 1194(e) would result in a change in the MFP of at least 15 percent or have a significant impact on the Medicare Program. AbbVie strongly encourages CMS to revise its proposal, which risks establishing an entirely arbitrary process that purports to allow CMS to cherry pick drugs for renegotiation without any accountability.

Moreover, as mentioned above, it is entirely inappropriate for CMS to predetermine that renegotiation will result in an MFP change of 15 percent or more. Although CMS disclaims that the agency "does not presume that the result of a renegotiation will reflect these approximations,"[128] the process that CMS has established does just that. Congress directed CMS to establish a renegotiation process that is "consistent" with the process for originally "negotiating" a selected drug's MFP.[129] A fundamental requirement of the "negotiation process" is that the section 1194(e) factors form "the basis" for initial offers and counteroffers of the MFP.[130] If CMS enters the renegotiation process having already determined that the MFP will change by at least 15 percent, the agency will have a clear bias to drive the renegotiated MFP in the direction that formed the basis for its selection.

Finally, with no clear methodology, it is impossible for manufacturers to predict whether they may be discretionarily selected for renegotiation, making an already burdensome task of compiling information for submission even more difficult—with just 30 days between selection and the time a manufacturer must submit required information. Manufacturers will be unable to prepare data without an understanding of the criteria CMS intends to use to determine eligibility or any insight into how the renegotiation process will work. The 30-day period between selection and submission of the required information is vastly insufficient for a manufacturer to collect data

[126] IPAY 2028 Draft Guidance § 130.2.1, Table 12 (pp. 196-197).
[127] IPAY 2028 Draft Guidance § 130.2.1, Table 12 (pp. 196-197).
[128] IPAY 2028 Draft Guidance § 130.2.1 (p. 194).
[129] SSA § 1194(f)(4)(B).
[130] SSA § 1194(e).

and provide a meaningful and robust submission.

IX. CMS Should Utilize Existing Private Market Solutions for MFP Effectuation and Should Not Impose Barriers that Conflict with these Solutions

AbbVie has significant concerns with CMS' MFP effectuation guidance, which abdicates statutory responsibility for nonduplication of the MFP and 340B discounts while also imposing barriers to existing, commercial solutions. For years, manufacturers, health plans, and dispensers have had systems and data exchanges in place to implement statutorily-mandated and contractual discounts. AbbVie believes that CMS' proposals for MFP effectuation, including use of the MTF, are operationally complex and will be less efficient and more expensive than existing private market solutions. As explained above, the MTF is inappropriate and unnecessary for selected drugs paid under Part B fee-for-service, where the government could leverage existing data flows with manufacturers and providers. AbbVie respectfully requests that CMS explore alternatives to the MTF and refrain from imposing barriers to the stakeholders' existing systems through new complex requirements.

In response to CMS' request for comments on "potential private market solutions that could offer an alternative to the MTF,"[131] AbbVie strongly believes there are existing private market solutions that are more effective and efficient than the MTF.

As AbbVie previously commented to CMS, we initially supported the agency's proposal to spearhead an MTF, with the understanding that CMS would adopt a fair, rational, and non-arbitrary process to avoid illegally stacking MFP rebates on top of 340B discounts.[132] To date, however, CMS has provided minimal operational information on the challenging MTF build and has issued agreements that exacerbate our concerns by failing to grapple with key operational defects. The resulting system is unnecessarily complex and likely will be unworkable for manufacturers and other stakeholders. With 93.2 percent of independent pharmacies stating that they either will not (or are considering not to) stock selected drugs,[133] it is critical that CMS seriously consider alternatives to the MTF. Indeed, AbbVie is already aware of dispensing entities that are concerned with cash flow issues and accommodating a new administrative reimbursement system with the MTF.

There are already existing data flows between manufacturers, health plans, and dispensers, and the parties are accustomed to exchanging this data to provide statutorily-mandated and

[131] IPAY 2028 Draft Guidance § 40.4 (p. 54).
[132] *See, e.g.,* AbbVie Comments on the Draft MTF Agreements, https://www.cms.gov/files/document/mtf-agreement-public-comments.pdf.
[133] NCPA News Release: *NCPA to CMS: A Third of Independent Pharmacies Won't Carry Drugs in the Negotiated Price Program, and 60 Percent More are Considering Dropping Out* (Jan. 27, 2025), https://ncpa.org/newsroom/news-releases/2025/01/27/ncpa-cms-third-independent-pharmacies-wont-carry-drugs-negotiated.

contractual rebates and price concessions as required throughout the supply chain. Stakeholders should be able to utilize these existing data flows to effectuate the MFP. Manufacturers already receive data from health plans, and the development of a new data system is not necessary to ensure that eligible individuals receive access to the MFP. For example, for Part D selected drugs, pharmacies could adjudicate medicines at the MFP so that the patient accesses the discounted price at the pharmacy counter. If the patient's health plan is required to send applicable claims-level data to the manufacturer, the manufacturer could then pay rebates directly to the plan, e.g., on a weekly basis, removing the need for the pharmacy to participate in the MTF. Relying on existing data flows between parties would mitigate concerns from pharmacies and other dispensers, including that they may not have the ability to reconfigure their internal claims systems to support MFP effectuation processes. Today, pharmacies and dispensing entities are not typically paid by manufacturers, but rather by CMS and plans. And manufacturers can reconcile statutorily-mandated price concessions independently without involving pharmacy economics. For example, with respect to the Part D Coverage Gap Discount Program and its successor, the Manufacturer Discount Program, CMS makes advance payments to Part D sponsors to effectuate manufacturer discounts.[134]

The MTF requires pharmacies to establish new payment reconciliation processes to receive the MFP refund amounts from manufacturers for the eligible drugs, which is complex and time-consuming for pharmacies, and presents high risk of error. Moreover, the MTF could result in slow and/or insufficient reimbursement to pharmacies. Manufacturers and health plans have sophisticated processes in place to exchange data and reconcile financial transactions while allowing the patient to access the appropriate drug price at the pharmacy counter. AbbVie requests that CMS not interfere with existing private market solutions that are sufficient for MFP effectuation and substantially less burdensome to stakeholders than the MTF. Utilizing these private market solutions could also save time and money for the federal government by eliminating the need to enter into MTF DM User Agreements with manufacturers and pay for the implementation of the MTF system. Additionally, it is crucial for CMS to consider more efficient systems, in light of the complexities associated with forthcoming Part B MFP effectuation.

While the MTF concept was well-intentioned, it has now become clear it will be unworkable. AbbVie strongly urges CMS to change course rather than expanding the MTF's role to Part B selected drugs.

X. Utilization of Rebate Models to Identify 340B Duplication Should Be Prioritized for Manufacturers of Selected Drugs

AbbVie appreciates CMS' consideration of ways to incorporate asynchronous 340B data into MTF processes in the future to help avoid duplication of the MFP and the 340B ceiling price

[134] 42 C.F.R. § 423.2320; SSA § 1860D-14C.

defined in section 340B(a)(1) of the Public Health Service Act ("PHSA").[135] Under the IRA, when a selected drug is administered to a Medicare patient of a 340B covered entity, the manufacturer is required to provide access to the lower of (1) the drug's MFP or (2) the drug's 340B ceiling price—but not both.[136]

CMS states that it will not, at this time, assume responsibility for nonduplication of discounts between the 340B ceiling price and MFP.[137] As we have repeatedly emphasized in prior letters to the agency, in failing to establish a mechanism to prevent duplication of the MFP and 340B ceiling price, CMS has ignored its obligation to comply with the statutorily-required pricing and nonduplication provisions of the IRA and left manufacturers in the untenable position of lacking access to the data necessary to provide such access. Moreover, the lack of a clear and transparent process for nonduplication introduces significant inefficiencies, including the increased risk of disputes over the applicable price for a particular unit. Not only could these disputes delay payments to covered entities and pharmacies, but they also would financially burden federal oversight and dispute resolution processes.

However, AbbVie believes that there are effective private market solutions to prevent duplication of discounts between the 340B ceiling price and MFP. As an example, certain manufacturers have proposed or implemented 340B Rebate Models to effectuate the IRA's nonduplication provisions. Under a Rebate Model, a manufacturer would offer a 340B rebate to a covered entity upon receipt of limited claims-level data requested from the covered entity that verifies that a claim is 340B-eligible. The Rebate Model would provide manufacturers of a drug subject to an MFP with data and tools to efficiently identify 340B claims and make available the lower of the MFP or the 340B ceiling price (as applicable), within CMS' 14-day payment window for providing an MFP. Even though it is clear from the statute's text that manufacturers may effectuate 340B ceiling prices through rebates,[138] when certain manufacturers informed the Health Resources and Services Administration ("HRSA") of their intention to implement a Rebate Model, HRSA took the position that rebate models are inconsistent with the 340B statute and threatened to expel the manufacturers from the Medicare Part B and Medicaid programs. This extraordinary step would jeopardize patient access to medications under these programs.

Now that the Administration is considering moving the 340B program to CMS,[139] 340B/MFP nonduplication will be squarely under CMS' sole jurisdiction. The Administration states that one of the key drivers of moving the 340B program to CMS is to "increase operational

[135] IPAY 2028 Draft Guidance § 40.4.5 (p. 95-96).
[136] SSA § 1193(d).
[137] IPAY 2028 Draft Guidance § 40.4.5 (p. 96).
[138] PHSA § 340B(a)(1) (directing the Secretary to "enter into an agreement with each manufacturer of covered outpatient drugs under which the amount required to be paid (taking into account *any rebate or discount*, as provided by the Secretary) to the manufacturer for covered outpatients drugs . . . does not exceed" the ceiling price.") (emphasis added).
[139] HHS, Fiscal Year 2026 Budget in Brief at 27, https://www.hhs.gov/sites/default/files/fy-2026-budget-in-brief.pdf.

efficiencies," and we believe that at a minimum, that should include streamlining implementation and oversight of the MFP/340B nonduplication requirement. Accordingly, CMS should not stand in the way of private sector Rebate Models, which would be an effective and efficient means to mitigate the risk of 340B and MFP duplication. If HHS continues to prohibit Rebate Models, while also refusing to assume responsibility for nonduplication of discounts between the 340B ceiling price and the MFP, there is significant risk of statutorily-prohibited duplicate discounting occurring. Moreover, by bringing transparency to the 340B program and MFP effectuation process, Rebate Models could potentially result in cost savings to the federal government.

XI. Conclusion

AbbVie strives to ensure that continued innovation and patient interests are upheld through the implementation of the IRA. Therefore, for at least the reasons outlined above, we respectfully urge CMS to reconsider the IPAY 2028 Draft Guidance and to respond meaningfully to feedback submitted.

* * *

AbbVie appreciates this opportunity to provide input on this Guidance. If you have any questions, please feel free to contact Hayden Kennedy, Vice President, Global Policy and U.S. Access Strategies at hayden.kennedy@abbvie.com.

Sincerely,

Hayden Kennedy
Vice President, Global Policy and U.S. Access Strategies
AbbVie Inc.

AMCP
Optimizing medicine.
Improving lives.

June 26, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via regulations.gov

Re: Medicare Drug Price Negotiation Program Draft Guidance

Dear Administrator Oz:

The Academy of Managed Care Pharmacy (AMCP) thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to provide comments in response to the Medicare Drug Price Negotiation Program Draft Guidance.

AMCP is the nation's leading professional association dedicated to increasing patient access to affordable medicines, improving health outcomes, and ensuring the wise use of healthcare dollars. Through evidence and value-based strategies and practices, AMCP's nearly 8,000 pharmacists, physicians, nurses, and other practitioners manage medication therapies for the 270 million Americans served by health plans, pharmacy benefit management firms, emerging care models, and government health programs.

Downstream Impacts

AMCP recognizes the importance of efforts to make prescription drugs more affordable for Medicare beneficiaries. We urge CMS to continually and rigorously oversee the program's implementation and its broader effects to ensure that it does not unintentionally hinder innovation and the development of new therapies. CMS should monitor the downstream impact of the Medicare Drug Price Negotiation Program on innovation and drug development and take appropriate action as needed to ensure that the United States remains the leader in pharmaceutical innovation.

Part B Drugs

The IPAY 2028 round of negotiations will see a substantial expansion of the Medicare Drug Price Negotiation Program, adding drugs reimbursed under Medicare Part B. While Part D drugs are typically dispensed by pharmacies with well-established payment processes with health plans and pharmacy benefit managers (PBMs), Part B drugs are typically administered in clinical settings where providers purchase the drug up front and are then reimbursed using one

of several methodologies.[1] CMS should consider the potential unintended consequences of this new environment on providers and patients.

To improve patient access to negotiated drugs, provider participation must be encouraged. Providers would benefit from detailed implementation guidance specific to billing for Maximum Fair Price (MFP) for Part B drugs. CMS will need to delineate how providers submit claims for drugs subject to the MFP with updated coding and reconciliation protocols. Such guidance will help providers obtain timely reimbursement and will help to ensure continued patient access to their needed medications.

Because providers in smaller practices are unlikely to have a reimbursement department with direct access to CMS updates, CMS should proactively consider all options for disseminating timely guidance and MFP-related billing instructions to providers. This will enable them to bill correctly and avoid reimbursement denials or overcharges for patients. CMS should also ensure that technical assistance is available to smaller and rural practices that may encounter greater difficulty adapting to major billing changes.

AMCP is also concerned about the potential for providers to avoid stocking a particular negotiated Part B drug if their financial incentives don't align, such as if MFP reimbursement is less than the acquisition cost for the drug, there are narrow margins on the drug, or there are regional differences impacting the market. CMS can mitigate such potential disruptions to patient access by proactively monitoring provider participation rates, regional access patterns, and other patient access issues. CMS should also institute temporary transition payments or other safeguards during the early phases of implementation to facilitate provider uptake.

Renegotiation

AMCP recommends that CMS further define the operational details of renegotiation to clarify criteria, enhance transparency, and build patient engagement into the processes. CMS should ensure that the renegotiation process includes structured opportunities for public engagement such as listening sessions, comments, and other avenues for input. AMCP believes that a formal notice-and-comment process would allow new evidence to be considered and would give patients, clinicians, and other affected parties the opportunity to submit updated clinical data, real-world outcomes, and patient perspectives. An evidence-based approach is needed so that the program remains responsive to evolving therapies while protecting access to care.

Effectuation of the MFP

Effectuating the MFP is the most important piece of the puzzle in the Medicare Drug Price Negotiation Program as it allows payers and patients to benefit from CMS' negotiations. CMS must ensure that systems are transparent, accurate, and include patient safeguards. AMCP applauds CMS' ongoing development of the Medicare Transaction Facilitator (MTF) program and appreciates the additional operational details included in the draft guidance. AMCP believes that additional clarity is needed around transparency, accountability, and procedural safeguards

[1] https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/payment/part-b-drugs

to mitigate for circumstances when the MFP is incorrectly applied. Additionally, notification and refund processes are needed for when a patient is charged more than the MFP.

Conclusion

AMCP appreciates CMS' work to expand the Medicare Drug Price Negotiation Program to include Part B drugs, to clarify expectations, and to formalize criteria for renegotiations, all while focusing on patient input and real-world evidence. AMCP encourages CMS to fine tune its operational procedures, improve transparency, and incorporate additional safeguards. These additional refinements will result in additional savings as well as improvements in care, access, and outcomes.

AMCP appreciates your consideration of AMCP's concerns and looks forward to continuing work on these issues with CMS. If you have any questions regarding AMCP's comments or would like further information, please contact Vicky Jucelin, AMCP's Manager of Regulatory Affairs, at vjucelin@amcp.org or (571) 858-5320.

Sincerely,

Susan A. Cantrell, MHL, RPh, CAE
Chief Executive Officer

June 26, 2025

Chris Klomp
Deputy Administrator and
Director of the Center for Medicare
Centers for Medicare and Medicaid Services (CMS)
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: **Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028**

Dear Deputy Administrator Klomp:

The American Cancer Society Cancer Action Network (ACS CAN) is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions, which will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

We appreciate the opportunity to provide comments on the draft guidance for the Medicare Drug Pricing Negotiation Program. To date, five oncology drugs have been selected by CMS for negotiation. Based on CMS' implementation of the program, we anticipate additional oncology therapies will be included in the next round of negotiated drugs. Because access to medically appropriate oncology therapies are a critical component of cancer care, ACS CAN wants to ensure that patients benefit from negotiation in terms of greater affordability of medications and continued access to the best treatments.

We appreciate how CMS continues to actively engage patients and patient advocates in the negotiation process – seeking input and implementing many of the recommended changes. We also commend the agency's commitment to increasing the transparency of the process for all stakeholders.

ACS CAN is keenly interested in how the continuing implementation of the Medicare Prescription Drug Negotiation Program will impact cancer patients. We have shared our thoughts with CMS throughout the process. The following comments on this draft guidance builds upon those observations and recommendations.

30.1 Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028

CMS is proposing to broaden the definition of what it considers to be a single source drug for the purposes of negotiation. Specifically, the guidance proposes that two drugs could be considered the same single source drug for purposes of negotiation because the modified version of one drug has an active ingredient that is not "biologically active" in treating the disease.

If CMS moves forward with this proposal the drugs most likely effected will be combination drugs including subcutaneous (or "SubQ") versions of the original drug that include additional moieties/active ingredients. In cancer therapy subcutaneous drugs – those injected rather than infused – are increasingly preferred by patients for several reasons: the ease of administration – no long infusion times or the administration of ports; reduced travel time to receive treatment because patients are not limited to getting treatments at infusion centers; and potentially getting care at home. The FDA continues to approve SubQ versions of oncology drugs[1] and more are in the pipeline. We urge CMS to carefully consider whether this change in policy could discourage innovators from developing additional SubQ therapies that benefit cancer patients.

30.1.1 Orphan Drug Exclusion from Qualifying Single Source Drugs

The proposed guidance reiterates that CMS will exclude a drug or biological product that is designated as a drug for only one rare disease or condition. While cancer is the second-leading cause of death in the U.S., cancer is not just one disease. There are actually hundreds of unique cancers, making many of them rare diseases. As such, over half of recently approved oncology medicines have been designated as orphan drugs. While drugs with a single orphan designation and approval are exempt from negotiation, the protection is not extended to products with multiple orphan designations, regardless of the number of approvals. Congress clearly intended the orphan exemption to be tied to orphan approvals rather than indications, and the disqualification of drugs with multiple designations despite a single approval provides a powerful disincentive for drug sponsors to explore new, lifesaving uses in rare diseases.

While the orphan exemption of a drug previously exempt due to its single approval as an orphan drug is lost after any subsequent approvals is not in question under current law, the commencement of the time-based exemption has been disputed. ACS CAN believes that the current nine or 13-year exemption from negotiation should begin with the approval that leads to the loss of orphan exemption rather than the drug's original approval date.

40.4 Providing Access to the MFP in 2026, 2027, and 2028

CMS states that the requirement that the price used for Maximum Fair Price-eligible individual cost-sharing and benefit administration cannot exceed the applicable MFP (plus dispensing fees) helps to ensure that MFP-eligible individuals will have access to the MFP at the point-of-sale for selected drugs covered under Part D.

ACS CAN believes that one of the fundamental tenets of the Medicare drug negotiation program is making prescription drugs more affordable for Medicare beneficiaries. To this end, we urge CMS to carefully monitor whether beneficiary cost-sharing does indeed reflect the negotiated price, and that savings actually accrue to beneficiaries. Specifically, we encourage CMS to conduct and make public a quantitative analysis of the impact of negotiation on beneficiary out-of-pocket costs for prescription drugs as well as a qualitative analysis through a survey of beneficiaries taking the negotiated drugs to ascertain whether and to what extent savings were realized. ACS CAN would be happy to work with CMS on a comprehensive patient survey.

[1]National Cancer Institute. FDA approves injectable Nivolumab, an alternative to IVinfusion. Feb 19, 2025. Available from: https://www.cancer.gov/news-events/cancer-currents-blog/2025/fda-opdivo-injection

50.2 Evidence About Therapeutic Alternatives for the Selected Drug

CMS is prohibited by law from using comparative clinical effectiveness research that treats extending the life of an individual who is elderly, disabled, or terminally ill at lower value than the life of an individual who is younger, nondisabled, or not terminally ill. As CMS considers evidence about alternative treatments to the drugs selected for negotiation, ACS CAN appreciates the agency's continued commitment to not use evidence from comparative clinical effectiveness research or information from other sources that devalues the life of any beneficiary We also commend CMS for reaffirming its commitment to not use Quality Adjusted Life Years (QALYs) in its determinations.

For some cancer patients, medication therapy may not be curative but may still provide additional years of life that are valuable to the individual and their families. ACS CAN continues to strongly oppose any policy or practice that diminishes the value of life for individuals with cancer. We further oppose the use of QALYs to determine whether to provide coverage or to set patient cost-sharing for a given treatment. Doing so fails to consider the value an individual may place on the quality of life provided by a given treatment. As such, ACS CAN supports patient-centered care that reflects patients' treatment goals and preferences.

60.3.1 Identifying Indications for the Selected Drug and Therapeutic Alternatives for Each Indication

CMS is asking for input on the possibility and feasibility of considering health care services payable under Medicare Part A or Part B as potential therapeutic alternatives to the selected drug for future rulemaking. Specifically, CMS is asking whether there are specific cases where a health care service could be a relevant therapeutic alternative to a selected drug.

In the cancer space most medical services would not be considered therapeutic alternatives to selected drugs but rather first line or second line treatments. For instance, in the case of some breast cancers surgery might be the first line treatment followed by drug therapy. The treatments would work sequentially – one would not be a therapeutic alternative to another. It is possible that some palliative care services could be a therapeutic alternative to very late-line cancer therapy but, overall, this kind of approach would not necessarily work for cancer treatments. Before making a change of this kind, ACS CAN urges CMS to clarify what specific A/B services it would consider and provide public comment on that specific list.

60.3.3.1 Analysis for Selected Drugs with Therapeutic Alternative(s)

The proposed guidance indicates that as part of the process for considering comparative effectiveness of a drug selected for negotiation and its therapeutic alternative CMS will consider patient-centered outcomes, patient experience data, and caregiver perspectives. In addition, the agency will also consider the extent to which negotiated drugs and therapeutic alternatives address unmet medical needs. The guidance proposes CMS gather this information through both literature reviews and information submitted by manufacturers and the public including via patient focused events.

ACS CAN strongly supports the inclusion of patient and caregiver perspectives in CMS's decisions about the specific drugs subject to negotiation and potential therapeutic alternatives. Patients and caregivers have first-hand and unique knowledge of how the particular medicines they are taking affect their treatment and impact their quality of life. Their perspectives should play an important role in CMS's decisions.

60.4.1 Engagement with Primary Manufacturers and Interested Parties Prior to Initial Offers

The proposed guidance indicates that CMS will hold another round of patient meetings and clinical town halls as a means of collecting patient and clinician experience.

ACS CAN participated in three of the recent CMS patient meetings as well as the clinical town hall on the second round of negotiations. We thank CMS for the opportunity to share our views. These meetings were much improved over the initial round of the virtual patient town halls. The moderated format provided greater opportunity for patients and representatives of patient advocacy organizations to detail their experiences taking the medications identified for negotiation. We encourage you to continue these meetings for each round of negotiations, to broaden participation to include caregivers, and to provide participants with a full list of questions prior to the events.

We also recommend that CMS consider undertaking its own direct patient surveys or partner with advocacy organizations to survey a broad group of patients taking each of the drugs identified for negotiation. Earlier this year ACS CAN conducted its own online survey of cancer patients taking each of the oncology drugs identified for negotiation to collect patient experience data to share with CMS. The survey was designed to capture Medicare Part D-enrolled patient experiences related to making treatment decisions, the impact of treatment on daily life and well-being, and any challenges or barriers accessing treatment including nonadherence or lack of treatment. The survey findings – which we have shared with CMS – provided important insight about specific areas of concern patients have related to their particular drug including availability of alternatives, overall costs, barriers to accessing the drug, and impact on quality of life. We believe the information generated from these kinds of surveys would continue to be useful to CMS in its consideration and we urge you to collect this kind of information.

80. MFP-Eligible Individuals in 2026, 2027, and 2028

CMS is soliciting comments on how best to monitor MA plans' use of Part B step therapy (ST) practices to ensure compliance with program rules and any data or policy clarifications that may be needed for implementation.

ACS CAN commends CMS for its plan to monitor MA plan use of step therapy. We have been increasingly concerned about the misuse of utilization management (UM) techniques and the impact on access to cancer therapies. When used appropriately UM tools can help to protect patients by preventing unwarranted services or procedures. But frequently UM is a barrier to necessary care.

To fully understand the extent of UM use and potential misuse ACS CAN published an analysis in May 2024[1] examining the extent to which ST restrictions exist for certain drugs that treat breast cancer - cyclin-dependent kinase 4 and 6 (CDK 4/6) inhibitors. The CDK 4/6 class includes four drugs: Ibrance (which was included on the first list of negotiated drugs), Kisqali, Kisqali Femara co-pack, and Verzenio. While the study found that no plans explicitly require ST in the formulary design, many plans included ST embedded within their prior authorization criteria. Ibrance included ST requirements 23% of the time and ST requirements were dependent on treatment type.

[1] American Cancer Society Cancer Action Network. Step therapy in Medicare Part D oncology drugs. May 2024. Available from https://www.fightcancer.org/sites/default/files/acs_can_part_d_formulary_analysis_final.pdf

The likelihood of plans' increased use of UM and other formulary restrictions underscores the importance of a thorough and robust formulary review process. ACS CAN will be conducting another study of UM and the impact on cancer treatments and will share those findings with CMS.

While CMS reviews formularies for coverage, tier placement, and utilization management we urge you to make this information readily available to the public. And while CMS also conducts outlier tests across each area of review based on formularies among other Part D plans and best practice formularies, these outlier tests only capture differences among plans. We urge CMS to undertake a broader review across plans to identify potential systemic issues.

90.2.2 Centralized Intake System for Complaints and Disputes Related to MFP Availability and MTF Functionality

CMS proposes to establish a centralized system to address complaints and disputes related to MFP availability. CMS anticipates that the types of complaints it may get include reports that the MFP was not made available to beneficiaries.

We support CMS making available a system that provides an avenue for beneficiaries to direct complaints about the operation of the new negotiation system. We urge you to provide clear direction for beneficiaries on how to use the system including the types of complaints most appropriate to send. We urge you to require that all beneficiary inquiries be responded to in a timely manner, including information on any final resolution. We also ask that you establish a maximum allotted time for resolution of complaints brought by beneficiaries. CMS should also publish annually a report detailing the number of complaints filed by beneficiaries, the resolution of those complaints, and any action CMS has or will take in the future to amend its guidance/future regulations to address beneficiaries' concerns.

110. Part D Formulary Inclusion of Selected Drugs

The proposed guidance acknowledges that CMS is concerned that Part D sponsors may be incentivized in certain circumstances to disadvantage selected drugs by placing these drugs on less favorable tiers compared to non-selected drugs, or by applying utilization management that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs.

ACS CAN shares that concern. Part of the success of the negotiation program depends on whether beneficiaries actually realize savings while maintaining access to the drugs they need most. It would be unfortunate if insurer manipulation of formulary placement undermined the potential success of the negotiation program.

We are pleased that CMS has acknowledged the potential problems regarding formulary management and plans to monitor insurer actions. Given the increasing number of oncology drugs being subject to negotiation we urge CMS to be particularly rigorous in its review of plan formularies' use of UM tools for all drugs within a category and class for which there is an MFP drug.

Conclusion

Thank you for the opportunity to provide comments. If you have any questions or need additional information, please feel free to contact me directly or Kirsten Sloan, Managing Director, Public Policy at Kirsten.Sloan@cancer.org.

Sincerely,

Lisa L. Lacasse, MBA
President
American Cancer Society Cancer Action Network

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June 25, 2025

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicare Drug Price Negotiation Program Draft Guidance

To Whom It May Concern:

ADAP Advocacy is writing to express our grave concerns regarding the proposed guidance on the implementation of the Medicare Drug Price Negotiation Program ("Negotiation Program") established in Sections 11001 and 11002 of the Inflation Reduction Act (IRA; P.L. 117-169). As proffered, this guidance for the submission of proposed medications slated for price negotiations poses a significant risk to Persons Living with HIV/AIDS (PLWHA), as a majority of the life-saving medicines developed to treat the condition would currently qualify as drugs eligible for the Negotiation Program, despite the distinct risk that manufacturers may choose to remove medications from the U.S. market, rather than subject their companies to price negotiations.

While ADAP Advocacy's objections to the Negotiation Program's proposed implementation are several, our primary request is for the creation of a carve-out exemption for all medications used for the treatment of HIV/AIDS in the U.S. that would prevent these treatments from being eligible for any future Medicare price negotiations.

About ADAP Advocacy

ADAP Advocacy is a national 501(c)(3) non-profit organization whose mission is to promote and enhance the AIDS Drug Assistance Program (ADAP) and improve access to care for PLWHA. ADAP Advocacy is the only national grassroots organization dedicated exclusively to ADAP, ensuring that there are adequate resources nationwide to eliminate or prevent waiting lists for services. Our purpose is to better engage people living with HIV/AIDS by providing a platform whereby they can offer their personal experiences, challenges, knowledge, insight, and solutions to solving this perpetual problem. ADAP Advocacy has worked tirelessly to ensure that PLWHA in the U.S. can access the medications they need to achieve and sustain viral suppression, undetectability, and untransmissability (more commonly known as "U equals U").

The State of the HIV Drug Market

Since the 1980s, HIV treatment has advanced significantly, moving away from hard-to-tolerate, multi-pill regimens with relatively high treatment abandonment rates to the highly effective single-pill regimens that emerged in the late 2000s and early 2010s, with the introduction of Atripla (Gilead Sciences; efavirenz, emtricitabine, tenofovir disoproxil fumarate). Over time, single-pill regimens have largely replaced the need for multi-pill regimens except for patients with multidrug-resistant (MDR-HIV) strains of the disease. While single-pill regimens currently dominate the HIV treatment market in the U.S., only a few drug manufacturers make single-pill regimens in the U.S., which include Complera (Gilead), Odefsey (Gilead), Stribild (Gilead), Genvoya (Gilead), Delstrigo (Merck), Juluca (ViiV Healthcare), Dovato (ViiV), Triumeq (ViiV Healthcare), Symtuza (Johnson & Johnson), and Biktarvy (Gilead) (National HIV Curriculum, 2025).

Since 2020, HIV treatment has once again taken a significant step forward with the U.S. Food and Drug Administration (FDA) approval of the first long-acting agent (LAA) designed to treat PLWHA using a single injection either once every month or every other month. Cabenuva (ViiV Healthcare; cabotegravir; rilpivirine) is a first-of-its-kind all-in-one injectable treatment that reduces patients' pill burden and helps to improve compliance with treatment regimens. This advancement is likely to continue throughout the 2020s, with additional companies releasing LAAs, giving patients living with HIV/AIDS even greater choice to receive the medications that are right for them.

Medicare's Role in HIV/AIDS Drug Coverage

While Medicare Part B currently covers HIV screenings and many medical services, these life-saving HIV medications are currently covered under Medicare Part D. As of 2020, roughly 28% of PLWHA were covered by Medicare, making it the second-largest source of federal financing for HIV care and treatment in the U.S. (Dawson, et al., 2023). Dawson et al. found that 63% of Medicare spending in 2020 for beneficiaries living with HIV/AIDS was for Part D prescription drugs, and Part D spending for Medicare beneficiaries living with HIV/AIDS was 14 times higher than for beneficiaries without HIV/AIDS.

Approximately 77% of Medicare beneficiaries living with HIV/AIDS first qualified for the Medicare program based on disability, rather than age, compared to just 22% of the general Medicare population. Additionally, 61% of Medicare beneficiaries living with HIV/AIDS are dually enrolled in Medicare and Medicaid, with most being fully eligible for Medicaid services, including long-term care and supports. These patients are among the most chronically ill and have the highest costs.

Guidance on the Implementation of the Negotiation Program Threatens Continued Innovation and Treatment Availability

Each of the most popular single-pill HIV regimens used to treat PLWHA was approved by the FDA seven or more years ago. Dovato (ViiV; dolutegravir, lamivudine) was the most recently approved, receiving FDA approval in April 2019 (National Institutes of Health, 2025). Additionally, none of these medications currently have any approved generics commercially available in the U.S., making each of them eligible for potential inclusion in the Negotiation Program.

Beyond the single-pill regimens, several single-component HIV treatments remain on the market for which there are currently no generic alternatives, including seven (7) nucleoside reverse transcriptase inhibitors, three (3) non-nucleoside reverse transcriptase inhibitors, three (3) integrase strand transfer inhibitors, four (4) protease inhibitors, one CCR5 antagonist, one (1) attachment inhibitor, one (1) post-attachment inhibitor, one (1) capsid inhibitor, one (1) pharmacokinetic enhancer, and six (6) combination medications that serve as part of multi-pill regimens. Just three (3) of the individual drugs from this list of various HIV medication types have FDA approval dates within the seven-year window that would exempt them from inclusion in price negotiations.

The current and proposed structure of the Centers for Medicare and Medicaid Services' (CMS) price negotiations is such that drug manufacturers are required to accept or counter as a starting point for negotiation a Maximum Fair Price (MFP) that might be 75% or less than the market price, depending on how long the medication has been on the market. Should the manufacturer decide to counter, and CMS rejects the offer, the manufacturer then has just three more negotiation meetings before receiving a final offer from CMS. They must either accept, reject, and pay an excise tax to keep the entirety of their products on the Medicare market, or remove their products from Medicare altogether.

This process essentially leaves manufacturers in the unenviable position of having to choose between operating a business with the reasonable expectation that the products they produce—and upon which hundreds of thousands of PLWHA rely to stay alive—will generate enough profit to continue both operating and developing new therapies or exiting the market.

The number of manufacturers with HIV therapies under their respective drug portfolios has already dwindled over the last decade, as Bristol Myers Squibb, AbbVie, and Johnson & Johnson no longer operate in this space. Whereas it isn't uncommon for a manufacturer to exit a disease market, it is a business decision that unfolds over decades. The draft guidance will serve to exacerbate an already shrinking market for HIV therapies. CMS's so-called price negotiations do not resemble typical contract negotiations, essentially adopting a "take it or leave it" attitude toward manufacturers. This approach threatens to create a troubling trend whereby companies become unable to bring their drugs to consumers in a way that makes financial sense. The HIV space may further shrink, leaving patients with only a handful of options that may or may not work to treat their specific strain of HIV.

The Risk to PLWHA and the General Population

The primary risk facing PLWHA is that if manufacturers choose to exit the HIV space rather than continue to sell their medications with Medicare, patients may lose access to treatment. While treatment cessation for any disease state can cause serious complications, the nature of the HIV retrovirus is such that it can quickly mutate to develop resistance to a treatment regimen if that regimen is suddenly halted. This can create a strain of HIV that is multidrug-resistant, making the virus more difficult and significantly costlier to treat.

Beyond the risk of MDR-HIV for the patients directly impacted, when PLWHA lose access to their medications, risks to the general population increase, as well.

Much of the past decade in HIV advocacy has been dedicated to the scientific discovery that patients whose HIV is virally suppressed—meaning that the number of actively replicating HIV cells per milliliter has dropped below 50 or 20 copies/ml—are unable to transmit HIV to someone else through sexual contact. When patients lose access to the antiretroviral medications that help them achieve viral suppression and undetectability, they risk transmitting HIV with every sexual encounter, perhaps doing so with a newly multidrug-resistant strain.

With 28% of PLWHA relying upon Medicare to sustain viral suppression and undetectability, any threat to treatment adherence should be considered a threat as well to the general population.

Additional Concerns Related to the Negotiation Program

In addition to HIV-specific concerns, ADAP Advocacy also has the following specific concerns with the proposed implementation of the Negotiation Program:

1. How CMS will determine the MFP and initial offer to manufacturers remains frustratingly opaque.

   As set forth in 60.3, the methodology for determining the initial entails a process that is not and cannot be standardized from medication to medication due to multiple factors, including the availability and number of therapeutic alternatives—which may number from one alternative to dozens—and a series of calculations that are not made available to manufacturers until months after the MFP determinations are made.

   This fundamentally prevents manufacturers from making informed and reasonable counterproposals, thereby hindering them from fairly entering negotiations with the assumption that both parties are negotiating in good faith.

2. The definition of "selected drug" is overly broad.

   As set forth in 30.1, CMS indicates that it will include as a selected drug "...all dosage forms and strengths of a drug with the same active moiety and the same holder of a New Drug Application (NDA)." It also states that it will investigate whether the same manufacturer holds multiple NDAs for the same active moiety with non-identical names.

   This raises considerable concerns that multiple FDA-approved medications will be swept into CMS price-setting because they share an active moiety or ingredient, regardless of their indicated use. This would essentially invalidate the statutory 7-year age limit set by CMS, as many formulations receive secondary and tertiary FDA approvals over time, often under different trade names, and may represent a significant advancement for patients after efficacy is demonstrated in a different disease state from their original indication.

   Once again, this process will be largely opaque, leaving manufacturers with little to no recourse outside of years-long litigation to determine which of their products may be included in price-setting under the Negotiation Program.

3. Public comment periods on the entirety of the Negotiation Program's implementation have largely excluded patient input.

   CMS has long promised to incorporate the voices and opinions of patients with lived experience when developing administrative rules and policies, but has largely failed to make adequate efforts to *actively* engage patients in the process.

   The process of engaging patients in federal policy is admittedly not an easy one, in no small part because much of how legislative and administrative policy is crafted and written requires expert-level knowledge and understanding of the intricacies of the American healthcare system and its structure.

   It is well established that fewer than 1 in 5 U.S. adults are aware of healthcare costs before receiving care (Marken, 2024), and even fewer understand how those prices are calculated. While CMS is determined to lower the costs paid by Medicare for prescription drugs, there is little evidence that it has actively engaged with either manufacturers or consumers about how Wholesale Acquisition Costs or current market prices for medications are established. Moreover, few patients are even aware that payors, such as Medicaid, Medicare, ADAPs, and commercial insurers, engage in price negotiations with manufacturers at all. They are aware only of the prices they pay at the counter.

   This information gap means that a vast majority of patients are ill-equipped to comment knowledgeably on the implementation of the Negotiation Program, resulting in many not engaging in the public commenting process, even if they are aware of its existence.

   When patients are not directly engaged, public comment periods become little more than sounding boards for various stakeholders to submit comments that may or may not be used in the determination of final rules.

The utilization of Quality-Adjusted Life Years and similar cost-efficiency metrics continues to devalue the lives and humanity of people living with disabilities and older Americans. Our final concern is that CMS will utilize Quality-Adjusted Life Years (QALYs) and other cost-efficiency metrics to determine MFPs and initial offers. While QALYs have been used in other countries to determine whether or not drugs will be allowed on their markets, the basis for how QALYs determine "perfect health" fundamentally excludes the reality of living with one of many types of disabilities and scores treatments lower based on their ability to achieve a "perfect health" outcome.

A prime example of this is how "no problems walking" is used as a measure of "perfect health." While the basic assumption is that everyone should have no problems walking, the reality is that many people living with disabilities, chronic ailments, limb differences, or who are simply older Americans may *have* "problems walking." This does not mean that they are unable to function, unable to lead a fulfilling life, or that they experience life "imperfectly." It simply means that they fall outside the standardized metric of "perfect."

Should CMS incorporate QALY or similar metrics in their price calculations, Medicare beneficiaries—many of whom will qualify for Medicare due to a disability—may end up paying the price should drug manufacturers choose to reject CMS's offers and remove their drugs from the Medicare market.

Recommendations

In summary, ADAP Advocacy makes the following recommendations:

1. CMS should immediately make a **carve-out exemption** for all medications used for the treatment of HIV/AIDS in the U.S. *in order to* prevent harm to both persons living with HIV/AIDS and the general population;

2. CMS should implement a standardized Market Fair Price calculation methodology that replaces the methodology laid out in section 60.3 that is clear, transparent, and made available to manufacturers at the time the Market Fair Price is determined and when the initial offer is made to manufacturers;

3. CMS should revise its definition of "selected drug" as set forth in section 30.1 to ensure the inclusion of multiple formulations and strengths of medications is limited to ensure that price determinations and negotiations are made in good faith;

4. CMS should undertake an immediate patient engagement campaign prior to the implementation of the proposed guidance for the Negotiation Program to ensure that Medicare beneficiaries have a clear understanding of how the Program will directly impact them and to allow patients to provide meaningful feedback and opinions to help guide the program to better patient-centered outcomes; and

5. CMS should exclude any cost-effectiveness calculations that utilize biased and discriminatory metrics, including Quality-Adjusted Life Years and similar measures of medical intervention efficacy.

Thank you for allowing ADAP Advocacy the privilege of commenting on Medicare Drug Price Negotiation Draft Guidance for 2028, and we look forward to providing any additional comments or clarification should they be deemed necessary.

Respectfully submitted,

Brandon M. Macsata
CEO

BMM:mjh

June 26, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: "Medicare Program; Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program Draft Guidance; Comment Request," [CMS-4210-N]

Dear Dr. Oz:

On behalf of Advancing American Freedom, we are writing to file a comment in response to the Centers for Medicare & Medicaid Services' (CMS) proposed rule, "Medicare Program; Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program Draft Guidance; Comment Request." We are concerned with pricing structures that shift from a market-based approach and fail to specify transparent criteria for valuing medicines, which in turn worsens public health outcomes.

On April 15, the President signed "Lowering Drug Prices by Once Again Putting Americans First," a series of vague proposals to decrease drug prices.[1] The order calls for the development of a pricing plan by 2028, emphasizes the importance of accurate Medicaid rebate payments, and seeks to align manufacturer payments with drug value. We are concerned about its provision urging the Center for Medicare and Medicaid Innovation (CMMI) to develop a future Medicare payment model, given the CMMI's broad authority. With such broad authority, the costs and pitfalls within the pricing plan could negatively affect the people on a much larger scale.

The President's "Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients" policy was more worrisome.[2] The order's Initial Price Applicability Year 2028 (IPAY) guidance includes the aforementioned CMMI Medicare model testing (which can be done without further action in Congress). The Trump-Vance Administration reused the Biden-Harris definition of Qualifying Single Source Drugs, which leads to wasted money among drug manufacturers.[3] The IPAY guidance does nothing to boost orphan drug production and takes a more reserved approach toward orphan drug policies, which could leave those with rare diseases vulnerable.

Additionally, the Trump-Vance Administration is using the same price setting methodology as the Biden-Harris Administration, basing its Maximum Fair Price (MFP) on therapeutic

[1] https://www.whitehouse.gov/presidential-actions/2025/04/lowering-drug-prices-by-once-again-putting-americans-first/
[2] https://www.whitehouse.gov/presidential-actions/2025/05/delivering-most-favored-nation-prescription-drug-pricing-to-american-patients/
[3] https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf

alternatives, not necessarily on alternative drugs. The price setting creates uncertainty that risks market inefficiency and could contribute to shortages. Moreover, the alternatives used to set the MFP are left undefined ("therapeutic alternatives to the selected drugs, data related to unmet medical need, and data on impacts to specific populations, among other considerations").[4] Although naming a few factors, CMS ends the definition with the vague statement "among other considerations," which effectively allows any factors, including the artificially lowered prices of socialist European countries, to determine its pricing.[5] The uncertainty brought by these rules prevents drugmakers from making informed decisions about where to allocate future capital. In short, shifting from a market-approach to a regulatory one hinders drugmakers from adjusting to public health needs.

We expect this shift from a market approach to price controls to fail the American people. The economic value of a good or service is determined by the price it can fetch in the free market. Adam Smith,[6] whose writings were familiar to America's Founders, recognized this insight, noting:

> The things which have the greatest value in use have frequently little or no value in exchange; and on the contrary, those which have the greatest value in exchange have frequently little or no value in use. Nothing is more useful than water: but it will purchase scarce any thing; scarce any thing can be had in exchange for it. A diamond, on the contrary, has scarce any value in use; but a very great quantity of other goods may frequently be had in exchange for it.[7]

Nor was this insight original to Smith. Rather, it was put to paper after the investigations of the 16th-Century Scholastics of the School of Salamanca.[8] These Scholastics recognized that value depends largely on a combination of utility and scarcity as determined by those willing to pay. As Saint Bernardino of Siena wrote in 1591, "Water is usually cheap where it is abundant. But it can happen that on a mountain or in another place, water is scarce, not abundant. It may well happen that water is more highly esteemed than gold because gold is more abundant in this place than water."[9]

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[4] https://www.cms.gov/files/document/ipay-2028-draft-guidance-fact-sheet.pdf
[5] For more information see https://advancingamericanfreedom.com/say-yes-to-medicaid-reform/ (May 2025) and https://advancingamericanfreedom.com/aaf-the-biden-harris-inflation-reduction-act-ira-is-devastating-seniors/ (August 2024)
[6] See generally Adam Smith, An Inquiry into the Nature and Causes of the Wealth of Nations (London: 1776).
[7] Adam Smith, *The Wealth of Nations*, Book I Chapter IV. https://oll.libertyfund.org/titles/smith-an-inquiry-into-the-nature-and-causes-of-the-wealth-of-nations-cannan-ed-vol-1
[8] Alejandro A. Chafuen, *Christians for Freedom: Late Scholastic Economics*, 96-97 (San Francisco: Ignatius Press, 1986). See further discussion on the folly of government price setting in https://advancingamericanfreedom.com/aaf-comments-regarding-filing-of-proposed-rule-change-to-amend-the-nyse-listed-company-manual-to-adopt-listing-standards-for-natural-asset-companies/ (January 2024).
[9] *Id.*

Pharmaceuticals are expensive due to the exorbitant costs of research and development for drug production. Many socialist foreign governments have pursued policies that render their drug prices artificially low, rendering America's drug prices artificially high. The Administration recognized this by including a section in the "Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients" executive order entitled "Addressing Foreign Nations Freeloading on American-Financed Innovation," which instructs "The Secretary of Commerce and the United States Trade Representative [to] take all necessary and appropriate action to ensure foreign countries are not engaged in any act, policy, or practice… that has the effect of forcing American patients to pay for a disproportionate amount of global pharmaceutical research and development, including by suppressing the price of pharmaceutical products below fair market value in foreign countries."[10] We applaud that policy and call on the Administration to prioritize that approach, similar to its NATO strategy of convincing allies to meet defense spending goals and paying their fair share. However, the order's other provisions cancel out that section's benefits. Under a price control regime, pharmaceutical manufacturers will have insufficient funding to continue developing innovative medicines that save lives across America and around the world. By pressuring foreign nations to eliminate their own price controls, while declining to adopt them ourselves, America would experience both lower pharmaceutical prices and maintain the same standard of modern medical innovation we have come to enjoy.

We urge CMS to reform the 2028 IPAY guidelines in line with our recommendations.

J. Marc Wheat
General Counsel
Advancing American Freedom
Vice President Mike Pence, Founder

Paul Teller
Executive Vice President
Advancing American Freedom
Vice President Mike Pence, Founder

[10] https://www.whitehouse.gov/presidential-actions/2025/05/delivering-most-favored-nation-prescription-drug-pricing-to-american-patients/

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June 26, 2025

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Drug Price Negotiation Program Draft Guidance

Submitted via email to: IRARebateandNegotiation@cms.hhs.gov

Dear Deputy Administrator Klomp:

AHIP appreciates the opportunity to provide feedback on the Draft Guidance issued May 12, 2025, on the Medicare Drug Price Negotiation Program. AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to making health care better and coverage more affordable and accessible for everyone.

The Draft Guidance addresses important issues in the Negotiation Program, including the potential for drugs payable under Part B to be included starting in 2028. Our attached comments address various policy and operational issues associated with this change. For example, we highlight the need to consider Part B drug costs for enrollees in Medicare Advantage plans when determining which drugs to select for negotiation, and the process for ensuring providers have access to the maximum fair price for Part B drugs.

We also address other components of the Draft Guidance, including our support for CMS's continued flexibility on tier placement and utilization management requirements for selected drugs. To enhance competition and affordability, we include recommendations to allow additional flexibility for formulary substitutions for selected drugs when cheaper generics and biosimilars become available.

Thank you again for the opportunity to offer comments on the draft guidance. We look forward to continuing to work with CMS on prescription drug affordability.

Sincerely,

Mark Hamelburg
Senior Vice President, Federal Programs

AHIP Detailed Comments on Medicare Drug Price Negotiation Program Draft Guidance

30.1 Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028

In general, a qualifying single source drug is determined based on data aggregated across dosage forms and strengths of the drug. CMS will identify a potential qualifying single source drug using: 1) for drug products, all dosage forms and strengths of the drug with the same active moiety and the same holder of a New Drug Application (NDA), inclusive of products that are marketed pursuant to different NDAs; and 2) for biological products, all dosage forms and strengths of the biological product with the same active ingredient and the same holder of a biologics license application (BLA), inclusive of products that are marketed pursuant to different BLAs.

The draft guidance describes how CMS has identified potential qualifying single source drugs in prior price applicability years for "fixed combination" drugs, i.e., two or more drugs that are combined in a single dosage form. If a fixed combination drug has two or more active moieties/active ingredients, the distinct combination of active moieties/active ingredients has been considered one active moiety/active ingredient. Therefore, all formulations of this distinct combination offered by the same NDA/BLA holder are aggregated across all dosage forms and strengths of the fixed combination drug. Given that Part B drugs will first be eligible for inclusion in initial price applicability year 2028, CMS solicits comments on whether it should modify the fixed combination drug policy, including potentially grouping fixed combination drug products with products containing at least one but not all of the active moiety(ies)/active ingredient(s) into the same potential qualifying single source drug under Part B and/or Part D.

AHIP Comments: The statute mandates that CMS aggregate a drug across dosage forms and strengths, including new formulations, for maximum fair price (MFP) purposes. Nothing in the statute specifies that CMS aggregate by active moiety/ingredients. Just as CMS is not bound by the Food and Drug Administration's (FDA's) NDA and BLA enumeration system to define a drug, CMS is also not bound by the FDA's method of listing active moieties when determining how to aggregate a drug across formulations.

Given that CMS has clear discretion in how to approach this issue, there are various policy reasons why it should take an expansive approach to defining a single source drug for MFP purposes. A rigid approach that disaggregates fixed combination drugs into separate combinations unless they have identical active moiety/ingredients – even when some of those active ingredients or moieties are not biologically active (or "clinically meaningful") – provides a roadmap for drug manufacturers to evade the statutory requirements. Section 1192(d)(3)(B) of the Social Security Act is clearly concerned with the potential for product hopping, as it requires CMS to aggregate across varying forms of administration of the same active moiety, including extended-release versions, despite the fact they actually have clinically meaningful differences from immediate release versions. Thus, if CMS allows manufacturers to product hop out of the statutory requirements simply by adding a clinically meaningless active moiety or ingredient to a product, it would unduly penalize manufacturers who invest in clinically meaningful improvements such as extended-release formulations.

CMS should use the full discretion afforded by the statute in aggregating all formulations of fixed combination drugs as a single source drug except to the extent there are combinations of active moieties/ingredients that have clinically meaningful differences. This would allow a fixed combination drug formulation to be treated as a single source drug despite the existence of active ingredients or active moieties in one or more of the drugs that are not present in the other drug(s).

Moreover, should CMS aggregate extended release and other dosing formulations common in orally administered drugs but not aggregate the addition of hyaluronidase to administered drugs, CMS could inadvertently encourage a development shift toward administered drugs to avoid participation in the MFP process. We strongly encourage CMS to recognize the expansiveness of the formulation definition within statute and ensure that it is equally applied to oral drugs as well as administered drugs.

30.2 Identification of Negotiation-Eligible Drugs for Initial Price Applicability Year 2028

The draft guidance addresses the process CMS will use to identify Part B high-spend drugs eligible for negotiation for initial price applicability year 2028, the first year these drugs will be eligible to be selected for negotiation. CMS indicates that it will rely on Part B claims data to calculate the Total Expenditures under Part B for each qualifying single source drug during the 12-month applicable period. In general, Part B drugs and Part D drugs that are qualifying single source drugs will be ranked by combined expenditures, with CMS selecting up to 15 negotiation-eligible drugs with the highest Total Expenditures under Part B and Part D for negotiation for initial price applicability year 2028.

AHIP Comments: The draft guidance does not mention Medicare Advantage (MA) in the calculation of Total Expenditures under Part B even though MA covers more than half of all eligible Medicare beneficiaries. Failing to account for Part B drugs paid by MA plans would skew the ranking of high-cost drugs in the Medicare program. We encourage CMS to reflect Part B drug costs for MA enrollees in the final guidance. At the same time, such a process should not be implemented with any new data or reporting requirements for MA plans, consistent with the President's directives to reduce regulatory burdens. We request that CMS provide MA plans with an opportunity to comment on any process that CMS might intend to use to account for Part B drug costs of MA plans in Total Expenditures.

40.4 Providing Access to the MFP in 2026, 2027, and 2028

Section 1193(a) of the Social Security Act requires a Primary Manufacturer of a selected drug to provide access to the MFP to MFP-eligible individuals and dispensing entities. Beginning in 2028, Primary Manufacturers must also provide access to the MFP to hospitals, physicians, and other providers of services and suppliers with respect to MFP-eligible individuals who are furnished or administered a selected drug.

CMS states that access to the MFP must be provided by a Primary Manufacturer in one of two ways: (1) prospectively ensuring that the price paid by the dispensing entity or Part B provider

when acquiring the drug is no greater than the MFP, or (2) retrospectively providing reimbursement for the difference between the dispensing entity or Part B provider's acquisition cost and the MFP.

The draft guidance does not include detail on these requirements for Part B selected drugs. CMS indicates that it intends to align the policies and operations for providing access to the MFP for selected drugs payable under Part B with those for selected drugs covered under Part D. As part of that, CMS signals that the Medicare Transaction Facilitator (MTF) could be expanded to support MFP effectuation for Part B drugs. However, CMS solicits comments on potential private market solutions that could offer an alternative to the MTF and the extent to which interested parties perceive a need for ongoing MTF support over time.

AHIP Comments: AHIP has significant concerns about the use of the MTF for Part D drugs. These and additional concerns apply to the potential expansion of the MTF for Part B drugs.

The MTF is an entirely new infrastructure that requires systems and operational updates and potentially new connections along the supply chain. The MTF data and payment modules have yet to be utilized to effectuate the MFP for Part D drugs. We believe it is premature for CMS to suggest expanding the MTF before stakeholders have any experience with the MTF, and before likely operational and technical difficulties are identified. This is particularly important because an expansion of the MTF to Part B drugs would add new complexities, operational challenges and administrative burdens throughout the healthcare system. It would require an expanded MTF infrastructure that not only incorporates data from Part B drug claims from a single program (as in the case of Part D), but it would also have to address claims by enrollees in MA and Fee-for-Service (FFS). In addition, it would require broad participation and integration of data from physicians and hospitals.

In the draft guidance, CMS reiterates that section 1193(a)(3)(A) of the Act places the obligation on the Primary Manufacturer to ensure that the MFP is made available to dispensing entities that dispense the selected drug to MFP-eligible individuals. Similarly, section 1193(a)(3)(B) of the Act places the obligation on the Primary Manufacturer to ensure that the MFP is made available to Part B providers that furnish or administer the selected drug to MFP-eligible individuals. The MTF is not required in statute.

Instead of potentially expanding the MTF to support MFP effectuation for drugs payable under Part B, we urge CMS to pursue an alternative to the MTF that places the onus on manufacturers to support MFP effectuation for both Part B and Part D drugs. For example, it could include mechanisms such as prospective discounts or prospective sales of selected drugs to Part B providers and dispensing entities, combined with virtual inventory management systems and pharmaceutical wholesaler chargebacks where applicable. This latter policy option was outlined in the draft guidance to address the needs of dispensing entities with cash flow concerns. We believe it should be considered for broader applicability.

To develop and implement an alternative to the MTF that relies on a prospective approach by 2028, we encourage CMS to convene stakeholders along the supply and payment chains of both Part B and D drugs to assess how such an approach could best be operationalized.

80 MFP-Eligible Individuals in 2026, 2027, and 2028

In general, a "maximum fair price individual" for 2028 will include an MA enrollee who is furnished or administered a selected drug payable under Part B. CMS solicits comments on how best to monitor MA plans' use of Part B step therapy practices to ensure compliance with program rules and any data or policy clarifications that may be needed for implementation.

AHIP Comments: We believe existing MA program rules and reporting requirements should be applied to selected drugs. We are not aware at this time of any additional requirements or clarifications that are needed.

In particular, 42 CFR § 422.136 requires MA plans that implement a step therapy program for Part B-covered drugs to: 1) apply step therapy only to new administrations of Part B drugs, using at least a 365 day lookback period; 2) establish policies and procedures to educate and inform health care providers and enrollees concerning its step therapy policies; and 3) ensure that the step therapy program has been reviewed and approved by the MA organization's pharmacy and therapeutic (P&T) committee. CMS can monitor potential issues relating to an MA plan's use of Part B step therapy practices through the Part C reporting requirements that cover organization determinations and reconsiderations. Moreover, CMS has the authority to conduct audits relating to step therapy.

Consistent with the President's directive to reduce regulatory burdens, CMS should rely on existing processes and avoid establishing any new requirements or reporting burdens unless and until there is an indication that process changes may be needed.

80.1 Direct Member Reimbursements and Access to the MFP for Selected Drugs in 2026, 2027, and 2028

The draft guidance requires processes for direct member reimbursement (DMR) that provide access to the MFP for MFP-eligible individuals who pay cash for selected drugs rather than submit claims through the Part D benefit.

AHIP Comments: AHIP appreciates CMS outlining procedures for DMR requests involving in-network and out-of-network (OON) claims. However, we believe the final guidance should include additional clarifications and detailed examples to facilitate implementation of the DMR procedures. For example, for DMRs involving OON claims, the guidance states that a plan sponsor is responsible for reimbursing the enrollee at least the difference between the cash price paid to the dispensing entity and the MFP plus any dispensing fees. However, the draft guidance does not address how plan sponsors should process a DMR request when a plan does not know the dispensing fees. We also request that CMS provide quantitative examples of DMR for in-network and OON claims in each benefit phase.

In addition, the draft guidance states that "Primary Manufacturers and Part D plan sponsors may establish a reimbursement process related to DMR requests for MFP-eligible claims as necessary to ensure MFP effectuation for these MFP-eligible individuals." Given that the manufacturer has

the responsibility to ensure access to MFP prices for MFP-eligible individuals, CMS should include instructions in the final guidance that require manufacturer engagement with Part D plans to ensure the impacts on plans are minimized.

110 Part D Formulary Inclusion of Selected Drugs

For contract year 2028, CMS indicates that it will continue the guidance it issued on formulary inclusion policies for prior years. In general, this means formularies must include all dosage forms and strengths of a selected drug. CMS will not impose explicit tier placement or utilization management requirements that apply uniformly across selected drugs in all formularies. However, through its formulary review process, CMS will expect Part D sponsors to provide a reasonable justification, including clinical factors and program requirements, to support: (1) placement of selected drugs on non-preferred tiers; (2) placement of a selected drug on a higher cost-sharing tier than non-selected brand drugs in the same class; (3) step therapy that requires utilization of an alternative brand drug prior to a selected drug; or (4) imposition of more restrictive utilization management (e.g., step therapy and/or prior authorization) for a selected drug compared to a non-selected brand drug in the same class. CMS also commits to monitoring trends in formulary placement for selected drugs.

AHIP Comments: We support the continuation of the formulary inclusion policies that apply to initial price applicability years 2026 and 2027. This includes our support for CMS not creating new, uniform tier placement or utilization management restrictions for selected drugs. For example, many selected drugs may be older due to the criteria to be eligible for negotiation, and newer drugs may be the preferred standard of care or the best option for new patient initiation. It is critically important that P&T committees be able to assess individual drugs for patient safety and pharmacoeconomic purposes. We also appreciate the draft guidance providing plans with the flexibility to support enrollee access to biosimilars when available.

Inappropriate tier placement or other requirements could also unduly impact formulary, rebate and other negotiations pertaining to non-selected Part D drugs.[1] And as more drugs become subject to negotiation over time, multiple drugs within a therapeutic class may have negotiated prices; the manufacturers of these drugs may be willing to offer additional price concessions for preferred relative formulary placement, reducing overall Part D drug spending.

In addition to supporting the continuation of these policies, we also highlight the importance of timely notices related to the MFP process. For example, the draft guidance (in Section 60.6) reiterates the statutory requirement that CMS publish, by November 30, 2026, the MFP for each selected drug for initial price applicability year 2028 for which CMS and the Primary Manufacturer have reached an agreement on an MFP. Given the formulary inclusion requirement and other provisions (e.g., a Part D plan's negotiated price for a selected drug cannot exceed the MFP plus any dispensing fee), this publication deadline is critical for allowing Part D plans to

[1] CBO and MedPAC reports have outlined how limiting formulary flexibility and tools impacts the ability of Part D sponsors to negotiate rebates and can contribute to higher net prices. See https://www.cbo.gov/system/files/2022-01/57050-Rx-Spending.pdf and https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_reporttocongress_sec.pdf.

appropriately operationalize these provisions and incorporate them into dispensing entity negotiations and bid development for 2028.

Part D sponsors also need to be notified in a timely fashion of when the formulary inclusion requirement no longer applies to a previously selected drug. Section 60.6 stipulates that CMS will publish on its website when a drug is no longer a selected drug and the reason for that change. However, it does not address whether Part D sponsors will be directly notified of the change. We encourage CMS to leverage existing communications vehicles such as HPMS memos to notify Part D sponsors of any removal of drugs from the selected drug list.

110.1 Formulary Inclusion Exception Successor Regulation for 2027 and 2028

The Final CY 2026 Part D Redesign Program Instructions allows Part D plans to make an immediate substitution of a generic or interchangeable biologic for a selected drug if the generic drug/interchangeable biologic was not available on the market, and therefore could not have been included on formulary, when the initial formulary was submitted for CMS approval.

The draft guidance indicates that this rule will apply to 2027 and 2028. In addition, the draft guidance proposes to clarify that removals of selected drugs under this process cannot be automatically carried over to subsequent years within the price applicability period. Instead, the removal of a selected drug in a given year must independently meet the immediate substitution requirements for that year. CMS indicates this approach is required because CMS considers each plan year's formulary to be separate and distinct from the prior year formulary.

AHIP Comments: AHIP has supported maximum flexibility for allowing the substitution of drugs and biologics for selected drugs. This flexibility can be an important tool for Part D sponsors in negotiating lower costs for enrollees and taxpayers while maintaining access to treatments that patients need. While we appreciate the ability to permit substitution of interchangeable biologics, we also supported an alternative outlined in the Draft CY 2026 Part D Redesign Program Instructions (but not ultimately adopted) that would permit non-immediate maintenance changes of non-interchangeable biosimilars.

With respect to this draft guidance, we encourage CMS to reconsider the proposed approach that prevents immediate substitutions from carrying over to subsequent years. This interpretation undermines the benefits afforded by the introduction of generic/biosimilar competition to selected drugs and could stymie plan efforts to improve the affordability of Part D. We believe Congress, when it referenced the predecessor regulation in statute and addressed successor regulations, likely did not consider, or intend the program to be limited by, CMS' process for reviewing formularies. Instead, Congress likely intended for the exception to the formulary inclusion requirement to consistently apply once generic or biosimilar competition exists for a selected drug, to promote greater competition and affordability.

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June 26, 2025

Chris Klomp
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, Maryland 21244-1859

RE: Medicare Drug Price Negotiation Program Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp,

The Alliance for Aging Research ("Alliance") appreciates the opportunity to review and comment on the Medicare Drug Price Negotiation Program (MDPNP) Draft Guidance for 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, 2028. The Alliance is the leading nonprofit organization dedicated to accelerating the pace of scientific discoveries and their application to vastly improve the universal human experience of aging and health. The Alliance appreciates CMS's willingness to revisit and solicit comment on several key areas, including the patient-focused engagement process and the grouping of qualifying single source drugs. We also strongly believe that CMS must, and has legal authority to, be more proactive in establishing expectations and guardrails to prevent inappropriate or excessive applications of utilization management.

Inclusion of Part B Drugs

In compliance with the statute, CMS has included Part B drugs in the IPAY 2028 guidance. This will have long-term impacts on patient access if not implemented with thoughtful consideration of how CMS policy will shape the therapeutic landscape. The Alliance maintains that the lower price garnered by CMS through IRA implementation will not inherently translate to lower costs seen by beneficiaries, especially those who already have Medigap or other coverage that already covers the bulk of their out-of-pocket costs. Uncertainty in pricing and availability of

therapeutics subject to negotiation could have ripple effects that go beyond price alone—affecting how and where patients access care, which treatments remain available, and how providers make decisions about furnishing these drugs. These dynamics are particularly important to monitor given the unique nature of Part B drugs, which are often used to treat serious or complex conditions and administered in clinical settings where provider behavior and reimbursement levels play a critical role in patient access.

Our concerns about the MDPNP have always centered around access, and inclusion of Part B drugs in 2028 introduces an entirely new aspect, provider participation. It is essential that CMS keep reimbursement rates at a level that still incentivizes providers to stock and furnish these therapies. This is a known risk as past reimbursement shortfalls during Average Sales Price volatility have led to providers pulling back from participation.[1] CMS should monitor for such dynamics and consider whether temporary transition payments or acquisition cost safeguards are needed to preserve meaningful access for all patients, particularly during the early phases of implementation.

This disparity is even more meaningful in rural areas. Smaller and rural physician practices are more vulnerable to price shifts, and patients rely more heavily on the individual doctors and specialists they see there. If providers stop dispensing the negotiated drugs, sometimes the most used of the program by volume, patients in these areas may face delays, be referred to hospitals or larger centers, or be required to travel farther for care. These are expensive and avoidable consequences of the MDPNP on beneficiaries.

30.1 Qualifying Single Source Drugs

CMS has chosen to combine all indications, dosage forms, and strengths of a medication together as one "drug" for the purpose of applying the MFP. The Alliance has concerns about the downstream impacts of this decision on areas of medical research. For example, the manufacturers of some glucagon-like peptide 1 (GLP-1) agonists are currently in clinical trials for conditions that are very different from their originally approved indication of diabetes, such as Alzheimer's disease and slowing the progression of kidney disease. The difference in patient population and condition is significant, requiring separate clinical trials and substantial investment. However, if a drug in the future is subject to the current QSSD grouping guidelines, there will be greatly reduced incentives to perform these types of additional research, leaving potentially very meaningful treatments unexamined. Further, Medicare's negotiated price for a

[1] Medicare Payment Advisory Commission. "Report to the Congress: Medicare and the Health Care Delivery System, Chapter 2, 'Medicare Part B Drug Payment Policy Issues.'" Jun 2017. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch2.pdf

QSSD may or may not incorporate costs associated with additional research and development (R&D) of a drug with an existing approved FDA indication.

We are further concerned about the potential disincentives this narrow interpretation poses surrounding post-approval R&D, particularly efforts to develop distinct formulations and alternative routes of administration that address unmet needs. For example, studies show strong and consistent patient preference for subcutaneous administration of therapies over intravenous administration due to time savings, convenience, reduced emotional distress, less pain, and improved comfort.[2]

The Alliance asks CMS to explore with the wider patient community and other subject matter experts the degree to which application of an MFP on a QSSD constitutes a deterrent for investment and research into novel indications. We hope manufacturers and pharmaceutical companies will continue investing significantly in novel areas regardless of CMS policy, but we are cognizant of real-world considerations and are concerned about the unnecessary risks the current formulation of the QSSD policy raises for the development of novel uses of therapeutics. Over time, this policy could impact patients in nearly every disease area, including areas with significant unmet need.

60.3 Issues Resulting from CMS' Lack of Transparency About Methodology and Potential Use of Discriminatory Metrics

CMS must shine light on the overall process for selecting and setting the maximum fair price (MFP). Currently, there is little to no public information on the process and methodology used by CMS as they negotiate prices. However, CMS is a public agency – not a private payer – and there is little need for a similar level of secrecy or guarding of "trade secrets" around methodology.

There is material public interest in how CMS is establishing the MFP, given that millions of beneficiaries take the medicines subject to negotiation and may face the impacts that result as negotiated prices take effect in 2026. We encourage CMS to change course and publicly release information on the methodology used to establish the MFP and price negotiation. Further, releasing this information will encourage drug manufacturers to collect relevant data, either during the clinical trial process or through real-world data collection, to provide a robust base of information on factors likely to be considered in Medicare negotiations in the future.

[2] Aguiar-Ibáñez, R., Fotheringham, I., Mittal, L. *et al.* "Differences Between Intravenous and Subcutaneous Modes of Administration in Oncology from the Patient, Healthcare Provider, and Healthcare System Perspectives: A Systematic Review." *Advances in Therapy vol. 41.* https://doi.org/10.1007/s12325-024-02985-9

There is also interest in ensuring that metrics assessed as discriminatory are not used in price negotiation. While CMS has noted that they will not be using the quality adjusted life year (QALY) to set the MFP, there have been explicit mentions of other equally discriminatory metrics in guidance. In the June 2023 Revised Direct Negotiation Guidance, CMS noted that many commenters recommended metrics such as the equal-value of life years (evLY) gained – which was developed and is calculated in part by using the QALY[3] - or the Health Years in Total metric. To these comments, CMS responded, "CMS will review cost-effectiveness measures and studies that use such measures for initial price applicability year 2026 to determine if such measures are permitted under section 1194(e) of the Act."[4] The public is not able to know the degree to which this research was conducted or the implications it had on the initial prices the Agency proposed. This is especially notable given the finalization of the updated final rule on Section 504 of the Rehabilitation Act, which confirmed that agencies under the umbrella of the Department of Health and Human Services cannot use metrics that discount the value of life extension on the basis of disability.[5]

Further, methods for the underlying data collection used to complete the QALY, evLY, and similar analyses are incomplete and immature. At present, these analyses rely solely on clinical trial data, which typically include exclusion criteria that disqualify individuals from participating in a trial based on comorbidities, age, and other factors. As a result, clinical trial data often reflects a population that differs significantly from real-world users, meaning that any calculations of evLY is not representative of a drug's entire intended user base. Negotiated drugs are not new to the market, and so CMS should not be relying primarily on preclinical data, but rather should incorporate analysis of real-world data and real-world evidence.
CMS must be transparent about data collection and analysis in calculating the MFP, as well as the role of the engagement sessions, so that stakeholders can meaningfully hold the Agency accountable for the methods it chooses to deploy.

The new Administration has the opportunity to commit to CMS' stated goal of "learning from, collaborating with, and engaging with the public" by ensuring that key stakeholders are not left in the dark about price setting metrics, tactics, and considerations.

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[3] O'Day, Ken and Dylan J. Mezzio. "Demystifying ICER's Equal Value of Life Years Gained Metric." Value & Outcomes Spotlight. https://www.ispor.org/publications/journals/value-outcomes-spotlight/vos-archives/issue/view/overcoming-vaccine-hesitancy-injecting-trust-in-the-community/demystifying-icer-s-equal-value-of-life-years-gained-metric
[4] Centers for Medicare and Medicaid Services. "Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026." 30 Jun 2023. https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf
[5] Department of Health and Human Services. "Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance." Federal Register Vol. 89, No. 91. https://www.govinfo.gov/content/pkg/FR-2024-05-09/pdf/2024-09237.pdf

60.4 Negotiation Process (and Improvements to the Patient-focused Engagement Process)

The Alliance appreciates and acknowledges the effort that CMS has made this year to improve the format of the listening sessions and the overall patient engagement process. We noticed a significant improvement in the patient experience during this year's listening sessions. We appreciated the closed, roundtable format and the more conversational nature of the meetings compared to prior years. We also noticed and appreciate how responsive CMS was to our feedback that participants should be allowed anonymity, rather than livestreamed.

In this guidance, CMS notes that it will not organize some sessions based on condition or therapeutic area, rather than by a specific drug. This is a significant improvement, as it is often preferable to speak about clinical need, therapeutic alternatives, and relevant data holistically for relevant drugs, rather than either focusing only on a single drug or, alternatively, repeating the same information across multiple sessions. This will allow the Agency to collect more comprehensive feedback and have a clearer picture of patient experiences across different treatments.

The Alliance appreciated the opportunity to participate in the MDPNP roundtable and town hall discussions for the 2026 round of negotiations. In our view, these discussions, especially the roundtable events, saw notable improvement over the last round, allowing for greater participation and positive engagement reflecting the views of patients and their advocates as well as clinicians. While a few were not so well attended, we suggest additional outreach moving forward to ensure the inclusion of broader perspectives. We were especially pleased that the roundtable format allowed for interactive discussion between the invited participants. While the Town Halls were generally positive, they did not offer this opportunity. Despite the decision to break discussions of 16 separate drugs into two 3-hour sessions, this was still a major time commitment for many to participate. Breaking these important discussions into even smaller time segments could facilitate even more patient participation in the future.

CMS can continue to improve patient engagement by adopting best-practices from organizations like the Food and Drug Administration and the Patient-Centered Outcomes Research Institute. These organizations have developed effective two-way discussion formats, often incorporating both in-person and virtual participation options. CMS could also look to international examples, such as the European Medicines Agency and various industry engagement efforts, for innovative patient engagement strategies. For instance, Novartis has

been proactive in incorporating patient-centered outcomes into their engagement models.[6] CMS has the chance to lead by example as more research and payer groups work to include the patient perspective in their models and assessments.

110. Formulary Inclusion of Selected Drugs and Resulting Incentives for Increased Abuse of Utilization Management Techniques

A recent report from the Government Accountability Office (GAO) found that, "Part D plan sponsors frequently gave preferred formulary placement to highly rebated, relatively higher-gross-cost brand-name drugs compared to lower-gross-cost competitor drugs, which generally had lower rebates."[7] As a result, plans are at risk of losing significant rebate revenue when CMS sets a maximum fair price (MFP) for the drugs selected for negotiation. At the same time, plans are facing a significant increase in financial liability in the catastrophic phase of the benefit as a result of the Part D redesign. All of these factors will drastically increase incentives for plans to find levers by which to control their growing costs, including by narrowing formularies, adopting more rigorous utilization management strategies like prior authorization or step therapy, or promoting drugs other than those CMS has selected for negotiation. As a result, beneficiaries face a growing risk of burdensome or clinically inappropriate utilization management requirements, potential treatment delays, or loss of coverage altogether.

We support CMS's acknowledgement of these factors and stated concern that sponsors may be "incentivized in certain circumstances to disadvantage selected drugs by placing selected drugs on less favorable tiers … or by applying utilization management that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs."[8] We also believe that the draft guidance's reiteration of existing rules regarding formulary placement and tiering, as well as noting specific behaviors related to the placement of drugs selected for negotiation, is a good first step.[9]

However, given the high stakes for beneficiaries, the agency should go further. Increased application of UM – particularly when not clinically appropriate - puts patients at risk of delayed care and life-threatening adverse outcomes. For example, step therapy protocols require

[6] Samuel Knowles and Beyza Klein. "How Novartis Deploys a New Model of Creativity to Understand Patients Better." 25 Jul 2023. https://www.emerald.com/insight/content/doi/10.1108/IJPHM-11-2022-0100/full/html
[7] Government Accountability Office. "MEDICARE PART D: CMS Should Monitor Effects of Rebates on Drug Coverage and Spending." 19 Sep 2023. https://www.gao.gov/assets/gao-23-107056.pdf
[8] 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. Sec. 110. https://www.cms.gov/files/document/medicare-drug-price-negotiation-draft-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf
[9] Ibid.

beneficiaries to take (often a series of) less expensive and potentially less efficacious medications first. In this case, beneficiaries must fail to show the desired clinical improvement before becoming eligible for coverage for the medication their physician or medical provider initially prescribed.

Further, many beneficiaries may have selected their current plan because it resulted in the lowest out-of-pocket (OOP) cost burden.[10] However, given the new OOP cap on beneficiary costs in Part D, changes to plans' benefit parameters may result in a different plan having lower expected OOP costs. As a result, more beneficiaries are expected to switch plans in 2025 than in a typical year. However, when beneficiaries switch plans, they may be required to go through their new plan's UM structure (or, to have the process knowledge and capability to file for an exception with their new plan) to maintain continued access to drugs on their care plan. This is particularly problematic with step therapy, where a beneficiary may be required to stop their current medication and go back to take a medicine they have previously taken but that has not worked. These scenarios are likely to be seen in the real-world, given the increased "churn" in MA plan enrollment and projected expansion in UM protocols following from plans' increased liability in the catastrophic phase of the benefit.

As mentioned above, CMS has recognized the importance of these issues but has thus far declined to take important steps to strengthen formulary standards, increase transparency, and strengthen oversight. While CMS asserts that the agency "does not have sufficient information to determine whether changes to the formulary inclusion policies described in CMS's revised guidance for … 2026 are warranted," we disagree. The agency should not wait until harmful behavior is observed – especially when the impact on beneficiaries would not be evident in data patterns until significantly later - in order to take action. Post hoc changes once harms are already being experienced by beneficiaries are not appropriate, given that interruptions or delays in access can, in some cases place beneficiaries at risk of delayed care that can result in irrevocable loss of function or adverse outcomes.

We encourage CMS to take the following actions (as proposed in a report developed by Manatt and released on June 26, 2024) to protect beneficiaries, all of which the agency should be able to do with existing regulatory authority. The recommendations[11] from Manatt include:

[10] Gretchen Jacobson, Faith Leonard, Elizabeth Sciupac, and Robyn Rapoport. "What Do Medicare Beneficiaries Value About Their Coverage?" 22 Feb 2024. https://www.commonwealthfund.org/publications/surveys/2024/feb/what-do-medicare-beneficiaries-value-about-their-coverage

[11] Manatt Health. "Patient Impact of the Inflation Reduction Act Administrative Options to Address Changed Incentives for Formulary and Utilization Management." June 2024. https://www.manatt.com/Manatt/media/Documents/Articles/AAR-Patient-Impact-of-the-IRA_2024-06_d.pdf

1. *Require that drugs selected for negotiation—for which CMS has established a maximum fair price—be given preferred formulary status, without utilization management*. Current CMS rules only encourage placement of drugs selected for negotiation on preferred tiers with limited utilization management, by requiring plans to submit a clinical justification if they attempt otherwise. However, this provides no guarantees, and it would have CMS resource implications for reviewing each submitted justification. Moreover, CMS's guidance on reviewing clinical justifications is vague. Instead, CMS could adopt a blanket rule protecting drugs selected for negotiation. This could be supported by CMS's authority to disapprove plan designs likely to discourage enrollment. A plan tiering design that steers beneficiaries away from drugs selected for negotiation and towards drugs not selected with higher out-of-pocket costs to the beneficiary is likely to discourage enrollment of beneficiaries who need a particular drug that has been selected for negotiation. CMS could also justify this under its authority to set reasonable minimum standards for plans.

   CMS could also give additional guidance on the clinical justifications it will require for non-preferred treatment or utilization management of drugs selected for negotiation. This guidance could address more directly what a might constitute a valid justification.

2. *Adopt a public "watchlist" for specific adverse formulary decisions that CMS will not approve, to keep PDP sponsors from excessive narrowing of formularies*.

   When CMS disapproves a formulary design or utilization management practice, it could do more than simply require the sponsor to correct it. Instead, CMS could publicly announce to all sponsors that it has identified that specific practice as an issue, and that it will be on the lookout for it going forward. This could create clarity for plans and discourage the submission of similar plan designs. It could also give CMS an opportunity to demonstrate that the agency is being proactive in addressing noncompliance with formulary requirements. PDP sponsors who repeatedly submit formularies that require correction could be required to implement a corrective action plan to better consider their formularies before submission.

3. *Commit additional resources to formulary reviews so as to identify access issues before such issues can harm beneficiaries*.

   The importance of protecting beneficiaries through the first few years of IRA's implementation suggest CMS should devote additional resources specifically to formulary reviews and PDP sponsor monitoring. The IRA appropriates $341 million to

CMS to implement the IRA's Part D improvements. It would be prudent to devote some of those funds to expand the teams and tools used for the ordinary annual formulary review process and Part D plan monitoring functions.

4. *Explicitly and publicly identify more situations where plans must cover more than two drugs per category or class to ensure that formularies provide adequate coverage of drugs commonly used by beneficiaries*.

   Current CMS policy is that it follows "widely accepted treatment guidelines" and "general best practice" to determine whether a formulary has adequate coverage. It also published a list of commonly prescribed drug classes in 2010 for use in formulary reviews. This guidance is vague and out of date. Instead, CMS could publish more detailed lists of key areas where it demands adequate coverage on formularies, including specific minimum numbers and types of medications.

5. *Improve plan transparency so beneficiaries can more easily see when drugs have utilization management restrictions*.

   Beneficiaries shopping for coverage may struggle to easily identify when a plan they are considering has a utilization management restriction for a drug they take. Likewise, they may not know to look and see if a plan disfavors drugs selected for negotiation. CMS could adopt rules and improve transparency of this information by including it prominently in the Medicare Plan Finder and make specific utilization management policies easily searchable and accessible. Likewise, CMS could place a flag in the Plan Finder on plans that disfavor drugs selected for negotiation, to alert beneficiaries in advance.

6. *Enforce minimum payment rates to pharmacies, to prevent sponsors from diverting patients away from community pharmacies*.

   CMS could ensure broad access to covered Part D drugs at beneficiaries' chosen pharmacy by requiring that PDP sponsors pay at least the pharmacy's acquisition cost for covered drugs. While CMS ordinarily does not "interfere" in the negotiations between plans and pharmacies, this could be construed as falling within CMS's authority to set "reasonable and relevant" reimbursement terms plans must meet to satisfy the "any willing pharmacy" rule.

7. *Actively monitor appeals, grievances and exception requests filed by beneficiaries with their plans, to have near real-time view of access issues*.

   CMS could closely monitor rates of beneficiary appeals of coverage denials, complaints to plans about coverage and exception requests for coverage of drugs not on formulary or for preferred status of a non-preferred drug. Upticks in these processes could be leading indicators of specific problems on specific plan formularies that CMS could act on quickly. CMS currently collects this data on a quarterly basis, and perhaps not in sufficient detail to identify specific drug products or policies that trigger additional appeals. By increasing the pace and detail of this collection, CMS could improve its visibility and act more quickly. Additional regular audits of plans would demonstrate situations where plans are inadequately processing and reviewing appeals and exceptions. Publication of this data and CMS's enforcement activity could demonstrate that the agency is acting proactively.

8. *Improve appeals and grievance processes, to reduce the burden of challenging a plan's coverage decision*.

   CMS might also consider taking steps to improve the efficiency of the appeals process to relieve patients and providers of the burden of filing an appeal or a formulary or tiering exception request. These processes are the best immediate mechanism available to beneficiaries facing challenges with coverage or authorizations, and having them run smoothly is an important protection for 2025 and beyond. For example, CMS could consider requirements for seamless electronic prior authorization, appeals and exception requests. CMS could also ensure that beneficiaries are aware of these processes through better communication and education on rights to appeal or request an exception. Finally, CMS could make exception requests easier to obtain, such as by adopting a presumption in favor of granting an exception. This would support a reduction of administrative burden, as data has shown that millions of prior authorization requests are submitted annually, with most appeals of prior authorization denials being overturned.

9. *Adopt new actuarial equivalence tests to more accurately and quantitatively track whether plan sponsors are offering sufficient coverage of drugs selected for negotiation*.

   To protect beneficiaries in 2025, CMS could improve the sensitivity of its actuarial equivalence test to protect against adverse formulary tiering of drugs selected for negotiation. Beginning in 2026, CMS could separately test the actuarial equivalence of

out-of-pocket costs of drugs selected for negotiation to ensure that sponsors are actually offering an actuarily equivalent benefit for these drugs. In so doing, CMS will likely prevent PDP sponsors from quietly inflating the out-of-pocket costs for drugs selected for negotiation through inferior formulary tiers.

These recommendations from Manatt Health would lead to beneficiaries would serve to protect beneficiaries from any potential negative impacts of utilization management resulting from the MDPNP.

Conclusion

Thank you for the opportunity to provide input and comment on the draft guidance. The Alliance remains hopeful that CMS will put patient care and experience at the forefront of the negotiation process. Should you have any questions, please contact Adina Lasser, Director of Public Policy & Government Relations, at alasser@agingresearch.org.

Sincerely,

Scott Frey

Scott Frey
Senior Vice President of Public Policy & Government Relations

Adina Lasser

Adina Lasser
Director of Public Policy & Government Relations

June 26, 2025

Chris Klomp
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 212440-1850

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp:

On behalf of the Alliance for Patient Access (AfPA), thank you for the opportunity to comment on the draft guidance for implementation of the Initial Price Applicability Year 2028.

Founded in 2006, AfPA is a national network of policy-minded health care providers who advocate for patient-centered care. AfPA supports health policies that reinforce clinical decision-making, promote personalized care and protect the provider-patient relationship. Motivated by these principles, AfPA members participate in clinician working groups, advocacy initiatives, stakeholder coalitions and the creation of advocacy resources.

We are encouraged to see that CMS is committed to implementing the prescription drug negotiation program with the goal of transparency and engagement. Our comments will primarily focus on the agency's process of engaging patients and health care providers in its decisions and ensuring that access to crucial medications is not affected. Patients with chronic diseases, and their healthcare providers, have valuable experience that can inform CMS decisions on a treatment's clinical effectiveness, unmet needs and therapeutic alternatives, and it is imperative their perspectives are included in conversations about treatment value.

Utilizing and Improving Health Care Provider and Patient Engagement with CMS

As CMS structures the third round of drug price negotiations, CMS must continue to strive to provide opportunities for meaningful patient and provider input. We applaud CMS for providing the opportunity for patients and stakeholders to participate in the roundtables and town hall earlier this year. CMS held a listening session for each of the 15 selected medications, a recognition of the importance of lived experience with the medications and the conditions they treat. While the clinician town hall was a welcome addition to the roundtables and provided more opportunities for engagement and consideration of clinical benefits, there are still several ways CMS could improve the process and ensure patient input is properly taken into consideration.

To ensure input in the public listening sessions is meaningful and can drive informed policymaking, CMS should:

- Clearly identify what qualitative and quantitative information is being sought and how CMS intends to incorporate it into the negotiation process

- Report on how past patient input was used in the maximum fair price determinations, allowing participants to better tailor their input
- Ensure the process of providing both written and verbal comment is easily accessible to patients, care partners and health care providers
- Clearly identify who can participate and how they will be chosen
- Ensure diversity of speakers to best represent the Medicare and specific patient population
- Allow for additional methods of providing input such as recordings, Q&A, and written statements
- Establish a methodology for how qualitative patient experience data will be incorporated, developed with input from the patient community

We appreciate that CMS is seeking input to bring together stakeholders including patients, clinicians, beneficiaries, caregivers, and patient organizations. It is imperative that CMS continues to improve the transparency of the feedback process to ensure patients can share their lived experiences with the conditions or diseases treated by the selected drugs, as well as therapeutic alternatives to the selected drugs. By implementing the above principles, CMS will benefit from higher quality input and gain insights that will help better assess the value and benefit of treatments to Medicare beneficiaries.

Avoiding the Use of Discriminatory Metrics in Valuation of Treatments

We are concerned that the published guidance does not account for statutory limitations on the use of the quality-adjusted life years (QALYs) and other similar discriminatory metrics under the Affordable Care Act. When CMS is considering their approach to determining Maximum Fair Prices (MFPs), it is imperative that one-size fits all metrics such as the QALY, or equal value of life year gained (evLYG) are actively avoided in any and all valuation processes.

While we appreciate the guidance's commitment to not directly rely on the QALY in the negotiation program, if the value assessments that are being used to determine MFPs are still allowed to indirectly use the QALY or other discriminatory metrics, patients are still being put at risk of being devalued and further marginalized. At a minimum, CMS should restore the transparency requirement asking those that submit evidence for value assessments to disclose whether the studies they conducted used discriminatory measures that could devalue the lives of disabled or chronic disease patients.

Without clearly laid out transparency requirements and limitations around value assessment methodologies, there will continue to be a significant risk that discriminatory metrics will negatively impact the negotiation process. We urge CMS to consider the effects that even indirectly using metrics like the QALY could have on patients across the country.

Protecting Patients from Utilization Management

As the overarching changes to Medicare from the IRA, and particularly the drug price negotiation program, continue to be implemented, it is crucial that CMS proactively implements patient protections against potentially harmful utilization management practices from health plans. With many of the Medicare changes coming into effect, there are concerns that health plans will look to implement increased utilization management tactics that would lead to limited access to medications for beneficiaries. The drug price negotiation program coupled with the Part D redesign changes have already led to a noticeable increase in the usage of utilization management tactics by Part D plans.[1]

[1] Avalere Health, "2025 Part D Formularies Shift to More Coinsurance and UM." October 28, 2024. Available here: https://advisory.avalerehealth.com/insights/2025-part-d-formularies-shift-to-more-coinsurance-and-um

We encourage CMS to provide a publicly available and transparent process for patients to provide feedback on any negative experiences that they might have due to utilization management protocols or any other policies they may encounter. Ensuring that patients can provide direct feedback to CMS in the months and years following implementation of MFPs for their treatment would allow regulators to fully and clearly assess how the negotiation program and MFPs have impacted access, costs, and quality of care for countless patients. CMS will then be in a position to limit increased use of utilization management tools that impact patient access.

Policy Considerations Unique to Part B Medicines – Physician Reimbursement and Method of Administration

Physician Reimbursement

The drug pricing provisions allow unprecedented new price-setting authority for treatments in the Medicare program. Beginning in 2028, Maximum Fair Price (MFPs) will begin to take effect for any selected Part B drugs.

Medicines in Medicare Part B are often physician administered, with providers typically reimbursed at 106% of a medication's average sales price (ASP), which is the weighted average of all eligible manufacturer sales and includes rebates or discounts that are negotiated. However, the price negotiation program will shift provider reimbursement for any selected Part B drugs to 106% of the MFP, which has been on average 22% lower than selected drugs' net prices for the first round of selected drugs.[2] This has the potential to drastically reduce Medicare reimbursement for provider-administered medications that are selected for negotiation.

With Medicare provider reimbursement rates already being cut for a variety of services, further reduction of Part B medicine administrative rates would likely lead to significant patient access issues. Clinics and providers would be forced to reduce their medication inventory due to increasing financial deficits, leaving patients with fewer treatment options. This would not only disproportionately impact small and rural providers, who typically operate on much slimmer margins than large health care systems, but also significantly impact the large portion of the Part B patient population who suffer from chronic disease and rely on Part B medications.

We appreciate the efforts that CMS has made thus far in implementing feedback, and we urge CMS to consider the effects that including MFP in the calculation of ASP would have on patient access to crucial medications.

Method of Administration

Part B medications are often infused or administered via sub-cutaneous injections, with each having benefits for patient access. Sub-cutaneous administration may be less intrusive and take less time to complete. Additional methods of administration offer a range of options for patients. In particular, sub-cutaneous injection, rather than infusion, has been associated with higher rates of patient satisfaction and decreased patient anxiety.[3] CMS should ensure that drug negotiations do not disincentivize development of alternative methods of administration and continue to expand options for patients.

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[2] Avalere Health, "Commercial Spillover Impact of Part B Negotiations on Physicians." September 16, 2024. Available here: https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians

[3] Advances in Therapy, "Differences Between Intravenous and Subcutaneous Modes of Administration in Oncology from the Patient, Healthcare Provider, and Healthcare System Perspectives: A Systematic Review." October 19, 2024. Available here: https://link.springer.com/article/10.1007/s12325-024-02985-9

Conclusion

As CMS continues to implement the drug pricing negotiation authority provided by the Inflation Reduction Act, decisions will be improved by robust patient and provider input, both before and after implementation of MFPs. Implementing an improved input process, providing clear direction about what qualitative and quantitative information is most valuable, and explaining how CMS is incorporating that information in the price determination will help beneficiaries have a meaningful role. CMS should ensure that discriminatory metrics are neither directly or indirectly used in the valuation process and ensure that patients of all disease states and treatment areas are rightfully represented and advocated for. Finally, CMS should require plan sponsors to limit the increased use of utilization management and patient cost shifting that limit treatment options.

Thank you for the opportunity to provide this input on this important matter. AfPA supports efforts to include the patient and provider voice and is always willing to work with CMS to ensure that Medicare beneficiaries continue to have timely access to care. For any questions related to AfPA or our comments, please contact Josie Cooper, Executive Director, Alliance for Patient Access, at jcooper@allianceforpatientaccess.org.

Sincerely,

Josie Cooper
Executive Director
Alliance for Patient Access

June 26, 2025

Administrator Dr. Mehmet Oz
Deputy Administrator and Director Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via IRARebateandNegotiation@cms.hhs.gov

Re: Comments on CMS Draft Guidance for Medicare Drug Price Negotiation Program for IPAY 2028

Dear Administrator Oz:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to offer recommendations to advance affordability and access for Medicare beneficiaries. ACHP fully supports CMS's implementation of the Drug Price Negotiation Program including bringing Medicare Part B–covered drugs into the negotiation framework and renegotiating certain drugs previously negotiated for 2026 or 2027. We offer recommendations for CMS to close product hopping loopholes, ensure smooth implementation, enforce consistent application of the Maximum Fair Price across Medicare Advantage and require complete transparency from manufacturers to ensure the strongest possible outcomes for patients and the Medicare program.

ACHP is the only national organization advocating for a unique payer-provider aligned model of care that promotes true competition, delivering high quality coverage and care. ACHP members are local non-profit insurers providing affordable coverage options to tens of millions of Americans across 40 states and D.C. A robust and well function market is critically important to drive innovation and competition, ensuring consumers can select the right coverage for their needs.

It is essential that CMS eliminate loopholes that allow manufacturers to avoid fair negotiation and ensure that pricing rules apply consistently across all Medicare programs. Transparency and full disclosure from manufacturers are critical to achieving meaningful savings and protecting patient access. We offer these recommendations to enhance the Medicare Drug Price Negotiation Program and drive prescription drug affordability and access for America's seniors.

<u>Implementation</u>
The draft guidance requires Medicare-contracted plans to submit claim-level maximum fair price refund data within 14 days, including new requirements for Part B drugs. While the intent to improve transparency and pricing efficiency is clear, the proposed timeframes and system infrastructure assumptions exceed the operational capabilities of local health plans and their provider partners.

ACHP requests CMS implement a phased reporting schedule based on the number Medicare enrollees in a health plan – beginning with the largest plans first. Additionally, CMS may consider facilitating development of standardized data integration tools between Medicare Transaction Facilitators and plan PBM systems.

Local health plans may also face operational and financial burdens in ensuring access to maximum fair price compliant products. **ACHP urges CMS to provide a public, centralized national coverage determination directory of validated maximum fair price compliant products and include safe harbor provisions to protect plans from compliance risk when drugs are unavailable due to manufacturer-level delays.** Plans will continue to be responsible for ensuring member access to maximum fair price-compliant versions of drugs. However, multiple national coverage determinations, varying packaging and potential manufacturer delays may result in disruption of therapy or misalignment of pharmacy networks. These delays will create significant financial burdens on nonprofit, local health plans.

Sudden or frequent pricing changes can also further strain the stability and planning capacity of local health plans. **ACHP urges CMS to restrict mid-cycle maximum fair price renegotiations to no more than once annual and provide 120-day advance notice to MA plans of any changes affecting previously negotiated or rebated products.** While mid-cycle maximum fair price renegotiations based on changes in market dynamics or expanded indications may be appropriate for national-scale budgeting, it introduces volatile pricing risk, especially for plans locked into PBM or provider reimbursement contracts.

Accurate drug selection also depends on careful use of MA data. **ACHP requests CMS evaluate whether spending data from MA plans for Part B drugs materially differs from fee-for-service (FFS) Part B expenditures when identifying qualifying single source Part B drugs.** With the majority of Medicare beneficiaries in MA plans, ignoring differences in utilization or pricing between FFS and MA could skew spending assessments and drug rankings for Total Expenditures under Part B. If CMS uses MA data, it should do so collaboratively with plans without adding burdensome reporting.

<u>Formulary Management & Coverage Flexibility</u>

Health plans must retain formulary flexibility, particularly when more cost-effective alternatives to selected drugs are available. Mandating preferred placement of selected drugs would undermine negotiations with deeper discounts and increase costs for both patients and the Part D program. **ACHP urges CMS to continue not requiring explicit formulary tiering for newly selected Part B and Part D drugs.** ACHP also recommends CMS confirm that plans may continue to use step therapy and other evidence-based utilization management tools to manage selected Part B drugs, as outlined by local and national coverage determinations. **ACHP urges CMS to clarify how coverage policies for selected Part B drugs will interact with existing local and national coverage determinations.**

Additionally, it is critical for plans to understand whether formulary management can reflect clinical distinctions across diagnoses and whether the maximum fair price will vary by indication. If pricing varies by indication, CMS should clarify how those prices will be applied at the point of sale, especially when utilization management tools cannot verify diagnosis, to ensure accurate MFP application. **ACHP requests CMS clarify how the maximum fair price will apply to MA enrollees, particularly for drugs with multiple indications or indication-specific pricing.**

CMS must also close loopholes that allow manufacturers to avoid fair negotiation through minimal product modifications. **ACHP supports grouping fixed-combination drug products with those that share at least one active ingredient and have no clinically meaningful differences into the same Qualifying Single Source Drug (QSSD) for both drugs payable under Part B and/or covered under Part D.** We note this proposal will not significantly affect development of critical products since components deemed "not biologically active" against the indicated disease wouldn't need development. Further, we recommend a clear definition of "not biologically active" to prevent manufacturers from circumventing the policy and further closing the product hopping loophole, which lets manufacturers avoid negotiation through minor, non-therapeutic changes. CMS should actively target and prevent tactics where manufacturers make minor changes to new formulations to avoid price negotiations.

Strengthening Evidence Standards and Safeguarding Competitive Drug Markets

CMS should establish clear standards for the types of evidence that will be prioritized when adjusting the preliminary price during the negotiation process. We encourage CMS to balance manufacturer-submitted and unpublished data to strengthen the negotiation process. Manufacturers often publish only the studies they want considered, leaving out additional data that could inform a more complete and objective evaluation. Using this broader evidence base would support fair pricing and coverage decisions grounded in patient outcomes.

ACHP urges CMS to closely monitor and mitigate any unintended consequences of the negotiation provisions that could limit access to biosimilars or delay competition. Manufacturers are likely to continue using the court system to stall biosimilar entry and CMS should take steps to reduce these legal delays. We strongly support biosimilars as cost-effective, clinically appropriate alternatives to biologics.

ACHP looks forward to partnering with CMS to enhance the Medicare Drug Price Negotiation Program and improve outcomes for all beneficiaries. Please contact Michael Bagel, Associate Vice President of Public Policy at mbagel@achp.org or (202) 897-6121 to discuss these recommendations and collaborate on strengthening the Medicare Drug Price Negotiation Program for all Americans.

Sincerely,

Ceci Connolly
President and CEO
ACHP

June 26, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program – Draft Guidance for Initial Price Applicability Year 2028

Administrator Oz:

On behalf of the members of the American Gastroenterological Association (AGA), we write to share our comments on the Medicare Drug Price Negotiation Program Draft Guidance for Initial Price Applicability Year 2028. The AGA is the trusted voice of the GI community, advancing the science and practice of gastroenterology. Our organization includes over 16,000 members from around the globe engaged in all aspects of the science, clinical practice, and advancement of gastroenterology.

AGA appreciates CMS's commitment to lowering drug costs. In their practices, our members see firsthand how high drug and biologic costs burden patients. For some, high drug and biologic costs place access to necessary therapy out of reach, which leads to poor health outcomes - especially in the management of chronic diseases. AGA's advocacy priorities include ensuring patient access to necessary therapies as well as reducing the administrative requirements that overwhelm our members.

Erosion of the ASP through an MFP Calculation

Currently, gastroenterologists and other physicians who buy-and-bill Medicare Part B drugs are reimbursed at the average sales price (ASP) plus 6%, which was reduced to 4.3% by sequestration. This add-on payment helps cover costs of drug ordering, storage and handling, as well as a portion of the drug costs in instances when a physician's acquisition costs are higher than ASP. Under the draft guidance, CMS suggests incorporating the Maximum Fair Price (MFP) for Medicare negotiated drugs within the ASP. While the MFP has been implemented with the ultimate goal of reducing Part B drug payments, the blending of the MFP within the ASP calculation will erode the ASP, and the amount available for add-on payments will shrink significantly. This is concerning as the costs of ordering, storing and handling Part B drugs are unlikely to shrink due to the Medicare Drug Price Negotiation Program and have in fact only increased with inflation.

Unfortunately, gastroenterologists and other healthcare providers have already been subjected to "underwater" reimbursement for Part B drugs due to the over rebating of biosimilar products. Rebates have plummeted the ASP for many biosimilars, leading to a significant drop in provider reimbursement since it is tied to ASP. Unfortunately, the steep decline in ASP has no reflection on the acquisition cost of these medications by providers and facilities, and gastroenterologists across the country are purchasing Part B

biologics at a much higher rate than they are reimbursed for these medications. Far too often, physicians and facilities are more than 100% "underwater" on the reimbursement for infused medications purchased through buy-and-bill. Some physicians choose to still administer biosimilars to their patients, at a financial loss to the medical practice, because it is the best medication for the patient. However, this is not sustainable, and in many practices it is not currently an option physicians can afford to offer. In other situations, patients may need to seek infusion care at the hospital, which may have greater negotiating leverage to acquire biologics at a lower cost. However, its important to note that the cost of care provided in the hospital is more expensive for the patient and to the health care system.

Physicians' experiences with underwater biosimilar reimbursement is a fair indication of the challenges that medical practices will face if they are inadequately reimbursed for drugs selected through the Medicare Drug Price Negotiation Program. AGA opposes the proposed methodology for blending the MFP within the ASP and urges the agency to adequately reimburse providers through add-on payments that appropriately reflect the costs of ordering, storing and handling these drugs.

Accessing the MFP

Gastroenterologists are very concerned about the continuous decline in Medicare reimbursement and the impact this has on patient access to care, employing staff, and maintaining or replacing needed equipment. In fact, 32% of AGA surveyed members stated they were unable to hire needed staff due to declining reimbursements.[i] The financial viability of these medical practices is fragile, and significant disruptions can cause providers to retire early, sell their medical practice or close their practice, limiting access to gastroenterological care.

With these vulnerabilities in mind, AGA would like to express concern with CMS's proposal to have pharmaceutical manufacturers retrospectively reimburse medical practices for the difference between the dispensing entity or Part B provider's acquisition cost and the MFP. These medical practices are unlikely to be able to carry the cost differential while they await reimbursement from the pharmaceutical manufacturers. This model would place extreme hardship on our members and could jeopardize healthcare practices that buy-and-bill for medications across the country. AGA urges the agency to refrain from advancing a retrospective model for the MFP for Part B drugs.

Enforcement of Tiering and Utilization Management

AGA would also like to take this opportunity to note that CMS has been on record stating that it will not hold Medicare Advantage (MA) plans accountable for the tiering or utilization management of drugs selected for negotiation through the Medicare Drug Price Negotiation Program. While plans are required to cover the selected medications, CMS's deference on tiering and utilization management could ultimately determine whether patients have access to these medications.

Utilization management undermines shared decision-making between physician and patients, increases physician burden and often puts patients at risk by delaying access to necessary care. The lengthy approval process that medical practices must undergo to receive approval for patient prescriptions and procedures typically requires physicians or their staff to spend the equivalent of two business days each week completing prior authorizations — time that could have been spent taking care of patients. In fact, in a recent survey, 66% on respondents confirmed that prior authorization has increased for prescription drugs, with physicians noting that even many generic medications now require pre-approvals.[ii] In Medicare Advantage (MA) plans, physicians are reporting increasingly onerous prior authorization requirements for medical services and procedures that are impacting patient access to medically necessary care. Subjecting negotiated Part B drugs to burdensome prior authorizations will several limit access to these critical medications for Medicare beneficiaries.

In 2018, CMS issued a policy change and began to allow Medicare Advantage (MA) plans to use step therapy protocols on Part B drugs. Step therapy, also known as "fail first," is utilized by insurers to determine drug coverage and requires patients to try and fail on insurers' preferred medications (i.e. first tier) before covering the initial therapy prescribed by their health care provider. This practice requires patients to take medications they may have already tried and failed or have had adverse effects from in order to step through to the physician recommended treatment. Based on a 2015 study, 18 major health plans representing 97 million lives required 45% of patients who rely on biologics or immunologic drugs to step through one or more therapies with black box safety warnings before they were able to access a safer treatment.[iii]

Step therapy exposes gastroenterological patients to less safe medications. In fact, 91% of AGA members surveyed felt it had a somewhat or significant negative impact on patient access to clinically appropriate treatments and on patient clinical outcomes.[iv] With the increase of Part B biologics to treat diseases like inflammatory bowel disease (IBD), more and more patients with digestive diseases are subject to this policy and potential delays to medically-appropriate care. With one in three Medicare beneficiaries on an MA plan, this policy has the potential to greatly impact patient outcomes and health care costs in the Medicare program. It also has the potential to severely limit access to Part B drugs selected for negotiation. AGA urges the agency to take steps that ensure patients can access the drugs selected for negotiation by removing barriers implemented through tiering and utilization management protocols.

AGA shares CMS' concern about the effect that increasing out-of-pocket expenses have on access to Part B drugs, particularly for those with digestive diseases. High out-of-pocket expenses limit access to necessary therapies for people with digestive diseases and reduce therapy adherence, which can result in complications and more costly care such as emergency room visits, hospitalizations and surgery. However, we have concerns with some of the approaches proposed by the agency in executing the Medicare Drug Price Negotiation Program through IPAY 2028. AGA encourages CMS to exercise its authority to remove the Maximum Fair Price for negotiated Part B drugs from the Average Sales Price, protect medical practices from financial hardship and enact policies that ensure patients can access negotiated drugs. If you have any questions or assistance, please contact Kathleen Teixeira, Vice President of Public Policy and Advocacy, at Kteixeira@gastro.org.

Sincerely,

Lawrence Kim, MD, AGAF
President, American Gastroenterological Association

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[i] Clinical Gastroenterology and Hepatology. "American Gastroenterological Association Policy Priorities for Our 2025 Legislative Agenda." May 2025.
[ii] Alliance of Specialty Medicine. "Nationwide Survey of Practicing Specialists: Utilization Management Negatively Affects Clinical Care." December 2022.
[iii] Value in Health. "Formulary Management Of Branded Drugs With And Without Boxed Warnings Within Therapeutic Categories." May 2015.
[iv] Clinical Gastroenterology and Hepatology. "American Gastroenterological Association Policy Priorities for Our 2025 Legislative Agenda." May 2025.

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June 26, 2025

VIA ELECTRONIC DELIVERY
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The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act (SSA) for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028

Dear Administrator Oz:

Amgen Inc. (Amgen) appreciates the opportunity to submit comments on the Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the SSA for IPAY 2028 and Manufacturer Effectuation of the MFP in 2026, 2027, and 2028 posted on the Centers for Medicare & Medicaid Services (CMS) website on May 12, 2025 (IPAY 2028 Draft Guidance).

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.

We are pleased to provide CMS with feedback on certain aspects of the implementation of the Drug Price Negotiation Program (DPNP) for IPAY 2028. However, Amgen remains of the view that the government price controls on certain medicines furnished to Medicare beneficiaries—through the guise of price "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, and that the IRA itself is unlawful. This government price

setting is forcing biopharmaceutical companies to stop pursuing research and development (R&D) on many new drugs. Companies are having to rethink how and where they invest in medical innovation, with the government essentially picking winners and losers by discouraging the development of some types of treatments for certain patient populations. And though we continue to believe the IRA is unlawful, we submit these comments 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, and because the draconian penalties for non-compliance permitted by the IRA leave manufacturers with no real choice but to adhere to the statutory directives.

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 and patient access as it develops guidance for this and other IRA-related programs.

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I. RECOMMENDATIONS REGARDING DRUG SELECTION POLICIES (SECTION 30)

A. CMS Should Make the Process for Identifying Eligible Drugs More Transparent (Sections 30.2 and 30.3)

The IRA identifies eligible drugs for IPAY 2028 as the 50 qualifying single-source drugs (QSSDs) with the highest total Part D expenditures and the 50 QSSDs with the highest total Part B expenditures, with an exception for small biotech drugs. The statute then directs CMS to rank eligible drugs according to their expenditures and select the highest-ranked drugs.[1] Amgen urges CMS to clarify, with sufficient details to make the clarification meaningful, how it will aggregate expenditures and rank drugs as part of this process, in order to improve the ability of manufacturers to predict whether and when they are likely to be selected and prepare for price setting for IPAY 2028 and future years. As it stands, the process is unacceptably opaque, depriving manufacturers like Amgen the opportunity to provide meaningful comment or receive meaningful notice. For the same reasons, Amgen supports CMS publishing a "list of the up to 50 top negotiation-eligible drugs," and we urge the agency to additionally provide the rationale for including or excluding Part B and Part D drugs.[2]

CMS's current and draft guidance on how it will aggregate expenditures to identify eligible drugs is quite limited and manufacturers do not have access to the same data that CMS has. In the absence of a detailed methodology and access to CMS data, manufacturers must either undertake the cumbersome process of preparing more products for price setting than will ultimately be selected, or take the risk of being unprepared, which is not an option given the significance of price setting, the short turnaround for data submission after selection, and the disproportionately severe penalties set by the IRA. As noted in Section VIII below, preparing for price setting requires manufacturers like Amgen to spend considerable resources, including thousands of personnel hours, to compile CMS's required submissions, in addition to establishing infrastructure to eventually facilitate MFP effectuation. Such efforts necessarily reduce the amount of resources manufacturers are able to allocate to other activities, such as providing patient support and researching and developing innovative medicines. Failure to prepare for selection runs the risk that the manufacturer will fail to meet critical data submission deadlines, with civil monetary penalties of $1,000,000 per day, adjusted annually for inflation.[3] In addition to depriving Amgen and other stakeholders a meaningful opportunity to be heard about CMS's process and procedures, the lack of predictability in the selection process creates a significant and unnecessary burden on manufacturers that are committed to complying with DPNP requirements. This burden would be lessened if CMS provides more detail on how expenditures are actually aggregated and drugs are ranked, and reasons why high expenditure drugs are excluded.

For these reasons, Amgen supports CMS's contemplated policy of publishing a list of the top 50 eligible drugs, and we ask CMS to publish its lists of the top 50 QSSDs under Part B *and* the top

[1] SSA § 1192(b), (d).
[2] IPAY 2028 Draft Guidance §§ 30, 30.4.
[3] SSA § 1197(b) (setting forth penalties for violations of manufacturer agreement, including requirement to submit information).

50 QSSDs under Part D each year.[4] We note that the IRA itself directs CMS to identify 100 eligible drugs but to select, at most, 20 of those drugs in a cycle.[5] CMS is thus presumably already identifying these same drugs as part of the process Congress directed it to follow. CMS's contemplated publication could serve as a potential preview of which drugs might be subject to price setting in subsequent selection cycles. This would improve transparency and predictability and would benefit the agency, manufacturers, and other health care stakeholders.

B. CMS Should Finalize Its Proposal to Use Fee-for-Service (FFS) Part B Expenditures, Excluding Drugs Bundled or Packaged into Payment for Other Services, to Rank Eligible QSSDs, Consistent with the Statute (Section 30.2)

The IRA includes specific instructions regarding the identification of QSSDs eligible for price setting under the DPNP. One such instruction relates to the Medicare expenditures to be considered when aggregating expenditures for purposes of identifying and ranking high spend drugs under Medicare Part B. Amgen supports CMS making clear in the final IPAY 2028 guidance that it will identify such eligible drugs based only on FFS Part B claims data.[6]

The statutory provision that expressly enumerates the parts of Medicare that may be included in the aggregation of expenditures to identify an eligible QSSD is limited to Medicare Part B (with a corresponding provision limited to Part D). As noted above, the statute states that, starting with IPAY 2028, CMS must aggregate "the highest total expenditures *under part B* of title XVIII" to determine whether a QSSD is an eligible drug.[7] Amgen supports CMS's proposal to use FFS Medicare Part B claims data to calculate eligible Part B drug expenditures to assess whether a Part B drug is eligible for selection**.**

Amgen also supports CMS's proposal to "exclude expenditures for a drug or biological product that is bundled or packaged into the payment for another service" when calculating the total Part B expenditures for purposes of identifying an eligible QSSD.[8] We appreciate CMS's recognition that such exclusion is required by the IRA, which provides that the units for purposes of calculating the Part B aggregate expenditures do not include, among other types of units, units that are packaged into the payment amount for an item or service and are not separately payable.[9] CMS

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[4] IPAY 2028 Draft Guidance § 20.
[5] SSA § 1192(b), (d).
[6] *See* IPAY 2028 Draft Guidance § 30.2 ("CMS will identify Part B high spend drugs . . . using . . . Part B claims data for each qualifying single source drug[.]").
[7] SSA § 1192(d)(1)(B) (emphasis added); *see also* CMS, Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026, § 30.2 (Jun. 30, 2023) [hereinafter "IPAY 2026 Revised Guidance"], *available at:* https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf; CMS, Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027, § 30.2 (Oct. 2, 2024) [hereinafter "IPAY 2027 Final Guidance"], *available at:* https://www.cms.gov/files/document/medicare-drug-price-negotiation-final-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf.
[8] IPAY 2028 Draft Guidance §§ 30, 30.2.
[9] SSA § 1191(c)(5); *see* IPAY 2028 Draft Guidance §§ 30, 30.2.

should finalize its proposal to exclude drugs that are not separately payable from the aggregation of Part B expenditures.

C. CMS Is Not Permitted, By Statute, to Aggregate Expenditures Across Part B and Part D for Purposes of Ranking Eligible Drugs for Selection (Section 30.3)

CMS's proposal to combine the Part B and Part D expenditures of eligible drugs when ranking such drugs for purposes of selection is inconsistent with the IRA.[10]

For purposes of selecting drugs for a given IPAY, the IRA directs CMS to first identify up to 100 eligible drugs. Section 1192(d)(1) of the SSA defines this process as the identification of the 50 QSSDs "with the highest total expenditures under part D" and the 50 QSSDs "with the highest total expenditures under part B," "as determined by the Secretary . . . , during the most recent 12-month period for which data are available prior to such selected drug publication date."[11] Section 1192(b)(1) instructs CMS to then "[r]ank negotiation-eligible drugs described in subsection (d)(1) according to the total expenditures for such drugs under parts B and D of title XVIII, as determined by the Secretary, during the most recent period of 12 months prior to the selected drug publication date . . . , for which data are available, with the negotiation-eligible drugs with the highest total expenditures being ranked the highest."[12]

Thus, the ranking and selection processes in subsection (b)(1) rely on the identification of eligible drugs under subsection (d)(1), which looks exclusively to a given drug's expenditures under Part B or Part D, independently, as applicable for each of Part B and Part D drugs. The reference to expenditures "under parts B *and* D" refers only to the fact that the 50 Part B and 50 Part D eligible drugs are then ranked in a single list according to the expenditures under their respective Parts. The reference to "*total* expenditures" mirrors the language in subsection (d)(1) directing CMS to determine a QSSD's "*total* expenditures" under either Part B or Part D.[13] Nowhere does the statute direct or permit the aggregation of expenditures across both Parts B and D. If Congress had intended for expenditures under the programs to be combined, it would have said so explicitly in (d)(1), rather than simply reiterating the language of a provision that looks at Part B and Part D separately. Moreover, there would have been no reason for Congress to provide for the separate aggregation under (d)(1) at all if it had intended for CMS to simply re-aggregate the expenditures under (b)(1).

To adhere to the statutory selection procedures, CMS should abandon its contemplated approach to combine Part B and Part D expenditures for purposes of ranking eligible drugs and instead, rank such drugs in accordance with the IRA, according to the drugs' expenditures under whichever Part for which they qualified as selection-eligible drugs.

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[10] IPAY 2028 Draft Guidance § 30.3.
[11] SSA § 1192(d)(1).
[12] *Id.* § 1192(b)(1).
[13] Indeed, even CMS refers a drug's "*combined* Total Expenditures under both Part D and Part B," highlighting that the term "Total Expenditures," alone, refers to the total expenditures under a single Medicare program, per subsection (d)(1). *See* IPAY 2028 Draft Guidance § 30.3 (emphasis added).

D. CMS's New Interpretation Regarding Date of Licensure Is Improper (Section 30.1)

Amgen is concerned about CMS's newly-articulated approach for products with applications originally submitted as New Drug Applications (NDAs) and approved under section 505 of the Food Drug & Cosmetic Act but subsequently deemed to have approved Biologics License Applications (BLAs) under section 351 of the Public Health Service Act, effective March 23, 2020, pursuant to section 7002(e)(4)(A) of Biologics Price Competition and Innovation Act of 2009 (BPCI Act) (referred to in the Draft Guidance as "deemed biologics").[14] The Draft Guidance states that for such products, "CMS will consider March 23, 2020 to be the licensure date for purposes of identifying the time since licensure under section 1192(e)(1)(B)(ii)" of the IRA.[15]

CMS adopted this new interpretation without any, let alone sufficient, administrative process. Indeed, the Draft Guidance represents the first time that CMS has publicly stated that it adopted one statutory interpretation for IPAY 2026, but changed that interpretation, without notice, for IPAY 2027. "An agency may not . . . depart from a prior policy sub silentio or simply disregard rules that are still on the books,"[16] yet that is exactly what CMS did here. Furthermore, as the Supreme Court recognized in *Loper Bright Enterprises v. Raimondo*, statutes "do—in fact, must—have a single, best meaning" and "every statute's meaning is fixed at the time of enactment."[17] The Draft Guidance does not defend CMS's IPAY 2026 interpretation as the single, best meaning—even though CMS selected drugs for price setting based on that interpretation and manufacturers have had drugs included in the DPNP program pursuant to that selection. CMS also does not defend its new interpretation as a new single, best reading. Rather, the agency merely states that no "interested party" had suggested an alternative interpretation[18] for IPAY 2026, presumably as opposed to IPAY 2027. That, however, is not a relevant legal standard, and such year-to-year inconsistency is unjustified. Furthermore, based on a review of public comments, no "interested party" submitted a comment on the IPAY 2027 Draft Guidance arguing for a different interpretation.[19] This unidentified "interested party" therefore must have presented its argument outside of the public process, leading to CMS's change in approach. Agencies must interpret statutes consistently and transparently, and CMS's approach for both IPAY 2026 and IPAY 2027 has deprived the public and stakeholders of any meaningful opportunity to be heard.

Putting aside these process deficiencies, the approach articulated in the Draft Guidance is also improper because it conflicts with FDA's prior findings as to approval dates for deemed biologics, i.e., the date of original NDA approval.[20] Federal law empowers FDA to approve drugs and, in so doing, to determine their date of licensure. CMS lacks the authority to deviate from such findings.

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[14] IPAY 2028 Draft Guidance § 30.1.
[15] *Id*.
[16] FCC v. Fox Television Stations, Inc., 556 U.S. 502, 515 (2009).
[17] Loper Bright Enterprises v. Raimondo, 603 U.S. 369, 400 (2024).
[18] IPAY 2028 Draft Guidance § 30.1.
[19] *See* Public Comments on IPAY 2027 Draft Guidance, *available at:* https://www.cms.gov/files/document/public-comments-medicare-drug-price-negotiation-draft-guidance.pdf.
[20] See FDA, "Lists of Licensed Biological Products with Reference Product Exclusivity and Biosimilarity or Interchangeability Evaluations" (known as the "Purple Book"), *available at:* https://purplebooksearch.fda.gov/ (identifying the approval date of specific deemed biologics as the date of original NDA approval).

E. Another Example of CMS Arbitrarily Changing Statutory Interpretations from Year to Year Is its Proposed Change Regarding Fixed Combination Drugs (Section 30.1)

For IPAY 2028, CMS suggests that it is contemplating a new and different approach to aggregating certain fixed-combination products. With respect to its current approach CMS states "the distinct combination of active moieties / active ingredients will be considered as one active moiety / active ingredient for the purpose of identifying potential qualifying single source drugs," and, therefore, CMS will aggregate across all dosage forms and strengths for each distinct combination.[21] However, CMS indicates that while this approach "is generally appropriate," it might not be appropriate for certain fixed-combination products for which one of the active moieties or active ingredients is not "therapeutically" or "biologically active" against "the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference."[22] CMS provides an example where one active moiety or active ingredient in the fixed-combination product "affects the bioavailability" of the other active moiety or active ingredient "but is not therapeutically active" against the indicated disease state, and CMS concludes that the addition of such component "does not result in a clinically meaningful difference."[23] Amgen has concerns that this proposal is another example of CMS capriciously shifting its interpretations of the statute, rather than faithfully trying to determine its single, best meaning.

The problem starts with CMS's existing overly broad interpretation of a QSSD, which impermissibly aggregates drug products and biological products based on their active moiety or active ingredient, which is a concept that has no basis in the statutory language and is inconsistent with FDA's interpretations of the Food, Drug, and Cosmetic Act. Now, CMS is contemplating modifying this interpretation, but only with respect to certain fixed-combination drugs, without explaining why the agency believes it might be the better interpretation of the statute. CMS needs to conform its statutory interpretations with *Loper Bright*. In doing so, CMS must consider industry's reliance interests and fully explain the basis for a different approach.[24]

II. RECOMMENDATIONS REGARDING THE SPECIAL RULE TO DELAY THE SELECTION OF A BIOLOGIC FOR PRICE SETTING ON ACCOUNT OF ANTICIPATED BIOSIMILAR ENTRY (SECTION 30.3)

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[21] IPAY 2028 Draft Guidance § 30.1.
[22] *Id*.
[23] *Id*.
[24] In determining whether a party received fair notice, courts consider whether, "by reviewing the regulations and other public statements issued by the agency, a regulated party acting in good faith would be able to identify, with 'ascertainable certainty,' the standards with which the agency expects parties to conform." *General Elec. Co. v. EPA*, 53 F.3d 1324, 1329 (D.C. Cir. 1995). This "ascertainable certainty" rule prevents agencies from taking regulated parties by surprise. *See id.* at 1329-30; *see also Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 156 (2012).

Section 1192(f) of the IRA establishes a "Special Rule" that permits CMS to delay selection of a reference biologic for price setting for up to two years under certain circumstances:

(1) The reference biologic that would be selected for price setting but for the requested delay must be an extended-monopoly drug.[25]

(2) A manufacturer that intends to market a biosimilar of the reference biologic must request the delay before what would otherwise be the reference biologic's selected drug publication date.[26]

(3) CMS must determine that there is a "high likelihood" that the biosimilar will be licensed and marketed within two years of what would otherwise be the reference biologic's selected drug publication date.[27]

(4) Certain disqualifying circumstances must not be present.[28]

If CMS determines that the high likelihood test is met, one year of delay is granted. For a second year of delay, the biosimilar manufacturer must submit a second delay request before the selected drug publication date that follows what would otherwise have been the reference biologic's selected drug publication date.[29] If CMS finds that the high likelihood test does *not* continue to be met, including if the "significant amount of progress" requirement is not met, then the reference biologic is selected for price setting, and its manufacturer must pay a specified rebate.[30] If the test *does* continue to be met, CMS will grant a second year of delay.[31] If the biosimilar has not come to market by the end of the second year of delay, the reference biologic is selected for price setting, and its manufacturer must pay a specified rebate.[32] If, instead, the biosimilar comes to market by the end of the first or second year of delay, the reference biologic becomes ineligible for selection for price setting.

As discussed in more detail below, to further support effective implementation of the delay scheme, CMS should take the following steps for IPAY 2028 and future price applicability years:

- Take care in implementing the Special Rule to protect against disrupting a healthy biosimilar market.
- Publish a preliminary selected drug list that biosimilar manufacturers may use to assess the need to apply for a delay.
- Afford relief with respect to the Special Rule's timing requirements.

[25] SSA § 1192(f)(1)(A).
[26] *Id.* § 1192(f)(1)(B)(i)(1).
[27] *Id.* § 1192(f)(1)(A).
[28] *Id*. § 1192(f)(2)(D).
[29] *Id.* § 1192(f)(1)(B)(i)(II).
[30] *Id*. § 1192(f)(2)(B)(ii).
[31] *Id*. § 1192(f)(2)(B)(iii).
[32] *Id*. § 1192(f)(2)(C).

- Clarify that the high likelihood test, including the clear and convincing evidence standard, can be met in any of a number of ways, including provision of attestation by the manufacturer.
- Clarify what CMS views as the "reference product included in the Reference Drug."[33]

These measures would offer predictability and certainty in the biosimilar delay process and thus help preserve a robust biosimilar market that could generate savings for the Medicare program and its beneficiaries; help streamline the CMS process for reviewing and approving delay requests; and ensure that the selection of drugs for price setting remains focused on products without anticipated competition.

A. CMS Should Take Care in Implementing the Special Rule to Protect Against Disrupting a Healthy Biosimilar Market (Section 30.3.1)

It is critical that CMS adopt these five recommendations to ensure a robust biosimilar market. The introduction of biosimilar competition to the marketplace has created an estimated cumulative $36 billion in savings over the past eight years[34] and has the potential to exceed $154 billion in additional savings 2024 through 2027.[35] CMS has taken welcome steps to support investment in biosimilars, for example, through its current Medicare Part B coding policy. CMS's willingness to take a flexible approach to implementation of the biosimilar delay provisions and to communicate such approach to stakeholders would greatly boost biosimilar manufacturers' confidence that a viable marketplace for biosimilars will continue in the United States.

The Special Rule includes timing requirements for completion of activities that pose significant challenges given the operational realities facing biosimilar manufacturers, like Amgen. For example, the Special Rule requires that a request for a delay be submitted by the "selected drug publication date" of the reference product, which can be as soon as 11 years after FDA approval of the BLA of the reference product, and therefore prior to the expiration of the 12-year data exclusivity period for reference biologics. Furthermore, the Special Rule requires that FDA have accepted or approved the BLA of the biosimilar before granting a request for delay.[36] We appreciate the agency's recognition that more time may be needed to allow for acceptance of the BLA by FDA, and we support CMS stating that a biosimilar's application for licensure must be "accepted for review or approved by the FDA no later than January 15, 2026" for a delay request to be approved.[37]

Where a biologic is selected for price setting soon after its eligibility for selection, a biosimilar manufacturer ordinarily would not submit a BLA before the delay request submission deadline

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[33] IPAY 2028 Draft Guidance § 30.3.1.3.
[34] Association for Accessible Medicines, 2024 US Generic and Biosimilar Medicines Savings Report 29 (Sept. 2024), *available at:* https://accessiblemeds.org/resources/reports/2024-savings-report/.
[35] IQVIA, Biosimilars in the United States 2023-2027 at 29 (Jan. 31, 2023), *available at:* www.iqvia.com/insights/the-iqvia-institute/reports/biosimilars-in-the-united-states-2023-2027.
[36] IPAY 2028 Draft Guidance § 30.3.1.1 ("[F]or CMS to determine that there is a high likelihood of the Biosimilar being licensed and marketed prior to February 1, 2028, the Biosimilar's application for licensure must be accepted for review or approved by the FDA no later than January 15, 2026.").
[37] *Id.*

because the Biosimilar User Fee Act (BsUFA) date will not fall until after the expiration of regulatory exclusivity. And biosimilar development typically takes a number of years between initiation of development and submission of a BLA to FDA. Given the lead time for the development of biosimilars, it will be difficult or even impossible to accelerate clinical trials and other development milestones in response to the Special Rule. Biosimilars take years to bring to market at a cost of between $100 million and $200 million.[38] Depending on changes in U.S. regulatory guidance and increasing complexity of future biosimilar products, this development may range from 6 to 10 years. Considering that a reference product can be selected as soon as 11 years after FDA licensure, this leaves only a year or two of sales of the innovator product for a biosimilar manufacturer to evaluate before deciding whether to begin development of a competing product, in order to fall within the time frame of the biosimilar delay requirements. Moreover, it becomes difficult for the biosimilar manufacturer to predict the financial forecasting and planning because the parties do not know whether the reference biological manufacturer's product will be subject to the MFP or whether the two manufacturers will reach a settlement allowing the biosimilar to come to market and what the terms of that agreement will be (e.g., the licensed entry date). Uncertainty about CMS's implementation of the Special Rule is likely to result in development of fewer biosimilars.

As discussed in Section III.A below, CMS's "bona fide marketing" standard creates additional uncertainty that is making manufacturers more cautious when investing in biosimilars. Newly launched biosimilars face an uncertain uptake trajectory, especially under the pharmacy benefit where rebate dynamics create incentives for pharmacy benefit managers (PBMs) to favor products with higher list prices. Biosimilar manufacturers have no way of knowing whether a biosimilar currently in development will satisfy the vague standard of "bona fide marketing." Rather than pursuing flexibility to encourage biosimilar development in light of the challenges created by the DPNP, CMS has layered on an additional extra-statutory barrier to biosimilar entry through the "bona fide marketing" standard.

Our following slate of biosimilar delay recommendations is designed to promote predictability and a robust biosimilar market.

B. CMS Should Afford Relief with Respect to the Special Rule's Timing Requirements (Section 30.3.1)

Requests for delay must be submitted prior to the selected drug publication date.[39] So that CMS can review delay requests using the best available information, the request deadline should be as close as reasonably possible to the applicable selected drug publication date. Under the IPAY 2028 Draft Guidance, however, biosimilar manufacturers would continue to have to prepare these requests long before they know whether a particular reference biological product will be

[38] Amgen, *Amgen Biosimilars*, https://www.amgen.com/science/biosimilars (accessed June 9, 2025); Robert Haustein, Christoph de Millas, Ariane Höer & Bertram Häussler, *Saving Money in the European Healthcare Systems with Biosimilars*, 1 Generics & Biosimilars Initiative J. 120 (2012), *available at:* https://gabi-journal.net/saving-money-in-the-european-healthcare-systems-with-biosimilars.html.
[39] SSA § 1192(f)(1)(B).

selected.[40] These requests for delay will require time and resources for biosimilar manufacturers to prepare, possibly for multiple products, which will be unnecessary if the reference drugs are not likely to be selected. Accordingly, Amgen recommends that CMS publish a list of reference biological products likely to be selected ahead of the selected drug publication date, so that biosimilar manufacturers have reasonable advance notice to prepare a request for delay. We ask that this list be published by November 15, preceding the selected drug publication date to allow biosimilar manufacturers time to prepare a delay request if appropriate.

C. CMS Should Expand Options for Demonstrating that Patents Related to the Reference Drug Are Unlikely to Prevent the Biosimilar from Being Marketed (Section 30.3.1.3)

The standard set forth by CMS in the IPAY 2028 Draft Guidance for demonstrating that patents related to the reference drug are unlikely to prevent a biosimilar from being marketed can be nearly impossible to meet for biosimilar manufacturers. CMS states that it will continue to use the standard it adopted for IPAY 2027, which requires that: "(1) there are no unexpired patents relating to the reference product included in the Reference Drug that are applicable to the Biosimilar; (2) one or more court decisions or decisions by the United States Patent and Trademark Office (USPTO)'s Patent Trial and Appeal Board (PTAB) establish the invalidity, unenforceability, or non-infringement of any potentially applicable unexpired patent relating to the reference product included in the Reference Drug that the patent holder asserted was applicable to the Biosimilar; or (3) the Biosimilar Manufacturer has a signed legal agreement with the Reference Manufacturer that permits the Biosimilar Manufacturer to market the Biosimilar before the High Likelihood Deadline . . . ."[41]

Amgen appreciates CMS's request for comments "regarding whether there is additional or alternative evidence that may demonstrate that patents related to the Reference Drug are unlikely to prevent the Biosimilar from being marketed before the High Likelihood Deadline." We urge CMS to accept a biosimilar manufacturer's attestation as evidence satisfying this criterion.[42]

The standard in the IPAY 2028 Draft Guidance can be met if there are no unexpired patents, but that is not often the case. Where there is at least one unexpired patent, CMS's proposed standard creates a "catch 22" for biosimilar manufacturers due to the timing of FDA's biosimilar BLA approval process and patent litigation, in combination with the IRA limitation that CMS cannot grant a delay request if more than one year has elapsed since FDA approval of the biosimilar and marketing has not commenced.

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[40] IPAY 2028 Draft Guidance § 30.3.1 (stating that CMS will specify the deadline for an initial delay request once the Office of Management and Budget (OMB) approves the Drug Selection ICR and "anticipates providing a 30-day submission window," and that CMS will notify biosimilar manufacturers of CMS's decision on a biosimilar delay request "on or after" the selected drug publication date, i.e., February 28, 2026)

[41] *Id.* § 30.3.1.3.

[42] *Id.*

FDA typically approves BLAs approximately one year after submission. On the other hand, patent litigation typically begins around 10 months after a BLA is filed and lasts 2.5 to 3 years or even longer. A biosimilar applicant cannot count on obtaining a patent settlement or a court decision in time or guarantee that no potentially relevant patents will be issued by the delay request deadline. The delay request deadline may occur before the parties have completed the patent exchange process under the BPCI Act, which includes the sharing of patent information between the parties that could be used as factor in assessing what settlement terms may be reasonable based on the patent landscape. Additionally, the parties may want to assess information obtained during discovery and briefing, as well as consider initial decisions by the patent office or courts to evaluate possible settlement terms.

The existing option of obtaining a court decision to submit as evidence for the delay request is also difficult to satisfy due to the length of time litigation takes. It is difficult to predict ahead of time how long litigation will take (and whether a decision could be obtained by the deadline) because the timing depends on a number of factors such as the forum, number of patents, complexity and number of disputed issues, availability of dates in the judge's calendar for pre-trial hearings and trial, and the length of time after trial for the judge to issue a decision. Trial dates can also be delayed. Thus, court decisions are typically issued after the delay request deadline.

Therefore, if a biosimilar manufacturer waits to launch its biosimilar until litigation is resolved (either through a court order or settlement agreement), more than one year likely will have passed between FDA approval and marketing of the biosimilar, and the biosimilar manufacturer will be ineligible to request a delay.

Amgen appreciates CMS's consideration of USPTO decisions as an additional criterion for IPAY 2027 to the criteria adopted for IPAY 2026. We note, however, that this option will not be available in all cases.[43] The USPTO's PTAB generally takes about 18 months to issue decisions like Inter Partes Review and Post Grant Review decisions. As such, although USPTO decisions may be rendered more quickly than court rulings, they frequently will not be issued before the delay request deadline. And where new patents issue shortly before the deadline, it will be impossible for a biosimilar manufacturer to obtain the necessary decision. Furthermore, only certain arguments can be raised in patent office proceedings; for some arguments, such as non-infringement, a biosimilar applicant will have to wait for a court decision, which is unlikely to be issued by the deadline.

The other option would be for a manufacturer to launch "at risk," that is, despite litigation or potential for litigation. However, in this case, the manufacturer could not provide CMS with a court decision or settlement agreement to satisfy the Draft Guidance.

[43] *See* IPAY 2027 Final Guidance, at Summary of Public Comments ("After considering comments and conducting further review, CMS understands that many patent disputes involving biosimilars are adjudicated by the USPTO's Patent Trial and Appeal Board (PTAB), in addition to the traditional forum of federal court. Because both are common venues for resolving patent disputes between biosimilar and reference product sponsors, CMS is updating the guidance to include the consideration of PTAB decisions when reviewing whether a patent is unlikely to prevent the Biosimilar from entering the market.").

Thus, Amgen also recommends that the biosimilar manufacturer be able to certify that, to the best of its knowledge, no valid patents will be infringed once the biosimilar is launched. This new criterion allows the biosimilar manufacturer to rely on its assertion that patents are believed to be invalid, unenforceable, or not infringed. Some foreign agencies allow the biosimilar applicant to rely on such a certification to obtain regulatory approval.[44]

Accordingly, we ask that CMS revise its standard as follows. New text as compared to existing criteria in support of this standard is shown in italics, bold, and double underline.

> [O]ne or more court decisions or decisions by the United States Patent and Trademark Office (USPTO)'s Patent Trial and Appeal Board (PTAB) establish the invalidity, unenforceability, or non-infringement of any potentially applicable unexpired patent relating to the reference product included in the Reference Drug that the patent holder asserted was applicable to the Biosimilar;
>
> ~~***or***~~
>
> [T]he Biosimilar Manufacturer has a signed legal agreement with the Reference Manufacturer that permits the Biosimilar Manufacturer to market the Biosimilar before the High Likelihood Deadline, without imposing improper constraints on the Biosimilar Manufacturer~~;~~
>
> ***or***
>
> ***The Biosimilar Manufacturer certifies that, to the best of its knowledge, there are no valid patents that will be infringed upon once the Biosimilar is launched.***

CMS should include this additional option for demonstrating a high likelihood for the initial delay determination given the difficulty and unpredictability of being able to satisfy the existing criteria.

D. CMS Should Modify Its Standards for a Second Year of Delay in Its IPAY 2028 Guidance for Future Program Years (Sections 30.3.1.2, 30.3.1.3, and 30.3.1.4)

Amgen thanks CMS for establishing standards regarding the types of documentation and information that may constitute "clear and convincing evidence that the Biosimilar Manufacturer has made a significant amount of progress towards licensure and marketing of the Biosimilar since the Biosimilar Manufacturer's submission of the successful Initial Delay Request for the Biosimilar."[45] However, in the final IPAY 2028 guidance, we urge CMS to consider certain

[44] *See, e.g.*, Austl. Therapeutic Goods Act 1989 (Cth) s 26B (providing for "a certificate the effect that the applicant, acting in good faith, believes on reasonable grounds that it is not marketing, and does not propose to market, the therapeutic goods in a manner, or in circumstances, that would infringe a valid claim of a patent that has been granted in relation to the therapeutic goods"). Such certification is permitted even in the United States for generics, but there is no equivalent process for biosimilars. *See* Federal Food, Drug & Cosmetic Act § 505(j)(2)(vii); 21 C.F.R. § 314.94(a)(12).

[45] IPAY 2028 Draft Guidance § 30.3.1.4.

information as presumptively supporting the clear and convincing evidence standard for a second year of delay so that biosimilar manufacturers can plan ahead for future delay requests.

Specifically, CMS should find that a biosimilar manufacturer that meets the following criteria has satisfied the test for a *second* year of delay:

a) If the BLA for the biosimilar was pending review during the first year of delay:
   (i) FDA has since approved the BLA for the biosimilar; *or*
   (ii) The first cycle of review remains ongoing, i.e., FDA's BsUFA date has not yet occurred; *or*
   (iii) FDA has issued a complete response letter to the biosimilar manufacturer denying the BLA for the biosimilar but, as of the time CMS is assessing eligibility for a second year of delay, the biosimilar manufacturer has resubmitted the BLA for the biosimilar; *or*
   (iv) The biosimilar manufacturer's disclosures to investors or filings with the Securities and Exchange Commission (SEC), such as Forms 10-K or 10-Q, indicate that it plans to market the biosimilar within the requisite time frame; *or*
   (v) The manufacturing schedule for the biosimilar submitted to FDA indicates that commercial lots of the biosimilar are expected to be produced within the requisite time frame; *or*
   (vi) Agreements filed with the Federal Trade Commission (FTC) or the Department of Justice (DOJ) do not bar the biosimilar manufacturer from marketing the biosimilar within the requisite time frame.

Amgen urges CMS to adopt these criteria when considering a request for a second year of delay to help enable biosimilar competition, as intended under the statute.

E. CMS Should Clarify Terms Implementing the Special Rule (Section 30.3.1)

In its discussion of the Special Rule's initial delay request provisions, the IPAY 2028 Draft Guidance refers multiple times to the "reference product included in the Reference Drug."[46] This phrase is confusing, particularly given that it is not consistent with terminology used by FDA and understood by regulated industry. CMS should clarify the meaning of this phrase to facilitate understanding and implementation of the Special Rule.

It appears that CMS intends for "reference product" to refer to the presentations (e.g., dosage form, strength, route of administration) that serve as a biosimilar's "reference product(s)" in the biosimilar's marketing application. Indeed, several statements in the IPAY 2028 Draft Guidance suggest CMS is adopting a presentation-by-presentation interpretation of the term "reference

[46] *Id.* § 30.3.1.3.

product."[47] Such an interpretation would be consistent with FDA's approach toward interchangeability designations for biosimilars, under which FDA has taken the position that a biosimilar's "reference product" is determined on a presentation-by-presentation basis.

If this understanding of CMS's intention is correct, we urge CMS to replace the phrase "reference product included in the Reference Drug" with "presentation included in the Reference Drug" in the final guidance. If this is not CMS's intent, we ask that CMS clarify the meaning of "reference product included in the Reference Drug" in its final guidance.

III. RECOMMENDATIONS REGARDING THE MARKETING OF GENERICS AND BIOSIMILARS (SECTIONS 30.1, 70, AND 90.4)

A. We Urge CMS to Move Away from Its "Bona Fide" Marketing Standard (Sections 30.1, 70, and 90.4)

We urge CMS to adopt the "start marketing date" published in the National Drug Code Directory to determine the date a drug is "marketed." This would align CMS policy with both the statutory language of the IRA as well as FDA's jurisdiction under the Food Drug and Cosmetics Act, which is triggered by the introduction of a product into interstate commerce. This is the right approach for both legal and policy reasons.

As Amgen, the Pharmaceutical Research and Manufacturers of America (PhRMA), and many others have pointed out, the "bona fide" marketing standard is incompatible with the clear language of the statute. We refer to Amgen and PhRMA's comments on the IPAY 2026 and IPAY 2027 draft guidances for additional discussion.

Setting aside the very serious legal problems with CMS's definition, this approach creates an unnecessary barrier to a robust marketplace with biosimilars. As we have emphasized in other sections of these comments, predictability is essential when biosimilar manufacturers make decisions to invest in clinical trials and commercialization activities. The "bona fide" marketing standard is entirely undefined. In fact, in the IPAY 2026 Revised Guidance, CMS rejected requests that it establish specific market share or other objective requirements to define the market date and instead stated it would look at the "totality of the circumstances."[48] Such a "we know it when we see it" standard is subjective and unpredictable and makes it impossible for a biosimilar manufacturer to plan, much less to receive adequate notice and a meaningful opportunity to be heard.

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[47] *Id.* § 30.1 ("*If any strength or dosage form of a potential qualifying single source drug is the listed drug or reference product*, as applicable, for one or more generic or biosimilar products that CMS determines are approved or licensed, as applicable, and bona fide marketed based on the process described in this draft guidance, the potential qualifying single source drug will not be considered a qualifying single source drug for initial price applicability year 2028") (emphasis added)]; *id.* § 60.7 (". . . if CMS determines that at least one generic drug or biosimilar biological product satisfies the following criteria: (1) it is approved under section 505(j) of the FD&C Act *with at least one dosage form and strength of the selected drug as the listed drug or licensed under section 351(k) of the PHS Act with at least one dosage form and strength of the selected drug as the reference product* . . . ") (emphasis added).

[48] IPAY 2026 Revised Guidance §§ 30, 70.

Based on statements in prior guidance, we understand CMS's concern to be that a manufacturer might "launch into the market a token or de minimis amount of a generic drug or biosimilar for the selected drug and the manufacturer of that selected drug could claim that the MFP should no longer apply."[49] Amgen is not aware of such a scenario ever happening with a biosimilar and a reference product.

Moreover, to the extent that CMS is concerned about potential anticompetitive conduct, that is the remit of its sister agencies, the FTC, which "enforce[s] federal competition and consumer protection laws that prevent anticompetitive, deceptive and unfair business practices,"[50] and the DOJ, which "uphold[s] the rule of law."[51] And both federal and state antitrust laws provide for private rights of action, thus permitting an aggrieved person to pursue recovery. As noted above, agreements between brand and biosimilar drug manufacturers regarding the manufacturing, marketing, and sale of biosimilar versions of reference drug products must be filed with the FTC and the DOJ. The same is true for agreements between brand-name drug manufacturers and generic drug applicants. Thus, federal antitrust agencies, which have the statutory authority, experience, and expertise to assess the merits of competition involving biosimilars and generics, are best positioned to perform this assessment. With respect to marketing by manufacturers of biosimilars or generics that are not subject to agreements with brand-name manufacturers, there would be no reason for such manufacturers to go through the time and expense of the FDA approval process and launch of their products only to not compete vigorously in the marketplace.

Contrast the FTC's authority with the limited tools CMS has at its disposal. CMS's sole unique tool is to review Medicare claims data, but such data could suggest low utilization for any number of reasons, including PBM "rebate walls," initially slow uptake by prescribers, and data lags, that do not involve intentional "token or de minimis" launches. In the IPAY 2028 Draft Guidance, CMS indicates that it will also review "licenses or other agreements" that may "limit the availability or distribution" of generic drugs or biosimilars, but such reviews are squarely within the expertise and ongoing work of the FTC.[52]

If, despite marketplace incentives to compete and FTC's oversight, CMS sees the types of behavior it is worried about, it may be appropriate for CMS to take policy action. But we urge CMS not to create a barrier to biosimilar entry based on an entirely hypothetical and, in our view, unrealistic risk.

B. CMS Should Remove a Drug from the Selected Drug List Where a Generic or Biosimilar Is Timely Marketed After the End of the "Negotiation Period" But Before an MFP Takes Effect (Section 70)

[49] *Id.* at Summary of Public Comments; IPAY 2027 Final Guidance, at Summary of Public Comments.
[50] About the FTC, FTC, *available at*: https://www.ftc.gov/ (accessed June 24, 2025).
[51] About DOJ, DOG, *available at*: https://www.justice.gov/ https://www.justice.gov/ (accessed June 24, 2025).
[52] IPAY 2028 Draft Guidance §§ 30.1, 70, 90.4.

Amgen urges CMS to interpret the IRA to allow a reference product to exit the DPNP if a generic or biosimilar product is marketed after the "negotiation period" but before the start of the IPAY. Such reading aligns with the statutory definition of a QSSD—a threshold requirement for a drug to be subject to price setting. The statute defines a QSSD "with respect to an [IPAY],"[53] indicating that a product's status as a QSSD must exist as of the first day of the IPAY, not just on the selected drug publication date, as CMS suggests in section 70 of the IPAY 2028 Draft Guidance. Had Congress intended for QSSD status to be assessed only as of the selected drug publication date, it would have said so. Thus, a product that has become multisource before the IPAY should not be subjected to price setting.

This view also comports with the definition of "price applicability period," which means, "*with respect to a qualifying single source drug*, the period beginning with the first IPAY with respect to which such drug is a selected drug and ending with the last year during which the drug is a selected drug."[54] This reference to QSSD status signals that a product that has gone multisource and hence no longer meets the QSSD definition should not be subject to a price applicability period. Moreover, as the statute and CMS's Figure 1 show, only products that are QSSDs may be eligible drugs. A product that is no longer a QSSD cannot, by definition, be considered an eligible drug or a selected drug.[55]

Amgen's position aligns with subsection (c)(1) in section 1192 and its use of the phrases, "with respect to an [IPAY]" and "with respect to such year" in paragraph (1).[56] This phrasing supports the conclusion that "negotiation-eligible" status (and, hence, QSSD status) must remain in place as of January 1 of the IPAY for subsection (c)(1) to apply to the drug. Thus, this provision speaks to the exit process for drugs that remain QSSDs and selected drugs on the first day of the IPAY and then experience generic or biosimilar competition. Paragraph (2) "clarif[ies]" the application of paragraph (1) to a specific time period when various tasks otherwise would need to be performed by both CMS and the manufacturer, i.e., during the "negotiation period."[57] The provision does not address what happens if the generic or biosimilar is marketed after the "negotiation period," as there is no "negotiation process" to which the manufacturer is subject, and thus no need for a clarification that the process must stop. Paragraph (2)'s styling as a "clarification" shows that the statutory terms referenced in subsection (c) must be given full effect in subsection (c)(1). In other words, it does not change the fact that the statute defines QSSD "with respect to an [IPAY]."

This position is grounded in sound policy. Congress crafted the IRA to provide for price setting for *single source* products. CMS's current position undermines this intent by applying MFPs to products that are already multisource. This position thereby directly undermines generic and biosimilar competition and incentives for pursuing approval of such products. For generic and biosimilar companies, developing and marketing generic and biosimilar products within the time frames under the law is already challenging. The processes necessary to market a generic or

[53] SSA § 1192(e)(1).
[54] *Id*. § 1191(b)(2) (emphasis added).
[55] *Id*. §§ 1192(c) (defining "selected drug"), 1192(d) (defining "negotiation-eligible drug").
[56] *Id.* § 1192(c)(1).
[57] *Id.* § 1192(c)(2).

biosimilar product can be complex, and there are many steps that are not solely in control of the generic or biosimilar sponsor, including FDA review timelines. The price-controlled MFP may go into effect before such companies are ever able to market their products and may set a price below the level of economic viability. CMS's position compounds this problem by essentially providing that generic or biosimilar marketing in the last thirteen months before the IPAY does not trigger exit from the DPNP. In other words, a generic or biosimilar company that brings its products to market during these thirteen months will nevertheless be forced to compete with an MFP.

Amgen therefore urges CMS to revise its policy in the IPAY 2028 Draft Guidance to provide that a reference product exits the DPNP if generic or biosimilar marketing occurs after the "negotiation period" but before the first day of the IPAY. CMS also should amend Table 9 of the IPAY 2028 Draft Guidance as follows:

Date on which CMS determines that a generic drug or biosimilar is approved and marketed	**Result with respect to selected drug for the Negotiation Program**
The date that the selected drug list for initial price applicability year 2028 is published through ~~November 1, 2026~~December 31, 2027 (~~the end of~~ which includes the Negotiation Period for initial price applicability year 2028)	Selected drug remains a selected drug for initial price applicability year 2028, though MFP does not apply; selected drug ceases to be a selected drug on January 1, 2029.
~~November 2, 2026~~January 1, 2028 through March 31, 2028	Selected drug remains a selected drug and MFP applies for initial price applicability year 2028; selected drug ceases to be a selected drug on January 1, 2029.
April 1, 2028 through March 31, 2029	Selected drug remains a selected drug and MFP applies for initial price applicability year 2028 and calendar year 2029; selected drug ceases to be a selected drug on January 1, 2030.

IV. RECOMMENDATIONS REGARDING THE PROVISION OF THE MFP

A. CMS Should Allow for Additional Mechanisms to Validate Eligibility for the MFP; Allow Additional Time to Process Payment, Including Where There Have Been Adjustments to a Previously Filed Claim; and Further Refine the Medicare Transaction Facilitator (MTF) Mechanism (Section 40.4)

1. MTF Data Module (MTF DM) Claims-Level Data Elements and Implementation

Amgen appreciates that CMS finalized a list of claims-level and other data elements that the MTF would provide to manufacturers to validate accuracy of the MFP payment amount, and Amgen generally supports the expanded list of claims-level data elements that CMS identifies beginning with IPAY 2028. Providing these data to manufacturers will help them verify eligibility for the MFP,

beyond the validation conducted by Part D plan sponsors and the Part D Drug Data Processing System (DDPS), and consistent with all applicable legal requirements such as those under the Sarbanes-Oxley Act.[58] Additionally, Amgen encourages CMS to establish similar proposals for Part B claims, to allow manufacturers to verify eligibility for the MFP on those claims as well.

Amgen supports CMS's stated intent to include DDPS edits that seek to verify whether there are duplicate claims for the MFP that would identify whether an MFP rebate or adjustment to a rebate has been previously paid.[59] Including these DDPS edits will aid manufacturers in eliminating duplicate MFP claims.

Similarly, Amgen supports CMS's intent to withhold MTF notification to the manufacturer of MFP rebate liability until DDPS edits related to verification of the MFP eligibility are resolved.[60] Amgen urges CMS to finalize this proposal, and the list of DDPS edits for which it would withhold MTF notification until such edits are resolved, without change.

Amgen further requests that the agency confirm, in the final guidance, that manufacturers have no role in notifying dispensing entities of pending DDPS edits. As manufacturers do not receive claim data elements until DDPS edits have cleared, manufacturers should not be responsible for notifying dispensing entities that there are DDPS edits to resolve and should not be penalized if a dispensing entity's failure to resolve DDPS edits delays or otherwise interferes with how quickly the dispensing entity receives access to the MFP. As noted in the IPAY 2028 Draft Guidance, the 14-day prompt MFP payment window does not begin until the MTF transmits the claims-level data elements to the manufacturer validating MFP eligibility.[61] In addition, CMS notes that it will not transmit the claims-level data elements to the manufacturer until the MFP-related DDPS edits have cleared.[62] Where a dispensing entity has not promptly addressed those edits, any delay in access to the MFP is its own responsibility.

CMS should also regularly audit and otherwise monitor claims submitted to the MTF, publicly report any uncovered duplication and other error rates, and mandate corrective action, as warranted.

Finally, Amgen requests that CMS provide clear timelines over which it intends to test the MTF DM functions, both with respect to validating claims-level data from dispensing entities and communicating with the MTF Payment Module (MTF PM) once the MTF DM receives the payment-level data elements, as well as the scope of such testing. Doing so will allow manufacturers to better prepare for this process as we move towards the first year of MFP effectuation in IPAY 2026.

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[58] Sarbanes-Oxley Act of 2002, Pub. L. 107–204 (Jul. 30, 2002), https://www.govinfo.gov/content/pkg/COMPS-1883/pdf/COMPS-1883.pdf (accessed June 14, 2024.)
[59] IPAY 2028 Draft Guidance § 40.4.2.
[60] *Id.*
[61] *Id.* § 40.4.
[62] *Id.* § 40.4.2.1.

2. Prompt MFP Payment Window

CMS states that, in IPAY 2028 as in prior years, manufacturers must "provide access to the MFP . . . and transmit reports with claim-level payment elements to the MTF DM within the 14-day prompt MFP payment window."[63] CMS further states, as noted above, that the 14-day prompt MFP payment window will not begin until all DDPS data validation edits related to MFP-eligibility are resolved.[64] As an initial matter, Amgen appreciates CMS's proposal that the 14-day prompt payment window will not begin running until all DDPS data validation edits related to MFP eligibility are resolved. However, Amgen continues to have significant concerns about the length of the prompt payment window. The shortness of this window is not mandated by statute, and as raised in prior year comments, Amgen has many concerns related to the volume of claims that manufacturers would have to process within such window. For just one selected drug for IPAY 2026, average daily Part D claims were nearly 52,000 in 2022 based on an analysis of the Part D drug spending dashboard, which would have yielded the same number of MFP rebates. We understand that the data can come in great volume and as often as daily, making it hard to track the 14-day prompt payment window. This short time frame further warrants additional time, greater clarity, and implementation flexibility. Amgen is not aware of any other federal drug discount or rebate program with such a short payment processing time frame.[65] We again urge CMS to extend this window to 30 days to allow manufacturers sufficient time to appropriately process and effectuate payment for MFP claims.

Finally, CMS should clarify that the prompt MFP payment window begins on the date that the data are received by the manufacturer, instead of beginning "when the MTF sends data to the Primary Manufacturer that verify the selected drug was dispensed to an MFP-eligible individual" so that manufacturers are not penalized by any lag in transmission.[66] For comparable reasons, CMS should finalize the clarification in the IPAY 2028 Draft Guidance that the window ends on the date on which the manufacturer transmits the payment (as opposed to the date on which the pharmacy receives the payment).[67]

3. Transmission of MTF Data to Manufacturers

Given the challenges Amgen anticipates with the 14-day prompt MFP payment window (outlined above), we ask that CMS establish a policy for less frequent data transmissions. Specifically, CMS should finalize that the MTF transmit data to manufacturers no more frequently than every

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[63] *Id*.
[64] *Id.*
[65] For example, manufacturers had 38 days to pay discounts under the Coverage Gap Discount Program and Manufacturer Discount Program. CMS, Medicare Coverage Gap Discount Program Technical Guide, 9 (Aug. 2021), *available at*: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Coverage_Gap_Discount_Program_Technical_Guide_08.2021.v1.pdf; CMS, Revised Medicare Part D Manufacturer Discount Program Final Guidance § 80.2.3 (Nov. 17, 2023) [hereinafter "Medicare Part D Manufacturer Discount Program Final Guidance"], *available at*: https://www.cms.gov/files/document/manufacturer-discount-program-final-guidance.pdf. Although there is a 14-day prompt pay requirement in Part D, it is specific to reimbursement from Part D plans to pharmacies, not rebates from manufacturers to pharmacies. 42 C.F.R. § 423.520(a)(1)(i).
[66] IPAY 2028 Draft Guidance § 40.4.
[67] *Id*.

two weeks. Less frequent data transmissions are necessary both to ensure the MTF can appropriately validate and process data received from pharmacies and that manufacturers can complete data validation and 340B deduplication to ensure prompt and accurate payments to pharmacies.

4. Adjustments to MTF Data

CMS states in the IPAY 2028 Draft Guidance that the MTF will maintain a "credit/debit ledger system that tracks credits and debits related to MFP refunds at the dispensing entity NPI-level."[68] Such credit/debit system would allow MFP rebates to be subsequently reversed or adjusted; CMS suggests that the MTF DM will automatically identify a credit/debit and instruct the MTF PM to apply it.[69] Amgen appreciates CMS's intent to provide a reconciliation mechanism for reversals and adjustments where the MFP was previously paid, but asks CMS to revise this to instead transmit any credits or debits, with pertinent claims-level data, to manufacturers first, rather than automatically applying the credit or debit. Manufacturers must have the opportunity to validate pricing and payment values prior to credit application. This approach will improve data integrity and reduce reconciliation discrepancies between CMS and manufacturers by giving manufacturers an opportunity to confirm that they agree that an applicable credit/debit is due and how much before the credit/debit is executed.

Amgen encourages CMS to further specify that any adjustments to the MTF data that occur within a prompt MFP payment window *restart that window*. Restarting this window would be consistent with the requirements governing the reimbursement window between Part D plans and pharmacies.[70]

5. Contents of the Manufacturer Refund Report (MRR) File

In the IPAY 2028 Draft Guidance, CMS states that it will transmit to dispensing entities a remittance file based on the claims-level data elements passed through the MTF DM, following payment made using the MTF PM, and will issue a receipt file to manufacturers for informational purposes.[71] CMS intends that the receipt file will "provide a notice to the Primary Manufacturer that acknowledges receipt and processing of claim-level payment elements by the MTF DM" and the status of MFP refund payment, such as payment transmission and credit application.[72] In response to CMS's request for comment on the contents of the receipt file, Amgen asks that CMS include a mechanism for error notification in the event of issues withdrawing funds. Along with the data elements in the MRR, this notification is important to aid manufacturers in confirming that

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[68] *Id.* § 40.4.3.2.
[69] *Id.*
[70] 42 C.F.R. § 423.520; s*ee also* 76 Fed. Reg. 54,600, 54,613 (Sep. 1, 2011) ("If the sponsor does not provide notice to the submitting pharmacy of any defect or impropriety in the resubmitted claim within 10 days of the sponsor's receipt of such claim, the resubmitted claim is deemed to be a clean claim and must be paid consistent with the timeframes specified in § 423.520(a)(1) (within 14 days of the date on which a resubmitted electronic claim is received and within 30 days of the date on which a nonelectronically resubmitted claim is received).").
[71] IPAY 2028 Draft Guidance § 40.4.3.1.
[72] *Id.*

appropriate payment has been made so that they can ensure they are complying with DPNP requirements.

B. CMS Should Require the Use of 340B and Non-340B Modifiers to Avoid MFP/340B Ceiling Price Duplicate Discounts, Supported by a Clearinghouse and the Credit Mechanism, and Adopt a Policy of Non-Enforcement Where 340B Eligibility Cannot Be Timely Validated (Section 40.4.1)

1. Deduplication of 340B-Eligible and MFP-Eligible Units

By statute, a manufacturer of a selected drug cannot be required to offer both the MFP and the 340B price on the same unit. A manufacturer is required only to offer the lower of these two prices.[73] Amgen continues to urge CMS to mandate use of 340B and non-340B modifiers (as applicable) to identify 340B-eligible and 340B-ineligible units on any claim submitted for reimbursement as a condition precedent to the start of the prompt MFP payment window, with respect to units reimbursed under both Part B and Part D, as well as a condition of Part D reimbursement.[74] These data would serve to help identify 340B-eligible and 340B-ineligible units on any claim submitted for an MFP rebate under Part B or Part D in order to facilitate this process.

With respect to Part D, CMS adopted "the 'Submission Clarification Code' value of '20' and the 'Submission Type Code' value of 'AA' [] to the PDE record to indicate a 340B claim" effective January 1, 2025.[75] These codes are voluntary with respect to the PDE record, and CMS states in the IPAY 2028 Draft Guidance that dispensing entities may, but are not required to, provide these codes to the MTF via the "340B Claim Indicator" data element.[76] As drafted, these Submission Clarification Codes are insufficient to ensure 340B deduplication. Amgen urges CMS to (1) establish a Submission Clarification Code to reflect *non*-340B claims and (2) make both codes (or some alternative 340B and non-340B modifier) *mandatory* for dispensing entities in the PDE record and include them in the claims-level data provided by the MTF to the manufacturer.

With respect to Medicare Part B, CMS has already adopted 340B modifiers (but not non-340B modifiers) with respect to Part B units, for which, effective January 1, 2024, all 340B covered entities that submit Part B claims must use to identify 340B units.[77] These Submission Clarification Codes/modifiers would help ensure that manufacturers do not provide the MFP on

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[73] SSA § 1193(d).

[74] CMS has authority to require the appropriate use of these modifiers as a condition of Part D reimbursement. To appropriately implement Part D inflation rebates under section 1860D-14B of the SSA, CMS needs to be able to identify whether a Part D unit of a selected drug is subject to the MFP or the 340B price to determine whether the unit should be excluded from such rebates. *See id.* § 1860D-14B(b)(1)(B). CMS may condition payment of a clean claim on the appropriate use of these modifiers. *See, e.g.*, *id.* § 1860D-12(b)(3)(D) (general authority to add Part D contract terms); *see also id.* §§ 1102(a), 1871(a) (general rulemaking authority).

[75] IPAY 2027 Final Guidance 40.4.2.1.

[76] *See* IPAY 2028 Draft Guidance § 40.4.2.1.

[77] CMS, Part B Inflation Rebate Guidance: Use of the 340B Modifiers (Dec. 20, 2022), *available at:* https://www.cms.gov/files/document/part-b-inflation-rebate-guidance340b-modifierfinal.pdf.

any units identified as 340B-eligible where the 340B ceiling price is lower than the MFP. Amgen therefore urges CMS to adopt 340B and non-340B Submission Clarification Codes and non-340B modifiers for Part B units, and require that all entities that either dispense or administer MFP-eligible units use either a 340B or non-340B Submission Clarification Code or claims modifier, as applicable, for each unit billed under Medicare Part B.

Nonetheless, because covered entity compliance with the use of the Submission Clarification Codes (if finalized) or modifiers may not be unfailing, Amgen further supports the use of a neutral clearinghouse to help validate 340B eligible units and avoid MFP-340B duplication.[78] The clearinghouse could further help CMS by identifying 340B-eligible units for purposes of other programs, including the exclusion of such units from the Part D inflation rebate calculation.

Deduplication is most likely to be successful if enabled by the agency measures described above, i.e., the 340B and non-340B Submission Clarification Codes and modifiers and the clearinghouse.

2. Non-Enforcement Where 340B Eligibility Cannot Be Timely Validated

In the IPAY 2028 Draft Guidance, CMS acknowledges requests from "numerous interested parties for CMS to assume responsibility" for 340B nonduplication. In response, CMS states again that it "will not, at this time, assume responsibility for nonduplication of discounts between the 340B ceiling price and MFP" and instead "intends to provide [m]anufacturers with a process to identify applicable 340B-eligible claims through the reporting of claim-level payment elements to the MTF."[79] As further discussed in Section IV.B.1, this identification process is voluntary for dispensing entities.

First, Amgen urges CMS to ensure that the credit/debit system permits manufacturers to obtain credits when an MFP rebate was paid on a unit subsequently identified to be a 340B unit, in accordance with the revised credit/debit system as discussed above in Section IV.A.4, given the agency will not assume responsibility for 340B nonduplication.

Second, CMS should not pursue an enforcement action against a manufacturer if the manufacturer, despite good faith efforts, cannot timely identify whether a lower 340B ceiling price might be due because data are insufficient to determine whether the unit is or is not a 340B unit. In such cases, and as a result of the challenges of such identification of 340B-eligible units, the manufacturer would not be able to determine that the MFP rebate is in fact due until it receives the data necessary to identify the unit as non-340B, outside the 14-day prompt payment window.[80]

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[78] A 2023 report by IQVIA found that use of the Part B 340B modifier across a variety of 340B covered entities was limited with a particular lack of compliance by rural referral centers and sole community hospitals. Rory Martin, et al., IQVIA, Can 340B Modifiers Avoid Duplicate Discounts in the IRA? (Feb. 2023), *available at:* https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2023/can-340b-modifiers-avoid-duplicate-discounts-in-the-ira.pdf.

[79] IPAY 2028 Draft Guidance § 40.4.5.

[80] *See id.* ("[U]nless the claim for the selected drug is a 340B-eligible claim and the 340B ceiling price is lower than the MFP for the selected drug or unless access to the MFP was provided prospectively, the Primary Manufacturer is required to transmit the payment of an amount that provides access to the MFP of a selected drug to the dispensing entity within the 14-day prompt MFP payment window.").

This is particularly important with respect to units dispensed under 340B contract pharmacy arrangements, where the 340B ceiling price (if lower than the MFP) would be owed to the 340B covered entity and the MFP (if lower than the 340B ceiling price) would be owed to the 340B contract pharmacy (barring CMS facilitating payment of the MFP on such units to the 340B covered entity instead).[81] Under the 340B replenishment model, 340B covered entities determine only after a unit was dispensed whether the individual to whom the unit was dispensed was a 340B "patient," in which case the 340B covered entity later purchases a replacement unit at the 340B ceiling price. Thus, it necessarily will take considerable time to validate eligibility of a given unit for the 340B ceiling price and therefore also to determine whether the MFP or the 340B ceiling price is due on that unit, and CMS must allow manufacturers flexibility in taking the time needed to ensure that they are not providing the MFP on a 340B unit.

Further, because the 340B ceiling price is paid to the 340B covered entity and the MFP to the 340B contract pharmacy, no true-up to either entity could help a manufacturer satisfy its obligation to offer the lesser of the MFP or the 340B ceiling price to the entity to which such pricing is owed.

Finally, CMS also notes that it "is considering ways to incorporate asynchronous 340B data into MTF processes in the future."[82] Asynchronous data as to 340B claims is particularly key given that the timing of a 340B purchase may not align temporally with when an MFP claim comes through the MTF PM; such additional data will aid manufacturers in facilitating deduplication of the 340B price and the MFP. As such, Amgen strongly encourages CMS to promptly propose such processes in order to aid manufacturers in complying with the 340B nonduplication requirement.[83]

C. CMS Should Specify That Payment of the Standard Default Rebate Amount (SDRA) Is a True Default (Section 40.4.1)

CMS states that it intends to continue its policy of defining the SDRA as the difference between the wholesale acquisition cost (WAC) and the MFP for the selected drug, such that a manufacturer may pay this rebate amount to retroactively effectuate the MFP. Amgen supports using WAC to calculate the SDRA for Part D selected drugs. However, further evaluation is needed to determine an appropriate calculation for the SDRA for Part B selected drugs. We also ask CMS to specify that the SDRA serves as a true default for manufacturers to satisfy their obligations to provide access to the MFP for selected drugs.

Amgen appreciates CMS's statement in the IPAY 2028 Draft Guidance that where a manufacturer and dispensing entity agree to use the SDRA, "CMS intends to consider a retrospective refund paid pursuant to that calculation to be sufficient for the Primary Manufacturer to meet its obligation to make the MFP available to the dispensing entity," and requests the agency finalize this approach.[84] We agree with CMS that "a reliable refund amount" offers benefits to "both manufacturers and dispensing entities" given the "significant challenges [in] establishing a reliable

[81] *See* Public Health Service Act § 340B(a)(1); SSA § 1193(a)(3).
[82] IPAY 2028 Draft Guidance § 40.4.5.
[83] *Id.*
[84] *Id.* § 40.4.1.

actual acquisition cost for a selected drug that could be used to determine the MFP refund amount."[85]

However, for these same reasons, at least with respect to effectuating the SDRA for Part D, Amgen urges CMS to explicitly state that the MFP rebate amount can never be higher than the SDRA, including when acquisition costs are higher than WAC. In the IPAY 2028 Draft Guidance, CMS notes that it may investigate unresolved complaints that, following payment made at the SDRA, "the dispensing entity's acquisition cost was greater than WAC, and therefore, the MFP was not made available to that dispensing entity."[86] While it may be the case that pharmacies sometimes purchase drugs at a price higher than WAC, where that purchase is made through wholesalers and distributors, the costs above WAC are not representative of a price offered by the manufacturer in the market. Rather, the costs reflect upcharges by the wholesalers and distributors. If CMS were to require manufacturers to pay an MFP rebate that covers these additional costs, it would not only impose on manufacturers an obligation that exceeds that specified in the law, but also it would create adverse incentives for pharmacies and others in the pharmaceutical supply chain to increase profits by artificially inflating acquisition costs and thus MFP rebate amounts.

For example, prior to January 2024, Part D plan sponsors were permitted to agree to a Part D negotiated price with pharmacies that was higher than the final payment from the Part D plan sponsor to the pharmacy, thus artificially inflating the amount of the Coverage Gap Discount Program (CGDP) discount and the beneficiary coinsurance amount, which are calculated as a percentage of the Part D negotiated price. CMS has since prohibited this practice.[87] The Brookings Institute similarly has observed that vertical integration "permits MA plans to circumvent regulations aimed at constraining the profits that can be earned from the MA program."[88] Specifically, "a vertically integrated MA plan can move profits from the MA plan to the related business. This increases the MA plan's [medical loss ratio (MLR)] without reducing the parent company's profits, weakening the MLR constraint."[89]

To address these concerns, the following steps should be taken by CMS:

- Provide a non-exhaustive list of documentation that a manufacturer may require a pharmacy to submit to the manufacturer where the pharmacy claims a rebate in excess of the SDRA is due, including documentation as to the acquisition costs of the pharmacy (net of price concessions) (but without detail as to the pharmacy's specific reimbursement contracts and other arrangements).
- Where the MFP rebate requested is in excess of the SDRA, require pharmacies to certify to the government that they are not receiving remuneration or anything else of value in exchange for the excessive acquisition costs.

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[85] *Id*.
[86] *Id.* § 90.2.
[87] 87 Fed Reg 27,704, 27,847 (May 9, 2022).
[88] Richard G. Frank & Conrad Milhaupt, *Related Businesses and Preservation of Medicare's Medical Loss Ratio Rules*, Brookings, (Jun. 29, 2023), *available at:* https://www.brookings.edu/articles/related-businesses-and-preservation-of-medicares-medical-loss-ratio-rules/.
[89] *Id*.

- Monitor the number/percentage of pharmacies claiming acquisition costs above WAC and, if CMS notices an increasing trend in these arrangements, publicly report on it so that policymakers and stakeholders can take remedial steps as appropriate.

In addition, for Part B selected drugs, Amgen urges CMS to further investigate potential SDRA options, including a thorough assessment of the particular considerations in Part B and how such considerations may bear on whether a given SDRA option may be appropriate. For example, Part B drugs generally are purchased by hospitals, physician's offices, and other providers, rather than by dispensing entities that purchase Part D drugs, and these differing contexts may warrant different metrics to approximate acquisition costs. We ask CMS to seek public comment on its intended SDRA approach, once identified, consistent with the agency's obligation to use notice-and-comment to issue policies that create obligations for public stakeholders.[90]

D. CMS Should Further Clarify How It Will Determine the MFP Was Made Available (Sections 40.4 and 90)

In the IPAY 2028 Draft Guidance, CMS indicates that it intends to assess whether a manufacturer provided access to the MFP to a dispensing entity through "a fact-specific assessment" that will include factors such as "whether the retrospective refund amount authorized for payment or paid by the Primary Manufacturer is sufficient to account for commercially reasonable costs the dispensing entity is likely to encounter in the supply chain."[91] In response to CMS's solicitation for comment on these factors, Amgen asks CMS to clarify this specific factor further. By statute, manufacturers are obligated to provide "access to the maximum fair price," not commercially reasonable costs associated with it.[92] In order to provide feedback to CMS on this proposal, it is critical that CMS clarify what constitutes commercially reasonable costs and the basis for CMS's position that manufacturers are the entities responsible for addressing such costs.

Further, in response to CMS's request for other considerations it may take into account when assessing whether the MFP was made available, Amgen asks that CMS address in any finalized policy the non-duplication of the MFP and the 340B ceiling price. As discussed in Section IV.B, manufacturers cannot be required to provide both the 340B ceiling price and the MFP on the same unit. For example, there may be circumstances in which the manufacturer has offered a 340B ceiling price on a unit, which is later determined to be eligible for the MFP because the MFP is lower than the 340B ceiling price. In that case, CMS should clarify that a manufacturer need only provide the difference between the 340B ceiling price and MFP when determining whether

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[90] *See* 5 U.S.C. § 553(b)(A) (requiring notice-and-comment for agency rulemaking other than "interpretive rules, general statements of policy, or rules of agency organization, procedure, or practice," or for good cause); Administrative Conference of the United States, Information Interchange Bulletin No. 034: Distinguishing Between Legislative Rules and Non-Legislative Rules (Feb. 2024), *available at:* https://www.acus.gov/sites/default/files/documents/34%20Distinguishing%20Between%20Legislative%20Rules%20and%20Non-Legislative%20Rules.pdf; *see generally* IPAY 2028 Draft Guidance § 80 (stating that "CMS is soliciting comments in section 40.4 of this draft guidance related to the effectuation of the MFP for drugs payable under Part B and will address policies related to the effectuation of the MFP for drugs payable under Part B to Part B providers in the future.").

[91] IPAY 2028 Draft Guidance § 90.2.

[92] SSA § 1193(a)(3).

the manufacturer made the MFP available, and that that is the case even where the 340B ceiling price was offered to the parent covered entity (such as a hospital) and the difference between the 340B ceiling price was paid to the dispensing entity, such as a contract pharmacy.

E. CMS Should Further Clarify the Implementation of the MTF PM Options and Clarify Conditions of Participation for Pharmacies (Section 40.4.4)

1. Options for MTF Payment Facilitation

Amgen thanks CMS for permitting manufacturers to use the MTF to facilitate the payment of MFP rebates by manufacturers to pharmacies.[93] Amgen requests that CMS finalize this approach as drafted, or in the alternative, finalize that manufacturers may use the MTF to facilitate only retrospective rebates, but should not require access to the MFP to occur prospectively only.

2. Technical Considerations with the MTF

Amgen appreciates the agency's intent to outline further technical specifications as to the MTF portal in forthcoming technical guidance.[94] Amgen encourages CMS to engage in discussions with manufacturers regarding how the MTF DM and PM will operate on a technical level, including with respect to:

- The MTF DM's technical process for reconciling both claims-level payment elements and any open credits on the ledger system before instructing the MTF PM to apply the specified credit, or debit.
- The MTF PM's technical process for returning and reconciling funds from uncashed paper checks, including whether there will be an MRR for the return of funds.

Similarly, CMS should provide clear guidance on the timing of MTF PM payment to the dispensing entity following transmission of payment elements by the manufacturer to the MTF PM. For example:

- Once the MTF DM receives claims-level payment elements (Medicare Refund Advice (MRA) elements), what is the timing for the MTF DM to pass them to the MTF-PM?
- Does the MTF PM review claims-level data elements that it receives before it passes them on to the dispensing entity in the remittance advice, and how long will such review take?
- Once the manufacturer authorizes the claims-level data elements and transmits the MRA, how soon does the MTF PM transmit the payment authorized by the manufacturer to the dispensing entity?
- Following payment made to the dispensing entity, how soon is remittance from the MTF DM sent to the dispensing entity, and how soon will the corresponding receipt be sent to the manufacturer?

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[93] IPAY 2028 Draft Guidance § 40.4.
[94] *Id.* § 40.4.3.2.

3. Non-standard MFP Rebate Amounts

In the IPAY 2028 Draft Guidance, CMS states that nothing in the Guidance "precludes a [m]anufacturer and a dispensing entity from reaching agreements outside of the MTF to establish an adjusted refund amount based on the dispensing entity's acquisition costs."[95] Amgen appreciates CMS's statement that this adjusted refund amount could be paid "through the MTF PM or through an alternative process outside of the MTF PM that is mutually agreed upon by the parties;" Amgen requests CMS finalize this clarification to avoid the risk of confusion over when manufacturers can use the MTF to facilitate payment.[96]

Further, CMS should specify that a manufacturer will not be held responsible for failing to meet the prompt MFP payment window if the MTF payment facilitation process fails to timely transmit payment of any MFP rebates. This failure could occur, for example, if a pharmacy provides incorrect bank account information.

4. Pharmacy Participation in the Manufacturer's Elected Payment Option

CMS should specify that manufacturers can meet their obligation to provide access to the MFP by establishing a single process of making the MFP available to pharmacies. The manufacturer's chosen approach could be addressed in the effectuation plan submitted to CMS.[97]

Amgen appreciates that CMS, via rulemaking, finalized a requirement that Part D plan sponsors include in their pharmacy agreements provisions requiring the pharmacy to be enrolled in the MTF DM, beginning with contract year 2026.[98] Amgen asks CMS to further specify that this means that participation in the MTF payment facilitation process (i.e., the MTF PM), is effectively mandatory for pharmacies. Further, CMS should confirm that manufacturers need only honor payment made through the MTF PM where the manufacturer has elected that payment method. This approach would be similar to the approach to paying pharmacies under Part D, where Part D plan sponsors must pay most categories of network pharmacies for electronic, clean claims within 14 days (with a longer payment window for non-electronic claims) and pharmacies have to participate as an in-network pharmacy if they wish to benefit from the prompt payment period.[99]

If CMS does not adopt the above approach, manufacturers should be obligated to offer at most one additional MFP effectuation option to pharmacies, and CMS should expressly provide that manufacturers need only honor the payment effectuation options set forth in its MFP effectuation plan.

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[95] *Id.* § 40.4.3.1, fn. 71.
[96] *Id.*
[97] *See id*. § 90.2.1.
[98] 90 Fed. Reg. 15,834 (Apr. 15, 2025).
[99] SSA § 1860D–12(b)(4)(B), 42 C.F.R. § 423.520. If CMS allows pharmacies to opt out of the MTF payment facilitation process, CMS should require those that do so to notify manufacturers and provide contact and bank account information/provide for a process to notify manufacturers and provide contact and bank account information through the MTF.

F. CMS Should Establish a Limited List of Stakeholders Who May Access MFP Effectuation Plans and Should Continue with an Information Collection Request (ICR) on Information to Be Collected with Respect to These Plans (Section 90.2.1)

1. Confidentiality

Amgen appreciates that, in the IPAY 2027 Final Guidance, CMS finalized that it would not post manufacturer MFP effectuation plans on a public website.[100] In the IPAY 2028 Draft Guidance, though, CMS notes that it "may release these redacted plans to other applicable stakeholders (e.g., supply chain entities) upon request."[101] While Amgen appreciates this more limited scope of disclosure, Amgen continues to be concerned that because manufacturers may be required to include proprietary and otherwise confidential business information in the MFP Effectuation Plans, more guardrails are needed to ensure confidentiality of manufacturer-submitted information. Although CMS intends to try to redact such information, that redaction may not always be sufficient, and, under the statute, CMS is obligated to keep manufacturer-submitted information confidential for use only by CMS and the Comptroller General.[102] To help preserve the confidentiality of MFP effectuation plans, CMS should both work cooperatively with the manufacturer to redact confidential information in the plans and expressly limit the stakeholder types to which it would, under this policy, disclose the MFP Effectuation Plan to those in the drug supply chain. This approach would balance the need for transparency with the need to protect manufacturers' confidential information.

2. Information Included in MFP Effectuation Plans

CMS should specify and limit the level of detail that manufacturers must include with respect to each MFP payment effectuation approach. Amgen appreciates that CMS intends to publish and finalize a Medicare Transaction Facilitator for Initial Price Applicability Year 2026 and 2027 ICR by this summer, and "intends to publish a revised version of this ICR to address any evolving data collection needs for initial price applicability year 2028."[103] Amgen urges CMS to finalize and propose these ICRs as soon as possible, to allow manufacturers the maximum amount of time to prepare for development of MFP Effectuation Plans.

G. CMS Should Permit Appeals as Part of the Complaints and Disputes Resolution Process and Clarify Additional Aspects of Such Process (Section 90.2.2)

Amgen appreciates CMS's stated intent to establish a complaints and disputes resolution process for the DPNP and reiterates its request for the agency to follow through on such intent in line with the following comments. As CMS notes that it is not at this time including detailed information on the complaints and dispute process for Part B drugs, but intends to align the policies for Part B

[100] IPAY 2027 Final Guidance § 90.2.1.
[101] IPAY 2028 Draft Guidance § 90.2.1.
[102] SSA § 1193(c).
[103] IPAY 2028 Draft Guidance § 90.2.1.

with the policies for Part D, Amgen encourages CMS to adopt the following policies for both Parts D and B:

1. Dispute Process

CMS should adopt an internal agency appeals process, similar to that to be used under the Manufacturer Discount Program in 2025, with three levels:[104]

- The manufacturer or pharmacy files a complaint or dispute with CMS (as already intended by CMS for IPAY 2028).
- If the manufacturer or pharmacy disagrees with CMS's decision, it can appeal the decision to an Independent Review Entity (IRE).
- If a manufacturer or pharmacy disagrees with the IRE's decision, it can appeal to the CMS Administrator, who will issue a final decision.

To minimize excessive appeals, CMS could also develop reasonable aggregation parameters.

2. Timing

Amgen appreciates that CMS intends to establish a timeline for the complaints and dispute process. However, CMS states that complaints and disputes must be submitted to CMS "no later than 120 calendar days from the date of the subject of the complaint or dispute."[105] Amgen urges CMS to shorten this timeline to 60 days to align with the timelines under the Manufacturer Discount Program and ensure that disputes are raised and resolved promptly. Further, CMS should establish clear deadlines for the rest of the dispute and complaint resolution and appeals process comparable to those under the Manufacturer Discount Program:[106]

- *60 days for CMS to issue its decision.*
- *30 or 90 days to appeal the decision to the IRE*. Manufacturers and pharmacies would have 30 days from the date of CMS's decision to appeal or 90 days from the date of the complaint if CMS has failed to timely render a decision.
- *90 days for the IRE to issue its decision.*
- *30 days to request review by the CMS Administrator*.
- *90 days for the CMS Administrator to issue his or her final decision*.
- *90 days for the parties to take corrective action*.

3. Other

[104] Medicare Part D Manufacturer Discount Program Final Guidance § 100.
[105] IPAY 2028 Draft Guidance § 90.2.2.
[106] *See* Medicare Part D Manufacturer Discount Program Final Guidance § 100.

CMS should further clarify who can be an appropriate party to a dispute or complaint. For example, if a Part D plan sponsor submitted the wrong claims-level data to the MTF for transmission to the manufacturer, then the dispute should be handled between the pharmacy and Part D plan sponsor per the terms of their contract—not the manufacturer.

V. RECOMMENDATIONS PERTAINING TO ESTABLISHING AND IMPLEMENTING MFP FOR PART B DRUGS (SECTION 60)

A. Recommendations Regarding Exclusion of MFP Units from ASP

1. CMS Should Use Its Authority to Revise the ASP "Unit" Definition to Exclude MFP Units

Existing CMS guidance does not address whether the MFP should be included in the average sales price (ASP) calculation. Consistent with Congress's decision to not direct the inclusion of MFP transactions in the calculation of ASP, Amgen urges CMS to amend the regulatory definition of an ASP "unit" to exclude MFP units from the ASP calculation. Specific guidance regarding the treatment of the MFP in the ASP calculation is needed to ensure clarity and consistent treatment across impacted manufacturers, and exclusion is clearly the most appropriate approach for ensuring continued patient access to selected drugs. Such an approach also lies soundly within CMS's explicit statutory authority to define "unit" for ASP purposes.

2. Congress's Silence Supports Exclusion of MFP-Priced Units From ASP

The IRA includes no specific direction regarding the treatment of MFP-priced units in the ASP calculation. That silence gives rise to the presumption that they are not to be included. The separate natures of the ASP and MFP prices, and the significant negative consequences that could result from combining them, underscore that Congress would have explicitly provided for the inclusion of MFP-priced units in ASP if it had wanted that result.[107]

As noted below, including MFP-priced units in the ASP calculation would threaten patient access to selected drugs, and could pose a serious long-term threat to the innovation ecosystem. Given this backdrop, Congress's silence can reasonably be understood to indicate that MFP units should not disrupt the existing ASP regime, and CMS should take action to avoid such disruption.

3. CMS Should Exclude MFP Units from ASP to Ensure the MFP Does Not Negatively Impact Patient Access

[107] *See generally, e.g.*, *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001) ("Congress . . . does not, one might say, hide elephants in mouseholes." (citing *MCI Telecomms. Corp. v. Am. Telephone & Telegraph Co.*, 512 U.S. 218, 231 (1994); *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159–60 (2000))).

ASP is defined by statute as a market-based measure of average manufacturer prices to most purchasers, subject to certain exclusions.[108] The MFP, by contrast, is a non-commercial government price for Medicare, capped by a statutorily-defined ceiling.[109] It necessarily follows that including MFP-priced units in the ASP calculation would reduce ASP, potentially below the price that is available to purchasers outside of Medicare, and, therefore, threaten patient access to selected drugs covered by payers other than Medicare that continue to reimburse for such drugs based on ASP. Non-Medicare payers, including commercial plans and Medicaid, routinely rely on ASP to benchmark reimbursement rates for Part B drugs. As the inclusion of MFP-priced units would cause ASP to decrease, these payers' ASP-based reimbursement rates will become increasingly insufficient to cover providers' and suppliers' cost of acquiring the selected drug, thereby compromising their ability to furnish the drug to patients.[110]

The inclusion of MFP units in ASP also would erode the market-based design of ASP-based reimbursement. Congress adopted ASP-based reimbursement to replace average wholesale price (AWP)-based reimbursement to align the reimbursement benchmark more closely with "the actual prices paid by health care providers."[111] Payers and state Medicaid programs may rely on ASP for similar reasons. Market-based reimbursement helps ensure that payment rates remain

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[108] SSA § 1847A(c)(1), (2) (defining ASP by reference to "the manufacturer's sales to all purchasers" but excluding "[s]ales exempt from the inclusion in the determination of 'best price' under section 1927(c)(1)(C)(i)," which generally excludes prices associated with government programs).

[109] *Id.* § 1194(c).

[110] Avalere, *Commercial Spillover Impact of Part B Negotiations on Physicians* (Sept. 16, 2024), *available at:* https://avalere.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians ("ASP erosion over time will not only impact Medicare fee-for-service (FFS) payment, but it will also reduce commercial and MA reimbursement, which may compound the financial impact that providers face from the IRA."); Drug Channels, *The Inflation Reduction Act: 10 Predictions About Market Access and Drug Channels* (Apr. 18, 2023), *available at:* https://www.drugchannels.net/2023/04/the-inflation-reduction-act-10.html ("[I]t seems likely that MFP will be included in ASP computations. Consequently, physician practices will also get lower reimbursement from non-Medicare payers, further accelerating the consolidation of these businesses."); Avalere, *IRA Medicare Part B Negotiation Shifts Financial Risk to Physicians* (Nov. 29, 2022), *available at:* https://avalere.com/insights/ira-medicare-part-b-negotiation-shifts-financial-risk-to-physicians ("[T]he best price and ASP for negotiated drugs are likely to decline over time, depending on how CMS implements the provision. A substantial proportion of commercial and Medicare Advantage contracts with payers are structured based on the ASP, so MFP-based negotiations could place further financial pressures on providers.")

[111] Medicare Drug Reimbursements: A Broken System for Patients and Taxpayers: Joint Hearing Before the H. Subcomm. on Health & the Subcomm. on Oversight & Investigations of the Comm. on Energy & Commerce 107th Cong. 5 (2001) (statement of Rep. James Greenwood); *see also, e.g.*, Dep'ts of Labor, Health & Human Servs., Education, and Related Agencies Appropriations for 2003: Hearings Before the H. Subcomm. on the Dep'ts of Labor, Health & Human Servs., Education, and Related Agencies of the H. Comm on Appropriations, 107th Cong. 370 (Sept. 30, 2002) (colloquy with then-Health and Human Services (HHS) Inspector Gen. Janet Rehnquist) ("[T]he problem with the average wholesale price is that it is just a price catalogue . . . that doesn't really have any bearing to what [providers] pay."); Reimbursement and Access to Prescription Drugs Under Medicare Part B: Hearing Before the S. Subcomm. on Health Care of the S. Comm. on Finance, 107th Cong. (Mar. 14, 2002) (statements of Government Accounting Office personnel) (explaining that the failure of AWP to reflect the net sales price to purchasers led to the "problem of inflated AWPs," which "increases the profit of the suppliers or physicians who purchase the drug, because while not paying the artificially inflated AWP amount, they are reimbursed based on that inflated amount" (emphasis added)).

adequate for providers to acquire and furnish covered drugs, even as the acquisition costs for such drugs fluctuate with market dynamics over time.[112] The MFP is the opposite of market-based pricing, representing instead a government-imposed price constraint.

4. CMS Has Explicit Statutory Authority to Exclude MFP Units From ASP

Congress expressly vested CMS with broad latitude to define an ASP "unit," which the agency should exercise to exclude MFP-priced units from the ASP calculation. By statute, CMS is empowered to "establish the unit for a manufacturer to report and methods for counting units as [CMS] determines appropriate to implement [the ASP statutory scheme]."[113] Thus, CMS has authority to undertake rulemaking to modify how it interprets the ASP "unit" definition to exclude MFP units.

Legislative history and regulatory precedent confirm CMS's statutory authority to exclude MFP units from the ASP "unit" definition. The Conference Committee Report from the Medicare Modernization Act reflects Congress's intent that CMS would use this authority to exclude from ASP "those sales that do not reflect market prices," which, as noted above, MFP units do not.[114] The agency previously exercised this authority to exclude Competitive Acquisition Program (CAP) units from the ASP "unit" definition. CMS noted that ASP and CAP represented separate payment programs "intended to be alternatives to each other,"[115] and recognized stakeholders' concerns about the effects of including CAP prices in ASP given that the prices negotiated by CAP vendors did not represent market prices.[116] Upon weighing these considerations, CMS concluded that CAP units should be excluded from the calculation of ASP, and undertook rulemaking to interpret the ASP "unit" definition to exclude CAP units.[117]

The MFP raises the same core concerns raised by CAP prices and likewise warrants exclusion of MFP units from the ASP calculation. Specifically, the MFP similarly does not reflect a market price and, therefore, its inclusion would subvert the purpose of the ASP metric. The MFP is an artificial, governmentally imposed price constraint that intrinsically represents a deviation from prevailing market dynamics. Indeed, the MFP deviates from—and supersedes—ASP to establish Medicare FFS reimbursement rates for selected Part B drugs furnished to MFP-eligible individuals.[118] Given the separation of these alternative regimes, and the negative impacts on

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[112] *See* Susan Weidner & Michael Diaz, *Observations Regarding the Average Sales Price Reimbursement Methodology*, 27 Evidence-Based Oncology SP156 (2021), *available at:* https://www.ajmc.com/view/observations-regarding-the-average-sales-price-reimbursement-methodology.
[113] SSA § 1847A(b)(2)(B).
[114] *See* H.R. Rep. No. 108-391, at 587–88 (2003), *reprinted in* 1808 U.S.C.C.A.N. 1954–55.
[115] 70 Fed. Reg. 70,478, 70,479–80 (Nov. 21, 2005); 74 Fed. Reg. 61,738, 61,915–16 (Nov. 25, 2009).
[116] 70 Fed. Reg. at 70,479; 74 Fed. Reg. at 61,915.
[117] 74 Fed. Reg. at 61,915.
[118] *Cf. id.* (amending the ASP "unit" definition to exclude CAP units having "found compelling arguments from commenters about the separation of the ASP and CAP programs and that the two programs are intended to be alternatives to each other").

patient access that would result from combining them, CMS should exercise its statutory authority to amend the ASP "unit" definition to exclude MFP units from the ASP calculation.

B. CMS Should Continue Publishing the Quarterly ASP Payment Limit for Selected Drugs Paid for Under Part B

The IRA requires the Medicare program to reimburse a selected Part B drug based on its MFP instead of ASP.[119] As discussed above, ASP-based payment limits will remain integral to Medicare, Medicaid, and commercial payer functions. Therefore Amgen urges CMS to continue publishing the ASP-based payment limit for selected drugs otherwise paid for at the MFP plus 6 percent and to reassure stakeholders of its intent to do so.[120] Manufacturer obligations to report ASP for selected drugs will remain in place such that CMS will continue to have the ASP data needed to publish an ASP-based payment rate, and continuing to do so for a selected drug is critical for several reasons.

First, ASP-based payment rates are industry-wide reimbursement benchmarks, routinely relied upon by commercial payers and Medicaid. As noted in Section V.A, Congress specifically designed ASP to reflect actual market-based purchase prices for a drug, such that ASP-based reimbursement helps ensure adequate reimbursement to cover the cost of acquiring that product. Because of its suitability as a reimbursement benchmark, ASP often serves as the basis for commercial payment rates.[121] Likewise, state Medicaid plans rely on ASP to set market-based reimbursement rates.[122] The continued publication of the ASP-based payment amount for selected drugs is critical to avoid disruptions to reimbursement by these payers.

Second, ASP transparency can facilitate the smooth operation of Medicare by allowing manufacturers to confirm the accuracy of:

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[119] SSA § 1847A(b)(1)(B).

[120] *Id.*

[121] *See, e.g.*, U.S. Gov't Accountability Off., Physician-administered Drugs: Comparison of Payer Payment Methodologies (Aug. 1, 2016), https://www.gao.gov/assets/gao-16-780r.pdf (reporting that for "[t]wo large private payers[,] Medicare's rate—106 % of ASP—may be used as a benchmark for negotiation"); HealthTrust Performance Group, *Understanding Drug Reimbursement in Pharmacy*, The Source, https://healthtrustpg.com/thesource/ihp-pharmacy/understanding-drug-reimbursement-in-pharmacy/ (accessed Mar. 24, 2025) ("Commercial insurance reimbursement rates vary by health system contract but generally follow one of two methods. The first method *bases the commercial rate on the Medicare rate* . . . . The second method calculates reimbursement as a percentage of the drug's acquisition cost . . . ." (emphasis added)).

[122] *See, e.g.*, Fl. Admin. Code § 59G-4.251(8) ("Florida Medicaid reimburses for prescribed drugs administered by a licensed practitioner in an office setting at 106 percent of ASP . . . ."); Idaho Admin. Code § 16.03.09.665.01.e (providing that reimbursement for physician administered drugs "will be ninety percent (90%) of the Medicare Average Sales price plus six percent (6%) rate (ASP+6% rate)"); Ill. Admin. Code tit. 89 § 140.414(b)(2)(A) (providing that reimbursement for physician administered drugs shall be "the lowest of the provider's usual and customary charge to the public; or . . . Average Sales Price (ASP) plus 6 percent . . . or . . . [t]he State upper limit").

- Part B inflation rebate invoices. Whether and how much in rebates are due is determined by reference to whether the specified amount in the rebate period (i.e., a calendar quarter starting in 2023) exceeds an inflation-adjusted payment amount, where the specified amount is 106 percent of the lesser of ASP or WAC.[123]

- Biosimilar add-on payments. By statute, the 6 percent or 8 percent add-on payment amount for biosimilars is calculated based on the ASP of the reference biological product, even if payment for that product is based on the MFP.[124]

For all the foregoing reasons, Amgen asks CMS to continue publishing ASP-based payment rates for Part B drugs subject to an MFP.

C. CMS Should Calculate the Single Ceiling and Single MFP for Part B Drugs on the Unit Level (Section 60.2.1)

As with previous IPAYs, CMS is proposing to calculate a single MFP across all dosage forms and strengths of a selected drug.[125] For IPAYs 2026 and 2027, CMS had achieved this end by first calculating a single ceiling across all dosage forms and strengths of the selected drug at the 30-day equivalent supply level, a concept used under Medicare Part D to capture the amount of a drug that is typically dispensed to a patient on a monthly basis.[126] CMS is proposing to continue this methodology for IPAY 2028, including where manufacturers would need to make the MFP available under both Medicare Part B and Part D.[127]

In response to CMS's request for comments on this issue, Amgen urges CMS *not* to finalize this approach for drugs selected on the basis of Part B expenditures; instead, for selected drugs that are eligible due to their expenditures under Part B, CMS should calculate the single ceiling and establish the single MFP on the unit level, using the unit of measure applicable to the billing and payment code(s) for the drug. This would allow CMS to establish a single MFP subject to a single ceiling and then convert to payment under Part B and Part D.[128] This approach leverages CMS's pre-existing billing and payment code structure, reflecting the agency's prior determination of the therapy's most appropriate unit of measure, and avoids introducing unnecessary complexities into the MFP determination process. Simply put, we understand CMS chose to determine the single MFP for Part D drugs in IPAY 2026 and 2027 based on a 30-day supply metric because that is a standard unit of measure for pharmacy-dispensed drugs. For Part B drugs, the analogous standard unit of measure is that assigned to the drug's billing and payment code(s) and should be the starting point for those therapies.

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[123] SSA § 1847A(i)(3)(A)(ii) (citing § 1847A(b)(4) ("The amount specified in this paragraph for a single source drug or biological is the lesser of the following: (A) Average sales price [or] (B) Wholesale acquisition cost[.]")); 42 C.F.R. § 427.302(b) (cross-referencing the amount specified in statute and generally discussing this amount in terms of either ASP or WAC).
[124] SSA § 1847A(b)(8)(B)(ii)(II) and (iii)(II) (specifying that the add-on payment for biosimilars is calculated based on the lesser of ASP or WAC under Section 1847A(b)(4) of the SSA for the reference biological product); 42 C.F.R. § 414.904(i)(3)(B) (citing § 1847A(b)(4)).
[125] IPAY 2028 Draft Guidance § 60.1.
[126] 42 C.F.R. § 423.104(d)(2)(iv)(A)(2).
[127] IPAY 2028 Draft Guidance § 60.
[128] *Id.* § 60.1.

Under CMS's proposed approach, the agency has to engage in the fiction that dosing for a drug administered under Part B can readily be converted to the 30-day equivalent supply concept used under Part D. The 30-day equivalent supply is calculated as follows: "[i]f the days' supply reported on a PDE is less than or equal to 34, the number of 30-day equivalent supplies equals one. If the days' supply reported on a PDE is greater than 34, the number of 30-day equivalent supplies is equal to the number of days' supply reported on each PDE divided by 30."[129] CMS proposes to convert the Part B dose to a 30-day equivalent supply first by measuring the "days between service" for a drug administered under Part B, i.e., "the days between the first Part B claim's date of service and the immediately subsequent Part B claim or PDE record's date of service."[130] CMS would then determine the 30-day equivalent supply for the Part B drug by examining whether the "days between service" is greater or less than 34 in the same way that it would convert days' supply to the 30-day equivalent supply for purposes of the Part D program.

Drugs are dispensed and administered under Part B in a fundamentally different way than under Part D, as indicated by CMS's own methodology for reimbursing those therapies under the two programs. For example, "days between service" (Part B) and "days supply" (Part D) are distinct concepts. The former represents how many days there may be between one dose and the next where the patient may not be administered any amount of the drug in the interim. The latter represents how many days' worth of drug is being dispensed per 30-day period, where a patient may be taking less than one, one, or multiple doses a day. These distinctions between the "days between service" and "days supply" illustrate why CMS's proposal to convert Part B dosing to a 30-day equivalent supply is unworkable.

Moreover, there may be greater variability in the quantity administered across doses under Part B. A Part B drug may commonly have an initially higher loading dose to achieve the necessary therapeutic response before reducing to a maintenance dose. In other cases, a Part B drug may need to be titrated to help the physician establish the appropriate dose for a particular patient and/or dosing may be subject to more variability by weight or other patient characteristics. As a result of these circumstances, the number of days between the first and second dose may vary significantly from the days between later doses, thus further illustrating the limitations of the 30-day equivalent supply concept under Medicare Part B.

An approach that calculates the single MFP at the unit level for those drugs determined to be eligible based on Part B expenditures solves for these complexities while also accommodating the need to translate the single MFP to a 30-day supply amount where the drug has Part D utilization as well. First, CMS could calculate the MFP ceiling by converting the Part B payment amount under Section 1847(b)(4) of the Social Security Act per billing unit (used to calculate the ceiling under Part B) to that single unit level. Then, for any Part D utilization of that same drug, CMS could convert the 30-day equivalent supply for purposes of calculating the sum of the plan

[129] 42 C.F.R. § 423.104(d)(2)(iv)(A)(2).
[130] IPAY 2028 Draft Guidance § 60.2.1.1. There is also some suggestion in the examples in Section 60.2.1.1 of the IPAY 2028 Draft Guidance that CMS will look at the days between service between the second and third dose of a Part B drug as well, but it is not entirely clear how consistently or how often CMS will include those additional doses. *Id*.

specific enrollment weighted amounts (used to calculate the ceiling under Part D) to the unit level. Lastly, CMS could then use those amounts to calculate a single ceiling across Part B and Part D.[131] Similarly, CMS could then easily extend the single MFP back out to the appropriate Part B billing units and Part D 30-day supply amount for purposes of payment under Medicare Part B and Part D respectively. For all of the reasons outlined above, Amgen urges CMS to calculate the single ceiling, and establish the single MFP, on the unit level for those selected drugs that are eligible for selection based on their Part B expenditures.

In addition, given that CMS has not yet issued a full methodology for calculating the ceiling and setting a single MFP on the unit level, Amgen further urges CMS to publish that full methodology for comment by September 2025 to allow manufacturers time to raise any concerns with that methodology before drugs are selected for IPAY 2028.

D. CMS Should Not Substitute an Alternative to Payment Amount to Effectuate the MFP or Calculate the Single Ceiling (Section 60.2)

In the IPAY 2028 Draft Guidance, CMS indicates that "[it] is soliciting comments on how MFP effectuation should apply in cases where the selected drug is not paid under section 1847A of the Act, including whether it best effectuates the relevant statutory provisions in instances in which payment may be made under Part B for a selected drug on the basis of an amount other than ASP or WAC, for the Medicare Part B payment (and coinsurance) to be based on the lower of 106 percent of the MFP and the otherwise applicable payment amount."[132] Amgen believes CMS's proposed alternative is not supported by the text of the statute. Under those terms, Congress explicitly directed CMS to apply the MFP plus 106 percent as the payment amount for a selected drug during an applicable period, and gave CMS no authority to substitute another payment amount. Specifically, the statute states "the amount of payment determined under this section for the billing and payment code for a drug or biological . . . in the case of such a drug or biological product that is a *selected drug* . . . , with respect to a *price applicability period* . . . *106 percent of the maximum fair price* . . . applicable for such drug and a year during such period."[133] Where Congress permits CMS to substitute an alternative payment amount under Section 1847A, that substitution is limited to circumstances in which ASP is higher than other specified prices, with no such comparisons referenced as to the MFP. Indeed, the title for the section of the statute that authorizes such substitutions is "Limitation on Average Sales Price."[134] For example, average manufacturer price or widely available manufacturer price substitution under Section 1847A(d)(3)(C) applies where those amounts are a specified percentage lower than ASP.[135]

In addition, "CMS is soliciting comments . . . on other options to calculate the ceiling for MFP for selected drugs or biologicals payable under Part B that are not paid based on section 1847A(b)(4) of the Act."[136] By statute, Congress very explicitly directed CMS to calculate the ceiling for the

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[131] SSA § 1194(c)(1)(B).
[132] IPAY 2028 Draft Guidance § 60.
[133] SSA § 1847A(b)(1) (emphasis added).
[134] *Id.* § 1847A(d)(3).
[135] *Id*. § 1847A(d)(3)(C).
[136] IPAY 2028 Draft Guidance § 60.2.2.2.

MFP for "a drug or biological product for which payment may be made under part B . . ." based on "the payment amount under section 1847A(b)(4) for the drug or biological product for the year prior to the year of the selected drug publication date with respect to the initial price applicability year for the drug or biological product."[137] Payment for a drug or biological product under Section 1847A(b)(4) is based on the lesser of ASP or WAC, not some other payment amount, thereby leaving CMS no authority to substitute an alternative payment amount for purposes of calculating the single ceiling and setting the MFP.[138]

CMS has interpreted comparable cross references established under the IRA as limiting the kinds of pricing information it can rely on to implement the statute. For example, with respect to the Part B inflation rebate program, CMS has interpreted cross-references to Section 1847A(b)(4) of the SSA as limited to the lesser of ASP or WAC based payment methodology for purposes of calculating whether the current quarter payment amount has increased faster than the pace of inflation.[139] Here too, CMS should only be effectuating the MFP and calculating the ceiling based on the express amounts cross-referenced by statute under the DPNP.

VI. RECOMMENDATIONS REGARDING FORMULARY ACCESS UNDER PART D AND BENEFICIARY ACCESS TO PART B COVERED DRUG UNDER MEDICARE ADVANTAGE (MA) (SECTIONS 80 and 110)

A. CMS Should Take Additional Steps to Ensure Broad Beneficiary Access to Selected Drugs Under Medicare Part D in IPAY 2026 and Future Payment Years (Section 110)

The IRA amended the Medicare Part D statute to require Part D plans cover each selected drug.[140] The IRA also created an exception to the Part D statute's "noninterference" clause to allow CMS to require "a particular formulary" "as provided under section 1860D-4(b)(3)(I)" (i.e., to effectuate the coverage requirement for selected drugs).[141]

In its IPAY 2028 Draft Guidance, as well as in the IPAY 2027 and IPAY 2026 guidances, CMS states that it will require Part D plan sponsors to submit justification for any of the following formulary actions:

1. Placement of selected drugs on non-preferred tiers;
2. Placement of a selected drug on a higher cost-sharing tier than non-selected brand drugs in the same class;

[137] SSA § 1847A(c)(1)(B)(ii).
[138] *Id.* § 1847A(b)(4).
[139] 89 Fed. Reg. 97,710, 98,244 (Dec. 9, 2024).
[140] *SSA* § 1860D-4(b)(3)(I).
[141] *Id.* § 1860D-11(i).

3. Utilization management or step therapy requiring use of an alternative brand drug prior to a selected drug; or

4. More restrictive utilization management for a selected drug compared to a non-selected brand drug in the same class.[142]

We remain concerned that reviewing plan restrictions on a case-by case basis is insufficient oversight to protect beneficiaries who rely on selected drugs. If CMS is only considering restrictive formulary designs individually, there is a risk that broader market-wide trends of restricting access to specific selected drugs may be missed. While the IRA generally requires Part D plans to cover all selected drugs, the DPNP inherently creates financial incentives for plans to nevertheless impose restrictions on meaningful access to those therapies. Under the DPNP, point-of-sale (POS) prices for selected drugs under Part D will be lower than they were previously to reflect the lower MFP pricing plus any dispensing fee that may apply. Historically, stakeholders have expressed concern that Part D plans exhibit a preference for drugs with higher prices and, thus, higher rebates.[143] When POS prices for selected drugs decrease, Part D plan sponsors and their PBMs may favor other drugs in the selected drug's class with higher prices in order to access higher rebates and administrative fees. As a result, Part D plan sponsors may choose to place selected drugs on tiers with higher cost-sharing or more burdensome utilization management requirements to encourage patients to prefer higher-cost alternatives, with more substantial rebates and fees, instead. For these reasons, experts have warned that a selected drug's MFP—particularly in conjunction with the price pressures imposed on plans under the IRA's Part D redesign provisions—is likely to increase negative formulary treatment of selected drugs.[144]

A Part D plan could reasonably interpret the ambiguity in CMS's current guidance as permitting the use of elevated cost-sharing and/or burdensome utilization management requirements for selected drugs to "continue to manage costs." We are particularly concerned about plan restrictions in light of broader Part D formulary trends and the pressure on Part D plans as they implement benefit redesign and take on a greater share of catastrophic costs. A study in *Health Affairs* found that Part D plans have increased restrictions such as prior authorization, step therapy, and formulary exclusions from 2011 to 2020. Specifically,

- Increased Restrictions: The proportion of non-protected-class compounds facing restrictions rose from an average of 31.9% in 2011 to an average of 44.4% in 2020.

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[142] IPAY 2026 Revised Guidance § 110; IPAY 2027 Final Guidance § 110; IPAY 2028 Draft Guidance § 110.

[143] Christen Linke Young, *Medicare's Recent Actions to Promote Access to Lower Cost Drugs*, Brookings (Mar. 28, 2025), available at: https://www.brookings.edu/articles/medicares-recent-actions-to-promote-access-to-lower-cost-drugs/.

[144] *See, e.g.*, Cathy Kelley, *Medicare Part D Redesign Could Expand Rebate-Driven Formulary Exclusions In Program*, Citeline (Jan. 26, 2023), https://pink.citeline.com/PS147634/Medicare-Part-D-Redesign-Could-Expand-Rebate-Driven-Formulary-Exclusions-In-Program; Cathy Kelley, *Medicare-Negotiated Drugs May Not Get Favorable Coverage In Part D: Will CMS Intervene?*, Citeline (Apr. 16, 2024), https://pink.citeline.com/PS150091/Medicare-Negotiated-Drugs-May-Not-Get-Favorable-Coverage-In-Part-D-Will-CMS-Intervene.

- Formulary Exclusions: Exclusions of brand-name-only compounds surged, with 44.7% excluded by 2020.
- Utilization Management Tools: PBMs used tools like prior authorization and step therapy more liberally to control costs, which can delay or deny access to prescribed medications.
- Impact by Drug Type and Cost: Restrictions were more common for brand-name-only compounds. For instance, in 2020, 68.4% of brand-name-only compounds were either excluded or subjected to prior authorization/step therapy.[145]

The Office of Inspector General (OIG) has also found that Part D patients may face "avoidable extra steps" that delay patient care, including unapproved utilization management requirements, prior authorization, and step therapy. In instances where patients appealed coverage denials, 73% of initial denials were overturned.[146] These restrictions place an undue burden on patients that have real consequences for continuity of care, clinical outcomes, and quality of life.

Such a result would subvert the purpose of the DPNP. Specifically, such access barriers to selected drugs could render meaningless the requirement that a selected drug that has competition in a particular category or class be covered. It would also undermine the efforts CMS has expended to engage in a lengthy, time-intensive process to determine an MFP for each selected drug.

Formulary placement alone is insufficient to protect beneficiary access to selected drugs under Part D. The DPNP could create the unintended consequence of increasing barriers to access of selected drugs for beneficiaries and could distort competition among Part D drugs. CMS should take additional steps to ensure broad beneficiary access to selected drugs under Part D.

To preserve the purpose of the DPNP, selected drugs should be placed on formulary in a no less favorable position than other treatments for the same conditions and as it was prior to becoming selected. Additionally, CMS should make clear to Part D plan sponsors that utilization management requirements, including prior authorization and step therapy, should not be more restrictive than the terms of a selected drug's FDA-approved label, to help preserve patient access to these therapies. CMS should prohibit Part D plan sponsors from restricting beneficiary access to selected drugs through step-edits or other forms of utilization management in favor of non-selected drugs.

We strongly urge CMS to adopt these measures in final guidance applicable to IPAY 2026, IPAY 2027, IPAY 2028, and future price applicability years. We also note that rulemaking for CY 2027 MA and Part D programs offers additional opportunity for CMS to clarify obligations of Part D plans with respect to ensuring access to selected drugs through a notice-and-comment process.

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[145] Geoffrey Joyce, Barbara Blaylock, Jiafan Chen & Karen Van Nuys, *Medicare Part D Plans Greatly Increased Utilization Restrictions On Prescription Drugs, 2011–20*, 43 Health Affairs 391 (Mar. 2024), https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00999.

[146] *Id.* at 391 (citing Suzanne Murrin, HHS OIG, Some Medicare Part D Beneficiaries Face Avoidable Extra Steps That Can Delay or Prevent Access to Prescribed Drugs (Sept. 2019), https://oig.hhs.gov/oei/reports/oei-09-16-00411.pdf).

Additionally, for formularies and plan bids already submitted for 2026, we urge CMS to carefully review the submissions to ensure that selected drugs are not disadvantaged relative to their prior positioning and to other drugs in the therapeutic class.

B. CMS Should Prohibit MA Plans from Imposing Step Therapy Requirements on Part B Selected Drugs (Section 80)

In the final IPAY 2028 guidance, as well as in MA rulemaking, CMS should make clear that MA plans may not apply step therapy requirements to Part B selected drugs.

For basic MA benefits, CMS has clarified that "certain utilization management processes, such as clinical treatment guidelines that require another item or service be furnished prior to receiving the requested item or service, would violate" the requirements for MA organizations.[147] As CMS has recognized, inappropriate use of utilization management, including step therapy, hinders access to necessary therapies and causes disparities in care between Medicare beneficiaries.[148] Allowing step therapy within MA for Part B drugs generates similar barriers to access as for other types of items or services, yet CMS has not prohibited this practice.

Specifically, step therapy creates disparities in coverage between Traditional Medicare and MA that are inconsistent with the statutory and regulatory requirements to make the same benefits available under both types of Medicare. Medicare beneficiaries, especially those requiring Part B drugs, are likely being treated for complex, chronic, life-threatening diseases, such as cancer, which require careful management. Stopping or delaying therapy to try another drug, over the physician's best judgment, in order to comply with a step therapy requirement, could negatively impact health outcomes for some of the most vulnerable patients. Physicians and patient groups have expressed extensive concerns about this policy and urged CMS to reconsider its policy allowing step therapy in MA.[149] Step therapy protocols often do not take into consideration specific patient needs such as the presence of comorbidities, potential drug-drug interactions, or patient intolerances which might necessitate the use of different therapies.[150] For these reasons, Amgen has urged CMS to eliminate MA plans' ability to use step therapy for all Part B drugs. At minimum, CMS should eliminate MA plan's ability to impose step therapy for selected Part B drugs that is

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[147] 88 Fed. Reg. 22,120, 22,188 (Apr. 12, 2023).

[148] *See id.* ("[W]e have concluded that certain guardrails are needed to ensure that utilization management tools are used, and associated coverage decisions are made, in ways that ensure timely and appropriate access to medically necessary care for beneficiaries enrolled in MA plans.").

[149] *See, e.g.*, Letter to CMS from 50+ Organizations Opposing Step Therapy for Part B Drugs in MA (Nov. 23, 2021), *available at:* https://aafa.org/wp-content/uploads/2022/08/aafa-sign-on-letter-reinstatement-step-therapy-prohibition-ma-plans-part-b-drugs.pdf; Letter to CMS from 50+ Organizations Opposing Step Therapy for Part B Drugs in MA (Feb. 13, 2023), *available at:* https://www.aan.com/siteassets/home-page/policy-and-guidelines/advocacy/comment-letters/step-therapy-coalition---ma-rules-comment.pdf.

[150] Letter to CMS from Am. Med. Ass'n (Sept. 7, 2018), *available at:* https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-9-10-Signed-on-Letter-to-Verma-re-Step-Therapy.pdf; Letter to Congress from 50+ Organizations Opposing Step Therapy for Part B Drugs in MA (Sept. 12, 2018), *available at:* https://partbaccess.org/wp-content/uploads/2017/06/9.12.18-ASP-Coalition-Letter-on-CMS-MA-Guidance.pdf?et_cid=40538670&et_rid=1699568480&linkid=http%3a%2f%2fpartbaccess.org%2fwp-content%2fuploads%2f2017%2f06%2f9.12.18-ASP-Coalition-Letter-on-CMS-MA-Guidance.pdf.

more restrictive than the terms of a selected drug's FDA-approved label to help preserve patient access to these therapies.

Should the agency not take this approach, we urge CMS to develop and implement fundamental patient protections to better ensure that patients with serious medical conditions can continue to access the treatments that their physicians recommend in a timely manner, including: implementing strong coverage determination and appeals processes with short adjudication timelines; maintaining lengthy lookback periods to appropriately reflect complex therapy intervals and protect stability in patient treatments; requiring that plan documents identify which drugs are subject to step therapy; and prohibiting mid-year step therapy additions.

VII. RECOMMENDATIONS REGARDING CMS PROCESS TO SELECT IPAY 2026 AND 2027 DRUGS FOR RESETTING MFP (SECTION 130)

A. CMS Should Create a More Narrow and Predictable Selection Process

By statute, CMS is required to reset the MFP for all selected drugs that change status to a long-monopoly or extended-monopoly drug.[151] Of the remaining drugs eligible to have MFPs reset, namely those with a new indication or for which the Secretary determines there has been a material change of any of the factors described in Section 1194(e)(1) (i.e., manufacturer data) or (2) (i.e., evidence about alternative treatments), CMS must only select those likely to "result in a significant change" in the MFP.[152] CMS proposes in the IPAY 2028 Draft Guidance to consider "the likelihood that the new indication or material change would result in a new MFP that represents a 15 percent or greater change relative to the current MFP" and "whether such a change in the MFP for the drug would have a significant impact on the Medicare Program" when determining whether price resetting is likely to result in a "significant change" to the MFP.[153] CMS proposes to examine these factors through a holistic, amorphous inquiry based on "the totality of the information available and the circumstances" of the drug.[154]

With no limit on the "holistic," "totality"-based inquiry as to "material change," "significant change," and "significant impact"—each in themselves vague, unbounded phrases—manufacturers have no way to predict what circumstances will trigger price resetting beyond those few statutorily enumerated. Amgen strongly urges CMS not to finalize these proposals and to instead articulate a more narrow and specific set of facts that would prompt the selection of an IPAY 2026 or 2027 selected drug for resetting for years after IPAY 2028.

Given the massive breadth of materials necessary for price setting and resetting, manufacturers are not able to either be constantly prepared for or able to immediately pivot from business-as-usual into MFP resetting. In order to efficiently and effectively participate in the DPNP with the agency, manufacturers need to be able to reasonably predict when the MFP for a product might

[151] SSA § 1194(f)(2)-(3).
[152] *Id.*
[153] IPAY 2028 Draft Guidance § 130.2.1.
[154] *Id.*

be reset. CMS's proposal makes that a near impossibility for any previously selected drug that has not changed monopoly status, through its reliance on vague standards and subjective judgments that do not allow manufacturers to reasonably forecast whether a selected drug will be subject to resetting. Instead of finalizing these proposals, CMS should publish, in the final guidance, distinct, discrete, and explicit circumstances in which the agency would select a drug and, where resetting is based on a "material change" in the Section 1194(e)(1) and (2) factors, clearly outline *what* criterion, and what changes in those criterion, would constitute a material change.[155]

B. For IPAY 2028, CMS Should Only Select Drugs with a Change in Monopoly Status for MFP Resetting

For IPAY 2028 CMS should select only those drugs that are eligible based on a change in monopoly status to have MFPs reset, as required by statute and described previously. Given how recently IPAY 2026 and IPAY 2027 selected drugs will have had their MFPs set by the deadline for selection for resetting MFP for IPAY 2028, there is no rationale to support price resetting at this time. Only minimal changes could have occurred between the initial price setting and resetting of the MFP that are unlikely to result in a significant change in the MFP; at most, and when compared against the burden that the resetting process would entail for both the manufacturers and agency for these drugs, these changes do not support resetting except where required by statute.

At minimum, if CMS does not limit resetting of the MFP to the circumstances required by statute, it should adopt an even more limited list of circumstances in which resetting could occur for IPAY 2028. In sum, Amgen asks that CMS develop a set of narrow and specific circumstances in which price resetting will be triggered for future years and finalize that it will only select drugs made eligible on the basis of a change in monopoly status for price resetting in IPAY 2028.

VIII. RECOMMENDATIONS REGARDING THE PRICE SETTING FACTORS

A. CMS Should Limit Mandatory Disclosures to Information Necessary for Price Setting (Sections 40.2, 50.1, and 60.3, Appendix A)

We urge CMS to limit the burden of data production imposed on manufacturers of selected drugs by streamlining the data submissions required in support of the DPNP. 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(b)(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). In practice, CMS has required, and in the IPAY 2028 Draft Guidance intends to continue to require, manufacturers to submit detailed information in support of the Section 1194(e)(1) of the SSA negotiation factors related to manufacturer-specific data in a way that imposes a significant burden on manufacturers.

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[155] *Id.* § 130.2.

Not only does the submission of this information in the format required by CMS impose a significant burden on manufacturers, for the reasons outlined with respect to each Section 1194(e)(1) factor below, but Amgen does not understand how much of the information that CMS requires to be submitted was or will be of use to CMS in its price setting exercise. For example, CMS requires manufacturers to report novel pricing metrics with minimal guidance on their calculation methodologies.[156] Amgen and its subsidiary, Immunex Corporation, had to develop assumptions to satisfy the CMS reporting requirements with respect to each of their respective products selected for price setting. Other manufacturers had to do the same and likely relied on different—but no less reasonable—assumptions, such that data may not be directly comparable across submissions. Despite the considerable resources invested in compiling this information, it is not clear how these novel and undeveloped pricing metrics influence CMS's price determinations, if at all. CMS's development of MFP amounts seems to primarily be driven by therapeutic alternatives and clinical value information, not the manufacturer-specific data.[157] We therefore urge CMS to better align the effort required to submit information with the value it brings to the price-setting process.

1. Research and Development Costs

Amgen appreciates that CMS seeks to streamline its approach to collecting R&D costs from IPAY 2027, by reducing the number of categories across which manufacturers must allocate R&D costs.[158] However, CMS's stated intent to require manufacturers to break out R&D costs by (1) basic pre-clinical research and post-investigational new drug (IND) costs related to the selected drug and (2) those related to failed or abandoned products related to the selected drug still presents many of the same problems as the approach from IPAYs 2026 and 2027.[159] Specifically, instead of submitting total R&D costs as a whole, manufacturers must determine whether to include or exclude and categorize these costs according to CMS's R&D definitions that do not necessarily align with the selected drug's actual path to approval and marketing.

For example, CMS directs manufacturers to submit costs with respect to FDA approved indications for the selected drug from the date of initial discovery/acquisition.[160] CMS acknowledges that it may be difficult to identify the date of initial discovery but does not acknowledge the challenges that manufacturers might identify in gathering and categorizing costs

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[156] *Id.* at Appendix A; *see* 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) at 10–11 (Nov. 11, 2024) [hereinafter "IPAY 2027 Negotiation Data Elements ICR"], *available at:* https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202411-0938-010.

[157] *See* IPAY 2028 Draft Guidance § 60.3.2 (basing starting point for initial offer on prices of therapeutic alternatives); SSA § 1194(e)(2); CMS, IPAY 2026 MFP Explanations, *available at:* https://www.cms.gov/priorities/medicare-prescription-drug-affordability/overview/medicare-drug-price-negotiation-program/selected-drugs-and-negotiated-prices.

[158] IPAY 2028 Draft Guidance at Appendix A; IPAY 2027 Final Guidance at Appendix A; IPAY 2027 Negotiation Data Elements ICR at 10–11.

[159] *See* IPAY 2028 Draft Guidance at Appendix A.

[160] IPAY 2027 Negotiation Data Elements ICR at 13. Manufacturers are to use their best estimate for the date of initial discovery or, if it truly cannot be determined, are to use 52 months.

back to this date.[161] At the earliest, a drug is selected for price setting seven years post approval or eleven years post licensure for biological products.[162] Even by CMS's own statements, the date of initial discovery is, on average, 52 months (nearly five years) before that date, for a total of over 12 to 14 years before the earliest possible selection date.[163] However, for many drugs, the date of initial discovery may be even older. In the cases of Enbrel, first approved in 1998, and Otezla, approved in 2014, the timeframe between the initial date of discovery and the date of selection is over 30 years (i.e., approximately 25 years between approval and selection plus at least 52 months) and over 16 years (i.e., approximately 11 years between approval and selection plus at least 52 months) respectively. In the interim, manufacturer record keeping systems might have changed and the researchers responsible for the initial discovery of the molecule may no longer be with the company, making it incredibly difficult for manufacturers to identify whether research ultimately fits with CMS's R&D definitions. Moreover, research at that early stage of the process is not always categorized by indication in part because the manufacturer is still determining which indications might be appropriate, so it may be impossible to delineate between R&D costs "for Indications of the Selected Drug" and costs for failed or abandoned indications.[164]

Furthermore, for price setting purposes, CMS has stated that it would consider adjusting the initial offer price upward or downward based on whether the manufacturer has recouped its *total* R&D costs, which suggests the subcategories of R&D were irrelevant and will be irrelevant going forward.[165] CMS could limit the burden on manufacturers by simply requiring them to attest whether R&D costs had been recouped.

2. Prior Federal Financial Support

Similar concerns were also evident in the requested information regarding federal financial support.[166] As with R&D costs, federal financial support comes in a variety of forms, sometimes decades before a drug is selected for price setting, such that manufacturers do not track this information in the structured manner contemplated by CMS. A straightforward and objective indicator of federal financial support is a patent application containing a Government Interest Statement.[167] Instead of relying on information that a manufacturer can find through a search of

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[161] *Id.* at 13 (contemplating cases where "the length of the basic pre-clinical research period for the selected drug cannot be calculated").
[162] SSA § 1192(e)(1); *see, e.g.*, *id.* § 1192(f) (providing for up to two-year delay of selection for biologics with anticipated biosimilar competition).
[163] IPAY 2027 Final Guidance at Appendix A; IPAY 2027 Negotiation Data Elements ICR at 13.
[164] IPAY 2028 Draft Guidance at Appendix A.
[165] *See id.* § 60.3.4 ("CMS will consider the five factors outlined in section 1194(e)(1) of the Act in totality and apply an upward adjustment, downward adjustment, or no adjustment to the preliminary price. . . . In considering factor (1) above on R&D costs, CMS will consider the extent to which the Primary Manufacturer has recouped its R&D costs."); *see also* CMS, IPAY 2026 MFP Explanations, *available at:* https://www.cms.gov/priorities/medicare-prescription-drug-affordability/overview/medicare-drug-price-negotiation-program/selected-drugs-and-negotiated-prices.
[166] IPAY 2027 Negotiation Data Elements ICR at 25–28.
[167] *See* 35 U.S.C. §§ 201(b), 202(c)(6) (requiring a Government Interest Statement in patents arising out of "any contract, grant, or cooperative agreement entered into between any Federal agency . . . and any contractor for the performance of experimental, developmental, or research work funded in whole or in part by the Federal Government").

patent applications (which is a significant burden in itself), CMS also requires manufacturers to report tax credits or other types of funding that are insufficient to result in a Government Interest Statement.[168] Manufacturers typically do not track this information in any organized way and have to assess what level of diligence is appropriate to comply with CMS's submission requirements. 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 establish prices of selected drugs. If federal funding does not rise to the level of warranting a Government Interest Statement, its impact on a manufacturer's R&D costs for a selected drug is so attenuated that such funding reasonably could have only a negligible effect on the MFP amount. The Draft Guidance does not explain how CMS intends to weigh various forms of federal financial support and determine when, and by how much, to adjust a preliminary price.[169]

Furthermore, we caution CMS against overstating the impact of federal financial support on a manufacturer's R&D costs or revenues. As numerous analyses have shown, most federal support funds basic research, e.g., early, pre-clinical research to discover molecules of interest without immediate commercial applications, and many of the molecules identified through basic research ultimately fail to yield viable applications.[170] Because of the early-stage nature of federal funding, manufacturers have limited access to years-old grant documents that may not clearly indicate the purpose of the funding.

These concerns loom large given that, as noted above, CMS has not concretely explained how federal financial support will impact initial offers, stating only that the agency "will consider the extent to which the Primary Manufacturer benefited from Federal financial support with respect to the selected drug" and "may consider adjusting the preliminary price downward if funding for the discovery and development of the drug was received from Federal sources."[171] This guidance offers negligible insight into how CMS may consider this information, and the lack of clear standards heightens the risk of inconsistent agency determinations across selected drugs and across years.

3. Data on Pending and Approved Patent Applications, Exclusivities, and Applications and Approvals/Licensures

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[168] IPAY 2027 Negotiation Data Elements ICR at 27–28; IPAY 2028 Draft Guidance at Appendix A.
[169] IPAY 2028 Draft Guidance § 60.3.4 ("CMS will consider the extent to which the Primary Manufacturer benefited from Federal financial support with respect to the selected drug. For example, CMS may consider adjusting the preliminary price downward if funding for the discovery and development of the drug was received from Federal sources.").
[170] *See, e.g.*, Cong. Res. Serv., Federal Research and Development (R&D) Funding: FY2025 at 6 (Dec. 9, 2024), *available at:* https://www.congress.gov/crs-product/R48307 (reporting that "[t]he federal government is the nation's largest supporter of basic research" while "[f]or U.S. applied research, business is the primary funder"); Mike Henry, *US R&D Spending at All-Time High, Federal Share Reaches Record Low*, Am. Inst. Physics (Nov. 8, 2016), *available at:* https://www.aip.org/fyi/2016/us-rd-spending-all-time-high-federal-share-reaches-record-low ("[T]he federal government remains the nation's foremost sponsor of basic research, . . . [with] [m]uch of the federal funding for basic research go[ing] to universities and other institutions of higher education. . . . Private enterprise, however, leads in the funding and conduct of both applied research and experimental develop.").
[171] *See* IPAY 2028 Draft Guidance at Appendix A.

CMS should not require manufacturers to compile and submit information that CMS can access directly, such as publicly available information about approvals, patents, and exclusivities, as well as information available at other federal agencies. While the IRA authorizes manufacturer submission of "[d]ata on pending and approved patent applications, exclusivities . . . , and applications and approvals [or licensures] for the drug,"[172] there is no basis for making manufacturers responsible for compiling *all* information related to patents, exclusivities, and applications/licensures—particularly information that is readily available to the agency.

Additionally, CMS should clarify how it intends to use this information in determining MFPs. The Draft Guidance states that patents and exclusivities "may inform CMS' understanding of therapeutic alternatives and other available therapy for the purposes of adjusting for clinical benefit," but never specifically describes how it will determine when an adjustment is appropriate or the amount by which to adjust the preliminary price.[173]

4. Market Data and Revenue and Sales Volume Data

We urge CMS to limit the required market data to existing pricing metrics with established methodologies and to avoid "forward-looking" forecasts, so as to ensure consistency and comparability across submissions, while keeping the burden on submitting manufacturers commensurate with the value of submitted pricing information in CMS's development of MFP offers. In IPAY 2028 Draft Guidance, CMS solicits comment on the collection of "additional, forward-looking 'market data' for the selected drug."[174] CMS suggests these data could include forecasted net revenue and volume data for the selected drug for future periods, and provides examples of a manufacturer's annual forecast of U.S. net revenue, volume by indication, and net pricing for the selected drug itemized by the relevant market channel (e.g., Medicare, Medicaid, commercial or other); and annual gross-to-net ratio trend for the selected drug across all market channels and market share percentages and volume, by indication. CMS states that "these types of data are consistent with the section 1194(e)(1)(E) factor of 'market data and revenue and sales volume data for the drug in the United States.'"[175]

CMS should not require manufacturers to submit "forward-looking" market data as it is inappropriate for both policy and legal reasons. As a policy matter, forward-looking data are forecasts that may or may not be realized. Moreover, CMS requires primary manufacturers to certify that the data submission is "complete and accurate," and that notification will occur if information has changed.[176] Forecasts, by definition, constantly evolve based upon new information and changes to the business environment. Thus, it would be impossible to regularly notify CMS when information has "changed." In addition, requiring a delegated official to certify to the "completeness" and "accuracy" of what is merely a forecast places undue, unfair responsibility on such certifiers, who cannot reasonably opine as to whether the predictions will occur. Finally, a forecast does not constitute "data." In interpreting statutes, agencies must use the "ordinary

[172] SSA § 1194(e)(1)(D).
[173] IPAY 2028 Draft Guidance § 60.3.4.
[174] *Id*. § 50.1.
[175] *Id*.
[176] CMS, IPAY 2027 Negotiation Data Elements Form, CMS 10849 (Nov. 2024). *available at:* https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202411-0938-010.

meaning of terms unless context requires a different result."[177] The ordinary meaning of "data" is "factual information (such as measurements or statistics) used as a basis for reasoning, discussion, or calculation."[178] A prediction is not empirical, factual information akin to a "measurement" or a "statistic." Indeed, CMS may understand that it is stretching the meaning of the statute, as the agency states that its request for forecasted data is merely "consistent" with section 1194(e)(1)(E). This may indicate that the agency understands the statute does not clearly permit collection of predictions. For the above reasons, CMS should not collect "forward-looking" forecasts in its ICR.

For IPAY 2027, under the statutory factor for "[m]arket data and revenue and sales volume data for the drug in the United States," CMS required manufacturers to accurately report five new price types not reported in other contexts, based on single-paragraph descriptions of those price types.[179] CMS appears to be retaining these additional price types, e.g., those based on a "[m]anufacturer U.S. commercial average net unit price" and a "[m]anufacturer net Medicare Part D average unit price," for IPAY 2028, without issuing additional guidance on how to calculate them thus far.[180] Without this guidance, Immunex and Amgen had to develop assumptions to satisfy CMS's submission requirements in IPAY 2026 and 2027, and other manufacturers had to do the same, likely relying on different, but no less reasonable, assumptions.

In contrast to these pricing metrics unique to the DPNP, the other price types required under this factor, such as Medicaid best price, are the subjects of extensive guidance developed over decades of engagement between CMS and stakeholders. And even for these pricing metrics, gaps in guidance remain.[181]

Despite best efforts to draw the most reasonable assumptions, manufacturers may vary significantly in their interpretations of the sparse guidance with respect to the new price types, thereby impairing the comparability of data submitted by different entities. Moreover, despite the considerable resources invested in compiling this information, it is not clear how these novel and undeveloped pricing metrics influence CMS's price determinations, if at all.[182] Accordingly, there

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[177] *Gonzales v. Carhart*, 550 U.S. 124, 152 (2007).
[178] Data. Merriam-Webster, *available at*: https://www.merriam-webster.com/dictionary/data (accessed June 24, 2025).
[179] IPAY 2027 Final Guidance at Appendix A.
[180] IPAY 2028 Draft Guidance at Appendix A.
[181] *See, e.g.*, HHS OIG, Manufacturers May Need Additional Guidance to Ensure Consistent Calculations of Average Sales Prices (Dec. 2022), *available at:* https://oig.hhs.gov/oei/reports/OEI-BL-21-00330.pdf; HHS OIG, CMS Should Bolster Its Oversight of Manufacturer-Submitted Average Sales Price Data to Ensure Accurate part B Drug Payments (Dec. 2022), *available at:* https://oig.hhs.gov/oei/reports/OEI-03-21-00390.pdf.
[182] CMS has stated only that, "in considering factor (5) on market data and revenue and sales volume data for the U.S., CMS will consider how the data compare to the preliminary price. For example, if the average commercial net price is lower than the preliminary price, CMS may consider adjusting the preliminary price downward. If the average commercial net price is greater than the preliminary price, CMS may consider adjusting the preliminary price upward." IPAY 2028 Draft Guidance § 60.3.4. However, CMS has not explained how it will weigh the multiple variations of average commercial net price and other pricing metrics, how it will determine when an adjustment is warranted, or how it will determine the appropriate amount by which to adjust the preliminary price.

are significant challenges associated with reporting this pricing information, which ultimately cannot meaningfully be compared across submitters.

We urge CMS to engage with manufacturers so both sides can better understand the types of information CMS "requires" for price setting, how manufacturers can provide this information as efficiently as possible and within less than 30 days after the selected drug publication date, and how this information will factor into CMS's determination of an MFP.

B. CMS Should Reverse Its Intent to Exclude Certain R&D Costs (Sections 40.2, 50.1, and 60.3, Appendix A)

For the manufacturer's submission of information regarding R&D costs, CMS states in the IPAY 2028 Draft Guidance that it will exclude acquisition costs from the R&D cost section based on the mistaken assumption the cost is not driven by R&D.[183] Amgen urges CMS to abandon this ill-conceived policy when it issues its final guidance document.

Acquisition expenses reflect tangible and intangible R&D assets for which the acquiring company incurs a cost based on fair market valuation. Without considering such costs, CMS would consistently underestimate the investments required to develop selected drugs and make them available to the public. 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. And the product may be of greater benefit to patients in the hands of an acquiring company if the company has getter 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. Given that CMS proposes under section 60.3.4 to adjust the initial offer price upward or downward based on whether the manufacturer has recouped R&D costs, a product's MFP could depend on when in its life cycle it was acquired by the company that currently holds its BLA. By understating R&D costs in the MFP determination process, CMS's proposal will amplify the DPNP's destabilizing effect on pharmaceutical innovation.

C. CMS Should Assign Greater Weight to Evidence About Alternative Treatments (Section 50.2)

Amgen encourages CMS to provide clarity about the MFP price setting methodology including, but not limited to, any information or structure around how the different data elements will be weighted. CMS should assign a greater weight to IRA Section 1194(e)(2) factors that actually reflect the benefit the selected drug brings to patients, caregivers, and society and will help encourage the generation of additional evidence on the comparative health benefits of different treatments. CMS should place less weight on the IRA Section 1194(e)(1) factors that would diminish medicines' benefits and could stagnate innovation if overweighted. Basing prices for medicines on costs incurred by the manufacturer, instead of the value and benefits conferred by

[183] *Id.* at Appendix A.

the innovation, sends perverse, unintended signals to manufacturers to reduce R&D investments. This poses a significant threat to innovation and progress for future medicines.

* * * * *

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

Apellis

BY ELECTRONIC SUBMISSION VIA IRARebateandNegotiation@cms.hhs.gov

June 26, 2025

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp:

Apellis Pharmaceuticals, Inc. ("Apellis") appreciates the opportunity to comment in response to the above captioned guidance (the "Draft Guidance") setting forth the Centers for Medicare & Medicaid Services' ("CMS") proposed policies for implementing the Medicare Drug Price Negotiation Program ("Negotiation Program") for initial price applicability year ("IPAY") 2028.

Apellis is a biopharmaceutical company that has developed life-changing therapies for some of the most challenging diseases patients face. Apellis ushered in the first new class of complement medicine in 15 years and now has two approved medicines targeting C3, the central protein of the complement cascade. These drugs, which were approved under separate New Drug Applications ("NDAs"), include (1) EMPAVELI, a treatment for the rare disease of paroxysmal nocturnal hemoglobinuria ("PNH"), which affects approximately 5,000 Americans, and (2) SYFOVRE, the first-ever therapy for geographic atrophy secondary to age-related macular degeneration, a leading cause of blindness that affects approximately one million Americans, the majority of which are Medicare beneficiaries. Earlier this year, the Food and Drug Administration ("FDA") accepted and granted Priority Review designation of the supplemental New Drug Application for EMPAVELI for C3 glomerulopathy ("C3G") and primary immune complex membranoproliferative glomerulonephritis ("IC-MPGN"), which are severe and rare kidney diseases.

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Apellis has made very substantial investments in two very different drugs—SYFOVRE and EMPAVELI—which share the same active moiety, pegcetacoplan. The drugs, however, treat very different diseases and patient populations, have vastly different dosing and methods of administration (SYFOVRE by intravitreal injection and EMPAVELI is self-administered via an on-body injector), and are covered under different Medicare programs, with SYFOVRE covered under Part B and EMPAVELI covered under Part D.

Our comments are as follows:

- CMS should revisit prior guidance and find that, if two drug products are approved under two separate NDAs, such two products are not the same Qualifying Single Source Drug ("QSSD").
- In the event that CMS does not revise prior guidance as specified above, CMS should clarify that a Part D drug approved under one NDA and a Part B drug approved under a separate NDA are not the same QSSD.

We describe each of these comments in greater detail below.

I. CMS Should Adopt the Position that Drug Products Approved Under Different NDAs Are Not the Same QSSD (Section 30.1)

In both the 2026 and 2027 IPAY guidance documents, CMS adopted the position that a drug product approved under one NDA could be the same QSSD as a drug product approved under a separate NDA if the two drug products share an active ingredient or active moiety and the same manufacturer.[1]

CMS should revise this position and find that drug products approved under different NDAs are not the same QSSD. While other commentators have already provided detailed explanation as to why CMS should not treat such drug products as the same QSSD, we briefly reiterate those reasons:

- The statute unambiguously anchors the QSSD definition to a *singular* approval by FDA. In the case of drug products, a QSSD is "[a] drug... that is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act...."[2] The use of the singular "drug" shows Congress intended that a QSSD represent a single drug approval, not multiple approvals.

[1] For purposes of brevity, this comment letter refers to drugs approved under different NDAs being aggregated into one QSSD. However, the same issues apply to drugs approved under different biologics license applications ("BLAs") that are also aggregated into one QSSD.
[2] Social Security Act § 1192(e)(1).

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- The definition of QSSD under the Inflation Reduction Act ("IRA") makes no mention of the terms "active moiety" or "active ingredient," nor do any of the provisions that incorporate such terms by reference.
- The aggregation of "dosage forms and strengths" required under Section 1192(d)(3)(B) of the Social Security Act applies only to determining which drugs are eligible for negotiation; it does not tie to the definition of a QSSD.

These provisions demonstrate Congress's clear intent that two products approved under separate NDAs should not be treated as one QSSD.

CMS has said that the broad QSSD definition is intended to prevent manufacturers from engaging in "product hopping," where a manufacturer makes small changes to a product to extend patent life. However, small and innovative biotech companies like Apellis are not trying to game the system by engaging in "product hopping"—they are instead developing completely new products that treat different conditions and patient populations.

CMS's current interpretation of the definition of QSSD penalizes small biotechs like Apellis, stifling innovation. Apellis is serving patients by researching and developing new clinical uses for an active moiety that impacts the body's complement system, which is thought to play a significant role in a number of different therapeutic areas such as ophthalmology, hematology, nephrology, and neurology, yet CMS's interpretation creates strong incentives for manufacturers like Apellis to focus their efforts elsewhere.

For these reasons, we urge CMS to reconsider its past guidance and find that drug products approved under different NDAs are not the same QSSD.

II. CMS Should Clarify That a Part D Drug Approved Under One NDA and a Part B Drug Approved Under a Separate NDA Are Not the Same QSSD (Sections 30.1 and 60.2.1)

As noted above, Apellis fundamentally disagrees with the initial proposition that NDAs can be aggregated across products for determining a QSSD. However, even setting that aside, the introduction of Medicare negotiation in Part B further supports the conclusion that the statute does not permit aggregation of products across different Parts of Medicare, at the very least.

In the event that CMS does not modify its position on aggregation of different NDAs, we request that CMS clarify in the final guidance that it will not aggregate two products approved under different NDAs in the case where one such product's utilization occurs

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under Part D and the other occurs under Part B. Aggregating two drug products under that scenario raises additional conflicts with the IRA statutory scheme that defy Congressional intent. Moreover, doing so can create unreasonable results, as it can lead to a ceiling price for a Part B drug calculated based on the price of a Part D drug (or vice versa) or a blockbuster drug qualifying for the small biotech exception.

A. The IRA Defines Part D Drugs and Part B Drugs as Separate QSSDs

The IRA states: "the term 'qualifying single source **drug**' means, with respect to an initial price applicability year, subject to paragraphs (2) and (3), **a covered part D drug** (as defined in section 1860D–2(e)) that is described in any of the following **or a drug or biological product** for which payment may be made under **part B** of title XVIII that is described in any of the following:..."[3]

The statute makes a clear distinction between Part D drugs and Part B drugs. It defines a QSSD either as (1) a "covered part d drug" or as (2) a "drug or biological product" that is payable under Part B. The clear implication is that Part D drugs and Part B drugs are different categories of QSSDs, not a single QSSD.

Had Congress intended to treat Part D drugs and Part B drugs as one QSSD, it would have defined a QSSD differently. The more natural way to phrase such concept would have been to define a QSSD as a "drug or biological product for which payment may be made under either part B or part D of title XVIII." That phrasing does not divide Part D drugs and Part B drugs into different categories. But that is not how Congress drafted the statute, showing an intent to place the two different types of drugs—under two different programs with very different rules—as separate QSSDs.

Congress has used similar phrasing elsewhere in the Social Security Act when it intended to refer jointly to drugs payable under multiple Medicare or Medicaid programs. For example, in Section 1860D–2(e)(2)(A) of the Social Security Act, Congress expressly excluded from the definition of a covered Part D drug any drug "for which payment is available under part A or B." This demonstrates that, when Congress intends to address drugs covered under multiple parts of Medicare, it uses inclusive language that explicitly references those parts as a single category. The fact that Congress did not use language characterizing Part B and D drugs as a single category in the QSSD definition—despite employing such language in other provisions—underscores that it did not intend to treat drugs covered under Parts B and D as a single QSSD. Congress instead described them in parallel but separate terms, reinforcing the conclusion that products reimbursed under

[3] Social Security Act § 1192(e)(1) (emphasis added).

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different Medicare programs, governed by distinct statutory frameworks, are to be treated as separate QSSDs.

B. The Definition of a "Negotiation Eligible Drug" Shows That Congress Intended to Treat Part D Drugs and Part B Drugs as Separate QSSDs

As the Draft Guidance notes, after CMS identifies QSSDs, it then determines which drugs are negotiation eligible drugs. The IRA defines a "negotiation eligible drug" as a QSSD that is described in one of the following subparagraphs:

- "Part D High Spend Drugs.—The qualifying single source drug is, determined in accordance with subsection (e)(2), among the 50 qualifying single source drugs with the highest total expenditures under part D of title XVIII, as determined by the Secretary in accordance with paragraph (3)..."
- "Part B High Spend Drugs.—The qualifying single source drug is, determined in accordance with subsection (e)(2), among the 50 qualifying single source drugs with the highest total expenditures under part B of title XVIII, as determined by the Secretary in accordance with paragraph (3)..."[4]

With respect to Part D high spend drugs, Congress directs CMS to consider expenditures under Part D only. Similarly, with respect to Part B high spend drugs, only Part B expenditures are taken into account.[5]

Congress's direction that CMS should only consider expenditures under each program shows that Congress expected that QSSDs themselves would be defined as either Part D drugs or Part B drugs. CMS is first directed to determine the QSSDs under each program, and then CMS is directed to determine the highest spend QSSDs under each program. The alternative interpretation—that QSSDs are not program specific but negotiation-eligible drugs are program specific—has no basis in the statutory scheme.

The reference to "paragraph (3)" in the "Part D high spend drugs" and the "Part B high spend drugs" descriptions further shows that CMS should treat Part D drugs and Part B drugs as separate QSSDs. Paragraph (3) says, in part: "In determining whether a qualifying single source drug satisfies any of the criteria described in paragraph (1) or (2), the

[4] Social Security Act § 1192(d)(1).

[5] The Draft Guidance is somewhat unclear on this point. On one hand, the initial provisions in Section 30.2 reference looking solely at Part D expenditures for Part D high spend drugs and solely at Part B expenditures for Part B high spend drugs. However, Section 30.2 further states: "In accordance with section 1192(d)(1) of the Act, beginning with initial price applicability year 2028, the assessment of negotiation-eligibility for each qualifying single source drug is determined based on Total Expenditures for that qualifying single source drug under both Part D and Part B."

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Secretary shall use data that is aggregated across dosage forms and strengths of the drug, including new formulations of the drug, such as an extended release formulation, and not based on the specific formulation or package size or package type of the drug."[6] In other words, Congress directs CMS to aggregate spending on different products *within each program*. When determining "Part D high spend drugs," CMS is directed to aggregate expenses among certain Part D drug products. When determining "Part B high spend drugs," CMS is directed to aggregate expenses among certain Part B drug products. Nowhere does Congress suggest that aggregation should occur across these two very different programs, as this would create unsound results.

C. *Treating a Part B Drug and a Part D Drug as a Single QSSD Produces Untenable Results*

If CMS were to adopt a policy of treating a Part D drug and a Part B drug as the same QSSD, then such a policy could lead to incongruous results. A Part D drug could have its ceiling price set by the pricing of a Part B drug that happens to share the same active moiety, and vice versa. Certain drugs produced by the world's largest pharmaceutical manufacturers could qualify for the "small biotech drug" exception and be exempted from negotiation. These outcomes are clearly inconsistent with Congress's intent when it adopted the IRA.

<u>Ceiling Price Calculations</u>

The ceiling price calculation can produce unreasonable results when a Part B drug and a Part D drug approved under different NDAs are treated as one QSSD.

The ceiling price is the lower of the "subparagraph (B)" amount and the "subparagraph (C)" amount.[7] Both components of this calculation should be determined separately for Part D drugs and Part B drugs.

Subparagraph (B) Amount

The IRA requires a different formula in calculating the subparagraph (B) amount for Part D drugs and Part B drugs:

- "Covered Part D Drug—In the case of a covered part D drug (as defined in section 1860D–2(e)), the sum of the plan specific enrollment weighted

[6] Social Security Act § 1192(d)(3)(B).
[7] Social Security Act § 1194(c)(1).

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amounts for each prescription drug plan or MA–PD plan (as determined under paragraph (2)).

- "Part B Drug or Biological.—In the case of a drug or biological product for which payment may be made under part B of title XVIII, the payment amount under section 1847A(b)(4) for the drug or biological product for the year prior to the year of the selected drug publication date with respect to the initial price applicability year for the drug or biological product."[8]

The statute unambiguously treats Part D drugs separately from Part B drugs in calculating the subparagraph (B) amount. Further, these subparagraph (B) amounts are calculated very differently under the two programs. For Part D drugs, the subparagraph (B) amount is based on the amount that Part D sponsors pay pharmacies or other providers for drugs, minus any rebates or price concessions provided by manufacturers (called the "plan specific enrollment weighted amount"). For Part B drugs, the subparagraph (B) amount is not based on how much plans agree to pay to pharmacies and manufacturer rebates, but instead a manufacturer's own average sales price or wholesale acquisition cost pricing calculations, as reported to CMS.[9]

In the Draft Guidance, CMS proposes that, in the cases where a QSSD has both Part B and Part D utilization, it will use a utilization-weighted average formula to determine the subparagraph (B) amount.[10] However, the statute contains no language authorizing CMS to merge these two distinct pricing methodologies into a single blended figure. To the contrary, Congress deliberately structured the ceiling price formula to reflect the unique characteristics and payment systems of each program.

This statutory bifurcation becomes even more consequential when CMS aggregates a Part B drug and a Part D drug approved under different NDAs. In such cases, the utilization-weighted average approach can significantly distort the subparagraph (B) amount calculation. As noted above, drugs are determined to be a "negotiation eligible drug" based on their Part D or Part B expenditures—not both. Accordingly, combining the subparagraph (B) pricing information from an entirely separate drug that was not the basis for selection mismatches the statutory selection criteria and the price-setting methodology. This approach creates an incongruent result; CMS would be establishing a ceiling price using data from a drug that did not contribute to the product's selection for

[8] Social Security Act § 1194(c)(1)(B).
[9] The Draft Guidance also notes an alternative calculation may be used in cases where Medicare does not pay based on Section 1847A(b)(4).
[10] Draft Guidance at Section 60.2.1.

negotiation. In short, combining pricing data across Parts B and D for products approved under separate NDAs undermines the integrity of the ceiling price calculation and is unsupported by the text or structure of the IRA.

Subparagraph (C) Amount

Treating a Part D drug and a Part B drug as a single QSSD, particularly in cases where they are approved under different NDAs, creates serious inconsistencies in the calculation of the subparagraph (C) amount as well.

The subparagraph (C) amount is based on the non-Federal average manufacturer price ("non-FAMP").[11] In particular, it equals the applicable percent multiplied by the lower of (1) the average non-FAMP for the QSSD in 2021 (or if the drug was not yet approved by that year, for the first full year of market entry), increased to account for inflation, and (2) the average non-FAMP for the QSSD in the year prior to the selected publication date with respect to the applicable IPAY (e.g., for IPAY 2028 and a selected drug publication date in 2026, it is the average non-FAMP in 2025).

In the case of a Part D drug and a separate Part B drug with the same active moiety, FDA approval for the two drugs often occurs in different years. Moreover, since they are paid for under different programs, the non-FAMP amounts for the two drugs often would be very different. Yet by treating the two products as the same QSSD, CMS could effectively be establishing the subparagraph (C) amount—and therefore the ceiling price—based on the pricing for a drug that was not the applicable negotiation eligible drug. For instance, there could be a Part D drug that received FDA approval in 2018, and a Part B drug with the same active moiety that was not approved until 2023. If these two drugs were treated as the same QSSD, then the Part D drug's 2021 non-FAMP would determine the subparagraph (C) amount*, even if selection was based on spending on the Part B drug*.

In other words, a drug that was selected based on Part B spending could have the ceiling price determined based on the pricing of an unrelated Part D drug approved years earlier. Depending on the relative pricing and launch years of the two drugs, this could result in a ceiling price that is either substantially higher or lower than what would have been calculated had the subparagraph (C) amount been based solely on the Part B drug. The opposite could also occur, with a drug selected based on Part D spending having a ceiling price set based on the pricing of a Part B product.

[11] Social Security Act § 1194(c)(1)(C).

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This is irreconcilable with the structure and logic of the IRA. Congress intended that the ceiling price of a drug under the Part B program (or the ceiling price of a drug under the Part D program) reflect the historic pricing trajectory of the drug selected for negotiation—not that of a different product approved under a separate NDA and reimbursed under a different Medicare program.

Small Biotech Exception

For IPAYS 2026, 2027, and 2028, certain "small biotech drugs" are not eligible for negotiation.[12] As the name "small biotech" implies, the exception is intended to apply to drugs of manufacturers who are relatively small, meaning they could not have earned significant Medicare revenue during 2021. The "employer aggregation rule" reinforces this concept—by treating all affiliates as a single manufacturer under the small biotech exception, Congress aimed to ensure that the exception applies only to relatively small companies, not to companies that are subsidiaries of the largest pharmaceutical companies in the world.[13]

However, treating a Part B Drug and Part D Drug as a single QSSD turns the small biotech exception on its head, potentially expanding it to large companies who had significant Medicare revenues in 2021. Imagine, for example, a large manufacturer that produces many Part D products, one of which is a "blockbuster" drug with significant Part D revenues. Without the aggregation across the Part D and Part B programs, this blockbuster drug would not qualify as a "small biotech drug." It would not meet the "Part D drug" prong of the small biotech drug test, both because its expenditures are greater than 1% of Part D expenditures and because the drug does not account for 80% or more of the manufacturer's Part D revenue (since the manufacturer produces many other Part D products). In addition, it would not meet the "Part B drug" prong of the small biotech drug test because it is not a Part B drug at all.

But if aggregation across the Part D and Part B programs is permitted, then this blockbuster drug could become a small biotech drug. A QSSD may qualify for the small biotech exception if "either" the Part D drug or Part B drug test is met.[14] In this scenario, this blockbuster drug may share an active moiety with a Part B drug approved under a different NDA which has significantly lower utilization; since the manufacturer focuses on the Part D market, this may be the only Part B drug it offers. If CMS were to treat the Part D drug and a Part B drug as the same QSSD, then that would mean that *both drugs would*

[12] Social Security Act § 1192(d)(2).
[13] Social Security Act § 1192(d)(2)(B)(i).
[14] Social Security Act § 1192(d)(2)(A).

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qualify for the small biotech exception. That is, not only would the Part B drug with low utilization qualify for the small biotech exception, but the Part D blockbuster drug would qualify too, since it would be the same QSSD as the Part B drug. Such a scenario would result in one of the highest spend Part D drugs produced by a large manufacturer somehow falling into the definition of a "small biotech drug." This cannot be what Congress intended. Indeed, the possibility of this scenario makes clear that Congress envisioned that a Part B drug approved under one NDA and a Part D drug approved under a separate NDA would not be treated as the same QSSD.

D. The Limited References to Aggregation Across the Two Programs Are Consistent with Treating Part D Drugs and Part B Drugs as Separate QSSDs

As described above, the IRA generally treats Part D and Part B as separate programs, requiring QSSD determinations and spending calculations to be adopted separately under each such program. There are two examples where the statute does refer to the possibility of spending being aggregated across both Part D and Part B. Neither of these examples, however, conflict with the principle that CMS should not consider a Part D drug and a Part B drug approved under separate NDAs to be one QSSD.

The "Low Spend Medicare Drug" provision states that the term QSSD does not include "[a] drug or biological product with respect to which the total expenditures under parts B and D of title XVIII, as determined by the Secretary in accordance with subsection (d)(3)(B)" is less than $200 million for the year ending May 31, 2023, and as adjusted for inflation in subsequent years.[15] This provision would capture drugs approved under a single NDA (or biologics approved under a single BLA) that have spending under both the Part D and Part B programs, as sometimes occurs. But aggregating expenditures across a single NDA for purposes of determining whether one exception applies is very different from aggregating expenditures across two or more NDAs under all aspects of the Negotiation Program, in clear violation of Congressional intent.

Similarly, the "Selection of Drugs" provision directs the Secretary to "[r]ank negotiation-eligible drugs described in subsection (d)(1) according to the total expenditures for such drugs under parts B and D of title XVIII, as determined by the Secretary, during the most recent period of 12 months prior to the selected drug publication date...."[16] The provision is ambiguous as to whether any particular negotiation-eligible drug will have expenditures under both Parts B and D. Indeed, it would be

[15] Social Security Act § 1192(e)(3)(B).
[16] Social Security Act § 1192(b)(1)(A).

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consistent with the statute for CMS to consider only Part D expenditures for "Part D high spend drugs" and Part B expenditures for "Part B high spend drugs," particularly as the statute givens the Secretary discretion on this issue. Such an approach would still give meaning to Congress's direction to take into account expenditures under both programs, as the expenditures under each program would be used to determine the rankings.[17] Even if CMS interpreted this provision as requiring consideration of both Part B and Part D expenditures for the same QSSD, however, then such provision only shows that Congress envisioned that there would be some cases that a drug product approved under a single NDA would have expenses under both programs. As with the "Low Spend Medicare Drug" provision, there is no suggestion that Congress envisioned aggregation of expenses across the Part D and Part B programs in cases where the applicable Part B and Part D drug products were approved under different NDAs.

E. CMS Can Easily Implement a QSSD Definition That Separates Part D Drugs from Part B Drugs

Finally, CMS can readily follow Congress's direction related to the definition of QSSDs. Rather than having a single QSSD list that applies to both Part D and Part B, CMS would instead develop a Part D QSSD list and a Part B QSSD list. These separate QSSD lists would then be used to determine the two lists of negotiation eligible drugs, consistent with the text of the IRA.

III. Conclusion

We thank CMS for considering our comments.

The comments in this letter are based on the information currently available to Apellis, including any relevant laws, regulations, CMS policies, guidance, and interpretations currently in effect. Should there be any changes to such laws, regulations, policies, guidance, or interpretations, Apellis reserves the right to withdraw or modify these comments.

The comments in this letter are not intended to serve as Apellis' complete or conclusive positions on the issues addressed herein. If Apellis did not address all relevant issues raised by CMS's Draft 2028 IPAY Guidance, such omission should not be interpreted or construed as Apellis' agreement with any position, policy or interpretation of CMS on such issues.

[17] For instance, if Drug X was a Part D high spend drug with $1.5 billion in Part D expenditures and Drug Y was a Part B high spend drug with $1.3 billion in Part B expenditures, then Drug X would be ranked ahead of Drug Y.

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Apellis submits this letter solely in response to CMS' invitation for comments. These comments are not intended to, nor should they, be used for any other purpose or in any other matter, venue, forum, or setting. In making these comments, Apellis does not waive and, specifically reserves, all of its rights under applicable laws or regulations.

Please contact David Watson at davidw@apellis.com if you have any additional questions about our comments.

Sincerely,

/s/ David Watson

David Watson
General Counsel
Apellis Pharmaceuticals, Inc.

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APhA
American Pharmacists Association

June 26, 2025

[Submitted electronically to IRARebateandNegotiation@cms.hhs.gov]

Chris Klomp
Deputy Administrator of the Center for Medicare
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, Maryland 21244-1859

RE: Medicare Drug Price Negotiation Program Draft Guidance

Dear Deputy Administrator Klomp,

The American Pharmacists Association (APhA) appreciates the opportunity to provide CMS comments on the May 12, 2025, Medicare Drug Price Negotiation Program Draft Guidance. APhA commends CMS for recognizing the vital role pharmacies will play in the success of the Medicare Drug Price Negotiation Program. However, APhA recommends that pharmacies, especially those anticipating material cash flow problems, be able to continue serving the patients within their communities. More specifically, APhA urges CMS to reconsider mandating pharmacy participation and ensure pharmacies are paid promptly and adequately.

APhA is the only organization advancing the entire pharmacy profession. APhA represents pharmacists, student pharmacists, and pharmacy technicians in all practice settings, including but not limited to community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

40.4.2.2 Dispensing Entity Enrollment in the MTF DM

Previously, "CMS finalized in rulemaking a requirement that Part D plan sponsors, starting in contract year 2026, include in their pharmacy agreements provisions requiring the pharmacy to

be enrolled in the MTF DM."[1] CMS reasoned that "[d]ispensing entity enrollment in the MTF DM [(Medicare Transaction Facilitator Data Module)] is needed for necessary operations related to administration of the [Medicare Drug Price] Negotiation Program and the Part D program, including creating and making available remittances or ERAs [(Electronic Remittance Advices)], maintaining access to the complaints and disputes submission portal, facilitating continued access to selected drugs that are drugs covered under Part D, and ensuring accurate Part D claims information and payment."[2] CMS noted that commenters responding 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 MFP in 2026 and 2027"… "noted that small pharmacies that rely primarily on prescription revenue to maintain business operations would face material cashflow pressures due to the shift from payment by the Part D plan sponsor to a combination of Part D plan sponsor payment plus a potentially lagged MFP refund."[3] CMS is "concerned" following the receipt of these comments, but that "this challenge will be most acute in the transition period when MFPs for selected drugs first become effective in January 2026 and at the start of each subsequent initial price applicability year when MFPs for new selected drugs first become effective," and CMS "does not anticipate this challenge to continue with respect to a selected drug once MFP [(maximum fair price)] refunds for that selected drug are flowing and dispensing entities become accustomed to the 14-day prompt MFP payment window."[4]

APhA raised its concerns to CMS in its previous comments that mandating plan sponsors, including pharmacy benefit managers (PBMs), include in their pharmacy contracts a requirement for pharmacies to be enrolled in the MTF DM will force pharmacies to take unsustainable financial losses. APhA also echoed these concerns more recently in response to CMS's request for information regarding President Trump's Executive Order 14192, "Unleashing Prosperity Through Deregulation." Pharmacies are already struggling due to unsustainable reimbursement rates from PBMs, often far below the cost of dispensing these medications, including a minimum of 3% below the cost of dispensing brand medications. This mandate further hurts pharmacies and will likely result in more pharmacy closures.[5] As such, APhA recommends that pharmacy participation be voluntary to avoid being subject to underpayment reimbursements from PBMs. If CMS continues to mandate pharmacy participation, CMS should explore avenues that do not run afoul of the noninterference clause

[1] Chris Klomp, *Draft Guidance on the Medicare Drug Price Negotiation Program*, Centers for Medicare & Medicaid Services, 71 (2025). Available at: https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.
[2] *Id.* at 71-72.
[3] *Id.* at 73.
[4] *Id.*
[5] Ruichen Xu, et al., *Mapping U.S. Pharmacy Closures January 2014 to March 2024*, University of Pittsburgh (May 14, 2024). Available at: https://storymaps.arcgis.com/stories/21620f1e07c14d7f81adc4503faaf51e.

in section 1860D-11(i) of the Social Security Act. APhA notes that CMS in the past has cited this clause as the reason for their inability to protect pharmacies from underwater reimbursements made by the PBMs but points out that CMS is likely "interfering" here by requiring that any contract between the plan sponsor or its PBM and a pharmacy include a provision requiring a pharmacy to be enrolled in the MTF DM.

In this draft guidance, CMS stated that "[c]ommenters particularly noted that small pharmacies that rely primarily on prescription revenue to maintain business operations would face material cashflow pressures due to the shift from payment by the Part D plan sponsor to a combination of Part D plan sponsor payment plus a potentially lagged MFP refund."[6] In response, CMS plans to ask pharmacies to self-identify during enrollment if they "anticipate[] having material cashflow concerns at the start of the initial price applicability year due to the reliance on retrospective MFP refunds within the 14-day MFP payment window."[7] CMS then plans to share that information with Primary Manufacturers.[8] Primary Manufacturers will be required to include an approach to mitigate such cash flow concerns within their MFP Effectuation Plans, as described in Section 90.2.1 of the draft guidance.[9] In creating this requirement, CMS expects primary manufacturers to be better situated to address the material cash flow concerns that some pharmacies may face so that beneficiaries do not lose access to these drugs.[10]

APhA has concerns regarding the effectiveness of the Primary Manufacturers' MFP Effectuation Plans in ensuring that pharmacies facing material cash flow concerns can survive financially during this transition and under this program. As noted by CMS within this draft guidance, types of pharmacies expected to experience this problem include "sole proprietor rural and urban pharmacies with [a] high volume of Medicare Part D prescriptions dispensed, pharmacies who predominantly rely on prescription revenue to maintain business operations, long-term care pharmacies, 340B covered entities with in-house pharmacies, and Indian Health Service, Tribal, and Urban Indian (I/T/U) pharmacies."[11] Closing pharmacies, especially those listed above, as they often serve rural and underserved communities, or making it financially impossible for these pharmacies to stock these medications, will cause patient access issues. In this draft guidance, CMS notes that it "recognizes that the success of the Negotiation Program is, in part, dependent on Medicare beneficiaries' access to selected drugs through dispensing entities, which in turn necessitates that dispensing entities—particularly those that rely primarily on prescription revenue to maintain business operations—are able to timely access

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[6] Chris Klomp, *Draft Guidance on the Medicare Drug Price Negotiation Program*, Centers for Medicare & Medicaid Services, 73 (2025). Available at: https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.* at 73-74.

the MFP."[12] Accordingly, CMS should do more to ensure pharmacies remain open, allowing patients to access their necessary medications. APhA recommends that CMS prioritize efforts in its final guidance that require prompt payment and adequate reimbursement for the services pharmacists provide to Part D enrollees.

This draft guidance also provides that "CMS will evaluate the degree to which this pharmacy self-identification process provides useful data for Primary Manufacturers in developing MFP Effectuation Plans."[13] APhA appreciates CMS taking steps to evaluate the effectiveness of this process and how it will impact the development of the MFP Effectuation Plans. APhA encourages CMS to use this data to ensure that pharmacies facing material cash flow concerns are appropriately supported and that reimbursement never falls below a product's acquisition cost.

40.4.3 MTF Payment Facilitation

During its previous comment request period, CMS received many requests for CMS "to support the facilitation of MFP refund payments between Primary Manufacturers and dispensing entities."[14] Within this draft guidance, CMS has clarified that it "will not float or issue funds to a dispensing entity on the Primary Manufacturer's behalf in anticipation of a future MFP refund payment from the Primary Manufacturer to the dispensing entity."[15] The draft guidance mentions "the following approaches [that] might be pursued by interested parties to provide timely payment, potentially focused on dispensing entities that self-identify as anticipating having material cash flow concerns at the start of the initial price applicability year, and all of which could be paired with retrospective reconciliation once the Primary Manufacturer receives claim-level data elements from the MTF DM: (1) Primary Manufacturers could make prospective sales of selected drugs to dispensing entities at the MFP while leveraging virtual inventory management systems and pharmaceutical wholesaler chargebacks where applicable; (2) Primary Manufacturers could establish pre-funded MFP refund payment accounts directly with dispensing entities; and/or (3) Primary Manufacturers could leverage established relationships between dispensing entities and PSAOs [(pharmacy services administrative organizations)] to establish accounts that are pre-funded by the Primary Manufacturer for the PSAOs to use to disburse MFP refund payments to dispensing entities, with the PSAOs facilitating any necessary financial, reconciliation, and administrative services for the dispensing entity, thus minimizing the number of point of contacts for the Primary Manufacturer."[16]

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[12] *Id.* at 73.
[13] *Id.* at 74.
[14] *Id.* at 75.
[15] *Id.* at 77.
[16] *Id.*

APhA's previous comments urged CMS to reconsider mechanisms for prefunding the program to protect pharmacies from financial harm caused by its implementation. As CMS has made clear in this draft guidance that it will not prefund the program or float these costs, APhA stresses the importance of ensuring that pharmacies have viable ways to remain a part of the program because, without pharmacies, the program and CMS will fail to expand Americans' access to these medications. APhA again brings CMS's attention to studies it cited in its previous comments that show that pharmacies are considering or are already not stocking drugs with prices negotiated under Medicare Part D because of the cash flow problems and delays in payment due to the Inflation Reduction Act and that, on average, pharmacies will bear the burden of prefunding the program at the cost of almost $11,000 per week, with the estimated revenue loss between $40,279.04 and $46,475.82 per pharmacy per year.[17] As such, APhA urges CMS to implement protocols and safeguards that protect pharmacies from further financial harm, including prompt payment, adequate reimbursement, and appropriate education regarding the program.

While CMS provides three approaches for dispensing entities that anticipate having material cash flow concerns and Primary Manufacturers to take to resolve this issue, they are still inadequate. The first approach CMS recommends to solve material cash flows that dispensing entities may face is to have Primary Manufacturers "make prospective sales of selected drugs to dispensing entities at the MFP while leveraging virtual inventory management systems and pharmaceutical wholesaler chargebacks where applicable."[18] This approach fails to address the problem at hand and imposes an administrative burden on the pharmacy to track inventory and monitor chargebacks. The cost and labor burden of managing and operating the inventory in this manner, along with the unknowns surrounding pharmaceutical wholesaler chargebacks (e.g., reimbursement concerns), render this solution insufficient.

Another approach outlined in this draft guidance by CMS to solve this problem was that "Primary Manufacturers could establish pre-funded MFP refund payment accounts directly with dispensing entities."[19] This approach shifts prefunding away from CMS to Primary Manufacturers. Because this option to prefund would not be required, and the details

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[17] *Report for January 2025 Survey of Independent Pharmacy Owners/Managers*, National Community Pharmacists Association (Jan. 27, 2025). Available at: https://ncpa.org/sites/default/files/2025-01/1.27.2025-FinalExecSummary.NCPA_.MemberSurvey.pdf. *Unpacking the Financial Impacts of Medicare Drug Price Negotiation: Analysis of Pharmacy Cash Flows*, Three Axis Advisors (Jan. 2025). Available at: https://ncpa.org/sites/default/files/2025-01/January2025-ThreeAxisAdvisors-Unpacking-the-Financial-Impacts-of-Medicare-Drug-Price-Negotiation.pdf.

[18] Chris Klomp, *Draft Guidance on the Medicare Drug Price Negotiation Program*, Centers for Medicare & Medicaid Services, 77 (2025). Available at: https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

[19] *Id.*

surrounding any additional costs or burdens on pharmacies that have Primary Manufacturers prefund the program are unknown, this approach still falls short in ensuring that the implementation of this program does not overly burden all pharmacies, which may anticipate material cash flow concerns.

The last approach in this draft guidance from CMS related to dispensing entities having cash flow problems was that "Primary Manufacturers could leverage established relationships between dispensing entities and PSAOs to establish accounts that are pre-funded by the Primary Manufacturer for the PSAOs to use to disburse MFP refund payments to dispensing entities, with the PSAOs facilitating any necessary financial, reconciliation, and administrative services for the dispensing entity, thus minimizing the number of point of contacts for the Primary Manufacturer."[20] Again, this approach shifts the prefunding burden away from CMS to the Primary Manufacturers. The same concerns apply here as with the second option, as there is no guarantee that all Primary Manufacturers will pursue prefunding options. Thus, not many pharmacies will have access to a prefunded option.

In this section, CMS also states that "[n]either CMS nor the MTF Contractors will be responsible for funding or paying the refund amounts owed by the Primary Manufacturer in instances where the Primary Manufacturer does not pay an MFP refund owed to a dispensing entity, including in cases where the Primary Manufacturer may be unable to pay (e.g., bankruptcy, insolvency, etc.).[21] Additionally, "[n]either CMS nor its MTF Contractors will accrue any interest on funds held by the MTF PM [(Medicare Transaction Facilitator Payment Module)] during the period before the funds are transferred to the dispensing entity."[22] Further, CMS provides within the draft guidance that it intends the agency to bear the costs of operating the MTF PM.[23] As such, Primary Manufacturers and dispensing entities are not required to pay any fees associated with the MTF PM, including user and transaction fees.[24]

APhA supports CMS, not pharmacies, funding the costs associated with the MTF PM, as any additional financial burdens placed on pharmacies will lead to more pharmacy closures, further limiting patient access to their medications and pharmacist patient care services. Additionally, APhA encourages CMS to ensure the implementation process and related protocols and procedures work smoothly once required. Any problems with the rollout or administration of the MTF PM will cost pharmacies money, as they will have to divert staff time and financial resources to solve problems that arise during the transitional period. To achieve a smooth transition, APhA requests CMS continue to provide pharmacies, pharmacists, pharmacy

[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.* at 77-78.

technicians, and other pharmacy personnel with ample educational resources regarding best practices. APhA routinely updates its members regarding the implementation of this program and CMS resources available to them and extends an offer to CMS to collaborate on further disseminating new information to our nation's pharmacists.

90.2.1. Manufacturer Plans for Effectuating MFP

As mentioned above, CMS will share a list of dispensing entities that self-identify as anticipating material cash flow issues with Primary Manufacturers, which are required to have processes within their MFP Effectuation Plans to mitigate these concerns.[25] The draft guidance provides that prospective purchasing agreements and accelerated MFP refund timelines are examples of ways Primary Manufacturers can mitigate these concerns.[26] APhA supports mechanisms that alleviate the financial burdens associated with implementing this program. However, APhA is concerned about the unknown consequences of such mitigation strategies. Additionally, APhA is concerned that such arrangements might impose a cost or administrative burden on the pharmacy, which is already struggling to stay afloat. As such, APhA reiterates that pharmacy participation in the MTF DM should be voluntary, and CMS should prioritize policies and procedures that require prompt payment and adequate reimbursement for pharmacies.

APhA appreciates the opportunity to provide CMS with additional insight into how the Medicare Drug Price Negotiation Program Draft Guidance impacts pharmacies, pharmacists, and patients. APhA encourages CMS to utilize its authority to minimize the financial and operational burdens this guidance places on pharmacies, allowing them to stay open and continue providing access to these medications for patients nationwide. If you have any questions or would like to meet with APhA to discuss these comments, please contact Corey Whetzel, APhA's Senior Manager, Regulatory Affairs, at cwhetzel@aphanet.org.

Best,

Michael Baxter

Michael Baxter
Vice President, Government Affairs

[25] *Id.* at 170.
[26] *Id.* at 170-71.

June 26, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Administrator Oz:

Arnold Ventures welcomes the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the following draft guidance issued on May 12, 2025:

- *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028*

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work within the health care sector is driven by the recognition that the system costs too much and fails to adequately care for the people it serves. Our work spans a range of issues including commercial-sector prices, provider payment incentives, prescription drug prices, clinical trials, Medicare sustainability, and Medicaid.

We thank you for the opportunity to provide comments on the Medicare negotiation process. We also thank you and CMS staff for your continued efforts in the implementation of the Medicare Drug Price Negotiation Program, which will lower prescription drug costs for millions of Medicare beneficiaries.[1] We recognize the importance and difficulty of the task.

This letter provides comments on the following sections of the draft guidance pertaining to selection of qualified single source drugs and negotiation of the Maximum Fair Price (MFP):

- *30.1 Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028*
- *30.3 Selection of Drugs for Negotiation for Initial Price Applicability Year 2028*
- *60.1 Establishment of a Single MFP for Negotiation and Renegotiation Purposes*
- *60.2.2.1 The Sum of the Plan-Specific Enrollment Weighted Amounts*
- *60.3.2 Developing a Starting Point for the Initial Offer*
- *130.2.1 Selecting Drugs for Renegotiation Among Renegotiation-Eligible Drugs due to a New Indication or a Material Change in a Section 1194(e) Factor*

It also provides comments on the following section pertaining to effectuation of the MFP:

- *40.4.1 Retrospective Refund Amount to Effectuate the MFP and the Standardized Default Refund Amount*

SELECTION OF QUALIFIED SINGLE SOURCE DRUGS AND NEGOTIATION OF THE MFP

30.1 Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028

Recommendation: For the purpose of selecting qualifying single source drugs for negotiations, Arnold Ventures recommends that CMS only consider active ingredients/active moieties in unique combinations that are each separately biologically active against the disease that the drug was approved to treat.

[1] CMS. Negotiating for Lower Drug Prices Works, Saves Billions. August 2024.

CMS acknowledges that some combination products may include active ingredients/active moieties that are not needed for the treatment of the disease for which the product was approved. CMS is seeking comment on how it should treat these types of combination products.

Arnold Ventures supports CMS developing a set of criteria that limits when a combination product will be treated as a separate qualified single source drug for the purpose of drug price negotiation. This could help deter manufacturers from developing combination products to circumvent the drug price negotiation program. Manufacturers could do so by moving beneficiaries away from the original drug with a negotiated MFP to a combination product with a later approval date (also known as product hopping).

30.3 Selection of Drugs for Negotiation for Initial Price Applicability Year 2028

Recommendation: Arnold Ventures recommends that CMS develop methods to use encounter data from Medicare Advantage (MA) plans combined with Medicare Part B claims data to better estimate total sales of physician administered drugs to Medicare beneficiaries under Medicare Part B.

Under the Inflation Reduction Act (IRA), qualifying single source drugs are ranked by total Medicare sales in descending order before the top drugs by total expenditures are selected for negotiations. In initial price applicability year (IPAY) 2028, this will include Medicare Part B drugs for the first time in addition to Medicare Part D drugs. CMS has been relying on Medicare claims data for this ranking and selection, but doing so will omit spending for Medicare Part B drugs in MA plans.[2]

Roughly half of Medicare beneficiaries are in MA plans. By using encounter data from MA plans combined with Part B fee for service (FFS) claims data, CMS would be able to account for total Medicare spending on Part B physician administered drugs when selecting drugs for negotiations. In some instances, using only Part B FFS claims data would cause CMS to prioritize lower spending Part D drugs over higher spending Part B drugs when selecting drugs for negotiations, which means that CMS would not be maximizing savings for taxpayers and Medicare beneficiaries.

60.1 Establishment of a Single MFP for Negotiation and Renegotiation Purposes

Recommendation: Arnold Ventures recommends that if an alternative to the 30-day supply is used for a small number of drugs, it should NOT be a per-unit price.

CMS has chosen to standardize the MFP by using a price per 30-day supply because this facilitates the negotiation of a single price across all dosage forms and strengths. It also allows for a more direct comparison of prices across therapeutic alternatives, which might have different dosage forms and strengths.

CMS is seeking comments on whether an alternative method of measuring price, such as a per-unit price, might be appropriate for drugs where a 30-day supply is not representative of the typical use of that drug.

Arnold Ventures recommends that if an alternative to the 30-day supply is used for a small number of drugs, it should not be a per-unit price, because per-unit prices are not standardized to be comparable across different dosage forms and strengths. Additionally, drugs may be administered at a different frequency per day and over different periods of time. Neither a price per unit, nor a price per day, fully standardizes the price when comparing across different drugs.

[2] CMS has already noted data challenges in accurately reflecting utilization for Part B drugs in MA plans when implementing the inflation rebate for Part B drugs. See Young, C. The Inflation rebate for Medicare Part B-covered drugs should apply to Medicare Advantage. May 2025.

One alternative for standardizing the price across dosage forms and strengths, and across drugs is the price **per course of treatment**. For drugs that treat an acute condition and are taken for fewer than 30 days, a supply of up to 30 days or fewer would be the price "per course of treatment." For drugs taken once every three months for an entire year, CMS could also standardize the price across dosage forms, strengths, and different drugs by using the price "per course of treatment," which would be one year.

After negotiating a price "per course of treatment" with the manufacturer, CMS could then convert that back to a price for each administration of the drug so that administering the drug four times per year is equal to the negotiated price "per course of treatment." CMS could use the drug label, or the Medicare claims data to determine a standard amount of the drug that is taken "per course of treatment" and per administration within that course of treatment.

60.2.2.1 The Sum of the Plan-Specific Enrollment Weighted Amounts

Recommendation: Arnold Ventures recommends that CMS incorporate all price concessions from manufacturers to Part D plans, including those granted under the manufacturer discount program, when estimating the ceiling price that is based on the net price to Part D plans.

For Part D drugs, the ceiling price may be equal to the enrollment weighted average price across all Part D plans "net of all price concessions received by such plan or pharmacy benefit managers on behalf of such plan".[3] CMS guidance has interpreted this to be the negotiated price paid to the pharmacy at the point of sale less all rebates paid by the manufacturer to the Part D plan.[4]

Arnold Ventures recommends that CMS also include the manufacturer discounts provided to Part D plans under the redesign when calculating this ceiling price.[5] The manufacturer discounts lower the cost of drugs to Part D plans and those lower prices are incorporated into the Part D plan's bid. Therefore, we believe this would meet the definition of a price concession and should be incorporated into the ceiling price.

For IPAY 2028, CMS will be using PDE data from 2024 combined with DIR data to estimate this ceiling price. A ceiling price that incorporates both the manufacturer discounts under the redesign and rebates given to Part D plans will be possible to calculate from the data for 2025 for drugs selected in IPAY 2029 and thereafter.

60.3.2 Developing a Starting Point for the Initial Offer

Recommendation: Arnold Ventures recommends that biosimilars receive more weight when formulating the starting point price and the adjustments to the starting point price than what is reflected in the Medicare utilization data.

We agree with CMS that pharmaceutical therapeutic alternatives are the most analogous alternatives to a selected drug when determining the MFP for the selected drug.[6] Notably, this includes biosimilars and generics that are therapeutic alternatives to the selected drug.

However, in some cases, the take-up of biosimilar products by Medicare beneficiaries (in place of their brand-name counterparts) is slow in both Medicare Part D and Part B. For example, biosimilar versions of Humira were not

[3] 42 USC §1320f-3(c)(2)(A).
[4] These rebates paid by the manufacturer are referred to as Direct and Indirect Remuneration (DIR) payments.
[5] Under the Medicare Part D benefit redesign, manufacturers must provide a 10% discount on drugs in the initial phase of coverage to Part D plans, and a 20% discount on drugs in the catastrophic phase of coverage.
[6] See Section 60.3.1 "Identifying Indications for the Selected Drug and Therapeutic Alternatives for Each Indication" of this draft guidance.

given preferred formulary placement by Part D plans soon after they were first marketed---whereas generic drugs are usually placed on a lower cost sharing tier than their brand-name counterparts soon after they become available.[7]

Researchers have found that the design of both the Medicare Part D and Medicare Part B programs could be improved to encourage the use of biosimilar products over their brand-name counterparts. Therefore, the current utilization of biosimilars in the Medicare data underweights their benefits when considering evidence on both comparative effectiveness and cost. Because biosimilars are less expensive and just as effective as their brand-name counterparts, CMS should give greater weight to biosimilar products that are available within the same therapeutic class as the selected drug than what is reflected in the Medicare utilization data as CMS arrives at the starting point price and the initial offer price during the negotiation process.[8]

130.2.1 Selecting Drugs for Renegotiation Among Renegotiation-Eligible Drugs due to a New Indication or a Material Change in a Section 1194(e) Factor

Recommendation: Arnold Ventures recommends that the new entry of biosimilar or generics as therapeutic alternatives in the same class as the selected drug be evaluated as a potential material change that could qualify the selected drug for renegotiation.

During the negotiation process, therapeutic alternatives to the selected drug are identified. The secretary takes the prices of those therapeutic alternatives combined with other factors into consideration when negotiating the MFP. The IRA states that renegotiation can take place when a "material change" occurs to the therapeutic alternatives,[9] which includes not only new evidence on comparative effectiveness of therapeutic alternatives, but also the cost of therapeutic alternatives. Currently, the case where a biosimilar or generic drug first becomes available as a therapeutic alternative is not specifically mentioned in the guidance as an example of a material change prompting CMS to consider renegotiating a lower MFP for the selected drug. However, the entrance of biosimilar or generic therapeutic alternatives for a selected drug likely lowers the average price of the therapeutic alternatives and should be considered a material change that CMS would need to evaluate as an opportunity to renegotiate a lower MFP on the selected drug.[10] Additionally, CMS plans to collect information from manufacturers to determine when a material change has occurred. However, manufacturers will not have sufficient incentive to submit information to CMS about material changes that would lower the MFP, such as when a new lower cost therapeutic alternative to the selected drug becomes available. CMS will also need to collect information from stakeholders to be more fully informed about when a material change has occurred.

EFFECTUATION OF THE MFP

40.4.1 Retrospective Refund Amount to Effectuate the MFP and the Standardized Default Refund Amount

Recommendation: Arnold Ventures recommends that CMS not use a list price, such as the WAC price, as the standard price that approximates the acquisition cost of providers of Part B drugs for the purpose of effectuating the MFP.

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[7] See discussion of inclusion and placement of biosimilars in Part D formularies in the CMS proposed rule Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. Dec. 10, 2024.
[8] Sachs, R. and Frank, R. Analyzing the expansion of the Medicare drug price negotiation program to Part B. April 2025.
[9] 42 USC § 1320f-1(e)(2)(A)
[10] Sachs, R. and Frank, R. Articulating Policy Options Regarding Implementation of the Medicare Drug Price Negotiation Program's Renegotiation Provision. January 2025.

For Part D drugs, the manufacturer must provide access to the MFP to pharmacies, mail order services and other dispensing entities. For Part B drugs, the manufacturer must provide access to the MFP to hospitals, physicians and other providers.

For Part D, CMS has chosen the WAC to be the standardized pricing metric to estimate the pharmacy's acquisition cost. Thus, the standardized amount that the manufacturer pays the pharmacy to effectuate the MFP, as referred to in the guidance as the standardized default refund amount, is WAC – MFP. CMS requested comments on whether it should take the same approach for Medicare Part B.

The Part D and Part B markets operate differently. In Part D, pharmacies have little influence over which brand-name drug is dispensed to beneficiaries. This is generally determined by the physicians who write prescriptions and the Part D plans that design the formulary and set cost sharing amounts. In the case of Medicare Part B, providers purchase the drugs they administer from wholesalers or manufacturers and then bill Medicare separately for those drugs.

There is evidence that the WAC price is higher than the acquisition cost of the drug. For example, CBO found that WAC prices were 4.9 percent higher than the amount that Part D plans pay pharmacies for specialty drugs at the point of sale.[11] Since the average sales price (ASP) is an estimate of acquisition cost that incorporates rebates and discounts, it is likely that the gap between the WAC and the ASP is larger for Part B drugs than the gap between the WAC and the acquisition cost for Part D drugs, and some evidence suggests that the percentage gap can vary considerably by Part B drug.[12]

In cases where Part B drugs are therapeutically similar, the provider has an incentive to choose the drug with a higher markup because it is more profitable.[13] Additionally, if the standard reimbursement amount for selected Part B drugs were equal to WAC – MFP, then in classes where different Part B drugs are therapeutically similar, there would be an incentive for manufacturers to increase the gap between WAC and providers' acquisition cost in order to increase the profitability to providers of administering their selected drug. This could also put upward pressure on negotiated MFPs for Part B drugs as manufacturers would want to "leave room" to pay providers higher markups for their drugs. Finally, this ability to make selected drugs more profitable to dispense could affect which drugs are dispensed to beneficiaries in both FFS and MA plans, as the WAC – MFP formula would be used to effectuate the MFP for providers of Part B drugs to both FFS and MA beneficiaries. In some sense, allowing the manufacturer to determine the provider's mark-up through the WAC – MFP formula is similar to allowing manufacturers to pay fees to specialty pharmacies owned by PBMs to encourage them to dispense their high-cost drugs.

There are alternatives to the WAC prices that could be used to help approximate the acquisition costs of Part B drugs that are based on actual transaction prices. For example, CMS could take the ratio of the ASP to the WAC price prior to the MFP taking effect. For example, if that ratio averaged 95% for a particular Part B drug prior to the MFP taking effect, then the approximation of provider acquisition cost for that drug after the MFP takes effect would be 95% of its WAC. CMS could then monitor increases in the WAC prices over time to ensure that they are not increasing faster than actual transaction-based prices. If the WACs do increase faster than transaction prices, then that ratio could be adjusted downward accordingly. After adjusting the ASPs to approximate prices to the non-

[11] See Table 2 in Congressional Budget Office. A Comparison of Brand-name Drug Prices Among Selected Federal Programs. February 2021.
[12] MedPAC. Improving Medicare's payment for Part B drugs: Requiring pharmaceutical manufacturer reporting of sales price data. June 2019.
[13] See Chapter 4 in MedPAC. Report to Congress: Medicare and the Health Care Delivery System. June 2015. Previously when Part B payments to providers were based on list prices (AWPs) studies showed that manufacturers increased the gap between list prices and acquisition costs to make their drugs more profitable for providers to dispense. This was partly why the Medicare Prescription Drug Improvement and Modernization Act of 2003 changed Medicare Part B payment policy from being based on a list price (AWP) to an actual market-based price- the ASP. See ASPE. Medicare Part B Reimbursement of Prescription Drugs. May 2014.

Medicare market, CMS could compare changes in the WACs over time to changes in the adjusted ASPs. CMS could also compare growth in WAC prices to growth in the average manufacturer prices (AMPs) that are reported to CMS under Medicaid's Drug Rebate Program and also used to administer the Part D inflation rebates.

Manufacturers are not required to use the standardized default refund amount and can use alternative approaches as long as they can demonstrate that they have sufficiently compensated providers.[14] CMS needs to monitor the amount that manufacturers are compensating Part B providers, especially for Part B drugs in more competitive therapeutic classes, to assure that these transactions are not used as a means to increase markups to providers to encourage them to dispense a particular drug. The amounts paid by manufacturers to providers should not significantly exceed the standardized default refund amount.

CONCLUSION

Arnold Ventures is prepared to assist with any additional information needed. Comments were prepared by Anna Anderson-Cook, Ph.D., and Kate Young, MA, Director of Health Care at Arnold Ventures, with assistance from Andrea Noda, MPP, Vice President of Health Care at Arnold Ventures, and Mark E. Miller, Ph.D., Executive Vice President of Health Care at Arnold Ventures.

Please contact Andrea Noda at anoda@arnoldventures.org or Mark E. Miller at mmiller@arnoldventures.org with any questions. Thank you again for the opportunity to comment and for your important work to lower prescription drug prices for the Medicare program and its beneficiaries.

Sincerely,

Andrea Noda
Vice President of Health Care
Arnold Ventures

CC: Chris Klomp

[14] See Section 40.4.1 of CMS Guidance. Medicare Drug Price Negotiation Program: Final Guidance, Implementation of Sections 1191-1197 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price in 2026 and 2027. October 2, 2024.

June 26, 2025

IRARebateandNegotiation@cms.hhs.gov
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Drug Price Negotiation Program Draft Guidance

ASHP is pleased to submit our comments on the Centers for Medicare & Medicaid Services' (CMS) draft guidance regarding the implementation of the Inflation Reduction Act (IRA) Negotiation Program for initial price applicability year 2028 and manufacturer effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028. ASHP is the collective voice of pharmacists who serve as patient care providers in hospitals, health systems, ambulatory clinics, and other healthcare settings spanning the full spectrum of medication use. ASHP is the largest association of pharmacy professionals in the United States, representing 60,000 pharmacists, student pharmacists, and pharmacy technicians in all patient care settings, including hospitals, ambulatory clinics, and health-system community pharmacies. For over 80 years, ASHP has championed innovation in pharmacy practice, advanced education and professional development, and served as a steadfast advocate for members and patients.

We remain deeply concerned[1] that the framework outlined by the previous administration fails to deliver on IRA's cost savings by shifting program costs from manufacturers to providers. Further, the proposed framework creates significant new administrative burdens and reduces transparency in drug pricing in contravention of the April 15, 2025 Executive Order "Lowering Drug Prices by Once Again Putting Americans First."

Allowing manufacturers to impose their own bespoke rebate-based payment system to effectuate MFP creates an avalanche of new regulation and costs for providers that could be avoided by simply requiring upfront access to the MFP. We again urge CMS to reconsider the current framework and impose a commonsense, prospective payment approach to MFP access. To assist the agency in this effort, ASHP will be submitting a memo with legal justification for such an approach.

Our specific feedback on the draft guidance is as follows:

- **40.4 - Providing Access to the MFP in 2026, 2027, and 2028**: As noted above, we believe that the IRA statute requires CMS to ensure prospective access to the MFP for selected drugs. The draft guidance proposes that the 14-day prompt payment window for selected drugs requires that a manufacturer transmit a rebate within 14 days, not that the manufacturer verify that a dispenser has received the rebate. Although we understand CMS's proposal is meant to align prompt payment rules between Part D drugs generally and IRA selected drugs, the current IRA framework already imposes significant carrying costs on pharmacies dispensing IRA selected drugs. Defining prompt payment to require verification of payment receipt within 14 days is also a clear standard and would reduce the burden on providers and pharmacies.

[1]Please see attached letter to CMS regarding the increased costs and administrative burdens associated with rebate-based MFP models.

The proposed guidance also offers manufacturers far more control over the program that we believe the statute allows. Specifically, CMS states that under a rebate-based payment system, manufacturers can opt not use the standard default rebate amount and instead determine that "some other amount is appropriate and sufficient to make the MFP available." Again, allowing manufacturers carte blanche to impose their own models, with very limited intervention from CMS, will create an administrative nightmare. Bespoke models for every manufacturer and/or each selected drugs will shift the costs of administering the program from manufacturers to providers. They will also reduce transparency, making it far more difficult for dispensers and/or CMS to determine whether manufacturers are complying with IRA requirements.

- **40.4.5 – Nonduplication with 340B Ceiling Price:** We thank CMS for reiterating that "[n]othing in this guidance modifies a Primary Manufacturer's statutory obligations under section 340B(a)(1) of the PHS Act." As above, we believe that many of the issues outlined in this section would be best addressed by requiring upfront access to the MFP. Requiring manufacturers, rather than providers, to carry costs until MFP can be trued up may also incentivize manufacturers to provide timely access to MFP and 340B prices and would also better align with existing systems for identifying and refunding duplicate discounts.

  In the guidance CMS states that it will not take responsibility for identifying duplicate discounts. CMS further notes that it will "strongly encourage manufacturers to work with dispensing entities, covered entities and their 340B TPAs, and other prescription drug supply chain stakeholders (e.g., wholesalers) to facilitate access to the lower of the MFP and the 340B ceiling price, wherever applicable." TPAs are an intrinsic element of the 340B process – accounting for 340B claims within the IRA process will require engagement of TPAs. Many covered entities rely on TPAs for compliance assistance with HRSA and manufacturer 340B audits, as well as 340B program integrity requirements. Failing to require manufacturers to integrate with TPAs will create unnecessary administrative complexity, compounding the burden created by rebate-based MFP access. Providing manufacturers with so much discretion to determine the implementation and direction of the program will result in providers shouldering its costs, diluting the value of IRA's price-lowering mechanisms.

Thank you for your consideration of our comments. We continue to support CMS's efforts to create a workable IRA framework, and we stand ready to assist the agency in any way possible. Please do not hesitate to contact me at 301-664-8698 or jschulte@ashp.org if ASHP can provide any further information or assist the agency in any way.

Sincerely,

Jillanne Schulte Wall

Jillanne Schulte Wall, J.D.
Senior Director, Health & Regulatory Policy

June 26, 2025

Via Electronic Submission

PUBLIC DOCUMENT
CMS-4210-N

Mr. Chris Klomp
Deputy Administrator, and Director, Center for Medicare
Centers for Medicare & Medicaid Services
5900 Security Boulevard
Baltimore, MD 21244-1859

Re: Draft Guidance on the Medicare Drug Price Negotiation Program

Dear Mr. Klomp:

OVERVIEW

The Part B Access for Seniors and Physicians Coalition ("ASP Coalition"), representing more than 300 patient and provider organizations across the country, offers the following comments in response to Centers for Medicare and Medicaid Services (CMS) Draft Guidance entitled, "Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028," dated May 12, 2025. The ASP Coalition appreciates the opportunity to provide our perspective and recommendations, which focus on Maximum Fair Price (MFP) effectuation for Part B selected drugs beginning in Initial Price Applicability Year (IPAY) 2028, and the agency's related solicitation for feedback on whether a standard default refund amount (SDRA) should be utilized and how it should be calculated.

Specifically, the Coalition strongly urges CMS to exclude the MFP from calculation of Average Sales Price (ASP) in the Medicare Part B program. In addition, we recommend that, if CMS establishes an SDRA to effectuate the MFP for Medicare Part B selected drugs, the agency should fully account for the acquisition costs of the many providers who purchase drugs at prices above the MFP.

Our recommendations are intended to avoid a worst-case scenario of provider reimbursement cuts that would inevitably harm access to essential health services for beneficiaries with chronic and disabling conditions. Since Medicare Part B drugs will be included for the first time in the Medicare Drug Price Negotiation Program for IPAY 2028, it is essential that the agency's implementation approach address Part B provider concerns at the outset. This is necessary to avoid a downward spiral of reimbursement cuts that could decimate beneficiary access to Part B covered drugs, which has been under extreme pressure for many years.

PART B ACCESS
for Seniors and Physicians Coalition

Background – Impact of the Inflation Reduction Act on Medicare Part B Providers and Beneficiaries

Medicare Part B covers drug therapies for over 62 million beneficiaries, including those with cancer and other serious and complex chronic conditions such as rheumatologic, autoimmune and inflammatory conditions; and those with blinding eye diseases, Crohn's disease and ulcerative colitis, rare chronic diseases, and serious mental illnesses. Given the often life-threatening complexity of their health conditions, these beneficiaries require accessible medical care; yet, their providers face increasingly challenging reimbursement realities.

We remain deeply concerned that implementation of provisions included in the Inflation Reduction Act (IRA) will further worsen reimbursement cuts to Medicare Part B provider payments, resulting in even more provider practices closing, and consolidating into the more expensive hospital setting. The Coalition has been sounding the alarm since its inception that Medicare Part B reductions threaten the ability of physicians to continue to provide high-quality medical care to seniors and other Medicare beneficiaries. Most recently, a Milliman analysis released by the Coalition in May 2025 concluded that "under the IRA as written, provider reimbursement for Part B drugs will change from being tied to Average Sales Price (ASP) to being tied to what the act refers to as 'Maximum Fair Prices' (MFPs) for selected drugs. This change is estimated to decrease provider reimbursement (or increase provider costs) by $56.3B over 10 years.[1]"

Summary of Recommendations & Rationale

Implementation decisions by CMS will have a direct and material impact on the scope and severity of reimbursement changes affecting providers who serve Medicare beneficiaries in the Medicare Part B program. To that end, the Coalition has developed the following recommendations to help mitigate the most harmful cuts to providers.

Recommendation #1: Exclude the Maximum Fair Price (MFP) from Calculation of the Average Sales Price (ASP)

The ASP Coalition urges CMS to exclude the MFP from calculation of the ASP. This policy would help address multiple challenges associated with the IRA's Medicare drug price negotiation program, in which provider reimbursement will be based on the MFP rather than the ASP plus an add-on fee to cover acquiring, storing and administering the medicine. First, since Medicare will base provider reimbursement for Part B selected drugs using the MFP rather than ASP, Medicare reimbursement for provider-administered medicines subject to negotiation will be drastically reduced. In addition, the IRA has the potential to reduce reimbursement by commercial insurers, which has traditionally been based on the ASP across a wide range of

[1] (Michelle (Klein) Robb, 2025)

plans and payers. Failure to exclude the MFP from ASP would lower commercial reimbursement for physician-administered drugs. This is particularly true since MFP will likely be lower than ASP. A recent analysis by Avalere Health concluded that "physicians could lose at least $25 billion in add-on payments for 10 Part B drugs expected to be negotiated by CMS, with oncology products accounting for at least $12 billion.[2]" Removing ASP from the MFP will help reduce the scope of payment cuts that will inevitably affect health care providers as a result of the IRA. Mitigating these cuts is particularly important for providers that are small, independent, or who serve rural or other communities with low resources and high rates of chronic disease – these providers are essential to keeping Americans healthy and reducing the costs associated with unchecked chronic illnesses, while being least able to absorb further cuts.

Recommendation #2: If CMS Elects to Establish an SDRA to Effectuate the MFP for Medicare Part B Selected Drugs, the SDRA Should be Carefully Constructed to Fully Account for the Acquisition Costs of Providers Purchasing Drugs Above the MFP.

In Sec. 40.4 of the draft guidance, entitled "Providing Access to the MFP in 2026, 2027, and 2028," CMS requested input regarding "how the effectuation of MFP refund payments for drugs payable under Part B might differ from what is outlined for drugs covered under Part D;" and recommendations on whether to include "a standard default refund amount among the claim-level data elements and how such refund amount could be calculated," among other related issues. We note that CMS stated it "intends to provide detailed policy on providing access to the MFP for selected drugs payable under Part B in the future." CMS clarified that it is not "including detailed policy on providing access to the MFP for selected drugs payable under Part B;" however, the agency also indicated that, "to the extent appropriate and feasible, CMS intends to align the policies and operations for providing access to the MFP for selected drugs payable under Part B with those for selected drugs covered under Part D."

CMS guidance for the Medicare Part D program permits manufacturers to provide a retrospective refund to providers who purchase drugs at a price above the MFP, and the draft guidance specifies that the agency "believes using WAC to calculate an SDRA generally best approximates the acquisition costs of dispensing entities and offers a reliable refund amount for both manufacturers and dispensing entities that agree to use such a standardized pricing metric." Further, CMS suggested that using WAC "addresses concerns raised by interested parties that use of acquisition cost would create significant administrative burdens," adding that "WAC is a widely available pricing metric, published and regularly updated in common pharmaceutical pricing database compendia that would be accessible and transparent to interested parties in the MFP effectuation process," among other cited benefits.

The Coalition is concerned that, for Medicare Part B covered drugs, no pricing metric exists that approximates acquisition costs for the majority of providers. Moreover, superimposing

[2] (Milena Sullivan, 2024)

the Medicare Part D model for calculating an SDRA would significantly harm Part B providers. Most importantly, substituting the ASP for WAC in calculating an SDRA for selected Medicare Part B drugs would fail to account for the costs of all of the providers who purchase drugs at a price above the ASP. These providers would face a double challenge: reimbursement cuts associated with the shift from ASP-based reimbursement to MFP-based reimbursement, compounded by manufacturer refunds that fail to account for their true acquisition costs. Accordingly, the Coalition urges CMS to develop an SDRA approach carefully, and ensure that refunds required to be paid under the IRA fully compensate providers who purchase drugs at higher costs.

Conclusion

The ASP Coalition thanks CMS for your commitment to engage with stakeholders, improve transparency in the Medicare Drug Price Negotiation Program, and place beneficiaries at the heart of decision-making while fostering innovation. We urge CMS to implement our recommendations as you move forward with detailed guidance on inclusion of Medicare Part B drugs in IPAY 2028. We also request that CMS provide draft guidance and a further opportunity for stakeholders and interested parties to provide comments before finalizing any guidance related to inclusion of Medicare Part B covered drugs in the drug price negotiation program. We appreciate your consideration and look forward to engaging with the agency.

AVBCC ASSOCIATION for VALUE-BASED CANCER CARE
INTEGRATING COST, QUALITY, ACCESS INTO CLINICAL DECISION-MAKING IN ONCOLOGY™

"Principles" for Medicare Part B Effectuation of Maximum Fair Prices (MFPs)

Submitted June 26, 2025

The Part B Drug Maximum Fair Price (MFP) Effectuation Workgroup consists of stakeholders operating within the Part B drug patient, provider, supplier and manufacturer community. We are committed to providing the most valuable advice to policymakers on Medicare Part B MFP drug effectuation issues. We seek to partner with CMS to ensure the approach to MFP Effectuation under Part B achieves the following goals:

- Maintain and strengthen the patient-provider relationship;
- Assure that providers are able to provide high quality, timely and continuous care and treatment to patients;
- Assure that Medicare beneficiaries maintain timely and continuous access to Medicare Part B drugs;
- Develop a data-driven, transparent, workable and efficient implementation model that minimizes disruption across stakeholders and supports manufacturer compliance with statutory obligations.

The Centers for Medicare and Medicaid Services (CMS) is seeking comment on the development of a process that would effectuate the MFPs for Part B drugs starting in 2028. The agency is proposing to use a process similar to that adopted for Part D drug MFP effectuation; namely, a Medicare Transaction Facilitator Data Module (MTF-DM) and Medicare Transaction Facilitator Payment Module (MTF-PM).

We are committed to engaging CMS in an iterative approach that will result in the most transparent, efficient and workable process for pass through of the MFPs for Part B drugs. We believe that the financial or operational burden of the Part B drug effectuation process should not be placed on the providers or their patients. In addition, we believe that the agency must view any changes in Part B drug payment, including Part B drug MFP effectuation, in the context of the overall total adequacy of payments made to Part B providers for the Part B drug, the professional fees, and administration fees. In that regard, and consistent with our goals above, we offer the following principles to the agency:

1. The Part B drug MFP effectuation process should be implemented such that the total reimbursement to providers for the selected drug is made in a seamless and timely

manner, such as a Coverage Gap Discount Program (CGDP) type model. That is, while Part B drug claims may be sent to the manufacturer through an MTF-DM to help effectuate MFP refunds, CMS, rather than Part B providers, should bear the burden of "floating" the MFP refunds in order to mitigate financial hardship and disruption to providers that would negatively impact patient care.

2. To assure patient access to Medicare Part B drugs, the process adopted by CMS for Medicare Part B drug MFP effectuation should be transparent and workable, standardized among manufacturers, administratively simple, and inexpensive to administer. Infeasible or complex approaches could significantly impede access to and delivery of quality health care to Medicare beneficiaries by negatively impacting the economics and operations of provider practices, especially oncology practices.

3. In its implementation of the Medicare Part B drug effectuation process, CMS needs to recognize some of the key differences between the operations of the Medicare Part B drug program and Medicare Part D drug program. These differences include: the significant number and variety of health care practices and entities that provide Part B drugs which will increase operational complexity for MFP effectuation; the time frame for the processing of Part B claims and Medicare Advantage claims; Part B provider billing and reconciliation systems; provider payment cycle times for Part B drugs; the involvement of multiple Medicare Administrative Contractors (MACs) in the process; purchasing and distribution patterns for Part B drugs; standardized drug refund amounts; the Medicare Part D Discarded Drug Units Program; and, Medicare beneficiary cost sharing policies and procedures under Part B and Medicare Advantage.

4. The basis of the Standardized Default Refund Amount (SDRA) for Part B drug MFP effectuation should be based on a public, transparent benchmark that provides predictable and appropriate reimbursement for the providers' acquisition costs of Part B drugs. CMS needs to evaluate the impact of the benchmark chosen on both access to patient care as well as providers' administrative burdens.

5. To be consistent with the methodology for the calculation of a drug's Average Manufacturer's Price (AMP) with respect to the MFP, CMS should instruct manufacturers to exclude (i.e. not deduct) the MFP discounts from the calculation of a selected drug's ASP. This clarification is needed to ensure patient access to these medications in both government funded and commercial health care programs. The manufacturer reported ASP for selected drugs (excluding MFP) should be published by CMS.

6. To reduce administrative burden under the Part B drug MFP effectuation enrollment approach, CMS should use accurate and up-to-date provider enrollment and payment information that is already contained in existing CMS or contractor systems where feasible.

7. To ensure patient access to Part B drugs, CMS should monitor implementation of the Part B drug MFP effectuation process by Medicare Advantage plans (and their contractors), including such aspects as patient cost-sharing, coverage policies and restrictions. and payment policies for these selected Part B drugs.

8. As part of the approach to assure that manufacturers do not pay both a 340B discount and an MFP for the same drug, CMS should use 340B modifiers currently submitted by Part B providers to deduplicate 340B and MFP claims before they are sent to the manufacturers. CMS should enforce compliance with modifier use and extend the requirement to Medicare Advantage claims.

June 26, 2025

Chris Klomp
Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

SUBMITTED ELECTRONICALLY TO: IRARebateandNegotiation@cms.hhs.gov

RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Director Klomp:

AstraZeneca appreciates the opportunity to submit comments on the above-captioned draft guidance document (the Draft Guidance) regarding implementation of the Medicare Drug Price Negotiation Program (Negotiation Program) under the Inflation Reduction Act (IRA) for Initial Price Applicability Year (IPAY) 2028 and effectuation of Maximum Fair Prices (MFPs) for IPAYs 2026, 2027, and 2028.

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. AstraZeneca operates in over 100 countries and its innovative medicines are used by millions of patients worldwide.

I. Overview of Comments

AstraZeneca provides comments on the below topics, organized by order of appearance in the Draft Guidance:

Definition of Qualifying Single Source Drug and Selection of Drugs for Negotiation (Section 30)

- CMS should revise its current, legally unsupported definition of "qualifying single source drug," which groups all products with the same active ingredient or moiety as a single "drug" to instead define a "drug" at the level of a New Drug Application (NDA)/Biologics License Application (BLA). This revised definition would be consistent with the statute and would appropriately defer to the Food and Drug Administration (FDA)'s approach for identifying distinct drug products.

- CMS should continue to follow the FDA's judgments regarding which products constitute a fixed combination product involving multiple active ingredients, by continuing to treat each such fixed combination product as a separate qualifying single source drug. (Section 30.1)
- CMS should remove the "bona fide" marketing standard the agency established for determining generic or biosimilar competition, which is unsupported by the clear statutory text in section 1192(c) of the Social Security Act (the "Act"), and provide a clearer standard for determining marketing of generic or biosimilar competition. (Section 30.1.)
- CMS should correct its interpretation of the statutory exclusion of orphan drugs from the definition of qualifying single source drug (QSSD)[1] such that, in the context of an orphan drug, the 7- or 11-year period that must elapse before a drug can be considered for negotiation begins upon the date that the orphan drug exclusion no longer applies. (Section 30.1.1.)
- AstraZeneca appreciates CMS' plans to publish separate lists of the top 50 negotiation-eligible drugs by Part B and Part D spend and encourages the agency to publish this information as soon as possible to provide stakeholders time to plan for potential drug selection for future IPAYs. (Section 30.4.)

MFP Effectuation (Section 40)

- More detail and more opportunities for input on implementation of MFP for Part B products are needed, given the significant challenges that such effectuation will represent. (Section 40.)
- CMS should require Secondary Manufacturers to agree to comply with MFP obligations. (Section 40.)
- CMS should provide manufacturers with access to a 340B claims repository in time for manufacturers to be able to use such data for the purposes of IPAY 2026 MFP effectuation. (Section 40.4.5.)

Negotiation Factors and Process (Section 50 and 60)

- CMS should provide further clarity and structure to its selection of therapeutic alternatives by restricting selection to products with the same mechanism of action. (Section 60.3.1.)
- CMS should not incorporate non-pharmaceutical interventions as therapeutic alternatives, although it should consider the costs of such interventions in determining the value of a selected drug (Section 60.3.3.)
- The guidance should not specifically weight the statutory factors the agency is directed to consider by section 1194(e)(2), but the agency should provide greater clarity in its initial offer about how it has weighted such factors in developing its initial offer. (Section 60.3.)

[1] Social Security Act (SSA) Sec. 1192(e)(3)(A).

- CMS should provide explicit flexibility for manufacturers in addressing material cashflow issues identified by dispensing entities, confirming manufacturers have discretion in whether a dispensing entities' concerns are material, how to address these issues, and how to vary any plans to address such issues by selected drug. (Sections 40.4.3, 90.2.1.)

Formulary Inclusion (Section 110)

- CMS should provide significantly stronger guidance around what practices are unacceptable with regard to formulary inclusion of selected drugs. (Section 110.)

Renegotiation Process (Section 130)

- CMS should only engage in renegotiation in cases where the statute requires renegotiation, due to change in monopoly status, to create greater certainty for manufacturers and focus agency efforts on the highest-value negotiation efforts. (Section 130.1, 130.2.)
- CMS should develop a streamlined process for any renegotiation in order to reduce the burden of the renegotiation process for the agency, manufacturers, and other stakeholders. (Section 130.4.)

II. Definition of Qualifying Single Source Drug and Selection of Drugs for Negotiation (Section 30)

a. CMS Should Adhere to the IRA Statute and Define a QSSD by Reference to Individual NDA or BLA.

In Section 30.1 of the Draft Guidance, CMS proposes to continue the policy it established for IPAY 2026 and 2027, under which products with multiple NDAs or BLAs are aggregated into a single qualifying single source drug as long as they share an active ingredient / active moiety.

While this policy has been applied for prior IPAYs, it is inconsistent with the statutory text and greatly dilutes any incentive to further invest in the development of new products using existing active ingredients / active moieties. Accordingly, AstraZeneca urges the agency to correct this interpretation, both to protect incentives for innovation and to adhere to the plain language of the statute. Specifically, CMS should define a QSSD at the level of a single NDA or BLA, including for fixed combination products.

The statute defines a QSSD as a product that is either "approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act" (i.e., approved under an NDA), or "licensed under section 351(a) of the Public Health Service Act" (i.e., licensed under a BLA). That is, for both small-molecule drugs and large-molecule biological products, the statute unambiguously anchors the QSSD definition to the *singular* approval by the Food and Drug Administration (FDA) under

which the product is marketed.[2] The statute in no way authorizes CMS to convert the statute's focus on a *singular* FDA approval to a definition that sweeps in products with multiple separate FDA approvals through the addition of an "active moiety/ingredient" test. A QSSD should be defined no more broadly than the NDA/BLA under which the product is originally marketed.

While the agency has cited section 1192(d)(3)(B) of the Act to support its aggregation of NDA/BLAs in identifying QSSDs, that section describes the aggregation of *dosage forms and strengths* for purposes of calculating Parts B and D total expenditures to determine whether a drug that is *already* a QSSD qualifies as a "negotiation-eligible" drug. As the agency recognizes in the guidance's step-by-step process to interpreting the statute, the statute provides a sequential methodology for defining a QSSD and then selecting negotiation-eligible drugs. Specifically, section 1192(d)(3)(B) applies *after* the QSSD is identified and ensures that the different dosage forms and strengths of a QSSD are incorporated into the total expenditure calculation. The directive to aggregate across dosage forms and strengthens within a single QSSD, properly defined by reference to a single NDA or BLA, simply recognizes that a single NDA or BLA can have multiple dosage forms and strengths.

More broadly, CMS' incorrect interpretation of the statute in defining a QSSD is already undermining incentives for innovation, and CMS should take this opportunity to "minimize any negative impacts of the maximum fair price on pharmaceutical innovation," as directed by Executive Order 14273.[3] Pursuing an NDA or BLA for a new product affords patient access to new scientific advances, including products that are easier to administer, have fewer side effects, or treat new indications. For instance:

- In 2014, AstraZeneca received NDA approval from FDA in 2014 for LYNPARZA (olaparib) capsules, an anti-cancer product, which had a recommended dosage of 8 capsules, twice per day. Following subsequent research and development, AstraZeneca received a separate NDA approval from FDA in 2017 for LYNPARZA tablets, which reduced the recommended dosage from 8 capsules twice per day down to 2 tablets twice per day.

[2] Canons of statutory construction assume that a legislative drafter writes precisely and in accordance with the rules of grammar. *See, e.g.*, Arcadia v. Ohio Power Co., 498 U.S. 73, 79 (1990) ("In casual conversation, perhaps, such absent-minded duplication and omission are possible but Congress is not presumed to draft its laws that way.") Thus, Congressional reference to only a *singular* approval should be given weight. *See, e.g.*, Niz-Chavez v. Garland, 141 S. Ct. 1474, 1480 (2021) (emphasizing the use of "the singular article 'a'" to conclude that the statute referred to a singular term).

[3] Executive Order 14273, "Lowering Drug Prices By Once Again Putting Americans First" (Apr. 15, 2025), available at: https://www.whitehouse.gov/presidential-actions/2025/04/lowering-drug-prices-by-once-again-putting-americans-first/.

- In 2005, exenatide was first approved by FDA as the product twice-daily Byetta,[4] then as once-weekly Bydureon Pen in 2012,[5] then as once-weekly Bydureon BCise using a new, more patient-friendly device in 2017.[6] The FDA approved separate NDAs for each of these three formulations.

Obtaining NDAs or BLAs from the FDA involves a significant expenditure of resources, even if the new product shares the same active ingredient/moiety with an existing therapy, and the regulatory framework for such approvals rightly defers to FDA's authority in determining what changes require a new NDA, BLA, or supplemental NDA or BLA as appropriate. Combining separate NDAs or BLAs into a single QSSD significantly deters manufacturers from making investments that would otherwise advance the scientific understanding of disease states and bring new scientific applications to bear for patients. Evidence suggests that, under the previous administration's incorrect and anti-innovation interpretation of the statute, manufacturer investment specifically in post-approval applications has decreased.[7]

b. CMS Should Continue to Defer to FDA's Regulatory Role in Determining Active Ingredients for Fixed-Combination Products.

Even if CMS decides not to correct its interpretation of QSSD with relation to multiple NDAs or BLAs in general, it should not exacerbate this error by changing its approach to unique fixed-combination products, which it correctly has regarded as separate QSSDs.[8]

First, CMS' approach to different fixed combination products appropriately defers to the expertise of FDA in determining what moieties or ingredients are correctly regarded as active as opposed to inactive. Abandoning this approach would require CMS to undertake complex scientific and clinical analysis, which the agency is not well suited to do. Further, such an undertaking by CMS is an unnecessary use of government resources when FDA has already made such a determination of a product's active ingredients or moieties, a determination available in publicly available sources.[9]

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[4] https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/021773s049lbl.pdf.
[5] https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/022200s026lbl.pdf
[6] https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/209210s017lbl.pdf.
[7] Zheng, H., Patterson, J.A. & Campbell, J.D. The Inflation Reduction Act and Drug Development: Potential Early Signals of Impact on Post-Approval Clinical Trials. *Ther Innov Regul Sci* (2025), available at https://link.springer.com/article/10.1007/s43441-025-00774-2.
[8] Draft Guidance, p. 13.
[9] CMS has stated that it will identify a product's active ingredient or moiety "using public sources such as RxNorm, OpenFDA, FDALabel, and FDA's Active Ingredient-Active Moiety Relationship/Basis of Strength file" and "may also consult with FDA as appropriate to, for example, clarify whether a suffix or prefix in an ingredient name represents a genuine difference in active ingredient." Draft Guidance, p. 12.

Second, abandoning the current clear approach to fixed combination products will introduce significant new uncertainty to manufacturer research and development decisions. CMS proposes an example where, for instance, an active moiety/ingredient "affects the bioavailability" of another active moiety/ingredient, but is not "therapeutically active," but this approach would not provide any predictability or clarity. Rather, any such approach would necessarily require CMS to make judgments on an ongoing basis about particular ingredients.

The contemplated revision to the fixed-combination policy, by creating a new complex process and introducing new uncertainty, would exacerbate the Negotiation Program's "administratively complex" nature and contradict the administration's stated goals to "improve the transparency" of the Negotiation Program.[10]

c. CMS Should Develop a Clear, Statute-Based Standard for Determining that a Generic or Biosimilar of a QSSD Has Been Marketed and Publish Public Determinations of This Status.

Section 1193(c) of the IRA provides, clearly and simply, that a selected drug shall cease to be a selected drug if there is a product that "is approved or licensed (as applicable)" as a biosimilar or generic drug with the selected drug as the reference product, and that such generic or biosimilar product "is marketed." Going beyond this clear statutory text, CMS has created an unnecessarily complicated and complex process to determine whether a product is "bona fide" marketed. With the goal of improving the transparency of the Negotiation Program and better tracking the statutory text, CMS should remove its definition of "bona fide" marketing from the guidance and develop a clear standard for recognizing when a generic or biosimilar has been marketed.

One option that would provide much greater certainty would be determining a generic or biosimilar to be marketed based on the "market date" determined for the product under the Medicaid Drug Rebate Program (MDRP).[11] This approach would accomplish CMS' goals of increasing transparency in implementation of the Negotiation Program, as well as reduce unnecessary efforts by the agency to reach an independent determination for the purposes of the Negotiation Program when the agency has already determined that the product has been marketed for the purposes of another, related program. CMS has already recognized the value of using the MDRP market date outside of the MDRP for the purpose of determining whether a Part D drug is marketed, using it to define whether a product has been marketed for the purposes of Part D inflation rebate obligations.[12] Using the MDRP market date would reduce the substantial

[10] EO 14273.
[11] 42 C.F.R. 447.502 ("Market date ... means the date on which the covered outpatient drug was first sold by any manufacturer").
[12] Medicare Part D Drug Inflation Rebates Paid by Manufacturers: Initial Memorandum, Implementation of Section 1860D-14B of SSA, and Solicitation of Comments, Section 40.3 (Feb. 9, 2023), available at https://www.cms.gov/files/document/medicare-part-d-inflation-rebate-program-initial-guidance.pdf

uncertainty created by CMS' current opaque process for holistically determining whether a generic or biosimilar has been marketed.

In the absence of adopting the market date standard (or where a market date determination has not been made), CMS should simply consider any sales to meet the statutory definition of "marketed." The agency has taken a step toward greater clarity in this respect by acknowledging that a product that has been launched but has "relatively low" sales, in the absence of any agreements limiting the product's distribution, can be considered marketed—but the agency should go further and clarify that any sales meets the statutory definition.[13] A number of barriers unrelated to the reference manufacturer may stand in the way of a generic or biosimilar's early sales upon its initial marketing, including the fact that Part D plan sponsors often do not add a newly approved products to their formulary for 180 days, limiting uptake in early months of data.

CMS also requests comment on additional data sources it could use in determining whether a product has been marketed.[14] In determining whether a product has been sold and therefore is "marketed" for the purposes of the statute, AstraZeneca encourages CMS to use all available data sources, including commercial claims providers, as well as pharmaceutical distributor ordering platforms.

Finally, CMS could also improve the predictability of the drug selection process by making it clear when it has determined that it will not select a negotiation-eligible drug for negotiation at all due to generic or biosimilar competition. Given the administration's stated goals of improving transparency in the implementation of the Negotiation Program, CMS should publish the names, or at least the number, of drugs that were not selected because of generic or biosimilar competition.

d. The Time Period Preceding Negotiation Eligibility for Orphan Drugs Should Begin on the Loss of Their Orphan Drug Exclusion Rather than the Initial Approval Date.

The IRA's statutory text provides an important exemption from the definition of a QSSD, and therefore exemption from selection for negotiation. Specifically, Section 1192(e)(3)(A) provides for a general exclusion from the QSSD definition for certain orphan drugs, stating, "[T]he term 'qualifying single source drug' does not include any of the following . . . [a] drug that is designated as a drug for only one rare disease or condition under section 526 of the Federal Food, Drug, and Cosmetic Act and for which the only approved indication (or indications) is for such disease or condition," a designation provided by the Orphan Drug Act (ODA). In general,

[13] Draft Guidance, p. 15.
[14] *Id.*

Section 1192(e)(1)(A) requires that, to be a QSSD, seven years must have passed since the date of the approval of a drug under section 505(c) of the Food Drug and Cosmetic Act, or at least 11 years must have passed since the date of the licensure of a biologic under section 351(a) of the Public Health Service Act.

Under CMS' current interpretation of the orphan drug exclusion, when a product loses eligibility for the exclusion upon the approval of a new indication for a second disease or condition, the 7- or 11-year pre-selection period begins when the product was first approved. Perversely, this means that an orphan drug can lose eligibility for the orphan drug exclusion (by being approved for another orphan indication) within the 7- or 11-year period following the drug's initial approval, before the drug has become a QSSD—meaning that the exclusion provides no protection at all.

A more appropriate interpretation that gives the full effect to the orphan drug exclusion and the statute's express exclusion of eligible orphan drugs from the definition of a QSSD would be to begin the pre-selection "clock" for orphan drugs only on the date the product loses eligibility for the exclusion. This interpretation would follow both the plain language and overall structure of the statute, while also following the IRA's recognition of the important goals of the Orphan Drug Act to promote development of treatment for rare diseases.

Notably, the orphan drug exclusion constitutes a threshold exclusion from the definition of a QSSD, coming in a subsection titled "Exclusions" and stating that "the term" QSSD "does not include any of the following . . . (A) Certain Orphan Drugs."[15] Because excluded orphan drugs are excluded as a threshold matter from being considered QSSDs, the 7- or 11-year pre-negotiation period that would otherwise apply to a QSSD must be tolled until the product drug no longer meets the requirements of the orphan drug exclusion and therefore becomes a QSSD. Any other interpretation defeats the intent of specifically excluding relevant orphan drugs from the QSSD definition, as opposed to excluding them in some other way.[16] Without tolling the 7- or 11-year period, the protection of the orphan drug exclusion—and the goal of providing a threshold exclusion from the QSSD definition—would be significantly undermined, because no protection would be provided by the exclusion if the exclusion is lost before the 7- or 11-year QSSD period has elapsed.

Beyond the statute's structure and text, tolling the beginning of the 7- or 11-year period would support and preserve the important progress and vital incentives the ODA has provided in helping the benefits of medical innovation to reach patients with orphan diseases. The approach outlined here better enables innovator companies to pursue orphan indications by initiating the

[15] SSA Sec. 1192(e)(3)(A).
[16] Consider, by contrast, the small-biotech exclusion, which was specifically inserted as an exclusion to the definition of a "*negotiation-eligible drug*" under section 1192(d)(2) of the Act.

pre-negotiation period only upon a subsequent approval for a distinct disease or condition. Such an approach would also align with the Trump Administration's broader stated commitments not only to implement the Negotiation Program in a way that protects incentives for pharmaceutical innovation, but also to promoting treatments for rare diseases.[17]

Further, CMS could promote its stated goal of transparency within the Negotiation Program by publishing information on the drugs were ranked in the top 50 spend drugs in its published list for a given IPAY (as discussed in the next section of this comment), but were excluded on the basis of the orphan exclusion. At a minimum, the agency should consider publishing the number of products that were excluded under the orphan drug exclusion.

e. CMS Should Publish Negotiation-Eligible and Selected Drug Lists As Soon As Possible in Each IPAY Cycle.

In the draft guidance, CMS states that, for IPAY 2028, it will publish not only the list of 15 selected drugs for IPAY 2028 by February 1, 2026, but that it will also publish "a list of the up to 50 top negotiation-eligible drugs (including the up to 15 selected drugs) ranked by combined Total Expenditures under Part B and Part D."[18] AstraZeneca supports CMS' decision to publish a list regarding the top 50 negotiation-eligible drugs by spending, as this will provide valuable transparency for manufacturers and other stakeholders in preparing for future years of the Negotiation Program.

However, it is important to emphasize how challenging it is for manufacturers to plan for the current year of the Negotiation Program when selection of a drug is not made official by CMS until around February 1 of the year in which a drug is selected for negotiation. In preparing for negotiation, manufacturers not only must prepare large volumes of data on a selected product, but also strive to develop evidence that can inform the negotiation in a way that will allow the negotiation process to reflect the value that a product provides to Medicare and Medicare patients. It is highly challenging to develop this kind of evidence for submitting to CMS by March 1, just one month after a product has officially been selected.[19]

A variety of approaches may help manufacturers and other stakeholders in preparing for drug selection and negotiation with more lead time:

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[17] Makary MA, Prasad V. Priorities for a New FDA. *JAMA*, available at https://jamanetwork.com/journals/jama/fullarticle/2835314 ("the FDA will be focused on delivering faster cures and meaningful treatments for patients, especially those with neglected and rare diseases …").
[18] Draft Guidance, p. 41.
[19] SSA Sec. 1194(b)(2)(A).

- CMS could publish the list of negotiation-eligible drugs, and potentially the list of selected drugs, sooner than the February 1 deadline required by the statute. While the statute directs that selection must be made based on spending data for the 12 months ending October 31 the year before negotiation,[20] CMS could presumably analyze and publish such data as soon as December or January.
- Finally, while the statute requires that a manufacturer submit "the information described in" Section 1193(a)(4) by March 1 of a given year in which a drug is selected,[21] that provision only requires "information on the non-Federal average manufacturer price [non-FAMP] … for the drug for the applicable year or period" and "information that the Secretary requires to carry out the negotiation (or renegotiation process)." Because a substantial amount of the information submitted in response to the Negotiation Data Elements (NDE) Information Collection Request (ICR) is neither non-FAMP data nor required—specifically, CMS has considered section I of the NDE ICR, regarding the section 1194(e)(2) factors, to be optional—CMS could provide additional time after March 1 for the submission of such optional data (although AstraZeneca recognizes that this added time would not be especially substantial, given the need for such information to be submitted in order for negotiation to begin). Additional flexibility would provide extra time for not only manufacturers of selected drugs, but also members of the public, to provide detailed responses to section I of the ICR.

III. Negotiation Process

a. CMS Should Clarify and Improve Its Approach to Selecting Therapeutic Alternatives.

In Section 60.3.1 of the Draft Guidance, CMS largely maintains the methodology it has used in the IPAY 2026 and IPAY 2027 guidances to identify therapeutic alternatives for a selected drug. AstraZeneca recommends that the agency improve the transparency of the negotiation process by providing a more structured approach to identifying therapeutic alternatives. In particular, the agency should begin by identifying therapeutic alternatives by identifying products with the same mechanism of action, and only depart beyond that definition of therapeutic alternative in exceptional circumstances that the agency would specifically justify. Further, however CMS determines therapeutic alternatives, the agency should provide as much detail as possible in its initial offer for a selected drug regarding how it determined the therapeutic alternatives and how it considers the therapeutic alternatives to be used (e.g., if a drug is commonly used in combination with other drugs as an alternative to the selected drug, by listing the specific combinations considered by CMS to be therapeutic alternatives).

[20] SSA Sec. 1192(b)(1)(A).
[21] SSA Sec. 1194(b)(2)(A).

CMS solicits comment on "the possibility and feasibility of considering health care services payable under Medicare Part A or Part B as potential therapeutic alternatives to the selected drug."[22] AstraZeneca strongly recommends against this approach. For one, developing a comparable 30-day pricing point for a health care service would be highly complex, if not effectively impossible, and introduce further complications and uncertainty into the agency's development of a starting point for an initial offer, which is itself already not as transparent as it should be. However, the agency should, to the extent possible, consider the cost of health care services paid for by Medicare that may be prevented by the use of a selected drug as part of assessing the drug in relation to the statutory factors.

b. CMS Should Maintain Its Approach to Developing a Starting Point for Its Initial Offer and Make Its Methodology As Transparent As Possible.

In Section 60.3.2 of the Draft Guidance, CMS solicits comments on potential alternative starting points for calculating its initial offer, beyond the current methodology previously used for IPAY 2026 and IPAY 2027, such as an amount between the therapeutic alternatives' ASP/WAC, Part D net payment amount, or combined Part B/Part D average payment amount (as applicable) and the unit cost of production and distribution for the selected drugs. AstraZeneca opposes the introduction of additional possible methodologies for developing a starting point. The agency's process for calculating an initial offer itself is already quite complicated; additional possible methodologies would unnecessarily introduce further uncertainty and opacity into the negotiation process.

In Section 60.3.3 of the Draft Guidance, CMS solicits comments on whether the agency "should put greater emphasis on certain section 1194(e)(2) factors when adjusting the starting point to determine the preliminary price" and "which section 1194(e)(2) factors are most compelling in informing the section 1194(e)(2) adjustment and what approaches could be used to consistently apply those factors across selected drugs."[23] AstraZeneca recommends against identifying particular 1194(e)(2) factors as having greater weight than others in advance of a particular negotiation, noting that the statute itself does not direct a particular weighting of the factors. CMS' interest in "approaches [that] could be used to consistently apply those factors across selected drugs" is commendable, but given the heterogeneity of selected drugs, a unified approach would be challenging. However, manufacturers of selected drugs would benefit significantly from greater clarity in how CMS has weighted the 1194(e)(2) factors, and how CMS has applied them, when the agency sends its initial offer.

[22] Draft Guidance, p. 128.
[23] Draft Guidance, p. 133.

In Section 50.1 of the Draft Guidance, CMS solicits comment on potential "collection of additional, forward-looking "market data" for the selected drug that pertain to periods that overlap with the negotiation period and/or the price applicability period."[24] While AstraZeneca appreciates CMS' effort to consider a wide range of data from stakeholders, inviting the submission of forward-looking data would introduce substantial new complexity and uncertainty to the negotiation process. The concept of forward-looking data is not included in the statutory factors at Section 1194(e)(2), and such projections necessarily include substantial uncertainty that would complicate the negotiation process.

In Appendix A of the Draft Guidance, CMS has clarified that, in considering unmet need and therapeutic advance, it will "consider the extent to which the drug" is a therapeutic advance or addresses unmet need at the time "of consideration" rather than, as previously, "at the time of submission."[25] AstraZeneca appreciates this change, which recognizes the pace at which innovation occurs and clinical data is published, such that additional value may be demonstrated for a selected drug during the period between submission of the NDE ICR and conclusion of the selected drug's negotiation process.

IV. MFP Implementation

a. CMS Should Provide More Opportunities for Input Regarding Part B Effectuation.

The Draft Guidance provides very little detail beyond contemplating that Part B effectuation will work similarly to Part D implementation, including use of the same MTF modules/functionalities, "to the extent feasible."

Recognizing the significant complexity of Part B effectuation, AstraZeneca encourages CMS to provide further details regarding potential plans for Part B MFP effectuation as soon as possible. For instance, providing potential concepts for comment or publishing an RFI with specific questions for stakeholders, before the publication of the final guidance later this year and the beginning of rulemaking in 2027, would enable industry to provide much more meaningful input into this complex process.

b. CMS Should Require Secondary Manufacturers to Agree to Comply with MFP Obligations.

As it has in past guidances, CMS states that Primary Manufacturers are responsible for ensuring that the MFP is made available to dispensing entities that dispense the selected drug to MFP-

[24] Draft Guidance, p. 104.
[25] Draft Guidance, p. 213–214.

eligible individuals, including to ensure that the MFP is available for units of the selected drug for which there is a Secondary Manufacturer.[26]

As AstraZeneca has emphasized in past comments, it is not appropriate for CMS to hold Primary Manufacturers liable for any and all violations of Secondary Manufacturers with respect to making the MFP accessible to eligible entities. There is no clear impediment to CMS directly binding Secondary Manufacturers to the same requirements as a Primary Manufacturer via separate agreements. The statute does not distinguish between "Primary" and "Secondary" manufacturers, and while CMS may believe this distinction contributes to administrative simplicity, as soon as legal obligations and consequences (e.g., civil monetary penalties) attach to the agency's administrative decisions, such decisions must be supported by the statute. Absent clear statutory authorization, CMS cannot impose legal liability on one manufacturer for the violations of a different manufacturer; the agency must directly impose the consequences of any violation on the violating entity.

Imposing these obligations on Secondary Manufacturers would not add administrative complexity to the program, and would reduce the substantial uncertainty faced by Primary Manufacturers. CMS could separately require Secondary Manufacturers to sign near-identical agreements that directly obligate them to comply with the various requirements relating to the Negotiation Program that are directly under their control, including but not limited to, ensuring access to the MFP for selected drugs that they distribute to, or on behalf of, MFP-eligible individuals.

c. Manufacturers Need Access to 340B Claims Data In Order to Support Effective IPAY 2026 Implementation.

Under the IRA, a manufacturer "shall not be required to provide access to the maximum fair price" to 340B covered entities where they are eligible for 340B pricing and "shall be required to provide access to the maximum fair price" where the MFP is below the 340B price.[27] Unfortunately, although CMS acknowledges in the Draft Guidance, as it has in previous guidances, that it has received "requests from numerous interested parties for CMS to assume responsibility for nonduplication of the 340B ceiling price," the agency repeats that it "will not, at this time, assume responsibility for nonduplication of discounts between the 340B ceiling price and MFP."[28]

AstraZeneca encourages CMS to continue considering various ways to support 340B nonduplication efforts, but emphasizes that the essential step is for the agency to require covered

[26] Draft Guidance, p. 43.
[27] SSA Sec. 1193(d).
[28] Draft Guidance, p. 96.

entities to use a 340B claims modifier, whether through the Medicare Transaction Facilitator (MTF) or a separately established 340B clearinghouse. Neither a manufacturer nor the MTF will be able to determine whether an MFP discount or 340B discount is due without being able to proactively identify 340B claims.

CMS has authority under §1860D-12(b)(3)(D) of the Social Security Act to require the use of such a modifier through including a requirement for Part D plans to require the use of 340B claim modifiers by their network pharmacies that are affiliated with 340B covered entities. The agency has recognized its broad authority to require terms of Part D plans in order to implement MFP effectively through, for instance, finalizing its proposal to require Part D plans to require network pharmacies to participate in the MTF Data Module.[29]

In the Draft Guidance, CMS states specifically that it is "considering ways to incorporate asynchronous 340B data into MTF processes in the future."[30] AstraZeneca supports CMS in exploring this concept, but notes that its utility will be limited if manufacturers are not made aware in the coming months of whether or not such a functionality will be available for IPAY 2026. As manufacturers develop their effectuation plans, understanding the potential availability of 340B related data is essential.

d. CMS Should Provide More Flexibility for Manufacturers in Addressing Dispensing Entities' Anticipated Cash Flow Issues.

In Section 40.4.3 of the Draft Guidance, CMS discusses potential approaches for manufacturers to address dispensing entities' anticipated material cashflow concerns, and in Section 90.2.1, CMS discusses expectations for how manufacturers will outline plans to address these concerns in the plans submitted to CMS for MFP effectuation.

AstraZeneca appreciates that, in the final ICR for manufacturer MFP effectuation plans, CMS does not impose specific expectations on manufacturers to address concerns of dispensing entities that have identified material cashflow concerns, such that manufacturers are not bound to a dispensing entities self-identification as having such concerns.[31] AstraZeneca notes that this discretion is also implied in the final ICR for dispensing entities in stating that information provided by dispensing entities identifying cashflow concerns "will be treated as confidential and

[29] 90 Fed. Reg. 15792 (Apr. 15, 2025).
[30] Draft Guidance, p. 96.
[31] Appendix B: Drug Price Negotiation Program MTF DM Primary Manufacturer MFP Effectuation Plan Form, CMS-10912, available at: https://www.reginfo.gov/public/do/PRAViewIC?ref_nbr=202503-0938-001&icID=274426.

shared with Primary Manufacturers for purposes of informing Primary Manufacturer's development of their MFP Effectuation Plan only."[32]

However, AstraZeneca wishes to reemphasize that manufacturers that plan to rely on the MTF PM may be limited in their ability to describe their plans for mitigating material cashflow concerns from dispensing entities in their MFP effectuation plans while operational details regarding the MTF PM continue to remain uncertain.

AstraZeneca notes that there are likely to be significant differences between the cashflow concerns posed for dispensing entities by different selected drugs. AstraZeneca appreciates CMS' clarification in the final MTF ICRs that MFP effectuation plans may vary across a manufacturer's different selected drugs, but would further appreciate recognition that plans for addressing material cashflow concerns also should vary across different drugs.

Similarly, the cashflow concerns cited by dispensing entities are likely to evolve over time, and CMS should recognize that manufacturers' plans for addressing such concerns likely will have flexibility to evolve as dispensing entities adjust to MFP effectuation.

Finally, Primary Manufacturers cannot be practically accountable for Secondary Manufacturers' choices regarding MFP implementation and mitigation material cashflow concerns. CMS should clarify that Primary Manufacturers' plans for addressing material cashflow concerns need not encompass efforts by a Secondary Manufacturer.

V. Formulary Inclusion of Selected Drugs

In the Draft Guidance, CMS makes no substantive changes to its expectations for Part D plans regarding formulary placement of selected drugs, despite ongoing concerns by stakeholders that selected drugs may be disadvantaged in formulary placement. The agency states that it "did not see this occur in contract year 2025 with respect to selected drugs for initial price applicability year 2026" and "will continue to monitor trends in formulary placement for selected drugs," and AstraZeneca encourages CMS to continue this work and review feedback from stakeholders that may suggest discrimination against selected drugs.[33]

AstraZeneca appreciates that the agency also reiterated the practices it will regard as suspect—such as where a Part D sponsor steps a selected drug through a formulary alternative brand

[32] Appendix A: Drug Price Negotiation Program MTF DM Dispensing Entity and Third-Party Support Entity Enrollment Form, CMS-10912, available at: https://www.reginfo.gov/public/do/PRAViewIC?ref_nbr=202503-0938-001&icID=274425.
[33] Draft Guidance p. 185.

drug—in the CY 2026 Part D Formulary Submission Information HPMS memo.[34] But given the concerns around risks of unfavorable placement for selected drugs, as well as the importance of ensuring beneficiary access to selected drugs, CMS should add additional safeguards. For instance, the agency can and should state that it will presumptively reject, or require proactive specific justification, for formulary practices that do any of the four practices identified in the guidance as suspect (placing a selected drug on a non-preferred tier, placing a selected drug on a higher cost-sharing tier than non-selected brand drugs in the same class, stepping a selected drug through another brand alternative, or imposing more UM on a selected drug than a formulary brand alternative in the same class). Requiring specific justification in relation to the adoption of any of these practices for selected drugs would not impose particularly substantial burden on plans, while substantially simplifying the work required for the agency in examining formulary design for practices of concern.

VI. Renegotiation

a. CMS Should Adopt a Policy of Renegotiating Only Where Statutorily Required.

In Section 130.1 of the Draft Guidance, CMS appropriately notes that, under the IRA statute, a selected drug is eligible for renegotiation when particular statutory criteria are met: a change in monopoly status, a significant change in 1194(e)(1) or (2) factors.[35] In Section 130.2, the agency provides guidance on how it will select from renegotiation-eligible drugs which drugs will undergo renegotiation, basing this selection on 1) the likelihood that renegotiation will result in a change in MFP of 15 percent or more, and 2) whether such a change in the MFP would have a significant impact on the Medicare program, with the latter criteria taking into account both financial impacts on the Medicare program and beneficiary cost-sharing.

AstraZeneca appreciates that CMS has provided some clarity on how it will select from renegotiation-eligible drugs for renegotiation, but the agency can and should go further and state that it will only pursue renegotiation where statutorily required—i.e., when a product changes in monopoly status. Any other policy, like the complex set of considerations the agency has laid out in the Draft Guidance, would create huge amounts of uncertainty around renegotiation that will undermine incentives for manufacturers to invest in research and development, including for new indications. For instance, while the statute directs that a selected drug becomes eligible for renegotiation on the approval of a new indication, in many cases, a new indication approval will not provide a sound reason for the agency to renegotiate MFP. Particularly in oncology, it is quite common for a drug to receive approval for new indications, including for uncommon or rare diseases, such that a new indication will not substantially affect the usage of the drug.

[34] Issued Apr. 26, 2025.
[35] SSA Sec. 1194(f)(2).

Engaging in renegotiation only in the cases where a product changes monopoly status would not only provide greater certainty for industry, but also would reduce burden on manufacturers planning for potential renegotiation and eliminate complex bureaucratic determinations that agency would have to make to assess the potential impact of renegotiation where it is optional, rather than required, by the agency. In line with the agency's efforts to simplify the complexity of the negotiation program, large amounts of the guidance could be eliminated if the agency simply chose only to renegotiate where the statute requires renegotiation. Such a policy would also appropriately focus the resources of the agency on delivering the greatest value for the taxpayer, because renegotiation efforts would be focused on cases where the change in MFP is likely to be greatest (where the change in monopoly status results in a significant, statutorily directed reduction in the ceiling price).

b. The Renegotiation Process Should Be Streamlined to Reduce Burden on the Agency, Manufacturers, and Stakeholders.

In outlining its approach to the renegotiation process, CMS states that it is "considering whether conforming to the procedures, structure, and timing of the negotiation process is practicable for the renegotiation process and is soliciting comments on whether there are specific aspects of the negotiation process that may not be practicable for the renegotiation process."[36] AstraZeneca appreciates that the agency is considering whether the renegotiation process is practicable for the agency, manufacturers, and other stakeholders, and believes that the process as proposed by the agency will impose substantial amounts of unnecessary burden on the agency, manufacturers of renegotiated drugs, and stakeholders who may provide input on a renegotiated drug.

The negotiation process as implemented is extremely burdensome for manufacturers, involving input from diverse components of a manufacturer and involvement of senior leadership—an issue that the administration has recognized in noting that the process as implemented by the prior administration has been "administratively complex."[37] AstraZeneca encourages the agency to consider how the renegotiation process in particular can be simplified and abbreviated. For instance, a manufacturer of a drug selected for renegotiation could attest that certain elements of the NDE ICR submitted for initial negotiation have not changed, or have not changed in a material way, rather than having to resubmit the same information a second time during the renegotiation process.

[36] Draft Guidance, p. 203.
[37] EO 14273.

VII. Conclusion

AstraZeneca appreciates this administration's commitment to increasing the transparency and efficiency of the Negotiation Program and is ready to provide feedback on an ongoing basis on the implementation of the Negotiation Program and MFP effectuation.

If AstraZeneca can provide additional details regarding our comments enclosed, please do not hesitate to contact me at sarah.arbes@astrazeneca.com.

Sincerely,

Sarah C. Arbes
Head of Federal Affairs and Policy

June 25, 2025

Deputy Administrator Chris Klomp
Center for Medicare
Centers for Medicare & Medicaid Services (CMS)

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp:

Thank you for the opportunity to comment on CMS's draft guidance on the Medicare Drug Price Negotiation Program. This comment focuses on Section 30.2 and the identification of Part B high spend drugs. Specifically, this group of experts in policy, operational, and legal issues affecting the Medicare Drug Price Negotiation Program believes the identification of Part B high spend drugs under section 1192(d)(1)(B) of the Social Security Act can and should account for spending on Part B drugs administered to Medicare Advantage enrollees. Inclusion of such spending is necessary for the law to function as intended, is the best reading of the statute, and is operationally feasible.

Failure to Include Medicare Advantage Usage Distorts the Proper Functioning of the Law

Section 1192 of the Social Security Act, as amended by Section 11001 of the Inflation Reduction Act (IRA), governs the process by which CMS selects drugs for which prices may be negotiated under the Medicare Drug Price Negotiation Program. For initial price applicability year (IPAY) 2028 and later years, the statute directs Medicare to (1) identify qualifying single source drugs; (2) determine the 50 qualifying single source drugs with the highest "total expenditures under Part D" and the 50 with the highest "total expenditures under Part B"; (3) rank the combined list of drugs from highest to lowest total Medicare spending; and (4) select the up to 15 (or 20 in IPAY 2029 and beyond) highest spending drugs as drugs for which prices may be negotiated (with various exclusions and removals at each step of the process).

The IPAY 2028 negotiation is the first time that drugs paid for under Part B may be selected for negotiation, and, accordingly, the most recent draft guidance is the first time CMS has addressed policy and procedures applicable to Part B drugs. Specifically, CMS must describe for the first time how it will calculate "total expenditures under Part B" for these drugs. In Section 30.2, the agency proposes to use "Part B claims data" for the 12 months ending October 31, 2025 for purposes of this calculation.

However, "Part B claims data" are not a complete metric of "total expenditures under Part B," because Part B claims include expenditures *only* for claims paid for fee-for-service Medicare beneficiaries. This metric excludes expenditures associated with beneficiaries who receive their Medicare Part B benefits through enrollment in a Medicare Advantage (MA) plan. (CMS receives detailed information about the Medicare Part B drugs that MA enrollees receive from MA plans in the form of encounter data, but they do not receive claims with payment information in the way they do for fee-for-service beneficiaries.) Importantly, when a Part B

drug is selected for negotiation and the manufacturer agrees to a maximum fair price, that negotiated price unambiguously applies to utilization of the drug by MA beneficiaries.[1]

This exclusion of MA expenditures from the computation of total expenditures for Part B drugs would significantly distort the operation of the statute. The most recent estimates indicate that about 54% of all Medicare beneficiaries are enrolled in an MA plan.[2] Because overall use of prescription drugs by MA enrollees and those in fee-for-service Medicare are similar, it is likely that more than half of beneficiaries receive their Part B drugs through an MA plan – and this share is projected to grow over time. Accordingly, by looking only to fee-for-service claims data, CMS would exclude roughly half of total spending on Medicare Part B drugs thereby underestimating the true total spending on Part B drugs by roughly half. Importantly, this underestimate would not apply equally to all drugs and would be larger for some products and lower for others, given differential patterns of use.[3] Thus, when spending on Part B drugs is compared to spending on Part D drugs for purposes of selecting the overall top 15 (or 20) drugs by total Medicare expenditures, Medicare would be far less likely to select Part B drugs for negotiation.

A variety of negative consequences would follow. Most prominently, it would reduce the overall impact of the Medicare Drug Price Negotiation Program. Medicare would select Part D drugs with total expenditures that are *lower* than "true" Medicare spending on Part B drugs. Thus, negotiated price discounts would be applied to lower levels of prescription drug spending, thereby reducing the potential savings to beneficiaries and taxpayers from the negotiation program. This distortion would also create incentives for manufacturers and investors to prefer upstream investments in drug development projects that are more likely to lead to a Part B drug rather than a Part D drug coming to market. Similarly, to the extent an active moiety can be administered as either a Part B or a Part D drug, manufacturers would have incentives to shift usage into the Part B drug (like a physician-administered infusion or injectable), even though providers may recommend and patients may prefer a Part D self-administered formulation. Indeed, physician-administered formulations are likely to be more burdensome for patients and generally have more significant access barriers, potentially leading to lower medication adherence. Part B formulations may also be more expensive for the program. That is, the exclusion of Part B drugs administered to MA enrollees from the computation of total expenditures will have ramifications far beyond the Medicare Drug Price Negotiation Program. Furthermore, this distortion would create new incentives for manufacturers of Part B drugs to promote enrollment of their patient population into MA plans to reduce the likelihood of being selected for negotiation, for example, through targeted outreach or through pricing behavior.

All of these effects would be inconsistent with the goals of the law and would create unproductive and costly distortions in health care markets. These impacts are unnecessary because CMS has the legal authority and operational capacity to use a complete measure of total expenditures under Medicare Part B inclusive of spending for MA enrollees, as described below.

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[1] See Social Security Act Sec. 1191(c)(2)(b), discussed further below; see also Social Security Act Sec. 1852(a)(1)(B).

[2] Meredith Freed et al., "Medicare Advantage in 2024: Enrollment Update and Key Trends," KFF (Aug. 8, 2024) https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/.

[3] See Kelly E. Anderson et al., Prescribing of Low- Versus High-Cost Part B Drugs in Medicare Advantage and Traditional Medicare, 57 Health Servs. Res. 537 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9108062.

Section 1192(d)(1)(B) Is Best Read To Include Medicare Advantage Expenditures

Section 1192 instructs CMS as to how to measure total spending on prescription drugs and use that information to select drugs for negotiation. Beginning for 2028, the operative language directs CMS to identify "the 50 qualifying single source drugs with the highest total expenditures under part B of title XVIII, as determined by the Secretary ...,"[4] identify a parallel 50 drugs under Part D,[5] rank the resulting group of up to 100 drugs "according to the total expenditures for such drugs under parts B and D of title XVIII, as determined by the Secretary,"[6] and select the top 15 (or 20 for 2029 and subsequent years) drugs.[7]

The key question is how CMS should understand the term "total expenditures under Part B" -- and whether that term includes expenditures on Part B drugs administered to MA enrollees. As a starting place, the IRA defines "total expenditures" as follows:

> (5) Total expenditures.--The term 'total expenditures' includes, in the case of expenditures with respect to part D of title XVIII, the total gross covered prescription drug costs (as defined in section 1860D-15(b)(3)). The term 'total expenditures' excludes, in the case of expenditures with respect to part B of such title, expenditures for a drug or biological product that are bundled or packaged into the payment for another service.[8]

Notably, this definition is clear on what is *not* included as a relevant Part B expenditure (expenditures where payment for the drug is bundled with payment for another Part B service) but does not provide specific examples of what *is* included. The use of the word "total" would imply comprehensive inclusion of expenditures on Part B drugs, and absent indications to the contrary, that is the natural starting point for the agency's approach.

Some may argue that because the rules for MA plans are codified in Part C of the Medicare statute, not within Part B, expenditures within MA cannot be considered expenditures "under Part B."[9] However, such an interpretation would be based on a misunderstanding of the structure of Part C and the relationship between the provisions of Part B and Part C.

When it enacted the IRA, Congress made clear in the statute's text that Part B benefits received through MA plans are benefits received "under" Part B. In describing the individuals to whom a negotiated price applies, the statute reaches any "individual who is enrolled *under* part B of title XVIII, *including* an individual who is enrolled in an MA plan under part C of such title, if payment may be made under part B for such selected drug."[10] The IRA itself thus defines Part B drug benefits received through MA as Part B benefits covered by the statute. That text alone

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[4] Social Security Act Sec. 1192(d)(1)(B).
[5] Social Security Act Sec. 1192(d)(1)(A).
[6] Social Security Act Sec. 1192(b)(1)(A).
[7] Social Security Act Sec. 1192(a).
[8] Social Security Act Sec. 1191(c)(5).
[9] Drug manufacturers have advanced similar arguments under a different provision of the Inflation Reduction Act, related to inflation rebates. See, e.g., Christen Linke Young, "The Inflation Rebate for Medicare Part B-Covered Drugs Should Apply to Medicare Advantage," Brookings Institution (May 14, 2025), https://www.brookings.edu/articles/the-inflation-rebate-for-medicare-part-b-covered-drugs-should-apply-to-medicare-advantage/.
[10] Social Security Act Sec. 1191(c)(2)(B), emphasis added.

makes clear that expenditures for Part B benefits made through MA plans are among the "total expenditures under Part B" that must be included in determining the highest spend drugs.

Indeed, there is no logical basis for attributing to Congress the odd policy of applying the results of the negotiation to payment for MA drugs, but not including MA spend in the selection of those drugs. The agency is directed to select qualifying drugs based on total spending in order to maximize the reach of the program, whereas this exclusion systematically distorts that goal as noted above. For Congress to have created these market-distorting effects without comment is particularly implausible.

Nor would such an outcome be consistent with language used throughout the Medicare statute. In drafting these IRA provisions, Congress followed the basic approach of the Medicare statute, which consistently describes benefits provided through MA plans as benefits "under" Part A or B. For example, the foundational statutory text that defines the "basic benefits" for MA explains that plans "shall provide to members enrolled under this part [Part C]... benefits *under* the original [M]edicare fee-for-service program option."[11] That is, the statute fundamentally defines the services provided to MA enrollees as benefits "under" Part A and Part B.

Further, throughout sections 1191 and 1192, Congress created a variety of exclusions and limitations – e.g. excluding certain "small biotech" companies, certain orphan drugs, and biologics with an expectation of imminent biosimilar entry from being selected for negotiation. The language defining "total expenditures" similarly features a clear exclusion for drugs where payment is packaged with another service, as described above.[12] If Congress wanted to exclude expenditures for MA enrollees, they could have done so, and the fact that they did not specify an exclusion for expenditures amounting to more than half of the total expenditures by the Medicare program for Part B drugs indicates those expenditures should be included.

Finally, it is useful to underscore how Medicare funds flow to MA. MA plans are paid capitated payment amounts, and the share of the capitated payment that is attributable to benefits "under part B" (including payment for Part B drugs) is drawn from the Federal Supplementary Medical Insurance Trust Fund, i.e., the source of funding for fee-for-service Part B payments.[13] Therefore, payment to MA plans for Part B drugs is mechanically an expenditure "under" the same account as fee-for-service Part B claims.

Thus, there is no basis in the statute for excluding expenditures on Part B drugs for MA enrollees, and such spending should be included in the calculation of "total expenditures under part B."

Inclusion of Medicare Advantage Usage Is Operationally Feasible

CMS has proposed to look to "Part B claims data" -- which will reveal the dollar value of Medicare paid claims for Part B drugs received by fee-for-service Medicare beneficiaries over

[11] Social Security Act Sec. 1852(a)(1), emphasis added.
[12] Section 1191(d)(5) excludes from the definition of "total expenditures" those expenditures under part B for a drug or biological product that are bundles or packaged into the payment for another service. Although Medicare makes capitated payments to MA plans, these capitated payments are not packaged payments "for another service," and so MA expenditures do not categorically fall within the exclusion described in Section 1191(d)(5).
[13] Social Security Act Sec. 1853(f).

the specified time period. CMS does not possess claims data for MA enrollees and therefore does not have precisely the same source of information. However, the agency has workable options to exercise the authority that Congress has delegated to it to "determin[e]" total expenditures[14] to define a methodology to compute expenditures attributable to MA enrollees.

Specifically, CMS receives detailed encounter data from MA plans, which provide information on the specific services received by MA enrollees. The encounter data do not include the dollar value of the payment from an MA plan to the health care provider that administered the service, but they do include robust information about the services received. For Part B drugs, this will include the amount of the drug administered and other information about the specific dosage and form and strength. CMS can rely on the encounter data to provide a complete and accurate picture of the units of a drug that have been administered at the NDC-11 level (and can generally determine when payment for the drug has been bundled with other services). The agency can use a straightforward approach to assign a dollar value to these encounters by applying the fee-for-service methodology for payment described at Section 1847A of the Social Security Act, i.e., payment at 106% of Average Sales Price (ASP).

This calculation represents a reasonably accurate measure of the likely payment from MA plans to providers for Part B drugs. Moreover, it is an *exact* measure of how funds flow from the Part B Federal Supplementary Medical Insurance Trust Fund to MA plans: the share of the capitated payment attributable to this trust fund is based on the actuarial value of Part B services, which is in turn reflective of the ASP-based methodology.[15] Therefore, it can appropriately be considered a measure of "expenditures under Part B" for MA plans, and this calculation can appropriately be added to fee-for-service claims data to compute total expenditures.

Of course, claims data and encounter data are provided to CMS on different timelines, with encounter data lagging behind claims data by a significant margin. Therefore, the agency may require more time to lapse between the period of measurement and the computation of total expenditures to have accurate information for Part B drugs provided to MA enrollees. Fortunately, the statute unambiguously provides flexibility to CMS to make such a timing adjustment. Specifically, throughout section 1192 of the IRA, Congress directs CMS to look to the "most recent period of 12 months... for which data are available." The statute notes parenthetically that this 12-month period must "end[] not *later* than October 31 of the year prior"[16] – but does not specify how early the 12-month period could end. Therefore, CMS can determine how much additional time is necessary for reliable encounter data to be available and begin and end the 12-month period accordingly. Alternatively, CMS can require submission of encounter data for Part B drugs on a more rapid timeline – a change which may also be important to best effectuate negotiated prices for providers – and select the 12-month period accordingly.

Conclusion

For Part B drugs, "total expenditures under Part B" should reflect Medicare spending on drugs provided to both fee-for-service Medicare beneficiaries and MA enrollees. This is important to avoid distortionary incentives and promote proper functioning of the IRA. Moreover, it is the best reading of the statute: when a health care provider is paid for administering a drug covered

[14] Social Security Act Sec. 1192(b)(1)(A), (d)(1)(B).
[15] 42 C.F.R. 422.322(a)(1).
[16] E.g. Social Security Act Sec. 1192(b)(1)(A).

under Part B to an MA enrollee, that is properly understood as an expenditure under Part B and there is no indication Congress intended to exclude such spending. CMS can compute these expenditures by using MA encounter data to determine utilization at the NDC-11 level, and assigning payment based on the fee-for-service ASP methodology. We encourage the agency to make this adjustment and are of course happy to discuss these issues at any time.

Sincerely,[17]

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June 25, 2025

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
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Dear Mr. Klomp,

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' initial guidance for the third cycle of the Medicare Drug Price Negotiation Program.

I serve as executive director of the Bayh-Dole Coalition, a group of innovation-oriented organizations and individuals committed to preserving and strengthening the landmark Bayh-Dole Act of 1980. This pivotal law gave research institutions, national laboratories, and small businesses the right to retain patents on discoveries made with the help of federal funding — a simple but profound reform that aligned private-sector incentives with the public interest and transformed America's innovation ecosystem.

Bayh-Dole is widely credited with creating the life science industry as we know it. It has led to the creation of more than 18,000 startups and the disclosure of over 500,000 new inventions, including over 200 drugs and vaccines. Before Bayh-Dole's passage, the United States trailed Europe and Japan in biomedical innovation; today, companies based in our country account for more than half of all global investment in biopharmaceutical R&D.

The Bayh-Dole Coalition was established to protect this remarkable innovation engine by safeguarding the spirit of public-private collaboration and the strong intellectual property rights that fuel it. While issues of drug affordability are typically beyond our scope, we feel compelled to comment in this instance because CMS's draft guidance threatens the very incentives that make the Bayh-Dole model so effective — and that have made America the world's hub for medical innovation.

We understand and support the goal of lowering out-of-pocket costs for seniors. But we are concerned that one provision in the guidance could have serious unintended consequences: the proposal to group improved versions of drugs — such as new formulations or delivery mechanisms — with previously negotiated reference products, even when the new drugs are protected by their own patents. Under this rule, a new therapy could be subject to a previously negotiated Maximum Fair Price immediately upon entering the market.

This approach would erode the core intellectual property protections that drive biomedical innovation. Startups license early-stage, federally funded discoveries with the understanding that if they succeed in developing and patenting a new product, they will be granted a period of market exclusivity that gives them a chance to earn a return on their investment.

However, if CMS subjects new drugs to existing price limits, the financial calculus of new drug development will change dramatically. Patent protections on any potential medicine that shares an active ingredient with a previously negotiated therapy will be treated as void by entrepreneurs and investors. Funding for these potential medicines will dry up, and startups will once again hesitate to license the fruits of publicly funded science.

Such a scenario would be devastating for both businesses and patients. As you know, drug development is a supremely risky enterprise, with roughly 90% of candidates that enter clinical trials ultimately failing. Additionally, despite Bayh-Dole's impact, it remains very difficult for federally funded researchers to find private-sector partners. Venture-backed startups, which are uniquely willing to tolerate the immense costs of research and development, therefore play an indispensable role in bringing medical breakthroughs to market.

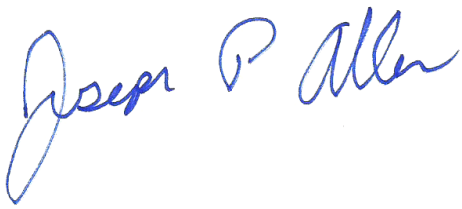
The United States is exceptional in the way small companies play a critical role in life sciences. Over half of U.S.-originated therapies approved by the FDA between 2011 and 2020 were developed by small companies. Meanwhile, nearly 75% of university licenses are granted to startups and small companies, alongside roughly 70% of NIH licenses.

By making the already-risky drug commercialization process even more unpredictable, the draft guidance would dissuade entrepreneurs from pursuing the creation of new therapies and groundbreaking improvements. It would undermine numerous existing startups and doom countless medical breakthroughs to languish on laboratory shelves, depriving patients of treatments that could have saved lives and alleviated suffering.

The guidance would also undermine America's global competitiveness at a moment when our leadership is being directly challenged — especially by China, which is investing heavily in biomedical innovation. To compete with foreign rivals, we will need to rely on the Bayh-Dole system and the decentralized model of innovation and entrepreneurship it supports. If we weaken the intellectual property incentives that undergird that model, we will put ourselves in serious danger of falling behind.

The Bayh-Dole Act made America the envy of the world in life sciences. That legacy is now at risk. We urge CMS to reconsider the implications of its proposed guidance — especially the provision grouping follow-on innovations under previously negotiated prices — and to preserve the market-based incentives that have made America the global leader in medicine.

Sincerely,



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June 26, 2025
VIA ELECTRONIC DELIVERY

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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RE: Medicare Drug Price Negotiation Program: Initial Memorandum, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 202, and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027 and 2028

INTRO TO COMMENTS:
The Biotechnology Innovation Organization (BIO) appreciates this opportunity to comment on the above-captioned draft guidance regarding the Drug Price Negotiation Program ("DPNP") under the Inflation Reduction Act of 2022 (IRA) issued by the Centers for Medicare & Medicaid Services (CMS or Agency) on May 12, 2025 (Draft Guidance).[1]

Our priorities regarding the Draft Guidance include the following:

- CMS should protect patient access to drugs selected for the DPNP and also take steps to minimize class effects and ensure against narrower formularies, increased use of utilization management, non-medical switching, and fail first requirements for both Part B and Part D drugs – all which present the risk of fewer choices for Medicare beneficiaries. CMS should describe in detail how they plan to conduct oversight of health plans to ensure compliance with the access protections required for the selected drugs and also protected class drugs. Stronger oversight is also needed in regard to patient access to Part B drugs in Medicare Advantage plans, particularly as Part B drugs will be subject to the DPNP for the first time with IPAY 2028.

- The Agency should protect access to orphan drugs by clarifying that, where an orphan drug loses eligibility for the orphan drug exclusion, the seven- or eleven-year qualifying single source drug (QSSD) clock runs from the date on which the drug lost eligibility for the exclusion. Orphan drugs with multiple, orphan-only indications for more than one rare disease should also qualify for the exemption.

- CMS should take steps to protect innovation and competition. The Agency should reconsider its current approach that identifies a QSSD by reference to common active moiety or ingredient.

[1] CMS, "Medicare Drug Price Negotiation Program: Initial Memorandum, 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), *available at* https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation.

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- Per the statute, a QSSD should be identified by reference to its unique NDA or BLA. Such an approach allows for ongoing research and development into new, unique uses for existing treatments. BIO also opposes any changes to its existing definition of fixed combination drugs. In addition, CMS should abandon its use of a "bona-fide" marketing standard. This created standard has no legal grounding and stands in the way of competitive markets and the introduction of biosimilars and generics to innovator products.

- The Agency should modify the guidance to protect access to Part B drugs and to minimize spillover effects into the commercial market. The guidance should clearly state that sales at the MFP are excluded from the calculation of ASP. In addition, policies should be considered to ensure sufficient provider reimbursement in Part B.

- The Agency should significantly streamline data submission requirements for manufacturers of selected drugs and incorporate additional processes to meaningfully incorporate the patient perspective, with a stronger emphasis on clinical benefit and unmet need over factors such as cost of production and research and development costs which are difficult to compare across companies and have no bearing on the value of a given therapy in clinical practice.

- CMS should promote beneficiary access to the MFP ("MFP effectuation") and prevent 340B duplicate discounts by facilitating accurate transactions between parties which will improve efficiency and minimize administrative burden, if not through the Medicare Transaction Facilitator (MTF), then through the use of an independent clearinghouse.

- The Agency should require pharmacies to participate in the MTF payment module (MTF-PM), as they are already required to participate in the MTF data module (MTF-DM). Part B providers should similarly be required to participate in the MTF to ensure that the MFP is effectuated properly in Part B.

- CMS must also address the significant operational challenges and technical requirements that still need to be clarified and provide a safe harbor for manufacturers' good faith effort to effectuate the MFP with an opportunity to correct.

Our more detailed comments follow.

Formulary Access (Section 80, 110): CMS must clarify and demonstrate how it will ensure robust beneficiary access to needed therapies, including selected drugs, and institute safeguards that ensure diversity across formularies to meet patient needs.

CMS should act to mitigate any way in which the MFP process results in narrower formularies and otherwise provides fewer choices to patients. In addition, CMS should monitor plan coverage and tiering design, clinical appropriateness of utilization management policies, cost-sharing levels, and patient out-of-pocket exposure. BIO encourages CMS to redouble its oversight of formulary requirements and to strengthen its policies regarding Part D coverage determinations and appeals as well as tiering

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exceptions. This is particularly crucial given the widespread and significant reductions in beneficiary access that has resulted since the passage of the IRA. One study that looked at changes in Part D formularies in branded drugs in competitive classes from 2024 to 2025 found that 81.3% of the drugs studied had a decline in coverage.[2] We appreciate the House Committee on Oversight and Government Reform's recent acknowledgment of these access concerns,[3] and encourage CMS to work with the Committee to protect formulary access to all selected drugs. CMS should also protect formulary access to MFP drugs within the six protected classes to ensure that those drugs are not penalized compared to non-MFP drugs within the protected classes.

Stronger oversight is also needed in regard to patient access to Part B drugs covered by Medicare Advantage plans, particularly as Part B drugs will be subject to the DPNP for the first time with IPAY 2028. A recent study should raise alarms about the access barriers Medicare beneficiaries face when they need medicines covered under Medicare Part B. Nearly all (94%) of physicians and providers surveyed said that step therapy requirements limit their ability to prescribe a Part B drug that they have deemed most clinically appropriate for their patients. Of further concern, 74% report that Medicare Advantage plan step therapy requirements for Part B drugs are not always aligned with clinical guidelines and best practices.[4] This is unconscionable. CMS should increase its oversight of the use of plan step therapy and take all necessary steps to stop practices that are inconsistent with clinical expertise.

<u>Qualifying Single Source Drugs (Section 30.1)</u>: BIO urges CMS to reconsider its approach to identifying a QSSD and its dosage forms and strengths by reference to common active moiety (drugs) or common active ingredient (biologics) and instead identify such a drug and its dosage forms and strengths by reference to unique New Drug Applications (NDAs) and Biologics License Applications (BLAs).[5] **CMS's current policy stifles ongoing biopharmaceutical research from small, mid-size, and larger companies into distinct new uses for existing drugs, many that would treat rare diseases or diseases with high unmet need. BIO also opposes any changes to its existing policy regarding fixed combination drugs.**

In the Draft Guidance, CMS proposes that—as it did in previous guidance—it will treat products as the same QSSD where, for drug products, they share the same active moiety or, for biological products, they share the same active ingredient, and the same manufacturer holds all applicable NDAs or BLAs.[6] This policy is irreconcilable with the statute and will ultimately discourage innovation to address unmet needs.

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[2] Patterson JA, Zheng H, Campbell JD. Impacts of the Inflation Reduction Act on 2025 Formulary Coverage in Medicare Part D Plans. Montreal, QC, Canada. Available at: https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session-2/impacts-of-the-inflation-reduction-act-on-2025-formulary-coverage-in-medicare-part-d-plans

[3] Comer Seeks Briefing on Biden Administration's Medicare Part D Redesign Over Concerns of Higher Drug Prices and Reduced Access. Press Release. June 18, 2025. https://oversight.house.gov/release/comer-seeks-briefing-on-biden-administrations-medicare-part-d-redesign-over-concerns-of-higher-drug-prices-and-reduced-access/

[4] https://advisory.avalerehealth.com/insights/white-paper-provider-survey-on-part-b-step-therapy-in-medicare-advantage

[5] For a discussion of the related and equally critical concern with CMS's "bona fide marketing" standard, please see the discussion below.

[6] Draft Guidance at 8.

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The statute requires products to be treated as the same QSSDs only where they share the same NDA or BLA. This necessarily follows from the plain text of section 1192(e)(1). The term "qualifying single source drug" is statutorily defined for products approved under an NDA by reference to whether seven years has elapsed since "such approval;"[7] likewise, the term is statutorily defined for products licensed under a BLA by reference to whether eleven years has elapsed since "such licensure."[8]

Congress's use of "such licensure" and "such approval" is intentional and unambiguous and must be given effect. Congress used this language to denote that a QSSD is determined by reference to a distinct approval or licensure—i.e., a distinct NDA or BLA. CMS has no authority to re-write the plain language of the statute by inventing an ultra vires policy of grouping together drugs based on their active moieties or active ingredients for the purposes of determining QSSDs. Where "Congress has been unambiguous, neither the Agency nor [a] court may diverge from that intent."[9]

Although the plain language of the statute is dispositive, BIO notes that other canon of statutory construction confirm Congress's unambiguous intent to distinguish QSSDs based on distinct NDAs or BLAs.[10] Of particular note, the statute defines "qualifying single source drug" by express reference to the Food, Drug, and Cosmetics Act (FDCA) and the Public Health Service Act (PHSA). It is well understood that a statute should be interpreted in the manner "most compatible with the surrounding body of law into which the provision must be integrated."[11]

CMS should therefore look to the well-established framework under the FDCA and PHSA for distinguishing among products. Under this framework, drug and biological products generally may be marketed only if approved or licensed by the Food and Drug Administration (FDA),[12] and manufacturers seeking such approvals or licensures must meet stringent requirements bearing on safety, effectiveness, and other considerations.[13] In implementing this framework, FDA has spoken directly to the circumstances under which a change to an existing product is so significant that it yields a new product warranting a new NDA or BLA, as well as the circumstances under which a change to an existing product is not.[14] It is manifestly reasonable and appropriate to rely on such FDA standards here, such that a

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[7] Social Security Act (SSA) § 1192(e)(1)(A).
[8] *Id.* § 1192(e)(1)(B).
[9] *Cabazon Band of Mission Indians v. Nat'l Indian Gaming Comm'n*, 827 F. Supp. 26, 29 (D.D.C. 1993), *aff'd*, 14 F.3d 633 (D.C. Cir. 1994). In addition, with respect to a Medicare Part D drug, a QSSD is statutorily limited to a product that is a "covered Part D drug." SSA § 1192(e)(1). In turn, a "covered Part D drug" is statutorily defined in relevant part by cross-reference to section 1927(k)(2). *Id.* § 1860D-2(e)(1). And, like section 1192(e)(1), section 1927(k)(2) distinguishes among products by reference to approvals or licensures. *See also* SSA § 1104 ("The right to alter, amend, or repeal any provision of this Act is hereby reserved to the Congress.").
[10] *See Chevron v. Nat'l Res. Def. Council*, 467 US 837, 843 n.9 (1984) (in addition to the plain text, the traditional tools of statutory construction are used to ascertain the intent of Congress).
[11] *Green v. Bock Laundry Machine Co.*, 490 U.S. 504, 528 (1989) (Scalia, J., concurring); *cf. Erlenbaugh v. United States*, 409 U.S. 239, 243–44 (1972) (under the rule of *in pari materia*, it is generally "assume[d] that whenever Congress passes a new statute, it acts aware of all previous statutes on the same subject").
[12] 21 U.S.C. § 355(a); 42 U.S.C. § 262(a)(1)(A).
[13] 21 U.S.C. § 355(c), (d); 21 C.F.R. §§ 314.105, 314.125 (NDA requirements); 42 U.S.C. § 262(a)(2)(C); 21 C.F.R. §§ 601.2(a), 601.4(a) (BLA requirements).
[14] FDA, Guidance for Industry: Submitting Separate Marketing Applications and Clinical Data for Purposes of Assessing User Fees (Dec. 2004), *available at* https://www.fda.gov/media/72397/download. For example, a new active ingredient (e.g., a different salt, ester, or complex of an

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product approved or licensed under a new NDA or BLA is a distinct QSSD.

Finally, while CMS purports to justify its broad QSSD definition on the IRA's "use of data" provision, that reliance is misplaced. Specifically, with respect to a QSSD, the statute requires CMS to aggregate Medicare expenditures "us[ing] data that is aggregated across dosage forms and strengths of the drug, including new formulations of the drug, such as an extended release formulation, and not based on the specific formulation or package size or package type of the drug."[15] As a threshold matter, we note that this policy is applied *after* the identification of QSSDs, namely to identify negotiation-eligible drugs based on their total expenditures. Moreover, contrary to statements made in the Draft Guidance, the identification of a QSSD by reference to its NDA or BLA can be reconciled with this text. In particular, because a single NDA or BLA can include multiple dosage forms and strengths, CMS would still be able to aggregate spend across all dosage forms and strengths approved under a given NDA or BLA.

There would be immeasurable policy benefits to giving effect to the statute as written and, as Congress intended, adopting FDA's application-based framework for distinguishing among products (as opposed to maintaining CMS's wholly invented, statutorily unmoored scheme for doing so). First, and most critically, doing so would avoid exacerbating the disincentive to develop next-generation therapies inherent in the DPNP to the point of suffocating all such innovation, to the detriment of patients in need. The sheer breadth of CMS's "qualifying single source drug" definition—which amalgamates drug products by common active moiety and biological products by common active ingredient—is already negatively impacting real-world drug development compared to the pre-IRA policy landscape. In a study published by Avalere, researchers explored six case studies of different products approved for chronic disease, rare disease, or cancer, finding that the risk of selection shifts manufacturer evaluations on whether to continue research and investments into those products.[16] Other studies have found that following the IRA's passage, there has been immediate and ongoing reductions in industry-sponsored trials, whereby the average monthly number of industry-sponsored trials on post-approval drugs decreased by 38.4%.[17] This subsequent shift in investment strategies has significant implications for patient access to new treatments and affects all patient populations, including those with rare, serious conditions and/or unmet need. It is evident that CMS' "qualifying single source drug" definition leaves no incentive for therapeutic advancement of existing products and will continue to have significant, negative impacts on innovation for years to come.

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approved moiety) should be approved under a new application. *Id.* at 3. In contrast, a new strength generally should be approved under a supplement. *Id.* at 4. The same is true for a new container size or package type of the same indication and route of administration. *Id.* Certain changes in dosage form and route of administration should be approved under a supplement, but others should be approved under a new application. *Id.* at 3.

[15] *Id.* § 1192(d)(3)(B). *See also* § 1196(a)(2) (directing CMS to "establish[] . . . procedures to compute and apply the maximum fair prices across different strengths and dosage forms of [the] drug and not based on the specific formulation or package size or package type of such drug.").

[16] "An Assessment of Regulatory Interpretation of Qualifying Single Source Drugs in Medicare Negotiation." Avalere. April 22, 2024.

[17] Zheng, H, Patterson, JA, Campbell, JD. The Inflation Reduction Act and Drug Development: Potential Early Signals of Impact on Post-Approval Clinical Trials. Ther Innov Regul Sci. 2025. https://link.springer.com/article/10.1007/s43441-025-00774-2

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Biopharmaceutical innovation is incremental, relying on sustained and continuous improvements to molecules, pathways, and modes of administration to achieve maximum clinical benefit for patients. Researchers often cannot take significant leaps, and generally develop new active moieties or active ingredients with each generation of treatment, or develop advances in how to leverage newly discovered properties of known active moieties or active ingredients from improved efficacy and/or safety. In virology, for instance, unmet need may be described in terms of treatment experience - for example, patients who have a strain of virus that has evolved resistance to certain drugs. Certain combinations have been developed, and new combinations will need to be developed, to meet patient needs for complete regimens that are effective against the strains of virus that exhibit resistance against certain drugs. In some cases, there can be synergistic potential among co-formulated components of a complete regimen to achieve treatment goals. For example, further research and development on known active moieties/ingredients in new combinations can deliver innovation based on new understandings in pharmacokinetics, improving efficacy and/or safety.

By combining drugs at the active moiety or active ingredient level, CMS is harming investments into new therapies, including for orphan and other hard-to-treat diseases. A recent study by the National Pharmaceutical Council found that following the passage of the IRA, the percentage of drugs with a first orphan designation that later received a second orphan designation decreased by 48%.[18] For the sake of pharmaceutical and biotechnology innovation, and patient access to needed therapies, CMS's current framework cannot stand.

An alternative, application-based framework would not only help preserve incentives for continued innovation of active moieties/active ingredients, it would also create an easily administrable bright line rule based on a familiar standard, to the benefit of both CMS and manufacturers. A bright line rule would enable CMS to more readily identify relevant dosage forms and strengths for purposes of aggregating Medicare expenditures and applying the MFP.[19] And a bright line rule would enable manufacturers to more confidently track the seven- or eleven-year "qualifying single source drug" clock and thereby make more informed decisions about research and development.

For these reasons, BIO strenuously disagrees with CMS's approach to identifying a QSSD by reference to common active moiety (drugs) or common active ingredient (biologics). Both law and policy dictate that a QSSD be identified by reference to its NDA or BLA.

It is imperative that CMS abandon the approach set forth in the Draft Guidance—under which Medicare expenditures are aggregated, and the MFP is applied, across dosage forms and strengths of products that share the same active moiety (drugs) or the same active ingredient (biologics)—and instead specify that, for purposes of aggregation of Medicare expenditures and application of the MFP, dosage forms and strengths are also identified by reference to the NDA or BLA of the QSSD, consistent with the

[18] Early Signals of the IRA on Orphan Drugs. National Pharmaceutical Council Policy & Evidence Brief. 2025:05. Available at: https://www.npcnow.org/resources/early-signals-ira-orphan-drugs
[19] *See* SSA §§ 1192(d)(3)(B), 1196(a)(2).

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requirements of the statute.[20] Moreover, as set forth above, as a QSSD must be identified by reference to its NDA or BLA; it necessarily follows that the dosage forms and strengths of such a drug also must be identified by reference to the NDA or BLA of the drug.[21]

Finally, in the Draft Guidance, CMS states that it is considering an exception to its existing policy regarding fixed combination drugs "for which one of the active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference." BIO opposes any changes to its existing policy regarding fixed combination drugs as there is no statutory basis for CMS' proposed approach and therefore this proposal would result in an inappropriate expansion of the definition of a QSSD. CMS' proposed approach is also inconsistent with current FDA regulations. If the FDA has deemed a drug a fixed dose combination drug, it should be treated as such across agencies. Of further concern, CMS provides no insight into how it would actually attempt to make a determination of a "clinically meaningful difference," but any such assessment would be squarely within the purview of the FDA. We also do not believe CMS has the legal authority nor necessary expertise to make such a determination, as supported by CMS' position in the IPAY 2026 and IPAY 2027 guidance, where no such determination was considered, and the fact that there have been no changes in law that would then allow CMS to revise its treatment of fixed combination products. For all of these reasons, we urge CMS not to finalize any changes to its approach for fixed combination drugs.

Qualifying Single Source Drugs (Section 30.1) – Exclusion of Part B Vaccines

BIO urges CMS to exercise its discretion to exclude Part B vaccines from the Medicare Drug Price Negotiation Program (DPNP). There are ambiguities in the statutory text of the Inflation Reduction Act (IRA) that indicate that Congress did not intend for the DPNP to apply to Part B vaccines. CMS also has discretion to exclude influenza vaccines from the DPNP because influenza vaccines do not meet the agency's definition of a "qualifying single source drug" (QSSD). BIO therefore also urges CMS to further clarify that influenza vaccines do not meet the QSSD definition and are therefore excluded from the DPNP.

Two separate sections of the IRA – the section on maximum fair price (MFP) ceiling calculations for negotiated drugs in Part B and the section on biosimilar rebate calculations –refer to section 1847A(b) as the basis for determining key implementation provisions of the DPNP in Part B. However, the statutory reference to 1847A(b)(4) is not applicable for Part B vaccines because they are reimbursed under section

[20] Regardless of the "qualifying single source drug" definition adopted by the Agency, CMS must consistently apply such definition. As such, if CMS were to maintain that products that share the same active moiety (drugs) or the same active ingredient (biologics) are the same QSSD, BIO agrees that the market entry of a generic or biosimilar to any such product would disqualify all such products from treatment as a QSSD. *See* Initial Guidance at 10. Any other approach would be irreconcilable with CMS's stated "qualifying single source drug" definition. *See, e.g.*, *Nat'l Credit Union Admin. v. First Nat. Bank & Tr. Co.*, 522 U.S. 479, 501–02 (1998) (a basic canon of interpretation is that similar or identical language "be accorded a consistent meaning").

[21] The references to "formulations" in the statutory text do not change the analysis. In context, such formulations are plainly limited to formulations of the dosage forms and strengths of the QSSD. *See, e.g.,* A. Scalia & B. Garner, *Reading law: The interpretation of Legal texts* 199, 203-132–33 (2012) ("[T]he verb to include introduces examples, not an exhaustive list."). We note that formulations of dosage forms and strengths may be approved under the same NDA or BLA. *See* FDA, Guidance for Industry: Submitting Separate Marketing Applications and Clinical Data for Purposes of Assessing User Fees 3–4.

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1842(o)(1)(A)(iv). Under section 1847A(b)(4), reimbursement is based on Average Sales Price (ASP) or Wholesale Acquisition Cost (WAC), but under section 1842(o)(1)(A)(iv), reimbursement is based on Average Wholesale Price (AWP). While the IRA alters the payment rate for Part B drugs from ASP+6% to MFP+6%, it is significant that Congress did not amend the long-standing reimbursement rate for Part B vaccines as determined under section 1842(o)(1)(A)(iv). Moreover, because Part B reimbursement is based on AWP and vaccines are already subject to $0 cost sharing, negotiating Part B vaccines as part of DPNP would not result in any financial benefit to CMS nor its Medicare beneficiaries – the very policy aim of the DPNP. Collectively, these facts indicate that that Congress did not intend for Part B vaccines to be included in the DPNP.

As noted above, the first instance of statutory language ambiguity relates to the calculation of the maximum fair price ceiling for negotiated drugs under the IRA (Social Security Act § 1194(c) and section 60 of IPAY 2028 Draft Guidance). Under the IRA, the MFP ceiling sets the limit on the amount CMS can offer or accept with respect to the MFP for negotiated drugs.

For selected Part B drugs, the ceiling is set at the lowest of: (1) "the payment made under section 1847A(b)(4) for the drug or biological product" for the year before the selection; (2) the "applicable percentage" of the average non-Federal average manufacturer (non-FAMP) price for 2021, increased by an inflation factor; or (3) the "applicable percentage" of the average non-FAMP for the year before the selection year. The statute's reliance on Section 1847A(b)(4) of the Act is reiterated and recognized in the IPAY 2028 Draft Guidance such as Section 60.2 on negotiation of the maximum fair price. Because the first method to calculate the price ceiling relies on payment made under section 1847A(b)(4) and Part B vaccines are not reimbursed using the methodology described under 1847A(b)(4), there is no way for CMS to apply this three-part price ceiling formula established by Congress to Part B vaccines.

The second instance of statutory ambiguity relates to the calculation of biosimilar rebate calculations (Social Security Act § 1192(f) and section 30.3.1 of IPAY 2028 Draft Guidance). Eligibility for selection for the negotiation program depends, in part, on whether a generic or biosimilar product has come to market at the time of selection.

Under the IRA, selection for negotiation may be delayed for a biological if a competing biosimilar is highly likely to come to market within two years. However, if the biosimilar does not come to market within two years, the manufacturer is required to pay rebates for each quarter of delay. IRA directs that the calculation of the rebate for affected biosimilars relies on the payment methodology in 1847A(b), which does not apply to Part B vaccines.

Specifically, IRA states that the rebate amount for Part B biologicals is "the sum of the products of"; (1) "80 percent of the amount by which" the reimbursement for the biological "under section 1847A(b), with respect to each of the calendar quarters of the price applicability period that would have applied but for" the delay "exceeds" the (delayed) maximum fair price; and (2) the number of separately

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reimbursable units of the biological "administered or furnished" during the relevant period. Therefore, if a Part B vaccine for which selection for negotiation were delayed in anticipation of the launch of a competing biosimilar, and if the biosimilar did not launch within the two-year window, there would be no way to determine the amount of rebate owed by the manufacturer because Part B vaccines are not reimbursed under Section 1847A(b).

In addition to CMS' authority to exclude all Part B vaccines from DPNP based on ambiguities in IRA's statutory text, CMS has discretion to exclude influenza vaccines from the DPNP because influenza vaccines do not meet the agency's definition of a "qualifying single source drug" (QSSD). Section 30.1 of this Draft Guidance, consistent with prior years (IPAY 2026, 2027), establishes that each distinct combination of active ingredients in a biological product is treated as a separate potential QSSD. In response to comments on its 2027 Guidance, CMS acknowledged that these rules apply equally to vaccines and other products. For seasonal influenza vaccines, the active ingredients are the strain antigens, which vary annually as the strain changes each season. Under section 1192(e) of the Social Security Act, a QSSD must be at least 11 years post-licensure without serving as a reference product for any biosimilar. Given that influenza vaccines change their strain composition regularly, no single formulation remains unchanged for the required 11-year period post-licensure. Therefore, influenza vaccines do not meet the definition for QSSD designation, and CMS retains full discretion to exclude them from the negotiation program.

BIO encourages CMS to clearly exclude Part B vaccines from the scope of price negotiations in its implementation of the IPAY 2028 guidance based on the statutory ambiguities related to DPNP's applicability to Part B vaccines and the further definitional limitations of QSSD for influenza vaccines.

<u>Orphan Drug Exclusion (Section 30.1.1)</u>: BIO urges CMS to clarify the scope of the orphan drug exclusion in a manner that maximizes protections for orphan drugs. **Specifically, CMS should clarify that, where an orphan drug loses eligibility for the orphan drug exclusion, the seven- or eleven-year "qualifying single source drug" clock runs from *the date on which the drug lost eligibility for the exclusion***. **CMS should also enable manufacturers to submit evidence that an indication aligns with an orphan drug designation to account for situations where CMS is unable to determine eligibility for the orphan drug exclusion based on a review of FDA's orphan drug databases**.

By definition, orphan drugs target diseases affecting less than 200,000 people in the United States.[22] As such, such drugs are particularly susceptible to the chilling effect of factors that discourage research and development. On average, the development of a single drug takes anywhere from ten to fifteen years and costs upwards of $2.6 billion in research and development[23]—and the development of an orphan drug, often takes even longer and costs even more. Limited patient populations make it inherently more challenging for the developers of orphan drugs to recoup this investment, especially because orphan

[22] 21 C.F.R. § 316.10(d)(8)(ii).
[23] T. Sullivan, A Tough Road: Cost to Develop One New Drug Is $2.6 Billion, Policy & Med., https://www.policymed.com/2014/12/a-tough-road-cost-to-develop-one-new-drug-is-26-billion-approval-rate-for-drugs-entering-clinical-de.html (Mar. 21 2019).

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drug developers are overwhelmingly small emerging companies: Start-ups and emerging biotechnology companies are responsible for fully 85% of all orphan-designated products in development.[24]

It is vitally important that CMS take special steps to protect development of and access to orphan drugs. The stakes could not be higher for patients. There are over 10,000 known rare diseases, and approximately thirty new ones are identified each year.[25] While each rare disease affects only a relatively small number of patients, collectively, over thirty million Americans are affected by a rare disease, with an estimated cost to society in excess of $1 trillion annually.[26] Further, 95% of rare diseases currently have no approved medical treatment.[27] According to a 2020 IQVIA/National Organization for Rare Diseases report examining trends in rare disease innovation, "there are [only] 447 drugs with orphan-only indications, with 104 drugs approved for two or more orphan indications."[28] As such, there is a pressing need to maintain strong incentives for continuing orphan drug development.

Clarifying that the seven- or eleven-year clock starts on the date a drug loses eligibility for the orphan exclusion would help maximize protection for orphan drugs in a manner consistent with the statutory framework. Absent such clarification, an orphan drug that loses eligibility for the orphan drug exclusion could be virtually immediately subject to selection for negotiation, simply because it was designated as an orphan drug for a second rare disease or condition or because an indication was approved for a second rare disease or condition, negating the application of the exclusion in the first place. CMS's implementation of the orphan drug exclusion would thereby disincentivize progress in rare disease drug development, which is often predicated upon identification of promising new uses of existing therapies.

The study by the National Pharmaceutical Council described above also examined how the orphan drug exclusion affected ongoing clinical research, finding that, of the 64 orphan-designated oncology drugs initially approved by the FDA from 2008 to 2018, two-thirds or 66% would have been disqualified from the orphan drug exclusion due to a second orphan designation.[29] CMS should act to avoid these devastating consequences for orphan drug development which would circumvent the clear intent of Congress to establish the orphan drug exclusion as an exception to the QSSD definition. Indeed, our interpretation of the statute is that, for so long as a drug qualifies for the orphan drug exclusion, the product is entirely exempt from the QSSD definition and all of its sub-elements. Thus, the 7- or 11-year "pre-negotiation" period that would otherwise apply to a QSSD is tolled until the first day after the

[24] D. Thomas & C. Wessel, *2019 Emerging Therapeutic Company Trend Report, BIO Industry Analysis* 40 (2019), *available at* http://go.bio.org/rs/490-EHZ-999/images/BIO%202019%20Emerging%20Company%20Trend%20Report.pdf.
[25] Smith CIE, Bergman P, Hagey DW. Estimating the number of diseases - the concept of rare, ultra-rare, and hyper-rare. iScience. 2022 Jul 1;25(8):104698.
[26] S. Garrison, et al., *The Economic Burden of Rare Diseases: Quantifying the Sizeable Collective Burden and Offering Solutions*, Health Affairs Forefront, https://www.healthaffairs.org/do/10.1377/forefront.20220128.987667/ (Feb. 1, 2022).
[27] Nat'l Insts. of Health, *Delivering Hope for Rare Diseases* 1 (Jan. 2022), *available at* https://ncats.nih.gov/files/NCATS_RareDiseasesFactSheet.pdf.
[28] IQVIA, *Orphan Drugs in the United States* 7 (Dec. 2020), *available at* https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/orphan-drugs-in-the-united-states-rare-disease-innovation-and-cost-trends-through-2019/orphan-drugs-in-the-united-states.pdf.
[29] Motyka J, Patterson J, Salih R, Campbell J. Orphan oncology drug development: implications for the Inflation Reduction Act's Orphan Drug Exclusion. Houston, TX. Available at: https://www.jmcp.org/doi/epdf/10.18553/jmcp.2025.31.3-a.s1

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orphan drug no longer qualifies for the orphan drug exclusion.[30] Any other interpretation would contradict the intent of excluding eligible drugs from the QSSD definition and negatively impact on drug development decisions for rare disease treatments.

In addition, CMS should create a process that enables manufacturers to provide evidence that an indication falls within an orphan drug designation, where such fact is not ascertainable from FDA databases alone. In many cases, CMS will be able to readily determine whether a drug meets such criteria using publicly available information. This is because FDA maintains various databases containing relevant information.[31] But there are situations where an approved indication falls within the scope of an orphan drug designation but there is no corresponding grant of orphan exclusivity.[32] In such situations, CMS cannot rely on FDA's databases, because those databases principally track orphan exclusivity, rather than orphan drug designation.[33] CMS has stated it will "consult with" FDA as needed; but we believe such discretionary consultation is insufficient. In particular, CMS should clarify that acceptable evidence that an indication falls within an orphan drug designation could include written communication with FDA, whether pre- or post-approval and other sources of data provided by the manufacturer.

Implementing the above recommendations is necessary to mitigate the risk that the DPNP will deter the development of orphan drugs to treat those suffering from rare diseases. It is also fully consistent with long-standing Congressional policy favoring protection of orphan drugs. Such policy dates back to the early 1980s, when Congress enacted the Orphan Drug Act of 1983 to create various incentives to encourage and facilitate the development of new orphan drugs.[34] In keeping with Congress's long-held policy of protecting orphan drugs, CMS should make every effort to ensure that it does not hamper orphan drug innovation as it implements the DPNP and its orphan drug exclusion.

<u>Small Biotech Exception (Section 30.2.1)</u>: BIO continues to urge CMS to establish a dispute resolution process in implementing the small biotech exception.

We appreciate the ongoing engagement with the Agency regarding the process for applying for and receiving the small biotech exception. This exception provides critical protection and recognizes that small biotech manufacturers with a single product that represents much of their Medicare revenue would be disproportionately impacted by the DPNP, which could have an immediate impact on the ability of such manufacturers to invest in future research and development—in particular, in areas that predominantly affect the Medicare population.

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[30] See SSA § 1192(e)(3)(A) ("Exclusions.—In this part, the term [QSSD] does not include any of the following…(A) Certain Orphan Drugs.")
[31] Such databases include FDA's orphan drug designation/exclusivity database, the drugs@FDA database, and the Approved Drug Products with Therapeutic Equivalence Evaluations publication (Orange Book).
[32] There are various circumstances where this can arise. For instance, it can occur in certain circumstances where an orphan drug is approved for the same indication as a previously approved drug, but is not clinically superior to the previously approved drug. In such circumstances, although the indication falls within the scope of the orphan designation, it does not qualify for orphan exclusivity.
[33] Orphan exclusivity is, in itself, irrelevant for purposes of the orphan drug exclusion. The orphan drug exclusion is unambiguously based on whether all indications of a drug with a single orphan drug designation fall within the scope of that designation. It is therefore immaterial whether the drug also has (or had) orphan exclusivity.
[34] *See* Orphan Drug Act, Pub. L. No. 97-414, §§ 1, 2, 96 Stat. 2049, 2049–51 (1983), *as amended by* Pub. L. 98-551, 98 Stat. 2815, 2817 (1984).

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Unfortunately, the small biotech exception, as it exists today, is time-limited. It is focused on protecting products that received approval in the prior decade, not companies which have launched products in more recent years. We trust that CMS and the Administration can work with Congress to continue the exception, so that it applies to small biotech companies who are making investments in future products now and are at the forefront of developing new treatments needed by both Medicare beneficiaries and other patient populations.

We also continue to urge the Agency to establish a dispute resolution process under which a manufacturer can respond to and appeal a negative determination by CMS—similar to the process that has been instituted for the specified small manufacturer phase-in under the Medicare Part D Manufacturer Discount Program. Specifically, the small biotech manufacturer should have the opportunity to provide additional data or other information to the Agency to support its application for the small biotech exception.

We also continue to urge CMS to be flexible in its implementation of the exception, particularly given the small number of companies that are eligible. For example, if CMS determines that information submitted by the small biotech manufacturer is incomplete or unclear, we urge CMS to engage in a dialogue with the manufacturer to resolve any outstanding issues. We appreciate the Agency's consideration of these recommendations, which would help mitigate uncertainty for small biotech companies.

Selection of Drugs for IPAY 2028 (Section 30.3): BIO continues to recommend that, well in advance of the selected drug publication date, CMS should notify each manufacturer of each drug that it intends to select for the DPNP and afford each such manufacturer a reasonable opportunity to dispute the propriety of each such intended selection.

The process for selecting a drug for the DPNP is complex. Eligibility for selection is based on multiple factors, including—for instance—whether a sufficient number of years have elapsed since approval or licensure;[35] whether a generic or biosimilar has come to market;[36] whether the drug is eligible for the orphan drug exclusion;[37] whether the drug is a plasma-derived product;[38] whether the drug is a small biotech drug;[39] whether Medicare expenditures are sufficiently low to disqualify the drug from selection;[40] and whether Medicare expenditures are sufficiently high relative to other products to qualify the drug for selection.[41] Many of these determinations rely on data only CMS has and based on determinations that involve at least some degree of CMS discretion. It is thus very difficult to predict with precision whether a given drug will appear on the selected drug list for a given IPAY. Moreover,

[35] SSA § 1192(e)(1).
[36] *Id.*
[37] *Id.* § 1192(e)(3)(A).
[38] *Id.* § 1192(e)(3)(C).
[39] *Id.* § 1192(d)(2).
[40] *Id.* § 1192(e)(3)(B).
[41] *Id.* § 1192(d)(1).

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once a drug is selected, the manufacturer of the selected drug is required to generate a significant amount of information in a short period of time, which must be certified as to its accuracy and completeness.

The intricate nature of the selection process presents an inherent risk of a selection error. Notably, if a selection error were identified after the selected drug publication date, CMS would de-select the erroneously selected drug but could not select a substitute. By statute, for a given IPAY, starting with IPAY 2027, all drugs must be selected by February 1 of the year that is two years before the IPAY.[42]

CMS can readily mitigate this concern by adopting a process for soliciting feedback from manufacturers of potential selected drugs before the selected drug publication date. We strongly support CMS' proposal to publish the list of 50 negotiation-eligible drugs with the highest total gross covered prescription drug costs under Medicare Part D, which will help manufacturers of these negotiation-eligible drugs to prepare for selection in future IPAYs. We encourage CMS to make Medicare expenditure data it is using in its identification of negotiation-eligible drugs publicly available for the selection years, as the data in the Medicare spending dashboards is the only data that is currently publicly available (but we also understand is *not* the source for CMS' determination of negotiation-eligible drugs).

With respect to the 15 (for IPAY 2028) or 20 (for future IPAYs) drugs CMS has identified to be highest spend and therefore "selected drugs," CMS should then provide notice to each such manufacturer at least thirty days in advance of the selected drug publication date. CMS should afford the manufacturer at least fourteen days to identify to the Agency any basis on which the manufacturer believes the drug is not, in fact, eligible for selection. Such a pre-selection process would serve an important role in identifying selection errors and further the Agency's interests in transparency, efficiency, and informed decision-making.

In addition to providing advance notice to each manufacturer of a drug that the Agency intends to select for negotiation, CMS should provide advance notice to each manufacturer of at least each of the next five drugs that would be selected if one or more drugs that the Agency intends to select were found to be ineligible for selection. Doing so would promote efficiency and fairness by giving each such manufacturer the same opportunity to engage with the Agency regarding potential selection errors.

In addition, in advance of the deadline by which a biosimilar manufacturer must request a delay in the selection of a reference biologic for negotiation, CMS should enable such biosimilar manufacturer to ascertain whether the reference biologic is among the drugs that the Agency intends to select (or one of at least the next five drugs in line for selection). This would reduce the burden on biosimilar manufacturers as well as the Agency by eliminating the submission of biosimilar delay applications that prove to be unnecessary.

[42] *Id.* §§ 1192(e), 1192(a); *see also id.* § 1191(d)(1) (September 1, 2023, for IPAY 2026).

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Delayed Selection and Anticipated Biosimilar Entry (Sec. 30.3.1): CMS should improve the methodology for making a "high likelihood" determination to improve accuracy. CMS should also provide a process to provide notice to biosimilar manufacturers of CMS's initial determination with a an opportunity to raise disputes.

An accurate "high likelihood" determination reduces administrative burden. If CMS makes an erroneous determination based on outdated or incomplete information, the Agency will be required to administer the payment of a rebate by the reference biologic manufacturer. To ensure that CMS adjudicates a delay request based on the most current information possible, for the first year of a delay request, CMS should (1) set the delay request submission deadline as close as reasonably possible to the selected drug publication date and (2) permit broad supplementation of a timely request with late-breaking information or otherwise for good cause. Information bearing on the expected timing of licensure and marketing often rapidly changes. The expected timing of market entry can fluctuate based on a range of factors, including FDA communications regarding the BLA and changes to the manufacturer's production or distribution arrangements. In order for CMS to make an informed determination regarding eligibility for delayed selection, it is vitally important that the Agency rely on the most recently available information that bears on the likelihood of market entry within the requisite time period.

CMS should provide notice of its delay request determination in advance of the selected drug publication date and establish a dispute resolution process. The Agency should provide preliminary notice of an unsuccessful delay request in advance of the selected drug publication date and establish a process by which the biosimilar manufacturer can dispute an erroneous determination. The Agency should also inform the reference manufacturer that a biosimilar pause review has been triggered.

CMS should also accept and consider all information that the biosimilar manufacturer determines relevant to determining eligibility for delayed selection.[43] As noted above, there are countless factors that can affect the expected timing of licensure. It follows that CMS should not artificially limit the information that it considers in determining eligibility for delayed selection. Accordingly, it is vital that CMS enable the biosimilar manufacturer—the party closest to the information—to submit all information that it determines relevant to the initial year delay request.
There is clear statutory authority to enable the biosimilar manufacturer to submit such information. The statute provides that the biosimilar manufacturer must submit "information and documents necessary for [CMS] to make [the delayed selection determination], as specified by [CMS] . . . ."[44] In addition, the statute provides that, after CMS has reviewed the delay request, the biosimilar manufacturer must submit "any additional information and documents requested by [CMS] necessary to make [the delayed

[43] *See* SSA § 1192(f)(1)(B)(ii)(I)(aa) ("information and documents necessary for the Secretary to make determinations under this subsection, as specified by the Secretary"), (II) ("additional information and documents requested by the Secretary necessary to make determinations under this subsection").
[44] SSA § 1192(f)(1)(B)(ii)(II). The statute goes on to specify that such information "includ[es]" the information specified in section 1192(f)(1)(B)(ii)(III). *Id.*

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selection determination]."[45] CMS therefore has discretion to consider a broad range of information in support of the initial year delay request. The Agency should exercise such discretion and request submission of all relevant information as determined by the biosimilar manufacturer. Doing so would help ensure that CMS has the most pertinent information, as the biosimilar manufacturer is the entity best situated to identify the information that bears on the initial year delay request.

Notably, CMS also has clear legal authority to consider all such information submitted in the request in making a "high likelihood" determination, as the Agency itself has indicated in its assertion that it may consider additional information to administer or monitor compliance with the DPNP. Section 1192(f)(3) sets forth a set of circumstances under which CMS must find a high likelihood of timely market entry—based on a limited set of enumerated information and documents, including information and documents described in section 1192(f)(1)(B)(ii)(III) (subclause (III)).[46] Critically, section 1192(f)(3) cannot be interpreted to set forth the only set of circumstances under which CMS may find a high likelihood of timely market entry. The broader structure of section 1192(f) makes clear that Congress intended that the full range of relevant information and documents be considered by CMS, not only the limited set of information and documents enumerated in section 1192(f)(3). This is because section 1192(f)(1)(B)(ii)(I)(aa) (subclause (I)(aa)) clearly requires the biosimilar manufacturer to submit information and documents necessary to rendering the "high likelihood" determination—"includ[ing]" (but not limited to) the information and documents described in subclause (III).

The necessary implication is that there is information and documents—beyond the information and documents described in subclause (III)—which are also "necessary" to rendering the "high likelihood" determination in the initial year request. While the information and documents described in subclause (III) are accounted for in section 1192(f)(3), the remaining information and documents described in subclause (I)(aa) are not—despite being "necessary" to rendering the "high likelihood" determination. Thus, if section 1192(f)(3) were the only set of circumstances under which CMS may find a high likelihood of timely market entry, the language in subclause (I)(aa) requiring broad submission of pertinent information and documents beyond those in subclause (III) would be rendered a nullity.[47] Because the information and documents described in subclause (I)(aa) serve no other statutory purpose, the only way to give meaning to the entirety of subclause (I)(aa) is to assign it its most natural meaning: Information and documents described in subclause (I)(aa) are "necessary" to rendering the "high likelihood" determination and, thus, CMS may consider all such information and documents submitted in rendering such determination. Accordingly, section 1192(f)(3) does not set forth the set forth the only set of circumstances under which CMS may find a high likelihood of timely market entry.

There is every reason to think that Congress intended for CMS to consider all relevant evidence in rendering the "high likelihood" determination. Any other interpretation of the statute would yield an absurd result. Through subclause (I)(aa), Congress clearly granted CMS broad discretion to consider

[45] *Id.* § 1192(f)(1)(B)(ii)(II).
[46] *Id.* § 1192(f)(3).
[47] *See Duncan v. Walker*, 533 U.S. 167, 175 (2001) (a statute is not to be interpreted in a manner that renders any provision a nullity or otherwise meaningless).

information and documents "necessary" to rendering the determination. If CMS were to refuse to consider such information, it would be tantamount to the Agency acknowledging that it is rendering the determination without considering information and documents that the Agency itself has concluded is essential to doing so. It is hard to imagine more arbitrary and capricious governmental decision-making.[48] Accordingly, CMS should request all information that a biosimilar manufacturer concludes supports a "high likelihood" determination and consider all such information in rendering such determination.

Regarding second year delay requests, we encourage CMS to consider how to reduce burden on biosimilar manufacturers by requiring submissions only when new information or evidence is available. Further, there are instances that CMS should recognize that presumptively support the clear and convincing evidence standard for a second year of delay. For example, CMS could make a determination that a biosimilar manufacturer that meets the following requirements satisfies the test for a second year of delay. Specifically, if the BLA for the biosimilar was pending review during the first year of delay, any of the following could suffice:

- FDA has since approved the BLA for the biosimilar; *or*
- The first cycle of review remains ongoing, i.e., FDA's BsUFA date has not yet occurred; *or*
- FDA has issued a complete response letter to the biosimilar manufacturer denying the BLA for the biosimilar but, as of the time CMS is assessing eligibility for a second year of delay, the biosimilar manufacturer has resubmitted the BLA for the biosimilar; *or*
- The biosimilar manufacturer's disclosures to investors or filings with SEC, such as Forms 10-K or 10-Q, indicate that it plans to market the biosimilar within the requisite time frame; *or*
- The manufacturing schedule for the biosimilar submitted to FDA indicates that commercial lots of the biosimilar are expected to be produced within the requisite time frame; *or*
- Agreements filed with FTC or DOJ do not bar the biosimilar manufacturer from marketing the biosimilar within the requisite time frame.

Another standard CMS could consider is the absence of evidence that a biosimilar manufacturer will not be able to come to market, for example no evidence of statements of manufacturing delays or clinical study issues.

Removal from the Selected Drug List—CMS's "Bona Fide Marketing" Standard (Section 30.1, 70, 90.4): CMS must abandon its bona fide marketing standard. CMS' creation of a new "standard" for determining the date of marketing of a generic or biosimilar is incompatible with the statute and contrary to sound public policy. The starting point for that definition should be the plain English meaning of the word "to market."[49]

The statute anchors multiple important provisions to either (1) the date on which a generic or biosimilar

[48] *See* 5 U.S.C. § 706(2)(A).
[49] *Marketed*, Merriam-Webster Dictionary (11th ed. 2003). Merriam Webster defines this as "to expose for sale in a market; sell," and defines "on the market" as "available for purchase."

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is marketed or (2) the date on which CMS determines that a generic or biosimilar is marketed. With respect to the former date, a drug or biologic may be selected for the DPNP only if, by the selected drug publication date, it is a QSSD—which excludes a drug or biologic with respect to which a generic or biosimilar is marketed.[50] In addition, a biologic subject to a delay in selection for the DPNP is rendered ineligible for selection if a biosimilar is marketed by the date that is two years what otherwise would have been the selected drug publication date.[51] And a biologic may not be subject to such a delay if more than one year has passed since the biosimilar was licensed and the biosimilar is not marketed.[52]

With respect to the latter date, most notably, a selected drug ceases to be subject to the MFP at the start of the year that is "at least 9 months after the date on which [CMS] determines that at least one generic or biosimilar has been marketed."[53] In addition, a drug or biologic ceases to be subject to the DPNP if, before the end of the period, CMS determines that a generic or biosimilar has been marketed;[54] and a manufacturer of a selected drug subject to an ongoing excise tax ceases to be subject to such penalty on the date on which CMS determines that a generic or biosimilar has been marketed.[55]

In either case, the determination of the date of marketing of a generic or biosimilar is of enormous consequence throughout the program. CMS has stated its intent to continue to use an ill-defined and incomplete—and unlawful—process to make what is in fact an entirely straightforward determination. CMS's approach is deeply problematic and inaccurate for myriad reasons. Foremost is that the bona fide marketing standard is contrary to the plain language of the statute: CMS's standard is not rationally related to the actual date of marketing. As a definitional matter, marketing is "[t]he act[] . . . of bringing or sending a product or commodity to market."[56] As such, once the "action of buying or selling" has occurred, a product has necessarily been "marketed." i.e., **sold.**[57]

CMS itself has long recognized that the date on which a product is "marketed" is an objective point-in-time determination of the date on which it is made available for sale in the commercial marketplace—including in the course of implementing other provisions of the IRA as well as under the Part D program, which will source the data on which CMS intends to rely in effectuating its bona fide marketing standard. CMS determines when a product is "marketed" for purposes of the IRA's Part D inflation rebates by reference to the "market date" that the manufacturer must report under MDRP.[58] In turn,

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[50] SSA § 1192(e)(1)(A)(iii); (B)(iii). The statute refers to a generic or biosimilar that is both approved or licensed and marketed. We focus only on the latter because the date of marketing should never fall before the date of approval or licensure.
[51] *Id.* § 1192(f).
[52] *Id.* § 1192(f)(2)(D)(iii).
[53] *Id.* § 1192(c)(1).
[54] *Id.* § 1192(c)(2).
[55] Internal Revenue Code (IRC) § 5000D(b)(1)(B).
[56] Oxford English Dictionary, Definition of Marketing, https://www.oed.com/view/Entry/114186?rskey=36dfg4&result=2&isAdvanced=false#eid.
[57] *Id.*
[58] CMS, Medicare Part D Drug Inflation Rebates Paid by Manufacturers: Initial Memorandum, Implementation of Section 1860D-14B of SSA, and Solicitation of Comments, § 40.3 (Feb. 9, 2023), *available at* https://www.cms.gov/files/document/medicare-part-d-inflation-rebate-program-initial-guidance.pdf; FDA, National Drug Code Directory (July 22, 2022), *available at* https://www.fda.gov/drugs/drug-approvals-and-databases/national-drug-code-directory#:~:text=Marketing%20start%20date%20is%20the,no%20longer%20in%20commercial%20distribution.

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under MDRP, CMS has long defined the "market date" of a product by reference to the date on which the product entered commercial distribution, consistent with the plain language definition of "marketed."[59] And, under the Part D program, which will source the PDE data on which CMS intends to rely (in part) in effectuating its bona fide marketing standard, CMS has recognized that the date on which a product is "release[d] onto the market" triggers certain coverage-related obligations[60]—which by necessary implication means that CMS will have already recognized that a product has been released onto market by the time such coverage-related obligations yield PDE data showing utilization of the product.

CMS may not supplant wholesale the statute's objective point-in-time "marketed" standard with an extra-statutory standard based on the Agency's subjective judgment of sufficiency of utilization.[61] Such judgment is immaterial to whether a product is in fact marketed—i.e., is available to be bought and sold in the commercial marketplace. Likewise, CMS notes in the draft guidance that they will consider where "there is no evidence of agreements limiting distribution of the generic or biosimilar product" in whether a product is marketed, which CMS is neither adequately nor appropriately positioned to observe or determine.

Notably, Congress well knows how to statutorily impose a "bona fide" standard in the drug pricing context. Congress expressly established such a standard when amending the MDRP statute in 2010 to specify that only "bona fide" service fees are exempt from the calculation of AMP.[62] By contrast, Congress chose not to establish such a bona fide standard here. "[W]here Congress knows how to say something but chooses not to, its silence is controlling."[63]

CMS's extra-statutory bona fide marketing standard has vast legal implications. For example, as noted above, the date on which CMS determines that a generic or biosimilar has been marketed determines when the MFP terminates.[64] As such, through the bona fide marketing standard, CMS is effectively claiming for itself limitless discretion to prevent the MFP from timely (if ever) terminating, notwithstanding the fact that a generic or biosimilar has in fact come to market, based on the Agency's subjective assessment of whether PDE and AMP data show that the generic or biosimilar is utilized sufficiently.

With respect to the IRA's Part B inflation rebate, CMS determines when a product is "marketed" by reference to the "date of first sale" that the manufacturer must report for ASP purposes, which likewise is an objective point-in-time determination. CMS, Medicare Part B Drug Inflation Rebates Paid by Manufacturers: Initial Memorandum, Implementation of Section 1847A(i) of the Social Security Act, and Solicitation of Comments, § 50.3 (Feb. 9, 2023), *available at* https://www.cms.gov/files/document/medicare-part-b-inflation-rebate-program-initial-guidance.pdf.

[59] 83 Fed. Reg. 12,770, 12,784 (Mar. 23, 2018) (MDRP National Rebate Agreement); *see also* 42 C.F.R. § 447.502.

[60] CMS requires that Part D plan sponsor pharmacy and therapeutics committees "make a reasonable effort to review a new FDA approved drug product (or new FDA approved indication) within 90 days of its release onto the market and . . . make a decision on each new FDA approved drug product (or new FDA approved indication) within 180 days of its release onto the market, or a clinical justification will be provided if this timeframe is not met." Prescription Drug Benefit Manual, ch. 6 § 30.1.5.

[61] It is unclear, for example, whether CMS expects a generic or biosimilar to capture and maintain a certain percentage of the market.

[62] SSA § 1927(k)(1)(B)(i)(II) (as amended by Pub. L. No. 111–148, § 2503(a) (2010)).

[63] *Animal Legal Def. Fund v. U.S. Dep't of Agric.*, 789 F. 3d 1206, 1217 (11th Cir. 2015).

[64] SSA § § 1192(c)(2).

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Such policies are completely untethered to anything in the text or structure of the statute and run directly contrary to Congress's intent to allow market-based competition to govern where a generic or biosimilar has come to market to compete with a drug or biologic.[65] The Agency's approach is therefore patently unlawful. "[N]either federal agencies nor the courts can substitute their policy judgments for those of Congress."[66] CMS's effort to do so here is "effectively the introduction of a whole new regime of regulation," which "is not the one that Congress established."[67]

The Agency's unlawful standard also necessarily yields an inaccurate determination of when a generic or biosimilar was marketed. Many Part D plan sponsors will not add a newly approved drug to their formulary until the 180-day mark, and, thus, the first six months following the market entry of the drug will necessarily reflect only very limited uptake.[68] And some plan sponsors may choose not to add the drug to their formulary at all. In addition, even where plan sponsors add the drug to their formulary, widespread uptake of a new product does not occur overnight. After a new product is made available for sale, providers and patients typically transition to such product gradually as they become increasingly familiar with its benefits relative to pre-existing alternatives.[69] Such a product is in fact marketed during this uptake period, but CMS's standard ignores this fact and focuses instead on whether the product is adequately utilized, in contravention of the statutorily mandated standard.[70] Such shifts in utilization patterns over time do not mean that the market is not working as intended.

It is imperative that CMS abandon its unlawful and ill-advised standard and instead adopt as its standard the "market date" reported under MDRP. The MDRP "market date" standard should be used for identifying *both* the date on which a generic or biosimilar is marketed *and* the date on which CMS determines that a generic or biosimilar has been marketed.

Under MDRP guidance, "market date" is "the earliest date the drug was first marketed under the application number by any labeler."[71] Manufacturers report this date when reporting MDRP pricing data. As such, the MDRP "market date" is a familiar construct to both CMS and manufacturers, and carries the additional benefit of ensuring consistency across MDRP and the DPNP. And, unlike the "date of first sale" used for ASP reporting purposes, the MDRP "market date" is available for generics and biosimilars without regard to whether they are subject to ASP reporting.[72]

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[65] *See, e.g.,* SSA § 1192(c)(1).
[66] *Brown & Williamson Tobacco Corp. v. FDA*, 153 F.3d 155, 176 (4th Cir. 1998), *aff'd*, 529 U.S. 120 (2000).
[67] *MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218, 114 (1994).
[68] While plan enrollees may access a non-formulary drug via an exceptions process, access may not be immediate under such process; moreover, exception processes typically yield only a very small volume of utilization.
[69] *See* A. Lubby, Factors affecting the uptake of new medicines: a systematic literature review, 14 BMC Health Services Research 469 (2014) (describing the various factors that affect early uptake of new medicines).
[70] Other examples of deficiencies in CMS's approach include circumstances where low utilization is driven by uncontrollable factors such as supply shortages.
[71] CMS, MDRP Data Guide § 5.15 (Apr. 2022).
[72] The "date of first sale" is reported only for products subject to ASP reporting, and thus may not be available for all generics and biosimilars whose marketing is implicated by the DPNP. By contrast, the "market date" reported under MDRP is more broadly reported and is thus the superior metric to use. *See* CMS, Medicare Part D Drug Inflation Rebates Paid by Manufacturers: Initial Memorandum, Implementation of Section 1860D-14B of Social Security Act, and Solicitation of Comments, (Feb. 9, 2023), https://www.cms.gov/files/document/medicare-part-d-inflation-rebate-program-initial-guidance.pdf.

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It is particularly critical that the Agency equate the date on which CMS determines that a generic or biosimilar has been marketed with the MDRP "market date" because, as noted above, the difference of a single day in the date of CMS's determination can result in the MFP being extended for a full additional year. Failing to do so would have a dramatic chilling effect on the development of generics and biosimilars. Manufacturers would be seriously disincentivized against investing in the development of such products if there is a risk that they would be forced to compete with the MFP for an unduly extended period of time. This, in turn, would defeat Congress's objective of encouraging the development of generic and biosimilar market competitors.

For all of these reasons, we strongly oppose CMS's extra-statutory bona fide marketing standard, and strongly urge CMS instead to adopt the MDRP "market date" as a uniform standard for identifying both the date on which a generic or biosimilar is marketed and the date on which CMS determines that a generic or biosimilar has been marketed. And if there are instances where, for example, a manufacturer is not participating in the MDRP, a manufacturer should be afforded an opportunity to provide CMS input as to whether a generic is marketed or not.

Finally, we note our concern that CMS proposes to continue to monitor whether a generic or biosimilar continues to be "marketed" even after a determination has been made. We strongly urge CMS to abandon this approach – there is simply no basis for this ongoing "monitoring" – it was not contemplated by the IRA and is not supported by the statute.

Confidentiality and Data Use (Sections 40.2.1 and 40.2.2): BIO acknowledges CMS's stated confidentiality policy but recommends that CMS establish more fulsome safeguards to ensure that the Agency is adequately protecting the confidentiality of all proprietary information submitted to CMS under the DPNP. CMS should also establish a process to enable manufacturers to review a draft of the explanation of the MFP in advance of its publication and raise concerns about disclosure of confidential information.

The statute imposes a clear confidentiality requirement: "Information submitted to . . . [CMS] . . . by a manufacturer of a selected drug that is proprietary information of such manufacturer (as determined by . . . [CMS]) shall be used only by . . . [CMS] or disclosed to and used by the Comptroller General of the United States for purposes of carrying out [the DPNP]."[73] Congress imposed this confidentiality requirement for good reason. The statute mandates that manufacturers of selected drugs submit highly sensitive information—including, among other things, information regarding Non-Federal Average Manufacturer Price (Non-FAMP), research and development costs, production and distribution costs, and revenue and sales volume data.[74] It would be deeply disruptive to commercial markets if such proprietary information were disclosed or used in violation of the confidentiality requirement. Indeed, the Draft Guidance acknowledges the "highly sensitive" nature of information to be submitted under

[73] SSA § 1193(c).
[74] *Id.* §§ 1193(a)(4), 1194(e)(1).

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the DPNP.[75] In principle, BIO is encouraged that CMS continues to state that it will implement a confidentiality policy that is consistent with existing requirements for protecting proprietary information, including Exemptions 3 and/or 4 of [the Freedom of Information Act (FOIA)].[76] That said, we continue to believe there is a pressing need for more detailed specification as to how the Agency will safeguard confidential commercial information to ensure that the statute's robust confidentiality requirement is fully honored.

BIO therefore asks CMS to more fully specify the controls and safeguards that it will implement. We urge CMS to ensure that such controls and safeguards maximize the protection of confidential commercial information to be submitted under the DPNP. This would be fully consistent with the approach taken in other areas of federal law and policy, which have long given special consideration to such highly sensitive information. For nearly forty years, the Supreme Court has made clear that commercial trade secrets are a "property right [] protected by the Taking Clause of the Fifth Amendment."[77] Likewise, Congress has repeatedly made clear its expectation that commercially sensitive information be appropriately safeguarded. For example, even beyond FOIA's long-standing protection of "trade secrets and commercial or financial information that is obtained from a person and is privileged or confidential,"[78] the Defend Trade Secrets Act prohibits the "misappropriation" of trade secrets through public disclosure and established a private cause of action to enable affected parties to sanction such misappropriation.[79]

We also request that CMS confirm that it will ensure protections comparable to, not only those under FOIA, but also those under government price reporting law and policy. In developing the DPNP, Congress did not intend to disrupt the confidentiality requirements under other federal law and policy.[80] CMS's confidentiality policy should thus maintain the confidentiality of information protected against disclosure under all other federal law and policy. For example, under the Medicaid Drug Rebate Program (MDRP), "information disclosed by manufacturers . . . under [MDRP] . . . is confidential and shall not be disclosed by [CMS] . . . in a form which discloses the identity of a specific manufacturer . . . [or] prices charged for drugs by such manufacturer . . . ."[81] Similarly, Medicare Act provides that "[Average Sales Price (ASP)] information disclosed by manufacturers . . . is confidential and shall not be disclosed by

[CMS] in a form which discloses the identity of a specific manufacturer . . . or prices charged for drugs or biologicals by such manufacturer . . . ."[82] Likewise, the 340B Drug Pricing Program (340B Program) generally prohibits disclosures of information submitted by manufacturers under the program.[83] Where

[75] Draft Guidance at 48.
[76] *Id.*
[77] *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1004 (1984).
[78] 5 U.S.C § 552(b)(4); 45 C.F.R. § 5.31(d).
[79] 18 U.S.C. § 1839(5)(B)(ii)(II).
[80] *See Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 662 2d 467 (2007) ("[R]epeals by implication are not favored" and will not be presumed unless the "intention of the legislature to repeal [is] clear and manifest.").
[81] SSA § 1927(b)(3)(D) (subject to certain limited exceptions).
[82] *Id.* § 1847A(f)(2)(D) (subject to certain limited exceptions).
[83] Health Res. & Servs. Admin., General Instructions for Completing the Pharmaceutical Pricing Agreement 7 (2019), *available a*t www.hrsa.gov/sites/default/files/hrsa/opa/pharmaceutical-pricing-agreement-example.pdf.

confidential commercial information is protected against disclosure under these or any other federal programs, CMS should safeguard such information against disclosure to at least the same extent.

In addition, CMS should implement robust storage and access controls and safeguards to protect the confidentiality of sensitive information. Confidentiality requirements are only as meaningful as the data privacy and security protections that are implemented to safeguard sensitive information against inadvertent or malicious[84] improper disclosure. Accordingly, CMS should implement robust systems and protocols, including by ensuring that all proprietary information stored in the Health Plan Management System (HPMS) and in electronic communications with the Agency is secure and accessible only to CMS staff and only where there is a legitimate programmatic need for access to such information.

In doing so, CMS should look to the safeguards it has already established under MDRP. Under MDRP, CMS has implemented a system with numerous privacy and security protections to safeguard sensitive product and pricing data submitted by manufacturers. For example, the online interface allows a manufacturer to view its pricing data, such as its Baseline Average Manufacturer Price (AMP) data, while disallowing states, which do not have a programmatic need to view such information, from doing likewise.[85] CMS should ensure that similar controls are in place with respect to HPMS, given CMS's use of that system.

DPNP Factors (Section 50) and Process (Section 60): As set forth in previous comments to the Agency, BIO strongly urges CMS to emphasize factors that are most important to patients—those related to clinical value and unmet need—and to de-emphasize manufacturer-specific data elements such as cost of production and research and development costs. BIO encourages CMS to emphasize the negotiation factors outlined in section 1194(e)(2) over the factors in section 1194(e)(1), particularly for subpopulations of patients who are disproportionately affected by lack of access or availability of appropriate clinical treatment options. Further, CMS must clarify how it will evaluate the evidence it receives from stakeholders and how such evidence will be considered in identifying therapeutic alternatives and setting the MFP. BIO also urges CMS to ensure that the process for determining the MFP is predictable, transparent, and allows for meaningful engagement and dialogue with manufacturers and other key stakeholders, particularly the patient community.

Consideration of Factors and Transparency. We understand the IRA requires CMS to consider factors under both section 1194(e)(1) and section 1194(e)(2) and it does not specify how CMS should weigh the factors. We continue to recommend that CMS de-emphasize the manufacturer-specific data under section 1194(e)(1) and focus on the factors that matter most to patients—those that are focused on clinical value and unmet need specified in section 1194(e)(2).

[84] Malicious third-party cyber activities have increasingly targeted the federal government—in, part, because its databases are repositories of significant amounts of sensitive information. *Cf.* David E. Sanger, *Russian Hackers Broke into Federal Agencies, U.S. Officials Suspect*, N.Y. Times, https://www.nytimes.com/2020/12/13/us/politics/russian-hackers-us-government-treasury-commerce.html.
[85] CMS, *Medicaid Drug Programs User Manual* 1 (Nov. 3, 2021).

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It is vital that, in setting the MFP, CMS impose on itself bright-line limitations that mitigate the negative effects of the DPNP and the MFP on patient access and on therapeutic innovation. Setting higher MFPs for products that have advanced patient care and address unmet medical need will help maintain investment in assets and clinical programs that show scientific promise and address needs not served by current therapies. BIO asks CMS to commit to a policy where it will not set the MFP below a price shown to imperil patient access (or below the MFP ceiling, if higher than such price).

Moreover, in applying the section 1194(e)(2) factors, CMS should expand its definition for unmet medical needs to include both clinical and non-clinical benefits to better encompass patient, caregiver, and society value. For instance, it is important that CMS consider a patient and caregiver's mental and social well-being, improvement or maintenance of quality of life, improvements in clinical/disease outcomes, sustainable costs for patients, including both cost of treatment and cost of ancillary services, and other measurements of value. CMS should also consider and prioritize high quality, robust real-world evidence (RWE), evidence provided by clinicians with the necessary expertise, as well as evidence submitted by manufacturers—which have a vast depth and breadth of clinical and scientific expertise regarding their marketed therapies.

We also strongly support efforts to improve upon efforts to obtain critical feedback from the patient community. It is important that CMS effectively captures the patient experience by collecting data that truly matters to patients, including treatment adherence and patient-reported outcomes.

We also encourage CMS to make certain process improvements to provide transparency and predictability to manufacturers. For instance, it is critical that CMS is transparent in its approach in determining therapeutic alternatives to selected drugs, including by (1) providing to the manufacturer of the selected drug a written justification of such determination that shows that the determination was primarily driven by clinical guidelines and patient need as opposed to cost, (2) allowing the manufacturer a meaningful opportunity to object to such determination, including by submitting data and other information in support of such objection, and (3) meaningfully considering any such objection before making a final determination.

CMS should also be transparent and provide sufficient detail regarding how evidence was used to inform the identification of therapeutic alternatives for a selected drug, as well as the establishment of the starting point, preliminary price, the initial offer, and the response to any counteroffer, including what evidence was most impactful in CMS's analysis and why. It is important that the development of the initial offer and CMS's review of evidence should be patient-centered and focus on health equity and reducing disparities. To that end, we strongly support CMS's confirmation that evidence that uses discriminatory considerations such as quality-adjusted life years (QALYs) will not be considered. We note that other measures that have often been promoted as alternatives to QALYs—such as the Equal Value of Life Years Gained (evLYG)—are also problematic as they limit the value of interventions that both extend life and improve the quality of life—and CMS should similarly reject them. In reviewing the evidence, CMS should recognize both the current and future value of therapies and remain flexible to

keep pace with innovations in science and technology. Evidence regarding a therapy should be viewed in the context of its benefits to the Medicare program, as well as the overall health care system.

CMS should also provide a *meaningful* justification of its initial offer and its response to any counteroffer and afford the manufacturer a meaningful opportunity to comment on the response once the MFP is set. As noted above, Congress intended for the MFP to be set via "negotiation," meaning a bilateral "discussion or process of treaty" between the parties "aimed at reaching an agreement about a particular issue."[86] Open dialogue is vital and critical to CMS' ability to determine the MFP in a manner that reflects the statutory DPNP factors, as required by law. To this end, BIO asks CMS to specify that its initial offers and its responses to any counteroffers include *meaningful* explanations of how the Agency arrived at the offer or response, including by explaining how the offer or response is supported by the statutorily enumerated factors and any other information upon which the Agency relied, and how the Agency considered and weighted such factors and information.

Drug Price Negotiation ICR. CMS states that it will remove the attestation (checkbox) for a respondent to indicate whether their submission contains information on QALYs. BIO opposes the removal of this attestation, as the attestation helped the Agency avoid considering QALYs during the DPNP process. While we agree with the need to streamline questions throughout the ICR forms, it is imperative that information that may contain QALY data be clearly delineated so that CMS does not draw conclusions from biased information sources. We look forward to providing more detailed feedback through our Drug Price Negotiation ICR comments.

Calculation of Initial Offer and Therapeutic Alternatives. BIO opposes the potential methodology outlined in CMS' solicitation for input on developing initial offers using reference pricing benchmarks or cost of production and distribution.

In developing an initial offer, CMS should not consider starting points that are below the ceiling price, including any pricing points informed by reference prices, cost of production and distribution, or other price points not informed by clinical value to the Medicare beneficiary. We strongly oppose calculating initial offers based on any reference prices derived from other domestic programs or 1194(e)(1) factors because these do not reflect clinical value to Medicare beneficiaries, create additional disincentives for innovation, and exacerbate existing disadvantages between small molecule drugs vs biologics.

We also disagree with CMS' approach to consider total gross covered drug costs (TGCDC) *net of Manufacturer Discount Program (MDP) payments* when identifying the prices of therapeutic alternatives. Such discount payments are reflective of statutory Part D plan design and not reflective of a true market price.[87] We also oppose the use of ranges associated with therapeutic alternatives that have not yet been identified to inform the starting point. Since therapeutic alternatives are not identified to

[86] Oxford English Dictionary, Definition of Negotiation, https://www.oed.com/view/Entry/125879?redirectedFrom=negotiation#eid.
[87] Draft Guidance at 130.

the public in advance, using ranges to inform the starting point is both unpredictable and lacks transparency.

CMS notes that it is exploring the "possibility and feasibility" of considering health care services payable under Medicare Part A or Part B as potential therapeutic alternatives. CMS should not move forward with a policy of this nature. Healthcare services are not an appropriate comparator to pharmacologic medicines under the DPNP. Further, the scope of traditional P&T committees to determine drug coverage is to reviewing drug alternatives and assess comparative effectiveness. Therapeutic drug classes themselves can already be very broad, and expanding beyond pharmaceutical products may lead to reviews that are too broad in scope.

Manufacturer-submitted information and Process Improvements. CMS should significantly streamline data submission requirements and de-emphasize manufacturer specific data elements such as cost of production and research and development costs which are difficult to compare across companies and have no bearing on the value of a given therapy in clinical practice.

For instance, CMS should implement process efficiencies to reduce burden on manufacturers and CMS by limiting collection of data not meaningful to the price-setting process (e.g., allowing for a "check-box" to reflect R&D cost recoupment rather than burdensome data collection and submission requirements). CMS states it is considering collection of additional, forward-looking "market data" such as forecasted net revenue and volume data. We strongly oppose such an approach, as such information is highly variable and dynamic, and its submission would add to manufacturer burden – instead CMS should be exploring efforts to streamline and prioritize the information it collects.

Finally, we recommend that CMS allow supplemental submissions for material changes or good cause. Manufacturers should have the opportunity to bring any new information to the table, as necessary. In addition, allowing more time between the MFP explanation publish date and the manufacturer submission deadline would allow manufacturers to provide more applicable information to CMS.

Determination of 30-Day Equivalent Supply for a Selected Drug (Section 60.2.1.1)

BIO appreciates the complexity of the issues the agency is seeking to address with the 30-day equivalent supply calculation. In this section we discuss the need to refine this policy if the agency moves forward and also urge the agency to increase transparency into the process by sharing and aligning on an appropriate methodology for the 30-day calculation.

BIO has significant concerns regarding CMS' proposed approach for establishing a 30-day supply equivalent. Specifically, CMS' approach may create calculated prices that are inconsistent with clinical use. For example, products with variable dosing may see significant undervaluing because equivalents are rounded up if they are dosed more frequently than once every 34 days. The CMS methodology more fairly represents utilization for products dosed less frequently by dividing dose intervals by 30. If CMS moves forward with the 30-day equivalent supply policy, BIO urges the agency to treat products

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dosed on less than 30 day increments the same way it treats other products, dividing by 30 in all instances.

BIO also has concerns about the use of claims data to determine the dose intervals for negotiated drugs. The use of claims data will tend to undervalue products where treatment must be interrupted (e.g. for surgery or adverse reactions), with a potential to differentially affect Part B therapies, including oncology products. BIO recommends that treatment intervals be based on FDA label, rather than claims data. The current policy would further exacerbate reductions in reimbursement providers face during treatment interruptions.

There may also be instances where a product may have multiple NDCs that contain different quantities of the same unit (e.g., milligrams (mgs)) but deliver a therapeutically equivalent dose to a patient. In those instances, a manufacturer may choose to offer those NDCs at parity price rather than linearly price based on the unit quantity. To adjust for non-linear pricing across NDCs where different dosing levels are intended to be priced at parity, CMS should provide additional clarity and apply appropriate adjustments to ensure the MFP is consistently and accurately applied to different dosages or strengths with non-linear pricing.

Renegotiation (Section 130)

We urge CMS to adopt a more targeted approach to selecting drugs for renegotiation and focus renegotiation on those drugs that have a change in monopoly status as required by statute. Particularly for IPAY 2028, given that prices have recently been set for IPAY 2026 and 2027, it is unlikely that there had been a fundamental change in the negotiation factors that would result in a significant change in the MFP for these drugs.

If, however, CMS continues as it proposes, CMS must provide greater transparency into the criteria and data inputs used to identify drugs selected for renegotiation. Clear insight into the rationale and methodologies for applying the proposed 15% MFP change threshold – and CMS's rationale for the 15% threshold itself – would help manufacturers better understand and prepare for potential renegotiation. Additionally, CMS should streamline data submission requirements, and we request that manufacturers be granted flexibility in the submission of data during the renegotiation process, recognizing that manufacturers may have new or updated evidence on clinical benefit, market dynamics, or other factors that were not available during the initial round of negotiation.

Interaction Between Inflation Rebates and ASP and Selected Drugs (Section 120):
A manufacturer should not be obligated to pay an inflation rebate on a selected drug in both Medicare Part B and Part D because Medicare expenditures on a selected drug are already constrained by the maximum fair price.[88] With respect to a selected drug, Medicare is shielded from the increase in

[88] *Id*. §§ 1847A(b)(1)(B); 1860D-2(d)(1)(D).

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expenditures occasioned by a price increase that outpaces inflation that an inflation rebate is intended to address. Medicare does not need to be made whole on account of such a price increase, and, thus, no inflation rebate should be due.

Regarding Part B drugs, by statute, the Part B inflation rebate calculation is based in relevant part on the amount by which "106 percent of the amount determined under paragraph (4) of [section 1847A(b) of the SSA] for [a part B rebatable drug] during the calendar quarter . . . . exceeds . . . the inflation-adjusted payment amount . . . for such part B rebatable drug during the calendar quarter."[89]

Importantly, the circumstances under which an amount is "determined" under paragraph (4) is dictated by section 1847A(b)(1) (paragraph (1)).[90] Specifically, paragraph (1) dictates a payment amount of, "in the case of a single source drug or biological . . . , 106 percent of the amount determined under paragraph (4) *or* in the case of such a drug or biological product that is a selected drug . . . , with respect to a price applicability period . . . , 106 percent of the maximum fair price . . . applicable for such drug and a year during such period."[91]

In other words, the payment amount for a selected drug is determined under paragraph (1), and such payment amount is determined without regard to paragraph (4). Rather, it is only the payment amount for a non-selected drug that is determined under paragraph (4).

It necessarily follows that the Part B inflation rebate calculation has no application to a selected drug. With respect to such a drug, there is no amount "determined under paragraph (4)," and therefore Part B inflation rebates have no applicability. Thus, with respect to a selected drug, Medicare is shielded from the increase in expenditures occasioned by a price increase that outpaces inflation that an inflation rebate is intended to address. Medicare does not need to be made whole on account of such a price increase, and, thus, no inflation rebate should be due.

In addition, for IPAY 2028, the guidance should clearly state that, for selected drugs, sales at the MFP are excluded from the calculation of Average Sales Price (ASP). CMS should exclude the MFP from the ASP calculation to avoid triggering unintended inflation rebates in the event that a drug is removed from the list of selected drugs. Including MFP in ASP would artificially lower the ASP while the MFP is in effect, creating the appearance of a price increase once the MFP is no longer applied- even when there has been no actual pricing action by the manufacturer. This could wrongly trigger inflation rebates under Part B. Notably, MFP is already excluded from Average Manufacturer Price (AMP), which is used to determine inflation penalties under Part D. For consistency between Parts B and D, CMS should adopt a similar approach for Part B and ensure that inflation rebates are based on a pricing metric that excludes the MFP.

[89] SSA § 1847A(i)(3) (emphasis added).
[90] *See id*. § 1847A(b)(1).
[91] *Id*. § 1847A(b)(1)(B) (emphasis added).

Protecting Access to Part B Drugs

Excluding MFP from ASP is also necessary to protect beneficiary access to Part B drugs. The inclusion of MFP units in the ASP calculation would increasingly deflate ASP over time. As a result, ASP-based provider reimbursement would increasingly become inadequate. Eventually, providers would be left financially underwater if they were to furnish a selected drug to an MFP-ineligible individual, creating a very real risk that providers would no longer furnish such drugs to beneficiaries. A study by the Part B Access for Seniors and Providers Coalition found that the change in the ASP calculation for MFP units would decrease provider reimbursement by $56.3 Billion, with the largest reduction expected to come from oncology providers.[92] This access threat extends beyond Medicare Part B as ASP is a reimbursement benchmark commonly used by payers in the commercial marketplace.

The ASP statute unambiguously confers on CMS broad authority to define "unit" for purposes of the ASP calculation "as . . . [CMS] determines appropriate."[93] CMS undoubtedly may exercise such authority to exclude MFP units from the ASP calculation to avoid patient access concerns. The legislative history of the ASP statute makes abundantly clear that Congress intended for CMS to exercise such discretion in this way in precisely this sort of circumstance. When Congress delegated CMS the authority to define "unit" for purposes of the ASP calculation, it specifically stated that it was doing so to allow for the exclusion of "those sales that do not reflect market prices" from ASP.[94] By definition, MFP units do not reflect market prices and should be excluded. There is also clear Agency precedent for excluding units that do not reflect market prices from the ASP calculation. In 2005, CMS carved Competitive Acquisition Program (CAP) units out of the ASP exclusion by excluding such units from the "unit" definition.[95]

Manufacturer Effectuation – Part B And D (Section 80, 90, 100)

BIO remains concerned about CMS' limited visibility into the end-to-end technical requirements of the systems necessary to effectuate the MFP. In the absence of clearly defined specifications, manufacturers have had to move forward with designing and building their own systems based on their own reasonable assumptions and the limited information provided. As a result, manufacturers are now constrained in their ability to make any late-stage adjustments without jeopardizing the ability to meet the September 1st deadline for submission of the Manufacturer Effectuation Plan and the mandated January 1st effective date for the MFP. At this stage in implementation, BIO urges CMS to ensure that manufacturers are protected from CMPs in scenarios in which CMS may add any major requirements or technical specifications that haven't yet been accounted for, which would be infeasible for manufacturers to adopt in light of the September 1st and January 1st deadlines. BIO also opposes CMS' proposal to create an earlier due date of June 1st for some components of the Effectuation Plan. Most

[92] Holcomb, K, Ulin, I, Robb, M. Impact of the Inflation Reduction Act on Part B Provider Payment and Patient Access to Care. Milliman Report Commissioned by Capitol Council on behalf of the Part B Access for Seniors and Providers Coalition. Available at: https://www.milliman.com/en/insight/ira-impact-on-part-b-provider-payments
[93] SSA § 1847A(b)(2)(B).
[94] *See* H.R. Rep. No. 108-391, at 587–88 (2003).
[95] 70 Fed. Reg. 39,021, 39,077 (Jul. 6, 2005); *see also* 74 Fed. Reg. 61,738, 61,915 (Nov. 25, 2009).

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critically, given the compressed implementation timeline and this lack of insight into CMS' end-to-end technical requirements, we urge CMS to grant manufacturers a safe harbor for good faith efforts to effectuate the MFP. Manufacturers have had to make complex operational decisions based on the limited end-to-end visibility, and despite best efforts, unintentional inaccuracies may result from this lack of guidance. Manufacturers should not be subject to civil monetary penalties (CMPs) for these good faith efforts, particularly when errors stem from areas beyond manufacturers' control.

MTF Registration and Termination Processes. While BIO appreciates the fact that dispensers are required through their Part D contracts with plan sponsors to participate in the MTF data module (MTF-DM), we reiterate that dispensers must be required to participate in the MTF-PM. Additionally, we are concerned that manufacturers have not been given sufficient opportunities to engage with the MTF-PM. Transparent communication and meaningful collaboration among all stakeholders are essential for the successful implementation of MFP effectuation.

While we understand that CMS may consider leveraging private market solutions in the future, we strongly urge CMS to continue to prioritize the use of the MTF. No private market solutions are currently able to perform all of the MTF's critical functions. Further, CMS should not shift financial and operational burden onto manufacturers if the Agency proposes any potential alternatives to the MTF.

Refund Timing and Amounts. As BIO has commented in the past, we remain deeply concerned that the 14-day prompt-pay window does not provide enough time for manufacturers to process all MFP claims accurately and thoroughly to ensure compliance with the effectuation program. The complexity of ensuring consistent compliance and payment accuracy is apparent in all MFP claims, including but not limited to 340B claims. The 14-day timeline is far less than when typical 340B claims are reconciled. Additionally, the 14-day window is far less than the time window provided to managed care plans, who often may not identify 340B claims, if they do at all, for at least 30 days on average.

CMS should grant an extended prompt pay timeline, similar to the uniform process and operational timeliness of the current coverage gap discount program, which is 38 days. It is critical that the prompt pay window be expanded so that manufacturers can effectively make the determination of the lower of the 340B or the MFP and scrub for duplicate claims and errant claims. As manufacturers scrub data to process the claim, they not only verify patient eligibility, but also must verify that the quantity is correct and that each claim is unique and has not been previously submitted or duplicative of another claim. Accordingly, the 14-day window is insufficient and creates significant operational challenges for manufacturers who must support intensive claim verification.

Finally, we reiterate our opposition to CMS' persistence to hold manufacturers responsible for mitigating dispensers' cash flow challenges, which is not found in statute. For future years, we encourage CMS to prefund MFP discounts through the MTF-PM to keep dispensers whole. As CMS continues to develop the MTF-PM system requirements to facilitate payment between dispensers and

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manufacturers, it is critical to accurately identifying 340B-eligible transactions to ensure compliance with the 340B non-duplication requirement.

Claims-Level Data Elements. BIO urges CMS to work closely with manufacturers to ensure that appropriate data fields are considered for the MTF data exchange so that all entities can comply with their statutory obligations to support verification of claims, which includes determination of whether a drug is also 340B eligible and which price point (MFP or 340B) is lower. It is essential that primary manufacturers be given the claims-level data necessary to confirm eligible claims, which involves a thorough and meticulous process of scrubbing claims for inaccuracies, errors, potential fraud, and other challenges. BIO welcomes the opportunity to engage further with the Agency. BIO has previously shared recommendations on claims-level data elements in both Part D and B, and would be happy to provide them again if needed.

340B Nonduplication. It is critical that CMS prioritize effectuating the MFP properly by ensuring compliance with the 340B non-duplication requirement. As we have commented on the past, CMS should quickly adopt a claims clearinghouse model to validate 340B claims and prevent duplicate discounts. CMS could also mandate timely use of a 340B claim indicator for dispensing entities to help identify duplicate discounts.

Mandatory use of 340B claim indicators or modifiers is critical in enabling manufacturers and CMS to accurately identify 340B claims to avoid duplicate discounts, as required by statute. CMS should make clear that CE's obligation to maintain adequate records includes the timely use of modifiers on all pharmacy claims to identify the claim as 340B or non-340B, and that these modifiers must be applied consistently across all channels to help identify and verify 340B prescriptions.

To enforce CEs' compliance with their statutory obligations, we recommend that CMS (1) reject Part D claims submitted without required modifiers and (2) conduct periodic audits on their appropriate use. CMS should require CEs to include the appropriate 340B / non-340B modifier on the Part D PDE record within 72 hours of the prescription being filled at the pharmacy, and prior to the exchange of the PDE data with the MTF DM for "MFP" effectuation. This timeline is feasible, as CMS has acknowledged that

TPAs can identify most 340B claims within the 72-hour period following dispense. Because the success of this solution requires CE compliance and accountability for data accuracy, to enforce CEs' compliance with required modifiers, CMS will reject Part D claims submitted without required modifiers, and CMS will conduct periodic audits on their appropriate use.

Mandatory modifiers, paired with a 340B Claims Data Repository, will help to ensure all 340B claims are accurately captured and identified. The claims data repository would provide a centralized database that contains critical claims level data on 340B units under Part D to ensure accurate identification of 340B claims and verification of claims. In establishing the repository, CMS should make clear that CEs must participate as part of their audit obligations.

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Civil Monetary Penalties (CMPs). As mentioned previously in this letter, BIO continues to be concerned that manufacturers may be held liable and subject to CMPs if rebate amounts are deemed to be incorrect. We request that manufacturers be given a safe harbor for its good faith effort to make the MFP available to the dispensing entity and be given the opportunity to correct potentially incorrect rebate amounts without fear of incurring CMPs.

Complaint and Dispute Process. While we appreciate that CMS outlines a general distinction between disputes and complaints and offers a help desk for operational issues with the MTF, it is evident that more clarity is needed around the procedural steps, evidentiary standards, and criteria CMS will use to evaluate complaints and disputes. It also remains unclear how stakeholders will be notified of outcomes that result from the complaint or dispute, and whether there will be an opportunity for an appeal or further engagement. To support fair and consistent implementation, CMS should articulate a clear, transparent process for both complaints and disputes, including expectations for documentation, criteria for evaluating the merits of complaints and disputes, roles and responsibilities of stakeholders, how complaint and dispute information will be kept confidential, and other protocols. Additionally, CMS should establish timelines for resolving complaints and disputes to ensure timely responses and prevent prolonged uncertainty for matters that require urgent resolution.

Part B Effectuation Requests for Comment. As CMS considers how Part B will be effectuated for IPAY 2028, we urge CMS to clarify in a timely fashion how it will align payment methodologies and MFP effectuation across Parts B and D. We also encourage CMS to account for the following considerations that underscore the need for early planning and preparation ahead of the 2028 effective date:

- *Provider Reimbursement Challenges:* physician reimbursement for the Part B drugs selected for "negotiation" will change from ASP+6% to MFP+6%. A study by Milliman estimated that this change will decrease provider reimbursement by $56.3 billion over ten years. BIO is concerned that a lack of appropriate provider reimbursement will reduce patient access to all physician-administered biologics that are critical for patient treatment of a disease. To that end, we urge CMS to exclude MFP from calculation of ASP. The exclusion of MFP from the ASP calculation will ensure both sufficient provider reimbursement and adequate patient access to therapies. We also encourage CMS to work with Congress to advocate for the passage of the Protecting Patient Access to Cancer and Complex Therapies Act, sponsored by Sen. Barrasso (R-WY), which would hold providers harmless while ensuring that Medicare and its beneficiaries benefit from reduced costs based on the negotiated MFPs.
- *Standard Default Refund Amount (SDRA):* For drugs covered under Part B, BIO remains concerned that setting the SDRA at the Wholesale Acquisition Cost (WAC) minus the MFP of the selected drug would not be an accurate reflection of costs when effectuating the MFP, particularly when the actual acquisition price is above WAC. Often, cumulative markups within the supply chain result in the actual acquisition price being significantly higher than the WAC. BIO recommends that dispensing entities should notify the Primary Manufacturer if their acquisition costs were greater than WAC. They should also send their acquisition cost before the

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MTF-DM transmits the claims-level data elements to the Primary Manufacturer to initiate the MFP payment window. If CMS does not adopt these changes, at the very least, CMS should cap the rebate amount and clarify the limited situations when a refund amount other than the SDRA is appropriate. BIO recommends that the SDRA should be the difference of ASP+6 and MFP+6.

- *Preventing Duplicative Discounts from the Discarded Drug Program*: It is essential that CMS account for the discounts already provided under the Discarded Drug Program under Part B so that manufacturers are not paying duplicative discounts on units that have already been, or will be, refunded under the program.
- *Ensuring Accuracy of Part B Modifiers on Claims*: Variability in coding practices across provider types and settings often leads to incomplete or inaccurate Part B modifiers on claims. This inconsistency underscores the need for accuracy of Part B claims data to ensure that MFP is effectuated properly. BIO encourages CMS to enforce the accurate submission of Part B modifiers on claims data. BIO also encourages CMS to implement non-340B claims modifiers on all claims. Finally, CMS should also require reporting of NDCs on Part B claims forms to enable MFP effectuation.
- *Need for standardized processes through an MTF:* The need for a standardized process facilitated through the MTF is critical in Part B given the significant volume of providers. Over a million different providers are estimated to participate in Part B alone. Because most manufacturers are not practically able to establish direct payment relationships with such a high volume of dispensers, the ability to rely on an MTF to facilitate MFP payments in Part B is imperative. It is critical that CMS define operational processes for Part B data and payment transfers in a timely manner. BIO also strongly believes that given the sheer volume of dispensers, CMS must prefund Part B MFP discounts through the MTF payment module (MTF-PM) to ensure providers are kept whole.
- *Accounting for third parties*: Ensuring alignment and clarity across third parties such as Medicare Administrative Contractors (MACs) and Group Purchasing Organizations (GPOs) will be critical to avoid disruption in Part B drug access and administration when effectuating the MFP in Part B.

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BIO appreciates this opportunity to provide feedback to CMS on the Draft Guidance. We look forward to continuing to work with the Agency on these important issues. Should you have any questions, please do not hesitate to contact Crystal Kuntz at 202-962-9200 or Ckuntz@bio.org.

Sincerely,

/s/
Crystal Kuntz
Senior Vice President,
Health Policy & Research

/s/
Melody Calkins
Director, Health Policy

MEDICARE DRUG PRICE NEGOTIATION PROGRAM
DRAFT GUIDANCE COMMENT

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz,

On behalf of the over 450 member entities of BioNJ, from biotechnology startups to the largest biopharma companies in the world to patient advocacy organizations and research institutions in New Jersey, we are writing to comment on the Centers for Medicare & Medicaid Services interpretation of a qualifying single source drug (QSSD).

BioNJ is the trade association for the life sciences ecosystem in New Jersey, and our member companies are concerned about how a QSSD is being contemplated according to the Inflation Reduction Act of 2022. This determines how medications associated with Part B that are targeted for price setting are identified. Draft guidance released by CMS on May 12th included an interpretation of a QSSD that implicated a medicine with the same "active ingredient or active moiety" would be considered to be identical for the purposes of price negotiation.

As you are certainly aware given your medical background, the process of biomedical innovation is iterative. As our sector identifies effective therapeutics, we continue to hone in on more and more effective iterations of a given molecule. This process results in therapeutics that are more effective and results in diminished side effects, and this encompasses everything from the therapeutics themselves to how they are administered. Both characteristics have a very direct effect on both Patient adherence and quality of life.

This draft interpretation fundamentally undermines that iterative process of innovation. As a result, there will be lower investments towards the development of new, more effective, and more convenient therapeutics for Patients. Candidly, this reflects an interpretation of biomedical science that is not based in science. It is based in a legal engagement of science, and it fails to appreciate the biochemical and medical nuances that distinguish what may appear to be similar therapeutics.

To ensure that innovation in one of the most challenging sectors in the United States is able to continue to lead the world, we are hopeful that you will identify QSSDs by reference to a distinct New drug Application (NDA) or Biologics License Application (BLA), which is consistent with the FDA's regulatory framework.

Thank you for your consideration and we will be happy to provide any further input from the life sciences ecosystem in New Jersey if helpful.

Sincerely,

Debbie Hart
President & CEO
BioNJ

Biocom California

June 26, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. 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 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Submitted electronically

Dear Administrator:

Biocom California appreciates the opportunity to offer comments on the draft guidance for the third cycle of negotiations for the Medicare Drug Price Negotiation Program ("MDPNP") issued by the Centers for Medicare and Medicaid Services (CMS)[1].

Biocom California is the largest, most experienced leader and advocate for California's life science sector, which includes biotechnology, pharmaceutical, medical device, genomics and diagnostics companies of all sizes, as well as research universities and institutes, clinical research organizations, investors and service providers. Biocom California drives public policy initiatives to positively influence the state's life science community in the research, development, and delivery of innovative products. California's life sciences industry generates over $414 billion in annual economic output, supports 1.24 million jobs, and produces $128.6 billion in labor and sole proprietor income [2].

While Biocom California supports the Inflation Reduction Act's (IRA) establishment of a $2,000 cap on out-of-pocket patient spending and the restructuring of the Medicare Part D benefit program, we have continuously raised strong concerns about the MDPNP provisions which have already had a negative impact on biotechnology innovation. We believe that the IRA does not balance promoting patient affordability and the role of the biomedical community in bringing innovative medicines to market. As the advocate for California's life science sector, we understand the importance for stakeholders to inform and guide the implementation of the MDPNP for initial price applicability year (IPAY) 2028 and we offer our comments below:

[1] https://www.cms.gov/files/document/medicare-drug-price-negotiation-draft-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf
[2] Biocom California 2024 Economic Impact Report Databook. https://www.biocom.org/eir/.

30.1 Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028

The guidance states that CMS will identify a potential qualifying single source drug by "all dosage forms and strengths of the drug with the same active moiety and the same holder of a New Drug Application (NDA), inclusive of products that are marketed pursuant to different NDAs." For biological products, CMS will consider "all dosage forms and strengths of the biological product with the same active ingredient and the same holder of a Biologics License Application (BLA) inclusive of products that are marketed pursuant to different BLAs."

Biocom California disagrees with CMS's approach to identifying a qualifying single source drug and its dosage forms and strengths by its common active moiety and common active ingredient for drugs and biologics, respectively. Instead, we suggest that CMS identify drugs and their dosage forms and strengths by referencing an NDA or BLA. The Food and Drug Administration's (FDA) application-based framework should act as a reference and be adopted such that a product approved or licensed under a new NDA or BLA (as opposed to a product approved or licensed under a supplement to an existing NDA or BLA) is a distinct qualifying single source drug. Utilizing this framework to distinguish products would be consistent with industry practice and incentivize innovation; unlike CMS's current definition of a "qualifying single source drug" which combines drug products by common active moiety and biological products by common active ingredient. Furthermore, utilizing FDA's application-based framework would enable CMS to more easily identify relevant dosage forms and strengths when aggregating Medicare expenditures and this would allow manufacturers to track the seven- or eleven-year "qualifying single source drug" clock more readily.

Furthermore, when discussing combination products on page 13, the draft guidance states that "CMS acknowledges that there may exist fixed combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference." **Biocom California opposes this language in the draft guidance since we do not believe that CMS has the adequate statutory authority nor staff with necessary expertise to determine what constitutes a "clinically meaningful difference." We recommend that CMS defer to the FDA for those determinations as this would be within the FDA's purview.** Additionally, this revision in the draft guidance does not align with the FDA's definition of fixed-combination products which states "[t]wo or more drugs may be combined in a single dosage form when each component makes a contribution to the claimed effects.[3]" Therefore, we oppose this recommended revision in the draft guidance.

It is unclear how the agency will determine what constitutes a "clinically meaningful difference" and which metrics will be used to assess this. **We recommend that the guidance include additional clarifying language explaining what a "clinically meaningful difference" would be and how CMS intends to determine this.**

30.1.1 Orphan Drug Exclusion from Qualifying Single Source Drugs

CMS explains that certain orphan drugs will be excluded when identifying qualifying single source drugs: "CMS will exclude a drug or biological product that is designated as a drug for only one rare disease or condition under section 526 of the [Food, Drug, and Cosmetics] FD&C Act and for which the only approved indication (or indications) is for such disease or condition." The limited scope of the orphan drug exclusion risks disincentivizing orphan drug research and development (R&D) and will impact a manufacturer's decision to continue R&D to expand a drug's indications to include additional rare diseases. **Biocom California urges CMS to consider the scope of the orphan drug exclusion in a manner that maximizes protections and continues to support and incentivize the development of orphan drugs and rare disease R&D.**

[3] 21 CFR 300.50

Additionally, in situations where an approved indication falls within the scope of an orphan drug designation but there is no corresponding orphan exclusivity, CMS cannot rely on FDA's databases as they track orphan exclusivity, rather than a designation, to determine eligibility for orphan drug exclusion. We appreciate that the agency "will consult with FDA as needed, including to determine whether a drug is designated for, or approved for indications for, one or more rare disease(s) or condition(s)." **However**, **Biocom California also suggests that CMS establish a process that enables manufacturers to submit evidence demonstrating that an indication falls within an orphan drug designation in situations where the agency is unable to determine eligibility for the exclusion based on FDA's databases.**

Lastly, Biocom California asks CMS to ensure that, where an orphan drug loses eligibility for the orphan drug exclusion, the seven- or eleven-year "qualified single source drug" clock runs from *the date on which the drug lost eligibility for the exclusion*. An orphan drug that loses eligibility for the orphan drug exclusion due to an expansion of indications for a second rare disease could be immediately eligible for negotiations. **This would further disincentivize drug developers from investing in rare disease R&D and we ask CMS to clarify these details in order to mitigate the risk that the MDPNP will deter necessary orphan drug development.**

30.2.1 Exception for Small Biotech Drugs

Per the IRA, a drug is exempt from negotiation for initial price applicability years 2026, 2027, and 2028 if the drug meets the exception for small biotech drugs ("Small Biotech Exception"). "The statute requires that CMS evaluate whether a qualifying single source drug qualifies for the [small biotech exception] based on Total Expenditures under Part B or Part D."

The Small Biotech Exception is a critical protection that recognizes the need for small biotech drugs to be exempt from negotiation. Biocom California encourages the agency to develop a dispute resolution process that enables manufacturers to respond to and appeal a negative determination. As part of this process, CMS should engage in a dialogue and small biotech companies should have the opportunity to provide additional data to support their application for the exception before CMS provides a final determination.

40.2.1 Confidentiality of Proprietary Information

CMS explains that it "will implement a confidentiality policy that is consistent with existing federal requirements for protecting proprietary information of Primary Manufacturers, including Exemptions 3 and/or 4 of [the Freedom of Information Act] FOIA, and that strikes an appropriate balance between: (1) protecting the highly sensitive information of manufacturers and ensuring that manufacturers submit the information CMS needs for the Negotiation Program, and (2) avoiding treating information that does not qualify for such protection as proprietary. Thus, for initial price applicability year 2028, CMS will treat information on non-FAMP [non-Federal average manufacturer price] as proprietary."

The guidance states that R&D costs and recoupment, unit costs of production and distribution, pending patent applications, market data, revenue and sales volume data will be considered proprietary. Conversely, data on prior Federal financial support, approved patent applications, exclusivities, and approved FDA applications will be considered non-proprietary since this data is publicly available. **Biocom California acknowledges and agrees with the information that will be considered proprietary versus non-proprietary. However, we believe there is a need for CMS to further explain how it intends to protect a manufacturer's confidential information and establish more robust safeguards to ensure that the agency is adequately handling proprietary information submitted as part of the process.**

We suggest that CMS focus on developing data privacy and security protection protocols that include robust storage and controls that limit access to confidential information to CMS staff on a "need-to-know" basis.

Furthermore, "CMS is required to publish the explanation of the MFP [maximum fair price] by March 1, 2027, for initial price applicability year 2028. In this public explanation and any other public documents discussing the MFP, CMS will make public the…data submitted by the Primary Manufacturer for their selected drug (and by the public as discussed in more detail in section 50.2.1 of this draft guidance) that are determined to be non-proprietary and will not disclose any protected health information (PHI), personally identifiable information (PII), or information that is protected from disclosure under other applicable law." **Biocom California appreciates CMS's discretion to not disclose PHI/PII, however, the possibility of inadvertently disclosing confidential information is possible. In order to avoid such a disclosure, we suggest CMS allow manufacturers the opportunity to review a draft explanation of the MFP prior to its publication and dispute any confidentiality concerns. This will ensure that manufacturers are comfortable with the information disclosed and no proprietary information is inadvertently released.**

40.4 Providing Access to the MFP in 2026, 2027, and 2028

In section 40.4, CMS details the ways in which a Primary Manufacturer may provide access to the MFP by either "(1) prospectively ensuring that the price paid by the dispensing entity or Part B provider when acquiring the drug is no greater than the MFP; or (2) retrospectively providing reimbursement for the difference between the dispensing entity or Part B provider's acquisition cost and the MFP." The Primary Manufacturer must transmit the payment amount within 14 calendar days of when the Medicare Transaction Facilitator (MTF) provides data to the manufacturer verifying that the drug was dispensed to an MFP-eligible individual.

We support the use of the MTF to facilitate the effectuation of the MFP and to minimize the operational burden of program administration for both manufacturers and pharmacies. The MTF is essential to streamline processes needed for the timely provision of MFP discounts to pharmacies. The MTF should facilitate accurate transactions between parties and prevent 340B duplicate discounts.

To ensure the MTF is operational for Part D drugs' MFP effectuation, CMS should consider prefunding the MTF (similarly to how CMS implemented the Coverage Gap Discount Program (CGDP)) to ensure pharmacies are able to stock MFP selected products. This will also lessen the burden for manufacturers who are required to offer the MFP, as manufacturers are not health plans and cannot prefund the MTF. Further, like the CGDP, CMS should allow a robust claims and disputes process to ensure program compliance to adjudicate claims for all entities involved in MFP effectuation. Additionally, in order to ensure there are not federally prohibited 340B duplicate discounts, as required by statute, CMS should include a claims modifier in the Part D MFP program similar to what has been done in the Part B Inflation Rebate Program.

For MTF PM requirements, we recommend that CMS continue to allow MFP refunds to be passed through to dispensing entities at the Primary Manufacturer's election. The IPAY 2027 guidance noted that "the MTF PM will provide participating Primary Manufacturers a means by which MFP refund payments can be passed through to dispensing entities at the Primary Manufacturer's election" and we suggest that CMS maintain this provision for IPAY 2028 MFP effectuation as well[4].

[4] Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027. https://www.cms.gov/files/document/medicare-drug-price-negotiation-final-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf

In the context of Part B effectuation, replicating the Part D MFP effectuation model for Part B covered drugs will create access challenges and a significant administrative and financial burden for health care providers. These providers will experience a decline in reimbursement from the Average Sales Price (ASP) to the MFP, while providing the same level of in-office administration services for the same product. As a result, this may lead providers to seek coverage under the pharmacy benefit or refer patients to infusion centers or health systems and this will lead to patient access challenges.

Lastly, we believe that CMS should also dedicate resources to educating beneficiaries about the MFP and patient smoothing. The IRA does not comprehensively account for beneficiary education and the impact of the final results of negotiation on patient out-of-pocket costs. **To ensure that patients have a clear understanding of their costs, we encourage CMS to continue to provide resources for comprehensive beneficiary education about the results of the negotiations so that they may accurately understand their out-of-pocket costs at the pharmacy counter.**

50. Negotiation Factors and 60. Negotiation Process

Section 50.1 of the guidance outlines the selected drug data factors to be reported by the Primary Manufacturer to CMS by March 1, 2026. These elements include 1) R&D costs and the extent to which those costs have been recouped; 2) current unit costs of production and distribution averaged across the Primary and any Secondary Manufacturers; 3) Federal financial support for the drug's novel therapeutic discovery and development; 4) data on pending and approved patent applications, exclusivities recognized by the FDA, and FDA applications and approvals; and 5) market data, revenue, and sales volume data for the selected drug in the United States for the Primary and Secondary Manufacturers.

While we appreciate CMS outlining the exact manufacturer-specific data required, it is unclear what the agency's expectations are regarding data quality and how it intends to assess these factors without standardizing each element. **In an effort to provide clear data that aligns with the relevant information requested by CMS, for information not explicitly needed for a calculation or required by statute, we suggest that the agency allow manufacturers to 1) submit the information which they believe is most relevant and aligns with these required elements and 2) provide a justification for the manufacturer-specific data they submitted.**

As noted in section 50.2, CMS will "consider evidence about alternative treatments to the selected drug, as available, including:

1. The extent to which the selected drug represents a therapeutic advance compared to existing therapeutic alternatives for the selected drug and the costs of such existing therapeutic alternatives;
2. FDA-approved prescribing information for the selected drug and its therapeutic alternatives;
3. Comparative effectiveness of the selected drug and its therapeutic alternatives, including the effects of the selected drug and its therapeutic alternatives on specific populations (including individuals with disabilities, the elderly, the terminally ill, children, and other patient populations, herein referred to as "specific populations"); and
4. The extent to which the selected drug and the therapeutic alternatives to the drug address unmet medical needs for a condition for which treatment or diagnosis is not addressed adequately by available therapy."

Furthermore, in section 60.3 *Methodology for Developing an Initial Offer*, when developing a starting point for the initial offer, CMS should not consider starting points that are informed by reference prices, the costs of production or distribution, or other factors that do not provide clinical value to Medicare beneficiaries. **We do not support these proposed methods as such alternative approaches would increase non-transparency in the MDPNP, creating greater uncertainty and further disrupting incentives for future research and development to address unmet medical needs**.

Setting prices based on costs or other benchmarks rather than value would disrupt patient access both presently and in the future. **When developing an initial offer, we support prioritizing factors which are most important to patients such as factors related to clinical value and unmet need and de-emphasizing manufacturer specific data elements such as cost of production and research and development costs.** Ensuring such evidence is appropriately weighted in the MFP will more appropriately reward products that have enhanced patient care and will help maintain the investment in promising R&D and clinical programs.

Biocom California also encourages an approach that places a greater emphasis on a range of high-quality robust evidence, including real-world evidence (RWE), and prioritizes information submitted by patients and clinicians with scientific expertise in their therapeutic areas.

Additionally, **Biocom California supports an open and transparent dialogue between CMS and the Primary Manufacturer when determining the MFP, including a discussion about how and why a specific therapeutic alternative was selected.** We ask CMS to provide manufacturers with details regarding the agency's evaluation of evidence related to therapeutic alternatives and MFP-setting, and to discuss this analysis with manufacturers. **We also suggest the agency consider circumstances when drugs should be priced as close as possible to the MFP ceiling in order to avoid imperiling patient access.** Setting higher MFPs for products that have advanced patient care and address unmet medical needs will help maintain investment in assets and clinical programs that show scientific promise and address needs not served by current therapies.

Furthermore, the guidance states that "[f]or the purposes of determining a single price included in an initial offer… CMS intends to base the single price on the cost of the selected drug per 30-day equivalent supply (rather than per unit—such as tablet, capsule, injection—or per volume or weight-based metric) for all formulations (including drugs payable under Part B and/or covered under Part D, as applicable), weighted across dosage forms and strengths." **We disagree with this proposed approach and suggest that the agency negotiate the single price for the selected drug on a per-unit basis rather than a 30-day equivalent supply basis.**

Lastly, to facilitate a transparent process, we ask CMS to provide 1) a <u>meaningful</u> justification of its initial offer, 2) its response to any counteroffer, and 3) afford the manufacturer a legitimate opportunity to comment on the response before the MFP is set. As part of this justification, we would ask the agency to provide a rationale as to how it arrived at the offer or response, including an explanation of how the decision is supported by the factors, how those factors were considered and weighted, and any additional information that was utilized as a part of the decision. Disclosing the basis of an offer or response would promote a robust and effective dialogue that informs more targeted discussions during the process.

<u>70. Removal from the Selected Drug List Before or During Negotiation, or After an MFP is in Effect</u>

CMS discusses that a drug will be removed from the selected drug list and no longer subject to the negotiation process when the agency determines that "(1) the FDA has approved a generic drug under section 505(j) of the FD&C Act that identifies as its reference-listed drug a product that is included in the selected drug, or the FDA has licensed a biosimilar under section 351(k) of the PHS [Public Health Service] Act that identifies as its reference product a product that is included in the selected drug; and (2) the generic drug or biosimilar, as applicable, is marketed pursuant to such approval or licensure." CMS will consider an approved generic drug or licensed biosimilar biological product to be marketed when the totality of the circumstances demonstrate that the generic drug or biosimilar manufacturer is engaging in bona fide marketing.

Biocom California disagrees with the agency's use of "bona fide marketing" as this is a subjective assessment, and we urge the agency to abandon "bona fide marketing." Instead, we suggest that CMS consider a product's market date as the date on which a generic or biosimilar is marketed and the date on which CMS *determines* that a generic or biosimilar has been marketed. Per CMS's Medicaid Drug Rebate Program (MDRP) Data, "market date" is defined as "the earliest date the drug was first marketed under the application number by any labeler[5]. The MDRP "market date" is a familiar term for both CMS and manufacturers and would allow for a consistent application and less burdensome adoption of this standard as part of the MDPNP.

110. Part D Formulary Inclusion of Selected Drugs

Research has demonstrated that Part D formularies have already become more restrictive over the past decade[6]. CMS indicates it "…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 that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs[7]. However, the draft guidance does not identify the specific steps CMS will take to strengthen its formulary oversight to ensure that beneficiaries have access to selected drugs. Absent clearer guidance from CMS, we are concerned that beneficiary access will deteriorate as the MDPNP is implemented.

We appreciate the opportunity to provide feedback on behalf of our members and thank you for your time and diligence in examining our comments. Please contact Biocom California's Regulatory Policy Manager, Zoe Bilis, at zbilis@biocom.org for additional information or questions. We look forward to continuing to work with you on this matter.

Sincerely,

Tim Scott
President and CEO
Biocom California

[5] CMS, MDRP Data Guide § 5.15 (Apr. 2022).
[6] 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
[7] https://www.cms.gov/files/document/medicare-drug-price-negotiation-draft-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf

PRIVILEGED and CONFIDENTIAL

Biosimilars FORUM

June 26, 2025

SUBMITTED ELECTRONICALLY

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Biosimilars Forum Comment on "Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

The Biosimilars Forum ("The Forum") appreciates the opportunity to comment on CMS's "Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028" ("IPAY 2028 Draft Guidance").

The Forum represents a diverse group of companies responsible for developing the majority of biosimilar products for the U.S. market.[1] We are dedicated to creating significant cost savings through biosimilar development and increasing competition in the market for biologic medicines to lower costs for patients and their families. The Forum respectfully submits these comments explaining why certain aspects of CMS's IPAY 2028 Draft Guidance should be reconsidered to ensure the continued viability of the biosimilars industry and harness the potential cost-savings of these critical products.

I. Background

The Biosimilars Forum is a non-profit organization with the mission of educating stakeholders on the value of biosimilars and advancing biosimilars in the United States with the intent of expanding access to biological medicines and improving health care while lowering costs. The Forum and its member companies actively collaborate with FDA as well as other regulators to ensure that biosimilars meet the rigorous U.S. standards of safety, efficacy, and quality to provide U.S. patients with access to cost-effective biologic medicines.

[1] Unless otherwise indicated, the term "biosimilar" includes interchangeable biosimilars.

Our members represent the majority of companies with the most significant U.S. biosimilars development portfolios and experience in the U.S. market, and our membership spans the entire biosimilar development pipeline, from initial research to regulatory approval to commercialization. Our membership includes nine biosimilar companies that collectively employ thousands of people in the United States as well as around the world. They have invested hundreds of millions of dollars in the U.S. over the past decade on research and development, manufacturing, patient outreach and advocacy, and commercialization of biosimilars.

Biologics play a critical role in the treatment of many serious illnesses, ranging from cancers to gastrointestinal disease to genetic disorders. Since the biosimilars pathway was established in the Biologics Price Competition and Innovation Act of 2009,[2] biosimilars have brought enhanced competition to the U.S. market, expanding patient access to high-quality treatment options while reducing costs. Since the first biosimilar was approved around ten years ago, these safe and effective medicines have generated substantial savings: biosimilars cost on average 50% to 85% less than the originator products they reference and have the potential to save the U.S. Government hundreds of billions of dollars. In fact, if all products with a patent expiring in the next 10 years were to have a biosimilar in the pipeline, the U.S. healthcare system could save an additional $189 billion in addition to savings generated by biosimilars already on the market or expected to enter.[3]

Biosimilar competition is crucial to lowering healthcare costs and maintaining a robust marketplace. Yet as a relatively new segment of the market, biosimilars have faced a number of obstacles to growth, including high costs of production and high regulatory burdens. A typical biosimilar costs from $100 million to $300 million to develop and takes six to nine years to go from analytical characterization to approval.[4] And that is exclusive of the cost of commercializing a new biosimilar in the U.S. or successfully navigating the patent challenges prior to launch. This is a rigorous scientific research and development process, but its cost and duration leaves the nascent biosimilar market particularly vulnerable to negative impacts from additional costs.

As a result, the Forum is concerned that there is a biosimilar void looming. The difficult cost structure and onerous timelines for biosimilar development mean that today only about 6 percent of the biologic medicines available on the market have a biosimilar counterpart. Currently, *only 10 percent* of the 118 biologics expected to lose patent protection in the next decade—for which biosimilars could offer enormous cost-savings—have biosimilars in development.[5] The Inflation Reduction Act ("IRA") creates a price-setting framework for certain "selected" drug and

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[2] 42 U.S.C. § 262(k).
[3] IQVIA, Assessing the Biosimilar Void in the U.S. (Feb. 3, 2025) available at: https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/assessing-the-biosimilar-void-in-the-us.
[4] McKinsey & Company, Three imperatives for R&D in biosimilars (Aug. 19, 2022) available at: https://www.mckinsey.com/industries/life-sciences/our-insights/three-imperatives-for-r-and-d-in-biosimilars.
[5] IQVIA, Assessing the Biosimilar Void in the U.S. (Feb. 3, 2025) available at: https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/assessing-the-biosimilar-void-in-the-us.

biological products[6] that make it more difficult for biosimilar manufacturers to recoup their investments, exacerbating this biosimilar void and undermining the development pipeline for the next generation of cost-saving biosimilar medicines.

II. Comments

The Forum is deeply concerned that, against the fragile biosimilar backdrop, the implications of some of the policies maintained in the Draft IPAY 2028 Guidance could endanger the much-needed growth of this still-emerging industry. Biosimilar producers must have sufficient incentives to bring these cost-saving medicines to the market, and sufficient clarity and transparency to plan development pipelines. In particular, the Forum is concerned that CMS's guidance approach would impose obligations on biosimilar manufacturers that are more onerous than those the statute permits and improperly capture reference products even after biosimilars have been approved and launched, therefore undermining biosimilars' ability to successfully gain market share. CMS continues in the Draft IPAY 2028 Guidance to negotiate and impose MFPs on reference products even in the face of imminent or actual biosimilar competition, as it has with Ustekinumab. And, CMS's implementation of the Special Rule to Delay Selection and Negotiation of Biologics for Biosimilar Market Entry ("Biosimilar Special Rule") imposes unnecessary constraints that substantially nullify biosimilars' opportunity to avail themselves of that provision, frustrating Congress's objective in preserving this vital route for biosimilar competition. The interpretations maintained in the Draft IPAY 2028 Guidance, for example, would find a high likelihood of licensure and marketing only in the narrowest of circumstances, chilling biosimilar development and reducing affordable options for patients since the millions spent getting a biosimilar to market would be wasted if the reference product is already at an artificially low price per the MFP under the IRA.[7]

In enacting the IRA, Congress recognized both that biosimilar competition is crucial to lowering healthcare costs and maintaining a robust marketplace, and that imposing price controls on biological reference products had the potential to disincentivize biosimilar development—in particular by unduly capturing reference products that already faced (or were about to face) biosimilar competition. Thus, Congress precluded CMS from imposing price controls on a reference product for which there is an approved and "marketed" biosimilar,[8] required de-selection of a reference product during a 9-month off-ramp period specified in the statute,[9] and afforded biosimilars up to two years of delayed selection of a reference product to give biosimilars time to enter the market under certain circumstances.[10]

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[6] Pub. L. No. 117-169, §§ 11001–11003, 136 Stat. 1818, 1833–62 (2022).
[7] The Forum maintains and incorporates by reference its earlier comments with respect to CMS' draft IPAY 2026 and draft IPAY 2027 guidance.
[8] 42 U.S.C. § 1320f-1(e)(1)(B)(iii).
[9] *Id*. § 1320f-1(c)(1).
[10] *Id*. § 1320f-1(f).

It is important for CMS to acknowledge the commitment of the members of the Biosimilars Forum to developing and marketing lower cost biosimilars. As mentioned, biosimilar development is an arduous, lengthy, and expensive undertaking. The decision to develop and market a biosimilar is a very serious decision our members do not make lightly. CMS's misinterpretation of Congressional intent by reading "bona fide" into the statute and minimizing opportunities to use the Biosimilar Special Rule, amongst other liberties taken in the IPAY 2028 Draft Guidance, threaten to upend the biosimilar market.

A. CMS Must Eliminate the Subjective "Bona Fide Marketing" Requirement.

The Forum remains deeply concerned about CMS's imposition of an extra-statutory "bona fide marketing" requirement. Several of the IRA's critical provisions are conditioned on when a biosimilar is "marketed." This includes whether or not a biological product is a "qualifying single source drug"—it cannot be if it is the reference product for a licensed and marketed biosimilar[11]; whether a selected drug will continue to be negotiation eligible[12]; and whether a selected drug can remain a selected drug.[13] The language of each of these provisions in the IRA is clear: they refer, without caveat or limitations, to whether the biosimilar is "marketed" which has an established meaning that has been clearly defined by the Department of Health and Human Services.[14]

Yet CMS's draft guidance continues to seek to impose an extra layer of obligation on biosimilars to show not only that the product is physically available for procurement and administration but also that such marketing is "bona fide."[15] CMS maintains in this new draft guidance that it intends to consider a biosimilar to be "marketed" only when the "totality of the circumstances" align to meet the agency's opaque, "holistic inquiry" that "will not necessarily turn on any one source of data."[16] The subjective "totality of the circumstances" standard has significant consequences for the prospect of biosimilar competition. Notwithstanding the actual date of marketing for a biosimilar, it can take weeks, months, or even longer before a fully licensed and marketed biosimilar passes CMS's arbitrary and as-yet undefined threshold. This subjective threshold is affected not only by uncontrollable market dynamics, but also by CMS's opaque processes, delays, and errors concerning CMS's Medicare Hospital Outpatient Prospective Payment System ("OPPS") and OPPS addenda files, all of which are beyond a biosimilar manufacturer's control. Such delays and errors disincentivize prescribing biosimilar products which causes the CMS threshold not to be reached. Moreover, because of the slowness of the Part D claims submission process, we recommend that CMS review Part D claims at the switch through

[11] 42 U.S.C. § 1320f-1(e)(1)(B)(iii).
[12] *Id*. § 1320f-1(c)(2).
[13] *Id*. § 1320f-1(c)(1).
[14] *See, e.g.*, Medicaid Drug Rebate Data Guide for Labelers § 4.15; 21 C.F.R. § 314.3.
[15] IPAY 2028 Draft Guidance at 29-30.
[16] IPAY 2028 Draft Guidance at 156-57 (§ 70).

the Part D transaction facilitator which indicates in as real time as possible, whether a pharmacist has prescribed a biosimilar product.

Thus, instead of maximizing the chance for biosimilars to gain a foothold and lower prices organically, CMS's *ultra vires* addition of a "bona fide" requirement creates artificial delay—and can result in price negotiation of a reference product regardless of biosimilar competition and without consideration of the time and resources it took to develop and launch that biosimilar. It also can result in reference products continuing to be subjected to "maximum fair prices" ("MFPs") after biosimilar launch, undermining those biosimilars' entry into the market. In this way, CMS has given itself unfettered discretion to prevent the MFP from ever terminating, creating significant uncertainty about biosimilars' ability to launch and destabilizing the market.

What is more, the amorphous "holistic inquiry" the agency proposes to undertake with respect to continued biosimilar marketing leaves biosimilar sponsors with no certainty as to how, or even whether, they can meet this subjective standard. While the Forum appreciates CMS's inclusion of examples of "bona fide marketing" in the IPAY 2028 Draft Guidance, those examples do not provide clear thresholds for when marketing will be considered "bona fide" and so lack the necessary transparency. In addition, some of the examples appear to layer on additional, extra-statutory requirements and ambiguities. One such example, for instance, suggests that PDE utilization must be "high and consistent" and biosimilar launch must have been "successful" in order for a biosimilar to be considered "marketed."[17]

The Forum is concerned that CMS's interpretation will chill biosimilar development and its promise of increased access and lower drug prices and contribute to the biosimilar void described above. Educating patients and physicians takes time, particularly as many are new to biosimilars. This process is further complicated by misinformation about biosimilars and rebate traps that frustrate biosimilar uptake and therefore, reliance on these subjective measures threatens to allow price negotiation of reference products before a biosimilar has had a fair chance of gaining market share. Under these circumstances, we anticipate less investment in biosimilar products which runs counter to the Administration's goal of lowering costs to American consumers. We urge CMS to abandon this artificial construct, which is untethered to the statute and harmful to the biosimilars industry and instead adhere to the accepted a definition of "marketed" as it was used in the statute.

B. CMS Should Provide Additional Transparency and Regulatory Flexibility with respect to the Biosimilar Special Delay

The Forum reiterates and incorporates our earlier comments with respect to the Biosimilar Special Rule. In particular, we wish to reemphasize that CMS should revisit the delay request process, allowing for earlier and more open communication with biosimilar companies to

[17] IPAY 2028 Draft Guidance at 15 (§ 30.1).

understand where they are in the development process. This will facilitate more accurately gauging of high likelihood of approval and launch well in advance of the selected drug publication date.

Licensure. The Forum is concerned that CMS's various timelines concerning the Biosimilar Special Rule further disincentivize biosimilar investment and development.

First, Biosimilars cannot be approved by the FDA until 12 years after the reference product has been launched and biosimilar manufacturers are precluded from submitting an application under section 351(k) for the first 4 years following the reference product's date of first licensure.[18] However, under the IRA, a biological reference product may be selected for imposition of an MFP 11 years after the date of first licensure (one year earlier than the end of the exclusivity period under the PHSA).[19] These timing considerations are important because under the current implementation of the Biosimilar Special Rule, CMS generally restricts eligibility for the Biosimilar Special Rule to biosimilar manufacturers with a filed or approved 351(k) BLA which unnecessarily precludes consideration of biosimilar products that are blocked from approval under the PHSA's exclusivity provisions. Moreover, this interpretation of high likelihood of licensure essentially truncates the *two-year* period for demonstrating high likelihood of licensure to a *one-year* period, because it ignores the 12 month period of time required for FDA review timeline for a biosimilar BLA.[20] This is particularly problematic for biosimilars given that a reference product may be selected for negotiation prior to the expiration of that reference product's exclusivity period. To maintain the viability of the Biosimilar Special Rule, we suggest that CMS determine there exists a high likelihood of licensure in additional circumstances, such as if the biosimilar manufacturer has had a BPD Type 4 Meeting (*i.e.*, a pre-BLA meeting) with FDA which indicates commitment to submitting a BLA when the exclusivity period ends.[21]

Marketing. The Forum is grateful that CMS is seeking comments on whether there is additional or alternative evidence that may demonstrate that patents related to a reference product are unlikely to prevent a biosimilar from being marketed. In particular, CMS is considering whether there are industry-recognized milestones that could be used for this purpose, and/or whether public-facing comments relating to the timeline for resolving the patent dispute could be useful tools.[22] We suggest that CMS consider any one of the following items submitted by the biosimilar manufacturer as demonstrating a high likelihood of marketing—, all of which would better align with the statute and the realities of biosimilar development and patent disputes.

- Public statements from the biosimilar manufacturer that it is planning for biosimilar launch

[18] Section 351(k)(7)(A),(B) of the FDCA (42 U.S.C. § 262(k)(7)(A),(B)).
[19] 42 U.S.C. § 1320f-1(e)(1)(B).
[20] The review performance goal in BsUFA III (covering FYs 2023 through 2027) for a new biosimilar product application is 10 months from the 60-day filing date. Biosimilar Biological Product Reauthorization Performance Goals and Procedures Fiscal Years 2023 Through 2027 at 4 (hereinafter "BsUFA III).
[21] A BPD Type 4 Meeting is a pre-submission meeting to discuss the format and content of a complete application submitted under section 351(k) of the PHSA. BsUFA III at 19.
[22] IPAY 2028 Draft Guidance at 37.

before the date that is two years after the selected drug publication date (e.g., press statements, excerpts from investor relations reports or meetings, and public statements from a corporate director). These statements could also be accompanied by an attestation signed by the General Counsel and/or Chief Executive Officer. The fiduciary obligations biosimilar companies owe to their shareholders ensure accountability, providing a preexisting check against self-serving statements;

- Public statements from the reference product sponsor that it is planning for biosimilar launch before the date that is two years after the selected drug publication date (e.g., in disclosures to the United States Securities and Exchange Commission);
- A copy of a notice of first commercial marketing pursuant to 42 U.S.C. § 262(l)(8), which the biosimilar applicant must provide to the reference product sponsor no later than 180 days before the date of first commercial marketing;
- An attestation that, for any ongoing patent litigation, the court has issued neither a preliminary injunction nor a permanent injunction preventing launch by the date that is two years after the selected drug publication date;
- Biosimilar market entry forecast by an industry-leading analytics firm, such as IPD Analytics. These firms prepare data-driven forecasts of anticipated market entry based on tracking litigation and mapping out the patent landscape; or
- An executive summary of a law firm's assessment of the asserted patents' invalidity and non-infringement.

In addition, CMS suggests that it will assess whether a biosimilar manufacturer is ready to operationalize marketing against: (1) public disclosures about capital investment, revenue expectations, and actions consistent with the normal course of business for marketing of a biosimilar biological product before February 1, 2028; and (2) a manufacturing schedule that is consistent with the public-facing statements and demonstrates readiness to meet revenue expectations."[23] The Forum generally agrees with CMS's proposal to assess these two factors, as long as disclosures about capital investment, revenue expectations, and other actions are optional and either publicly available or if private, kept confidential in accordance with applicable disclosure laws and that CMS considers any manufacturing schedule provided with appropriate context. As we have previously commented, the manufacturing schedule submitted to FDA—and thus submitted to CMS under section 1192(f)(1)(B)(ii)(III)(aa)--does not reflect any post-approval manufacturing dates. We maintain, however, that these manufacturing schedules are sufficient to demonstrate operational readiness, as they signal to FDA that an establishment is prepared and able to manufacture the proposed commercial product during application review.

C. CMS Should Not Adopt an Overly Burdensome Standard for a Second Year of Delay

[23] IPAY 2028 Draft Guidance at 37.

Flowing from CMS's overly restrictive view of high likelihood that effectively requires certainty of licensure and marketing for the Initial Delay Request, the agency has little room for consideration of whether a biosimilar manufacturer has demonstrated a "significant amount of progress" to justify a second year of delay.[24] Use of information from only two additional categories of information is considered: (1) agreements related to the biosimilar as filed with the Federal Trade Commission, and (2) "additional information and documents that CMS may request."[25] Considering the lack of detail included in the draft guidance with respect to this latter category, the Forum suggests that a more concrete proposal should be put forth for member companies to respond to. Knowing what kinds of additional information and documents CMS may wish to rely on would facilitate an informed comment.

FDA is better positioned to gauge the likelihood of licensure, and CMS's policy, therefore, should consider for example, whether the biosimilar manufacturer has held a Biological Product Development (BPD) Type 4 Meeting (i.e., a pre-BLA meeting) with FDA or has undergone a manufacturing facility inspection. This information is particularly insightful for an additional delay request as it indicates that the biosimilar manufacturer and FDA are close to starting the 10-month review clock, demonstrating there is a high likelihood that the biosimilar will be marketed by the high likelihood deadline for that IPAY. Moreover, we want to emphasize that if, after the initial delay year, the biosimilar manufacturer receives a Complete Response Letter ("CRL") from FDA, that should not preclude the reference product from being considered for an additional delay. This is because a resubmitted application in response to a CRL is reviewed within 6 months by FDA rather than the initial application review timeframe of 10 months. Thus the biosimilar manufacturer should be determined to have made significant progress, and CMS should find that the biosimilar product still has a high likelihood of being marketed by the deadline.

D. Need for Increased Transparency

In order to have a clear understanding of how CMS is managing the negotiation program (including selection of products for negotiation and removal from the selected drug list), the Forum requests additional information and transparency from CMS. This includes making available the data on which CMS intends to rely in determining whether any given biological product will be considered a qualifying single source drug or negotiation-eligible drug well in advance of the selected drug publication date; timely publishing a list of all reference products for which a biosimilar applicant submitted a Biosimilar Delay request; and, if CMS continues to implement its bona fide marketing requirement, publishing the criteria CMS intends to use to evaluate bona fide marketing and any data on CMS's tracking of bona fide marketing.

E. CMS Should Consider Domestic Prices Only in Setting MFPs

[24] IPAY 2028 Draft Guidance at 38 (§ 30.3.1.4).
[25] *Id*.

CMS has solicited comments on appropriate "starting point" options for developing an initial offer for a biological reference product.[26] The Forum takes no position on the question of MFP development or assignation at this time. We note, however, that reliance on prices that are not domestic—that is, reliance on any international reference or foreign pricing—would be inconsistent with the statute's text and intent. We therefore urge CMS to avoid undertaking those kinds of comparisons.

III. Conclusion

The Forum remains concerned that the IPAY 2028 Draft Guidance raises significant issues that are likely to stifle the biosimilar industry, directly contrary to Congress's intent. We urge CMS to adhere to the statutory definition of marketing and imbue appropriate flexibility into the Biosimilar Special Rule. Without modifications to support the biosimilars industry, CMS's guidance may ultimately prolong high healthcare costs and reduce patient access to more affordable medicines.

Respectfully submitted,

Juliana M. Reed
Executive Director
The Biosimilars Forum

[26] *Id.* at 129.

BlueCross BlueShield Association

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June 26, 2025

Chris Klomp
Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via email to IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Mr. Klomp:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) draft guidance on the Medicare Drug Price Negotiation Program (MDPNP) issued on May 12, 2025.

BCBSA is a national federation of independent, community-based and locally operated BCBS companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own.

BCBSA appreciates CMS publishing revised guidance for Initial Price Applicability Year (IPAY) 2028 and is eager to continue working with CMS as it implements the MDPNP for IPAY 2028 and effectuates Maximum Fair Prices (MFPs) in 2026, 2027, and 2028. Success for this program is largely dependent upon the partnership between CMS, health plans, pharmacies, and other entities in the prescription drug supply chain, and we look forward to continued collaboration on the implementation of the Inflation Reduction Act (IRA). Our comments below underscore the need to continue maintaining flexible coverage and benefit designs to meet a broad range of enrollee needs.

Detailed Recommendations on the Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial

Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027 and 2028

Section 110. Part D Formulary Inclusion of Selected Drugs

In its draft guidance, CMS indicates that all dosage forms and strengths of negotiated drugs must be covered on Part D formularies, but Part D sponsors may place them on preferred or non-preferred formulary tiers or impose utilization management practices based on medical appropriateness. CMS also noted that it will perform oversight to ensure beneficiary access to negotiated drugs.

BCBSA appreciates the consistency from the revised IPAY 2026 guidance and the IPAY 2027 final guidance to the draft IPAY 2028 guidance on the formulary inclusion for selected drugs. As noted in the draft guidance, CMS does not have sufficient information to determine any changes to these policies given the Part D program has not yet had experience with coverage of selected drugs. A Part D sponsor's pharmacy and therapeutics (P&T) committee will be responsible for evaluating the clinical profile of all drugs, selected and non-selected, using the existing statutory and regulatory requirements for formulary design that were in place prior to the enactment of the IRA. Additionally, P&T committees will have to determine formulary considerations and formulary placement for each selected drug, as stated in the draft guidance, while meeting the statutory requirement to cover all selected drugs on Part D formularies.

For instances when a Part D sponsor places a selected drug on a non-preferred tier after a recommendation from a P&T committee, an enrollee would still have access to that therapy as a covered drug. Even if there is higher cost-sharing with the selected drug, enrollees would have financial support from the Medicare Prescription Payment Plan, the annual $2,000 cap on out-of-pocket costs, and other changes to the Part D program (e.g., $35 insulin copay cap) that support patient access to selected drugs and all other covered Part D drugs.

BCBSA supports CMS maintaining the existing Part D formulary review standards that "permit Part D sponsors to use formularies and tiered cost sharing in their benefit design, subject to certain limitations, and requires them to have a cost-effective drug utilization management program that includes incentives to reduce costs when medically appropriate."[1] The current statutory and regulatory structure allows sponsors to rely on an independent P&T committee – a multidisciplinary expert group that is comprised of external doctors, pharmacists, and other health care professionals – to review medications based on current evidence-based medicine and decide which drugs to include on the formulary and where they should be placed. The clinicians serving on a P&T committee play a critical role in effective formulary management and provide consistent, uniform, and equitable drug coverage to meet members' clinical needs. The existing P&T committee structure is well suited for the nuance of drug coverage and tier placement of selected and non-selected drugs alike.

We thank CMS for consideration of our comments, and we look forward to future collaboration on IRA implementation. If you have any questions or want additional information, please contact Paul Eiting at paul.eiting@bcbsa.com.

[1] *CENTER FOR MEDICARE*. (2025). https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf

Sincerely,

Kris Haltmeyer
Vice President, Policy Analysis
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June 26, 2025
Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted via email to IRARebateandNegotiation@cms.hhs.gov

RE: Medicare Drug Price Negotiation Program Draft Guidance

Dear CMS Desk Officers:

Blue Cross Blue Shield of Massachusetts ("BCBSMA") appreciates the opportunity to provide comments on the *Medicare Drug Price Negotiation Program Draft Guidance (the "Draft Guidance").*

BCBSMA is one of 33 locally based, community operated Blue Cross and Blue Shield Plans that collectively provide health benefits to nearly 108 million Americans and contract with hospitals and physicians in every U.S. zip code.

At BCBSMA, our highest priority is to make quality health care affordable for individuals, families, and employers who have made us the health plan of choice in Massachusetts. Our promise and vision guide our efforts to create greater value for our members and employers. Founded in 1937 by a group of community-minded business leaders, BCBSMA is the leading private health plan in the Commonwealth—a not-for-profit company with a proud history of community and health care leadership.

Additionally, BCBSMA has a demonstrated commitment to provide coverage options for people with Medicare in Massachusetts and has continually offered a wide range of Medicare plans since the program began in 1966. As a general matter, we encourage CMS to continue to leverage our experience, and those of other regional Medicare Advantage plans, as a local plan with deep roots in the community. We strive to build products and benefits to meet the needs of our local members utilizing the depth of our insight and data to learn more about what services our members need and utilize. At BCBSMA, we have been committed to enhancing care coordination and improved quality outcomes for our members. Working with providers in our network, we have invested in developing products to meet the unique needs of our members, including designing low-cost or zero-premium Medicare Advantage options to deliver value to a broader population of Medicare beneficiaries. It is with our experience and background in the Medicare program that we respectfully offer these comments to CMS.

Sincerely,

/s/ Jeremy W. Meisinger, Esq.

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Senior Director, Federal Affairs
Government & Regulatory Affairs
Blue Cross Blue Shield of Massachusetts

Section 50 – Negotiation Factors

In considering the Negotiation Factors described in the Draft Guidance and in 42 U.S.C. §§ 1320f-3(e)(1-2), it is important that CMS evaluate the results of its prior negotiations against the objectives embodied in the Inflation Reduction Act, as well as the President's objectives identified in the two Executive Orders issued in relation to prescription drug prices.[1] Although CMS has rightly noted that the initial negotiation round can be expected to result in savings both to Medicare and to beneficiaries,[2] there is much progress still to made and doing so will require tougher negotiations on CMS's part than have been undertaken so far.

Fortunately, the IRA gives CMS significant discretion to take a more aggressive approach. Although the IRA specifies that CMS "shall consider the […] factors" outlined in 42 U.S.C. §§ 1320f-3(e)(1-2), the IRA nonetheless gives CMS substantial latitude to determine *how* it considers those factors. The IRA does not require any particular weighting of the factors, nor does it require CMS to privilege a manufacturer's view of the relevant data over all others. The Proposed Guidance, unfortunately, draws a distinction between the factors listed in subsections (e)(1) and (e)(2), appearing to argue that CMS may *only* consider information submitted by manufacturers when applying the factors listed in (e)(1).[3]

That reading is not compelled by the text of the IRA, which specifies that CMS must consider information "submitted by the manufacturer" in relation to the factors listed in (e)(1) but does not speak to *how* CMS should weigh or consider that information. As one example, although 42 U.S.C. § 1320f-3(e)(1)(E) specifies consideration of "[m]arket data and revenue and sales volume data for the drug in the United States," the IRA does not require CMS to ignore publicly-available information about sales and pricing elsewhere. Indeed, the President has argued forcefully that many drug manufacturers – including manufacturers of the drugs selected for negotiation – "deeply discount their products to access foreign markets, and subsidize that decrease through enormously high prices in the United States."[4]

The President's observation is especially apt in the case of GLP-1 agonists, which are included in the currently-occurring round of price negotiations and which have continued to drive rising pharmacy spending on the part

[1] "Lowering Drug Prices by Once Again Putting Americans First," issued April 15, 2025, and "Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients," issued May 12, 2025.
[2] *See, e.g.,* Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2026, CMS, August 15, 2024, *available at*: https://www.cms.gov/newsroom/fact-sheets/medicare-drug-price-negotiation-program-negotiated-prices-initial-price-applicability-year-2026.
[3] *See* Proposed Guidance, p. 102 (arguing that (e)(2) "does not specify what sources CMS must use" in relation to (e)(2) but also that CMS must "consider manufacturer-specific data for the factors described at section 1194(e)(1) of the Act").
[4] "Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients," issued May 12, 2025. The President made a similar point in "Lowering Drug Prices by Once Again Putting Americans First," arguing straightforwardly that "pharmaceutical manufacturers charge[…] patients in our Nation more than those in other countries for the exact same prescription drugs, often made in the exact same places."

of Medicare Advantage plans. These medications are covered by Medicare for diabetes and, like many drugs also included in the Medicare Drug Price Negotiation Program, are priced much more highly in the United States than they are elsewhere in the world. CMS cannot meaningfully evaluate multiple statutory factors related to GLP-1s if it considers merely the four corners of a manufacturer's data submission:

- "[T]he extent to which the manufacturer has recouped research and development costs"[5] inherently requires consideration of *all* sources of revenue by which a manufacturer might "recoup" the relevant costs and the manner in which manufactures have (or have not) done so in the United States and elsewhere.
- "Current unit costs of production and distribution of the drug"[6] cannot be meaningfully evaluated in a vacuum – to understand what "production" and "distribution" costs mean, CMS would have to understand how those processes serve a manufacturer's global approach to marketing their products, including the extent to which such costs serve markets in addition to the United States.
- "Market data and revenue and sales volume data for the drug in the United States"[7] likewise lacks crucial context if divorced from the manufacturers' global approach to marketing and pricing.

CMS thus should take a wider view that considers, *inter alia*, publicly-available information regarding the global pricing strategy of the manufacturers because that strategy speaks powerfully to what pricing the manufacturers themselves believe supports innovation versus merely widening their profit margins (which is not an objective that the IRA permits, let alone requires, CMS to consider).

To be clear, that wider view would not constitute an additional factor under 42 U.S.C. § 1320f-3(e)(1) that legislators chose not to include, nor would it constitute statutory overreach on CMS's part; rather, it would constitute a logical corollary to the IRA's clear statutory directive to evaluate what prices are fair based on what manufacturers spend on research, development, manufacturing, and distribution. CMS cannot accomplish that task by artificially limiting its view to only what global pharmaceutical manufacturers choose to share regarding their operations in the United States.

Section 110 – Part D Formulary Inclusion of Selected Drugs

The savings that CMS manages to achieve in negotiations are highly relevant not only to spending on Original Medicare, but also to spending in Part D because 42 U.S.C. § 1395w-104(b)(3)(I) requires plans to include drugs for which CMS has negotiated a maximum fair price in Part D formularies. Unfortunately, by proposing to "continue the formulary inclusion policies described in in CMS' revised guidance for initial price applicability year 2026 and final guidance for initial price applicability year 2027," CMS continues to favor manufacturers in

[5] 42 U.S.C. § 1320f-3(e)(1)(A).
[6] 42 U.S.C. § 1320f-3(e)(1)(B).
[7] 42 U.S.C. § 1320f-3(e)(1)(E).

a manner that is not compelled by the text of the IRA and that is inimical to Part D plans' ability to manage pharmacy spending.

Although the Proposed Guidance argues that CMS does not wish to "implement explicit tier placement or utilization management requirements that apply uniformly across selected drugs," the Proposed Guidance nonetheless does exactly that. The Proposed Guidance specifies explicitly that CMS will give special consideration to "any instances where Part D sponsors place selected drugs on non-preferred tiers," "any instances where a selected drug is placed on a higher cost-sharing tier," "any instances where Part D sponsors [require] step therapy," and "any instances where Part D sponsors impose more restrictive utilization management […] for a selected drug" in its annual formulary review. The Proposed Guidance further outlines CMS's "concern[…] that Part D sponsors may […] disadvantage selected drugs" in formulary treatment. Read together, the various provisions of the Proposed Guidance contain a clear message to Part D plans: if plans undertake to manage selected drugs as they do all other drugs in their formularies, there is a significant chance that CMS will disapprove their formularies.

None of the above-described restrictions is required by the IRA, which specifies only that Part D plans "shall include" negotiated drugs in their formularies. The IRA contains no discussion of the conditions under which a Part D plan must do so and makes no suggestion that negotiated drugs are subject to different or higher restrictions than other drugs covered under Part D. Thus, the special consideration that the Proposed Guidance affords negotiated drugs lacks statutory basis.[8]

That special consideration is damaging to plans' ability to manage pharmacy spending because Part D plans have historically been able to negotiate formulary access and tiering provisions as part of supplemental rebate agreements. But by foreclosing upon legitimate utilization management techniques as a matter of course, CMS undercuts Part D plans' leverage to negotiate further rebates with manufacturers. This outcome runs counter to the IRA's clear intention to lower prescription drug costs across *all* portions of Medicare. The IRA provides only that a wholesale formulary exclusion of a negotiated drug is prohibited; because the IRA itself says no more than that on the subject of formulary access, neither should the Proposed Guidance.

[8] It is especially relevant that the drafters of the IRA did not *ignore* formulary inclusion and thus did not implicitly provide additional authority to CMS to determine formulary treatment requirements. As the Proposed Guidance notes, there are "existing statutory and regulatory restrictions on formulary design" of which the drafters of the IRA were well aware; had Congress wished for selected drugs to be treated any differently or more carefully than other drugs under those restrictions, Congress would have said so.

Bristol Myers Squibb™

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

June 26, 2025

Chris Klomp
CMS Deputy Administrator, Director of the Center for Medicare
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Re: "Medicare Drug Price Negotiation Program" Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the "Maximum Fair Price" (MFP) in 2026, 2027, and 2028

Dear Deputy Administrator Klomp,

Bristol Myers Squibb (BMS) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) *"Medicare Drug Price Negotiation Program" Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the "Maximum Fair Price" (MFP) in 2026, 2027, and 2028 ("Guidance")*.[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. That is why 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. 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 compels manufacturers to express "agreement" that there is a

[1] CMS, "Medicare Drug Price Negotiation Program" Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the "Maximum Fair Price" (MFP) in 2026, 2027, and 2028 (May 12, 2025), *available at* Draft Negotiation Guidance.

"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.

The IRA will have vast ramifications for patients, providers, manufacturers, and other stakeholders across the country. BMS is concerned that CMS's implementation of the IRA could have sweeping negative repercussions with respect to 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 begins to finalize details on effectuating the MFP in the marketplace.

BMS appreciates the opportunity to provide the following comments on the Guidance. We intend our input to help CMS improve transparency and clarity of the IRA's "negotiation" program. 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,[2] and we offer them to help mitigate against the negative consequences the Guidance would have on innovation and, most importantly, patients.

Key comments include:

I. **Identification of Selected Drugs**: We oppose CMS' broad interpretation of a qualifying single source drug (QSSD) and its extra-statutory "bona fide" marketing construct. We are also strongly opposed to the draft language in the guidance that suggests CMS would apply an approach to the treatment of fixed combination drugs based on CMS' own view of the clinical function of individual ingredients. We are concerned with how narrow policies related to biosimilars and orphan indications will impact current and future innovation and patient access to medicines. We urge CMS to be targeted, flexible, and lawful in its approach to identifying QSSDs for the purposes of drug selection.

II. **Renegotiation**: While BMS appreciates the opportunity to comment on CMS' proposed renegotiation process, we emphasize the importance of transparency and consistency throughout this process for manufacturers. CMS should adhere to defined parameters and provide explanations as to how they make determinations on drugs that are selected for renegotiation, especially in cases where the determination for selection is at the discretion of the Agency.

III. **Effectuating Access to the MFP**: BMS asserts that significant operational and financial concerns remain with the MFP effectuation process. These include, but are not limited to: the complexity related to CMS's obligation not to require unlawful 340B duplication, lack of accountability and transparency across the supply chain, and burden on manufacturers. With the inclusion of drugs payable under Part B, it is imperative that CMS clarify the exclusion of MFP from ASP to preserve provider reimbursement and patient access.

IV. **Negotiation Factors and Negotiation Process:** We continue to note 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

[2] In general, we refer CMS to BMS' comments in response to the "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" Draft Guidance, released on March 15, 2023 (hereinafter referred to as the "IPAY 2026 comments") as well as 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 (IPAY) 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")

determining the MFP but to do so in the most effective and accurate way possible. Importantly, we continue to ask the Agency for the maximum level of flexibility and transparency in implementing the process. We strongly support CMS' efforts to directly and actively solicit patient-focused input from patients, beneficiaries, caregivers, and consumer and patient organizations, but CMS must make significant improvements for the process to be more meaningful, comprehensive, transparent, and relevant to understanding a medicine's value.

V. **MFP Eligible Individuals in 2026, 2027, and 2028**: It is essential that CMS prioritizes shared decision-making between patients and their providers to develop appropriate treatments plans and ensure patient access to Part B therapies are not adversely impacted by utilization management. BMS recommends that CMS monitor Medicare Advantage plans' use of utilization management to ensure step therapy protocols are based on appropriate clinical guidelines and enforce timelines for plans to respond to step therapy medical exceptions and appeals.

VI. **Manufacturer Compliance and Oversight**: BMS has concerns with the Agency's approach to monitoring manufacturer compliance and oversight. We are opposed to CMS bifurcating manufacturer effectuation plans with two separate deadlines. BMS encourages CMS to maintain the September 1 deadline for the submission of these plans. Additionally, CMS' approach to monitor whether "robust and meaningful competition" exists in the market for a given drug goes beyond the Agency's statutory authority.

VII. **Civil Monetary Penalties (CMPs)**: Given the unparalleled magnitude of contemplated CMPs in the IRA framework, BMS advocates for CMS to implement strong, special safeguards to protect against erroneous and inappropriate CMP application. Among other things, CMS should provide at least 30 days to cure any perceived deficiencies that could result in CMPs and CMS should offer the opportunity for manufacturers to dispute CMS' findings prior to imposition of CMPs.

VIII. **Part D Formulary Access**: BMS remains concerned with how onerous formulary management policies may impede access to care, particularly in light of IRA negotiations. We continue to be disappointed with CMS' passive approach to "monitoring" Part D plans' compliance with existing formulary requirements, and we implore the Agency to preemptively modernize and strengthen current formulary review standards. Given the negative downstream consequences that negotiation will have on the Part D program, including changing plan dynamics and increased utilization management (UM), we urge CMS to critically examine these impacts and prioritize shared decision-making between patient and providers, not health plans, on appropriate treatment plans.

I. Identification of Selected Drugs

A. BMS Urges CMS to Take a Targeted, Flexible, and Lawful Approach to Identifying QSSDs for the Purposes of Drug Selection

In IPAY 2028, CMS proposes a new standard for determining what constitutes a QSSD: that is an active moiety/active ingredient "is not biologically active against the disease state(s) the drug is indicated for," and therefore "does not result in a clinically meaningful difference," the agency will treat the fixed combination drug as the same drug as products containing only the other active moiety or ingredient of the combination product. Such approach is contrary to the plain language of the statute, is inconsistent with prior CMS guidance, and departs from well-established FDA regulations regarding fixed dose combination drugs. This interpretation

undermines incentives for innovation in a way that will be detrimental to current and future patient access to crucial medicines for years to come.

Under section 1192(e)(1) of the Social Security Act, a QSSD is a "covered Part D drug (as defined in section 1860D-2(e))" or a "drug or biological product for which payment may be made under Part B of the title XVIII" that:

- Has been FDA-approved for at least seven years (for drugs) or FDA-licensed for at least 11 years (for biological products), and
- Is not the listed drug for an approved and marketed generic drug or the reference product for a licensed and marketed biosimilar.

In previous guidance for IPAY 2026 and IPAY 2027, CMS interpreted the definition of QSSD to include in the aggregate "all dosage forms and strengths" of any product developed by the manufacturer with the same active moiety (for drugs) or active ingredient (for biological products), including products that are marketed pursuant to different new drug applications (NDAs) or biologics license applications (BLAs).[3]

With respect to fixed combination drugs, CMS now asserts in IPAY 2028 guidance that "direct combination of active moieties/active ingredients will be considered as one active moiety/active ingredient for the purpose of identifying potential qualifying single source drugs" and CMS therefore will aggregate across all dosage forms and strengths and NDAs/BLAs of each distinct combination associated with a given manufacturer.[4] This is inconsistent with IPAY 2026 and IPAY 2027 guidance, where CMS made clear that, for selection purposes, fixed combination products will not be aggregated with products containing only one of the active moieties/ingredients in the combination.[5]

The additional non-statutory QSSD standard now contemplated as part of IPAY 2028 guidance has no basis in the statute, which speaks nowhere about the role of each active ingredient and does not authorize CMS to attempt to make such a determination. Moreover, the proposed standard flatly contradicts the existing position expressed by CMS in IPAY 2027 final guidance, without any explanation for the reversal; cannot be reconciled with the specific and binding regulation of FDA (the agency with relevant expertise and responsibility for overseeing fixed dose combination approvals, and to which CMS regularly and appropriately turns on matters such as this) and is illogical and unworkable.

As a starting point, even assuming it is lawful and appropriate to aggregate QSSDs across NDAs/BLAs (which BMS does not concede and discusses further below), CMS previously has said (1) such aggregation will be done across NDAs/BLAs *for the same active moiety or ingredient*, and (2) a fixed combination product is considered to have a different active moiety/ingredient (i.e., the combination) than a product that contains one or the other (but not both) of the active moieties/ingredients in the combination.[6] Importantly, in making those distinctions, CMS has

[3] *See* IPAY 2027 Final Guidance § 30.1; IPAY 2026 Revised Guidance § 30.1. As has previously been communicated to CMS, BMS does not believe aggregating across NDAs/BLAs is appropriate, because each NDA or BLA defines a distinct product. Comment Letter Regarding IPAY 2026 Draft Guidance from BMS to CMS, 6 (April 14, 2023); Comment Letter Regarding IPAY 2027 Draft Guidance from BMS to CMS, 3 (Jul. 2, 2024). For purposes of this comment, however, BMS is taking aggregation by active moiety / active ingredient to be a given and focusing on application of that standard to fixed combination products

[4] IPAY 2028 Draft Guidance § 30.1. d

[5] *Id.*; *see* IPAY 2027 Final Guidance § 30.1; IPAY 2026 Revised Guidance § 30.1.

[6] *See* IPAY 2027 Final Guidance § 30.1; IPAY 2026 Revised Guidance § 30.1.

said it will rely on FDA determinations of what is an active moiety/ingredient and FDA's definition of "fixed combination drug."[7]

In that regard, FDA has by regulation defined these key terms:

- An ***active ingredient*** is "any component that is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body of man or other animals."[8]
- An ***active moiety*** is "the molecule or ion…responsible for the physiological or pharmacological action of the drug substance."[9]
- A ***drug substance*** is "an active ingredient that is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease or to affect the structure or any function of the human body."[10]
- A ***fixed combination prescription drug*** is a product containing "two or more drugs…combined in a single dosage form when each component makes a contribution to the claimed effects[.]"[11] This specifically includes "where a component is added…to enhance the safety or effectiveness of the principal active component[.]"[12]

Read together, these regulations tell us that, when FDA approves a fixed combination drug, the agency necessarily has determined that the product contains two or more components, each of which is a distinct ***active ingredient***, meaning an ingredient that contributes to the product's therapeutic effect, either by furnishing pharmacological activity or other direct effect on the disease or by affecting the structure or function of the body. There is no requirement that each active ingredient act directly on the disease or condition. Rather, FDA has said the contribution to therapeutic effect that makes a component an active ingredient can include that the component enhances the safety or effectiveness of another active ingredient.

The analytical scheme CMS is proposing cannot be reconciled with these FDA regulations. The CMS proposal rests upon a view that, if one of the active ingredients in a combination product isn't "biologically active against the disease state" – such as when the active ingredient "affects the bioavailability of [the other] . . . active ingredient . . . but is not therapeutically active against the disease state" – the active ingredient "does not result in a clinically meaningful difference."[13] These are invented terms, with no basis in FDA's (or CMS's) legal standards. And their resulting presumption is simply wrong; it is not supported by the science or medicine, as reflected in the views of FDA – the agency with authority, responsibility and expertise to make such a determination. FDA's fixed combination product regulation recognizes that a component that enhances the

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[7] CMS says it will rely on FDA databases, among other public sources, and FDA itself to identify the active moiety or active ingredient in a drug, and says "fixed combination drug" has the meaning specified in 21 C.F.R. § 300.50. IPAY 2028 Draft Guidance § 30.1. Reliance on FDA's authority and expertise in this context is appropriate and consistent with CMS's approach more broadly. There are numerous instances in which FDA's regulatory scheme implementing the Food, Drug, and Cosmetic Act provides the basis for CMS policies, standards, and statutory interpretations. *See, e.g.,* Social Security Act (SSA) 1860d-14B(g)(1)(C)(ii), 42 C.F.R. 428.101(a)(3) (regarding the determination of whether a therapeutic equivalent to a generic drug is legally marketed for purposes of identifying Part D rebatable drugs under the Part D inflation rebate program); 81 Fed. Reg. 5,184 (Feb. 1, 2016) (". . . for CMS to be able to verify that NDCs reported to the [Medicaid Drug Rebate Program] meet the definition of a [covered outpatient drug] we will be using drug information listed with FDA such as Marketing Category and Drug Type, for example, to verify that an NDC meets the statutory definition in section 1927(k) of the Act.").

[8] 21 C.F.R. §§ 210.3(b)(7), 314.3(b).

[9] 21 C.F.R. § 314.3(b).

[10] *Id.*

[11] 21 C.F.R. § 300.50(a). In this context, a "component" is an active ingredient. 80 Fed. Reg. 79,776, 79,779 (Dec. 23, 2025).

[12] 21 C.F.R. § 300.50(a)(1).

[13] IPAY 2028 Draft Guidance § 30.1.

safety or effectiveness of another component "makes a contribution to the claimed effects" of the product, which means the ingredient "result[s] in a clinically meaningful difference," to use CMS's language.[14]

In essence, the proposed CMS policy would adopt a new, narrower definition of "active ingredient" or "active moiety," solely for the purpose of the QSSD definition and then only in the case of fixed combination drugs. That bespoke definition conflicts with the FDA focus (based on the Food, Drug, and Cosmetic Act) on (1) furnishing "pharmacological activity"; (2) providing "other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease"; or "affect[ing] the structure or any function of the body of man or other animals."[15] CMS's proposed policy is not in any way contemplated, let alone authorized by, the statute.[16]

The new proposed standard for determining when a fixed combination drug is aggregated with other products for QSSD purposes has no basis in the science, flatly contradicts FDA's authoritative regulatory scheme, conflicts with CMS's previously enunciated approach, is unworkable, and is beyond the agency's statutory authority. While maintaining its objection to aggregating products across NDAs/BLAs, BMS respectfully urges CMS not to exacerbate the situation through this ill-advised proposal.

B. The Current CMS Proposal Risks Negative Impacts to Innovation for Patients

Approximately half of all indications and three-quarters of industry-funded clinical trials are a result of post-approval activity, and many post-approval clinical trials and indication approvals occur after or near drug selection and MFP effectuation dates.[17] **We implore CMS to identify QSSDs at the NDA/BLA level not only to be consistent with the statute and current standards, but to better preserve the balance of incentivizing innovation for patients.**

Identifying drugs at the NDA/BLA level is not only consistent with the statute, but also better supports continued investment in post-approval research and development, which are essential to advancing patient-centric innovation that responds to real-world needs. Many meaningful improvements in patient care occur through advancements that address critical access, safety, and quality-of-life issues for patients.

A prime example of such innovation is the development of subcutaneous (SC) products for therapies previously available only via intravenous (IV) infusion, many of which contain a second active ingredient to effectuate the resulting SC therapy. SC innovations offer a wide range of clinical, operational, and economic benefits that directly respond to unmet patient needs. The language regarding fixed dose combination drugs included in the

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[14] This is reflected in the approval standards for fixed combination products. As a general proposition, the sponsor of a proposed fixed combination product must demonstrate that each proposed active ingredient contributes to the product's safety or effectiveness, usually via a factorial study that has at least arms with active ingredient A alone, active ingredient B alone, and A+B. *See* Codevelopment of Two or More New Investigational Drugs for Use in Combination at 7 (Jun 2013), https://www.fda.gov/media/80100/download; 80 Fed. Reg. at 79,785 (describing FDA's interpretation of 21 C.F.R. § 300.50(a)(1)); *see also FDA Guidance for Industry, Human Immunodeficiency Virus-1 Infection: Developing Antiretroviral Drugs for Treatment* at 13 (Nov. 2015), https://www.fda.gov/media/72248/download.

[15] *See* 21 U.S.C. § 321(g) (defining "drug"). At the very least, an active ingredient that enhances the effect of another active ingredient by enhancing bioavailability would be affecting the structure or function of the body. As an example, FDA has approved fixed combination drugs that include a pharmacokinetic (PK) enhancer, such as ritonavir or cobicistat, as an active ingredient because of its ability to inhibit enzymes in the body that would break down another active ingredient in the drug product and decrease its effectiveness. *See, e.g.,* Kaletra (lopinavir and ritonavir), Evotaz (atazanavir and cobicistat). [Link to hyaluronidase?]

[16] Nor would the proposed approach be practical. By way of example, the principles enunciated by CMS, such as they are, provide no guidance on how CMS would aggregate for QSSD purposes a fixed combination product with three active ingredients, one of which CMS considers not to be "biologically" or "therapeutically" active.

[17] Grabowski, H., & Long, G. (2024). Post-approval indications and clinical trials for cardiovascular drugs: some implications of the US Inflation Reduction Act. Journal of Medical Economics, 27(1), 463–472. https://doi.org/10.1080/13696998.2024.2323903.

latest draft IPAY 2028 guidance suggests that CMS may have been considering specifically targeting combination products containing hyaluronidase. Hyaluronidase is a naturally occurring enzyme that depolymerizes hyaluronan, a polysaccharide found in the extracellular matrix of subcutaneous tissue. **Based on FDA's Active Ingredient-Active Moiety Relationship/Basis of Strength (one of the key resources referenced by CMS to inform active moiety/active ingredient under QSSD) as well as several FDA review documents of hyaluronidase-containing product applications, FDA explicitly considers hyaluronidase an active ingredient.** Indeed, this has required product manufacturers to file separate applications for hyaluronidase fixed dose combination drugs compared to the single active ingredient counterparts. Hyaluronidase has been approved as an independent, single active ingredient product by FDA in several instances as well (AMPHADASE®, VITRASE®, HYDASE™).

From a clinical perspective, hyaluronidase serves a specific purpose for many fixed dose combination drugs by enabling the development of subcutaneous formulations of previously intravenously administered products in a manner that maintains their effectiveness. For certain products to be administered subcutaneously, there needs to be sufficient volume of the active ingredient to maintain effectiveness of the drug. This becomes challenging with subcutaneous administration, as there is lower absorption and dispersion of the drug compared to an intravenously administered formulation. Hyaluronidase, by breaking down subcutaneous tissue, allows for an increased absorption and dispersion of the other active ingredient within the combination product, enabling formulation of a subcutaneously administered solution. In effect, hyaluronidase is added "to enhance the safety or effectiveness of the principal active component" and is critical to the clinical function of these products.

While CMS may ultimately choose to apply the proposed framework to certain types of fixed dose combination products, it should not extend to subcutaneous products that include an additional FDA-recognized active ingredient such as hyaluronidase.

There are certain unmet needs associated with IV immuno-oncology (I-O) administration, including potential long period of time spent in the clinic (e.g., due to treatment preparation and IV administration time in the infusion chair); potential challenges with implantable venous access ports (e.g., infection, thrombosis, rejection reaction, and port-pocket bleeding) or peripheral venous access (e.g., infection and phlebitis), which may require device replacement or removal; complex scheduling, preparation, and administration, potentially placing a strain on medical centers; and drug delivery that may be invasive and not rapid.

With the introduction of nivolumab and other novel immune-modulating treatments, outcomes have improved significantly; however, there exists a need for administration options that reduce treatment burden for patients and caregivers. Thus, a faster SC injection as compared with IV infusion allows for improved patient quality of life as well as efficiencies in medical resource utilization.[18]

A recent budget impact analysis predicted that switching 50% of patients from nivolumab IV to nivolumab + hyaluronidase SC, among a cohort of adults 65 and older, resulted in a direct cost savings of $637,000 over three years compared to IV administration, driven by a reduction in administration cost. Similarly, in a systematic literature review cost savings were reported across 42 studies when switching from IV to SC oncology products. SC oncology products had lower direct costs, including direct drug costs and total costs, incurred through reduced consumable costs for the preparation and administration of SC oncology treatments.[19] Along with cost

[18] Jin J-F, Zhu L-L, Chen M, et al. The optimal choice of medication administration route regarding intravenous, intramuscular, and subcutaneous injection. Patient Prefer Adherence 2015;9:923-42.
[19] George et al. Systematic literature review of intravenous versus subcutaneous administration of oncology therapies: A clinical, economic and patient perspective. Cancer Treatment Reviews. 2025. https://doi.org/10.1016/j.ctrv.2025.102974

savings, the use of nivolumab + hyaluronidase SC predicted a reduction in patient and caregiver time (~11,800 hours) as well as staff time (~2,400 hours) vs. nivolumab IV, potentially easing both logistical and financial burdens on families and healthcare systems and increasing productivity.[20] Likewise, this time savings between IV and SC oncology products was observed across the healthcare system in a systematic literature review evaluating 65 IV vs. SC oncology studies resulting in noticeable improvements in healthcare resource utilization.[21]

Beyond cost, SC innovations help mitigate "time toxicity" in the healthcare system. The high administration burden associated with IV treatments create bottlenecks in clinic scheduling and strains staff resources.[22] By simplifying administration, SC options improve clinic workflow efficiency and productivity, reduce time that patients spend receiving care, and relieve caregiver obligations. This is particularly important with I-O, where delays in therapy are often due to a lack of caregiver availability, as reported by patients.[23] SC delivery reduces that dependency, enabling more timely access to treatment, and better alignment with real-world patient needs.

Moreover, SC oncology therapies are overwhelmingly preferred by patients.[24] Studies show that 69%-98% of patients preferred SC oncology administration options over IV. Patients receiving SC oncology therapy reported higher satisfaction and lower rates of anxiety and depression compared to IV.[25,26] In a prespecified exploratory analysis of CheckMate 8KX (a phase 1/2 multi-tumor study of nivolumab + rHuPH20), a higher proportion of patients preferred SC administration over IV administration of nivolumab. Most patients were very satisfied with how nivolumab was administered and reported minimal pain/discomfort associated with SC injection. Most patients were not bothered by the duration of SC administration and indicated that it did not negatively impact on the time available to talk with their healthcare professional or interact/socialize with non-healthcare professionals.[27] Similar patient preference results were seen in another I-O SC study, where 71% of patients reported preferring SC I-O administration over IV due to shorter clinic time, increased comfort, and reduced emotional distress.[28] In addition to patients and caregivers, many providers also prefer subcutaneous oncology therapy administration, due to shorter infusion times, shorter patient chair time, and a lower risk of treatment related adverse events.[29] As the drug development process becomes increasingly collaborative and patient centric, it is essential to recognize that patient preference is not simply a matter of convenience; it is linked to treatment adherence, satisfaction with care, and long-term survivorship outcomes. Understanding patient unmet needs ensures that therapies are not just clinically effective, but also practically aligned with how patients live and receive care.

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[20] Chang et al. Assessing the Budget Impact and Time Savings of Introducing Nivolumab Hyaluronidase SC to Patients Receiving Nivolumab IV Across Multiple Indications on a US Healthcare Plan. ISPOR2025. Poster

[21] George et al. Systematic literature review of intravenous versus subcutaneous administration of oncology therapies: A clinical, economic and patient perspective. Cancer Treatment Reviews. 2025. https://doi.org/10.1016/j.ctrv.2025.102974

[22] Aguiar-Ibáñez, R., Fotheringham, I., Mittal, L. *et al.* Differences Between Intravenous and Subcutaneous Modes of Administration in Oncology from the Patient, Healthcare Provider, and Healthcare System Perspectives: A Systematic Review. *Adv Ther* **41**, 4396–4417 (2024). https://doi.org/10.1007/s12325-024-02985-9

[23] Nasso et al. Experiences and preferences of cancer survivors across the immunotherapy journey. ASCO2025. Poster

[24] Lonardi S, Ługowska I, O'Donnell A, et al. 616 Pharmacokinetics and safety of a subcutaneous formulation of nivolumab (NIVO SC) monotherapy: updated results from the phase 1/2 CheckMate 8KX study. Journal for ImmunoTherapy of Cancer 2023;11:doi: 10.1136/jitc-2023-SITC2023.0616

[25] George et al. Systematic literature review of intravenous versus subcutaneous administration of oncology therapies: A clinical, economic and patient perspective. Cancer Treatment Reviews. 2025. https://doi.org/10.1016/j.ctrv.2025.102974

[26] *Id.*

[27] CM8KX Patient Preference DataLonardi et al. Poster presentation at ESMO 2022. 739P.

[28] Tecentric PI & IMscin002 Primary results:
https://www.gene.com/download/pdf/tecentriq_hybreza_prescribing.pdfhttps://www.jtocrr.org/article/S2666-3643(25)00031-1/fulltext

[29] George et al. Systematic literature review of intravenous versus subcutaneous administration of oncology therapies: A clinical, economic and patient perspective. Cancer Treatment Reviews. 2025. https://doi.org/10.1016/j.ctrv.2025.102974

Furthermore, SC delivery reduces complexities associated with IV therapy, such as the need for IV catheters and/or, surgical port placement. This is particularly true among older adults with poor venous access, mitigating the risk of infection, infusion related adverse events, and thrombosis in case of ports.[30,31] In addition, SC delivery may potentially alleviate I-O hypersensitivity reactions, a time-intensive complication of I-O medication delivery. One study showed a 0.4% rate of hypersensitivity reactions with nivolumab + hyaluronidase SC delivery versus 2.9% with nivolumab IV delivery which may translate to lower healthcare resource utilization and fewer treatment disruptions for patients.[32]

In addition, SC therapies provide flexible options for patients and providers which may increase patient access to I-O treatments. SC products can be administered at satellite clinics or closer to patients' homes, helping address disparities in access for those unable to access institutional hubs or central infusion centers. This geographic flexibility is especially crucial with I-O, where timely and consistent treatment is essential for optimal outcomes. In a recent real-world analysis assessing the impact of socioeconomic disparities on access to I-O treatments across 32,500 patients across tumors, distance from treating provider consistently resulted in lower likelihood of receiving I-O therapy.[33,34]

Nivolumab + hyaluronidase SC was developed with a clear commitment to patient-centered innovation and BMS partnered with Halozyme to pursue potential new approaches to how medicines are delivered to patients. Developing a subcutaneous product from an existing IV therapy is a rigorous, resource intensive undertaking that requires significant scientific, regulatory, and financial investment. Manufacturers must conduct multi-year clinical trials to evaluate the safety and efficacy in order to meet the high standards of regulatory approval. Furthermore, the FDA has acknowledged the distinct nature of subcutaneous and intravenous formulations of nivolumab by granting a separate BLA for Qvantig. This distinction is further reinforced by the FDA Type B meeting feedback received on March 2, 2020, requiring a dedicated randomized trial to demonstrate pharmacokinetic (PK) comparability and anti-tumor efficacy of the SC formulation, underscoring that SC nivolumab is a therapeutically and regulatorily distinct product. CheckMate 8KX, a Phase 1/2 open-label, multicenter, randomized study of nivolumab SC administered was initiated in 2018 to describe the PK of nivolumab administered subcutaneously, with or without rHuPH20 and evaluate the PK of nivolumab SC 600 mg Q2W co-formulated with rHuPH20. CheckMate 67T is a Phase 3, open-label, randomized, study that was initiated in 2020 to evaluate SC formulation of nivolumab versus IV nivolumab. Furthermore, CMS has granted pass-through status to Qvantig.[35] This separate designation underscores CMS's own recognition of Qvantig as a distinct product from Opdivo IV, highlighting its individual therapeutic value and distinct clinical benefits.

Undermining the value of these innovations risks deterring future investment in exactly the kind of advancements that improve the patient experience and diminishes the enormous investment of time, talent, and capital that goes into optimizing therapies for the realities of patient care. Treating subcutaneous innovations as interchangeable with IV for policy purposes ignores the extensive body of evidence generated through post approval research.

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[30] Walsh G. *Journal of the Association for Vascular Access.* 2008;13(4):198-203.

[31] Venous Access Ports. CIRSE: Cardiovascular and Interventional Radiological Society of Europe. June 12, 2024.

[32] https://pubmed.ncbi.nlm.nih.gov/39288844/

[33] Shelley et al. Assessing the impact of socioeconomic disparities on access to immuno-onocology treatments. AMCP2025. Poster

[34] Ambroggi, Massimo, et al. "Distance as a barrier to cancer diagnosis and treatment: review of the literature." *The oncologist* 20.12 (2015): 1378-1385.

[35] Centers for Medicare and Medicaid Services. Pub 100-04 Medicare Claims Processing - Change Request 14091. CMS Manual System. June 2025. https://www.cms.gov/files/document/r13258cp.pdf

Post-approval innovation that leads to more convenient, safer, and more accessible therapies that are highly valued by patients, caregivers, and providers. A policy that aggregates drugs solely by active moiety risks undermining these incentives and discouraging the types of clinically meaningful improvements that patients most appreciate. We strongly recommend that CMS reconsider its current approach and adopt an NDA/BLA level framework for selecting drugs that supports innovation and aligns with the patient-centered goals of the Inflation Reduction Act.

C. CMS' Determination of "Bona Fide" Marketing is Inappropriate and Inconsistent with the Statute

Relatedly, BMS has serious concerns with CMS' policy to consider a generic drug or biosimilar product to be "marketed" when the "totality of the circumstances"—a standard so vague that it amounts to no standard at all—reveals whether a manufacturer is "engaging in bona fide marketing."[36] Those serious concerns are doubled by CMS' suggestion that it will continue to "monitor" marketplace sales to evaluate whether there is "meaningful competition"[37] from a generic or biosimilar, in determining whether a selected drug remains eligible to be negotiated. "Bona fide marketing" and "meaningful competition" are not phrases or concepts included in the statute, and CMS' attempt to create such standards is *ultra vires*, demonstrated by the following points:

- Under the statute, a selected single source product can no longer be defined as a "selected drug" after the Secretary's determination that at least one generic drug or biosimilar has been approved or licensed, as applicable, and "is marketed pursuant to such approval or licensure."[38] Although Congress gave the Secretary responsibility for the *determination* that such approval or licensure and marketing has occurred, the statute's plain words establish the objects of that determination.
- At a threshold level, negotiation applies only to a *single source* product, meaning that if a *different* source exists (*i.e.*, a generic or biosimilar), the product categorically cannot come from a single source. Further, the plain meaning of the statutorily unqualified term "marketed" reveals that Congress did not contemplate extra-statutory concepts related to degree of utilization or "meaningful" competition.
- Both CMS and FDA have long determined a product to have been marketed based on a point-in-time standard. For instance, CMS has long used this concept in the Medicaid Drug Rebate Program (MDRP), where "market date" has been defined in Guidance to mean "the earliest date the drug was first marketed under the application number of any labeler,"[39] and where "marketed" is defined under the National Drug Rebate Agreement to mean the date on which the product was first "available for sale by a manufacturer in the states."[40] This common-sense, established approach is more consistent with Congressional intent in its drafting of the "negotiation" provisions included in the IRA.

Interposing subjective, indefinite criteria in the determination of when a generic is "marketed" is inappropriate, subject to abuse, *ultra vires*, and inconsistent with the terms of the statute. It also risks introducing a number of practical complexities and drawbacks, including unnecessary lag with respect to termination of MFP and concomitant adverse effects on generic/biosimilar competition which could jeopardize future savings, contrary to what Congress has sought to promote.

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[36] CMS, IPAY 2027 Draft Guidance, p. 11.

[37] *Id.* at 115.

[38] *Id.* at 102.

[39] CMS, MDRP Data Guide § 5.15 (Apr. 2022).

[40] National Drug Rebate Agreement § I(l), 83 Fed. Reg. 12,770 (Mar. 23, 2018).

BMS therefore supports CMS taking a position that aligns with the "market date" reported under the MDRP because it presents an established, uniform standard that would help ensure that manufacturers are not inappropriately subject to selection, negotiation, application of an MFP, or an excise tax. Adopting this standard would also help ensure clarity and consistency in the identification of these key dates under Medicare negotiation. BMS urges CMS to use this standard for identifying both: (1) the date on which a generic or biosimilar is first marketed; and (2) the date on which CMS determines that to be the case (which, ideally, should be the same as the actual marketing date to prevent complexities involving potential inappropriate delay in removal from negotiation or MFP applicability). This approach would also support CMS' objective to encourage meaningful competition by providing predictability for generic and biosimilar manufacturers who would otherwise be concerned about their product's ability to compete with a selected drug's MFP.

D. CMS' Price Setting Could Undermine the Patient-Centric Incentives of the Orphan Drug Act

BMS remains concerned about how the IRA could risk undermining the patient-centric incentives at the core of the Orphan Drug Act (ODA). In the last 40 years, the ODA framework has supported the development, approval, and distribution of products that meet pressing, often unmet, public health needs, and otherwise might not ever be available. Historically, companies have launched their products in smaller indications that often impact the rare disease community; and the IRA may shift incentives such that companies will now prefer to launch indications that have greatest economic value and impact.

With respect to orphan drug exclusions, CMS' interpretation of the statute is overly narrow and short sighted with respect to research and development (R&D) incentives created under the ODA. Under CMS' current approach, an orphan drug will be vulnerable for negotiation as soon as it receives an additional orphan designation, disincentivizing manufacturers from conducting further research on more than one rare disease. Additionally, relying on the databases mentioned in the Guidance may not always provide an accurate reflection of whether a drug's indication falls within the scope of the orphan drug designation. CMS should adopt practices consistent with statutory requirements, and should allow manufacturers to present evidence to support their claims while also evaluating orphan designation at the time of selection (and not looking to any previous designation that has been withdrawn). **Furthermore, to maximize patient benefit and preserve incentives for manufacturers to develop future therapies for rare diseases, CMS should consider clarifying that the "clock" for identifying QSSD status of an orphan drug starts when it loses its status as an excluded orphan drug, not from the date of the earliest approval of the active moiety. Additionally, BMS recommends CMS apply the Orphan Drug Exclusion on an indication-specific basis, not a product-specific basis.**

E. CMS' Timeline for a Biosimilar Delay Request Could Lead to Operational Challenges and Inefficiencies

BMS remains concerned with CMS' proposed timeline for the biosimilar special delay request. Currently, manufacturers of biosimilar products will have to proactively submit their delay request prior to the selected drug publication date, forcing both biosimilar and branded manufacturers to speculate on which reference products will be selected for negotiation. The uncertainties imposed by this timeline can lead to inefficiencies, administrative burden, and operational challenges for the biosimilar manufacturer and undermine CMS' objective of bolstering competition and bringing biosimilars to the market more swiftly.

In implementing the requirements for granting an initial delay request for a biosimilar manufacturer, BMS believes CMS should set a deadline as close as reasonably possible to selection to help ensure the best available information for consideration of the request, whereas the date established creates a very tight timeframe that could result in critical information not being considered. The Agency could also notify the reference biologic

manufacturer of a request and subsequently delay selection while the Agency evaluates all information submitted, while also providing notice of determination in advance of the selected drug publication date, allowing the biosimilar manufacturer to bring any error or other concern to CMS' attention before such date.

Additionally, CMS should clarify what constitutes an agreement that incentivizes a biosimilar manufacturer to request a delay, and which agreements could disqualify the reference biologic from being eligible for the delay. CMS should not presume that the existence of an agreement between a biosimilar manufacturer and a reference biologic manufacturer necessarily incentivizes the biosimilar biological manufacturer to request a delay. CMS refers to the statutory unavailability of a delay request where an agreement exists between a biologic manufacturer and a biosimilar manufacturer that imposes "improper constraints"[41] on the biosimilar manufacturer but does not identify the contours of such an agreement that would give rise to such improper constraints in the view of the Agency. Consistent with the statute, the Agency should determine an agreement is disqualifying *only* when the agreement explicitly requires submission of an initial delay request. As the Agency recognizes, certain agreements could inform whether "high likelihood" exists of biosimilar entry in a specified period. Presuming "improper constraints" in an agreement, rather than looking to the language of the contract itself, risks nullifying the statute's contemplation of these other agreements informing "high likelihood" determinations.

F. CMS' Determination of High Likelihood Should be Based on the Best Available Information

BMS encourages CMS to reasonably make a "high likelihood" determination based on the best available information and consider further information that could help inform whether high likelihood exists (*e.g.*, FDA's views of data and information submitted in the BLA, FDA communications about BLA status, the biosimilar manufacturer's production and distribution arrangements and progress, and information the biosimilar manufacturer concludes to be relevant to the determination). The statute permits the Agency to consider such other information and could also permit a biosimilar manufacturer's supplementation through a timely request based on recent information or otherwise for good cause.

BMS seeks to clarify what constitutes clear and convincing evidence that a biosimilar will be marketed within the required period of time and would note that CMS should specify how it intends to apply this term, so that biosimilar manufacturers are on notice as to the standard that such submissions must satisfy and thereby can make informed decisions as to whether to make such a submission and, should they choose to do so, include the information needed to satisfy that standard. CMS should precisely define what clear and convincing evidence that a biosimilar will be marketed within the required time frame means in the specific context of the biosimilar delay provision. CMS' explanation of clear and convincing evidence should include examples of circumstances in which CMS will and will not grant a delay request. There is a range of information that informs whether there is a high likelihood that a biosimilar will be licensed and marketed within the specified period. Biosimilar manufacturers are in the best position to determine which information may be relevant to that determination—and there is no one-size-fits-all approach to identifying the types of information that will help CMS determine whether to grant any particular request for a delay. A precise definition will increase transparency with respect to how CMS intends to approach delay requests, helping reduce the likelihood of biosimilar manufacturers or CMS investing in delay requests that are unlikely to succeed.

II. Renegotiation

[41] CMS, IPAY 2027 Draft Guidance, p. 25.

A. CMS Should Adhere to the Statutory Circumstances that Define a Renegotiation-Eligible Drug

BMS appreciates CMS providing guidance on the renegotiation for IPAY 2028. We have concerns with CMS' proposed identification of eligibility. The statute clearly outlines the criteria that make a selected drug eligible for renegotiation, limiting eligibility to the following circumstances: A new indication is added to the drug, a change in monopoly status, or a material change to the section 1194(e) factors. However, CMS stated that the Agency anticipates "that selected drugs from initial price applicability years 2026 and 2027 with Part B utilization are likely to be determined to be renegotiation eligible drugs".[42] This is outside of the criteria clearly defined in the statute that make a selected drug eligible for renegotiation. **To ensure consistency in the determination of renegotiation-eligible drugs, CMS should refrain from creating additional, arbitrary criteria to increase the number of selected drugs "eligible" for renegotiation; and should adhere to the statutory circumstances that define a renegotiation-eligible drug.**

B. CMS Should Provide Additional Transparency to the Selection Process for Renegotiation-Eligible Drugs

BMS appreciates the opportunity to provide comments on CMS' proposed process for how renegotiation-eligible drugs, specifically those with a new indication or a material change to the section 1194(e) factors, are selected for renegotiation. CMS states the Agency will "select renegotiation-eligible drugs for which CMS expects renegotiation is 'likely to result in a significant change' in the maximum fair price"; and adopt a holistic inquiry of two criteria to assess this significant change.[43] BMS is supportive of a holistic inquiry to determine selection, however we would emphasize the need for this process to be accompanied by a greater level of transparency and accountability in CMS' determinations. One of the criteria CMS proposes to consider is whether a change in the MFP would have a significant impact on the Medicare Program. However, CMS does not provide clear guidelines by which they plan to make this determination. CMS should provide additional clarity regarding what factors the Agency would consider for this assessment. This increased specificity in how CMS is evaluating this criterion would increase transparency and predictability for manufacturers in the renegotiation process. In order for CMS' inquiry to truly be holistic, the Agency should incorporate a criterion that takes into account the value of a renegotiation-eligible drug. It is important that CMS' criteria are not solely based on financial impact to the Agency or the Medicare Program. CMS should be considering the clinical and non-clinical benefits these medicines bring to patients when determining whether they should be selected for renegotiation. BMS asserts that clarity in the selection of renegotiation-eligible drugs is critical. Therefore, we would be strongly opposed to CMS conducting a holistic review that does not rely upon clearly defined criteria to determine whether a renegotiation-eligible drug is selected.

Additionally, given renegotiation-eligible drugs with a new indication or a material change in a section 1194(e) factor are selected based on a determination made by CMS, BMS requests that the Agency provide advance notice to manufacturers of drugs anticipated for selection and offer manufacturers the opportunity to raise concerns. We ask that CMS consider providing a confidential report to manufacturers alone detailing the rationale for selection and any data sources used to make this determination. This added level of transparency would provide manufacturers insight into CMS' determinations on selected drugs and also promote consistency, while also allowing manufacturers the ability to raise concerns with the Agency regarding this assessment. At a minimum, the report should include: (1) the specific criteria CMS utilized in the holistic inquiry; (2) the evidence sources CMS considered, including third-party assessments the Agency may have formally or informally considered; and (3) how each of the criteria considered in the inquiry factored into CMS' determination for selection.

[42] CMS, IPAY 2028 at p. 190
[43] Id. at p. 194

C. CMS Should Provide a Clear Methodology for how the Agency Weighs Data Elements for Renegotiation

We thank CMS for the opportunity to provide comments on data collection for renegotiation. CMS notes their intention to utilize voluntary and mandatory data submissions in the renegotiation process. BMS appreciates the Agency allowing manufacturers to voluntarily submit section 1194(e)(1) data on selected drugs to inform renegotiation drug eligibility and selection, specifically in instances where renegotiation eligible drugs are not automatically selected for renegotiation. However, we would like to reiterate our concerns on the scope and burden of the information collection request (ICR) on manufacturers. The short timeframes for completing and submitting the data submission, especially in instances where a manufacturer may be subject to negotiation and renegotiation for different products in the same year, pose undue burden on manufacturers. Moreover, CMS continues to lack transparency in how these data elements are weighted, which significantly limits a manufacturer's ability to adequately prepare for the MFP process. In the spirit of transparency, CMS should provide a clear methodology for how the Agency weighs these data elements to determine if a drug is eligible or selection for renegotiation and how CMS establishes the renegotiated MFP based on the information submitted. Additionally, for mandatory data submissions, BMS recommends that, instead of requiring the resubmission of a completely new ICR, CMS allow manufacturers to indicate whether certain ICR responses have changed substantially since the submission of the original ICR and make the relevant updates. This would provide a level of predictability and improve upon a significantly burdensome process given manufacturers could be subjected to multiple data submissions for new or the same products (i.e., data submissions for negotiation, renegotiation, and updates to existing data).

D. CMS Should Be Transparent and Provide Manufacturers Flexibility in the Renegotiation Process

CMS requests comment on the proposed process for renegotiation. BMS supports the Agency conforming the renegotiation process to the procedures, structure, and timing of the negotiation process. However, since there could be instances where a manufacturer has a drug selected for negotiation and renegotiation for the same initial price applicability year, we urge CMS to provide flexibility in the implementation of this process given additional burden placed on manufacturers with the threat of being subjected to monetary penalties. If CMS chooses to conform the renegotiation process to the established "negotiation" process, the Agency should consider providing manufacturers more time to submit data and engage in both processes by proposing a longer timeline for the negotiation/renegotiation process. We reiterate our concerns with the "negotiation" process, given their applicability to renegotiation, and urge CMS to improve transparency in engaging with manufacturers throughout this process. We look forward to working with CMS on further improving the transparency of the renegotiation eligibility, selection, and overall process.

Overall, BMS strongly recommends against widespread renegotiation of MFPs that have been previously determined. While the IRA includes specific criteria for MFPs that must be renegotiated, the discretion provided to renegotiate more widely would be counterproductive for all stakeholders. CMS, HHS and the federal government more widely are under new and pressing budget constraints and workforce challenges that make it imperative that the government focus its efforts on required initiatives that will yield the greatest overall benefit. A wholesale renegotiation of MFPs from IPAY 2026 would force staff to devote considerable time and effort to the "negotiation" process and further disrupt patient access to needed medicines. Further, an untargeted use of the renegotiation provision would undermine incentives for manufacturers to agree to "negotiation" in future years if the law stipulates that "negotiated" MFPs remain in effect for the duration of a drug's inclusion in the "negotiation" program. Further reductions to 2026 MFPs could lead manufacturers to exit the Medicare market rather than agree to further reduced MFPs. While BMS objects to the overall "negotiation" program, we have operated as good faith partners in the process for selected drugs. Going back to undo this previous collaboration

would further weaken this program and jeopardize the Administration's wider goals to improve prescription drug affordability and access.

III. Effectuating Access to the MFP

A. Including MFP in ASP Will Lower Reimbursement for Providers and Cause Access Issues for Patients

BMS appreciates the opportunity to provide comments on the provision of access to the MFP for drugs payable under Part B. As a general matter, we note that the timeline for CMS finalizing the revised IPAY 2028 guidance overlaps with the submission of manufacturer effectuation plans, which are due on September 1st. Therefore, we would request that CMS not make significant changes to manufacturers responsibilities providing access to the MFP for 2026 to ensure that compliance with these requirements is feasible. This is particularly important as manufacturers are the only party facing civil monetary penalties and must comply with statutory requirements.

The statute requires that the MFP set by the government be available to Medicare-eligible beneficiaries only, given that this is a Medicare policy intended to reduce prescription drug costs for Medicare patients. BMS, however, is highly concerned with how the scope of the MFP could potentially be expanded beyond the intended Medicare market (i.e. "spillover").

The MFP risks spillover beyond Medicare in two ways: (1) diversion, where Medicare patient status is not established at purchase, risking MFP discount diversion to ineligible individuals; and (2) unintended reimbursement consequences, when commercial payers may seek to adjust to MFP-based reimbursement for non-MFP-eligible individuals and/or providers are reimbursed at the lower MFP payment rate (and not at Average Sales Price, or ASP), thus compromising patient access to therapies. And even if providers are reimbursed at ASP, if MFP is included in ASP, providers will be at risk of increased financial burden for a negotiated Part B product. BMS is concerned that financial and operational challenges related to utilizing MFP products could result in treatment switches to non-MFP products and jeopardize patient access to needed medicines.

To protect patient access to critical medicines in non-Medicare markets, BMS urges CMS to exclude MFP units from the definition of "unit" for purposes of the ASP calculation. Although Medicare reimbursement for an MFP-eligible Part B medicines will not be based on ASP, non-Medicare payers commonly rely on ASP as a metric (or simply "the Medicare payment rate") for setting reimbursement rates for such drugs. BMS is highly concerned that due to this dynamic, over time, the MFP will increasingly lower the ASP, and as a result, ASP-based reimbursement rates of non-Medicare payers will be increasingly insufficient to make providers whole for their acquisition cost of the selected drug. Moreover, there is a real risk that patients insured by non-Medicare payers will not have access to these drugs. BMS asserts, therefore, that it is critical that CMS act to exclude MFP units from ASP to protect patient access to critical medicines in non-Medicare markets.

Fortunately, CMS has clear authority to avoid this serious concern by excluding MFP units from ASP. The ASP statute defines "unit" for ASP purposes to mean:

> [W]ith respect to each National Drug Code (including package size) associated with a drug or biological, the lowest identifiable quantity (such as a capsule or tablet, milligram of molecules, or grams) of the drug or biological that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids. For years after 2004, the Secretary may establish the unit for a manufacturer to

report and methods for counting units as the Secretary determines appropriate to implement this section.[44]

The statute expressly delegates broad authority to CMS to define "unit" for ASP purposes – and, notably, the legislative history of the statute reveals that Congress specifically intended the exclusion of "those sales that do not reflect market prices" from ASP.[45] CMS has also previously exercised this authority to exclude specified units from ASP. For example, CMS has defined "unit" for ASP purposes to exclude Competitive Acquisition Program (CAP) units from ASP: CMS' ASP regulations provide that "[t]he method of counting units excludes units of CAP drugs…sold to an approved CAP vendor…for the use under the CAP…"[46] By excluding CAP units from ASP, CMS excluded from ASP units with prices negotiated by vendors under a federal program that it rightly determined did not reflect market prices, thereby honoring Congressional intent. In doing so, CMS noted that ASP and CAP prices were "intended to be alternatives to each other" and, thus, CAP units should not be included in ASP.[47] BMS asserts that MFP units should not be included in ASP – namely, because the MFP is available only with respect to the Medicare market, under certain circumstances. MFP eligible individuals do not include non-Medicare beneficiaries, and, thus, BMS believes that the MFP does not reflect a market price that should be reflected in ASP. In addition, the MFP is an alternative to ASP – it is used in place of ASP to establish Medicare reimbursement rates for MFP-eligible Part B products. For this reason, too, CMS should exclude MFP units from ASP, as it did with CAP units.

To preserve provider reimbursement and ultimately patient access, BMS strongly urges CMS to exercise its authority to define "unit" for purposes of ASP to exclude MFP from the ASP calculation.

B. <u>The Established Standard Default Refund Amount for Part B Drugs Should Preserve Provider Reimbursement and Ensure the MFP Will Not Be Incorporated into ASP</u>

We appreciate CMS for utilizing WAC as a standardized pricing metric for the calculation of the Standard Default Refund Amount (SDRA) in Part D. Additionally, with respect to a SDRA for MFP effectuation for drugs payable under Part B, this payment amount should be a public and transparent drug price value that compensates providers for the wide range of Part B providers' cost of goods. However, consistent with the policy adopted in Part D drug MFP effectuation, manufacturers and providers should be able to negotiate a different refund amount that effectuates the MFP. BMS asserts that any established SDRA for drugs payable under Part B preserves provider reimbursement and ensures that the MFP will not be incorporated into ASP, which could result in significant, harmful impacts to patients.

C. <u>CMS' MFP Effectuation Process has Significant Operational Challenges that Remain Unaddressed</u>

BMS appreciates CMS' ongoing efforts to create a Medicare Transaction Facilitator process with end-to-end transaction capabilities and is generally supportive of the MTF becoming a "platform" for carrying out critical front-and back-end functions of MFP effectuation, including the necessary ability to communicate with stakeholders directly involved in the MTF process. While we recognize the potential of the MTF process to ease the burden on all stakeholders, including manufacturers, BMS notes that in its current state, the MTF would fall short of this goal. MFP effectuation will come at a significant financial and operational cost to manufacturers, particularly for high volume, high value products. We hope to continue to engage with the Agency to ensure

[44] SSA § 1847A(b)(2)(B).
[45] *See* H.R. Rep. No. 108-391, at 587-88 (2003), reprinted in 1808 U.S.C.C.A.N. 1954-55.
[46] *See* 70 Fed. Reg. 39,021, 39,077 (Jul. 6, 2005). See also 74 Fed. Reg. 61,738, 61,915 (Nov. 25, 2009).
[47] *Id*. at 61,915.

operational success and help ensure a transparent and administratively efficient operationalization of the MFP. In the absence of CMS' action to address these concerns, we urge CMS to provide the highest degree of flexibility for manufacturers to establish the appropriate data sets, timeframes, and process to support compliance.

We are disappointed that CMS has, again, not addressed the payment window. As we have discussed in our comments on IPAY 2026 and 2027 and the MTF ICR, it is BMS's strong belief that CMS should lengthen the 14-day prompt MFP payment window, given the new processes that need to be developed to facilitate compliant MFP effectuation, including the additional 340B Program complexity and the short timeframe manufacturers were given to develop an MFP effectuation plan. Based on our significant experience with transaction processing, we again reiterate the compliance concerns related to verifying claims data within this timeline.

Currently, manufacturers must validate data from health plans and other entities to ensure proper identification of duplicate claims, fraud, etc. Without requirements for Part D plans to verify data, the compliance risk is even more heightened for manufacturers when effectuating and providing the MFP – meaning it is imperative that manufacturers separately validate MTF-related claims data. Despite CMS' stated goals, this still places an incredible financial and operational burden on manufacturers. **Therefore, we ask CMS to lengthen the 14-day prompt MFP payment window, or at a minimum, allow manufacturers who do not utilize the MTF payment facilitation process to agree with dispensers on an acceptable and compliant payment timeline.** CMS could also consider starting the 14-day prompt payment window only when the manufacturer obtains all of the data necessary to validate MFP eligibility, including whether the unit is a 340B unit.

To the extent possible, we urge CMS to aid in effectuating the MFP by utilizing an approach similar to the Coverage Gap Discount Program (CGDP), where the Agency would pass through MFP refund amounts at the time of claim adjudication. This would not only support manufacturers as we review claim-level data from the MTF and make payments more in line with standard business practices but also ensure dispensers receive prompt payment of MFP refunds.

The financial strain on dispensing entities is undoubtably an unfortunate outcome of the IRA. Even so, we have serious concerns regarding a manufacturer's role in the process of dispensing entities indicating they have material cashflow concerns. A manufacturer's obligation under the law is to provide the MFP to MFP-eligible individuals, and to pharmacies, mail order services, other dispensing entities, providers and suppliers with respect to such MFP-eligible individuals who are dispensed that selected drug during a price applicability – not to remedy cash flow concerns of other stakeholders that may or may not be occurring due to changes in the IRA. And practically speaking, it will place a huge, if not impossible, financial and operational strain on manufacturers to not only validate legitimate cash flow concerns but also to remedy them – instead of reducing burden on manufacturers, CMS has possibly chosen the most burdensome process for addressing cashflow concerns. Furthermore, BMS is concerned that entities may choose medicines with more favorable cashflow terms, instead of those with a more favorable clinical profile, which can lead to patient steering and adverse outcomes for patients.

BMS appreciates CMS' consideration of minimum necessary claim-level data elements that the MTF will send to a manufacturer. We note that many of these data elements are necessary data elements, including but not limited to elements that identify the plan benefit package and Part D beneficiary. If possible, BMS asks CMS to be more prescriptive on and clarify the purpose of each element; for example, the stated purpose of multiple data elements is similar, if not the same as others. While we appreciate the consideration of a minimum necessary dataset, we urge CMS to give manufacturers flexibility to establish the appropriate data sets and processes. Given the individual product and channel, as well as standard business practices, manufacturers are best-suited to determine which claim-level data elements are necessary and sufficient. Should the Agency not choose to give

manufacturers this flexibility, we ask CMS to work closely with industry to refine this list in the near term and over time. Additionally, we appreciate CMS' proposed approach to handling and processing claim edits in CMS' Drug Data Processing System. This a measured approach to addressing edits while taking into consideration the interests and obligations of manufacturers and dispensing entities. However, BMS remains strongly opposes the voluntary nature of the 340B Claim Indicator to be reported by the dispensing entity, we opine further in 40.4.5.

D. CMS Should Work with HRSA to Support Private Market Solutions that Allow Manufacturers to Comply with the 340B Nonduplication Requirement in IRA

The draft guidance reiterates the statutory prohibition on manufacturers providing both a 340B discount and MFP for the same unit of a drug but continues to offer limited direction on how manufacturers are expected to operationalize this requirement. As a result, manufacturers remain in a highly uncertain compliance environment – facing a clear statutory obligation, but with no reliable mechanism to identify 340B-eligible claims or prevent duplicative discounts. The guidance does not resolve the fundamental disconnect between manufacturers' legal responsibilities and their lack of access to the claims-level data needed to fulfill them. This uncertainty exposes manufacturers to significant compliance risk and undermines their ability to meet the statutory requirement in a consistent, legally sound, and administratively feasible manner.

To address this imbalance, CMS should expressly affirm that manufacturers may develop and rely on their own good-faith de-duplication methodologies. The agency should further confirm that reasonable, auditable approaches, when thoughtfully designed and consistently implemented, will be deemed sufficient for compliance. BMS remains concerned that, in the absence of clear regulatory protections and defined standards, manufacturers face significant legal exposure despite acting in good faith to fulfill their obligations.
We continue to urge CMS to require use of a standardized claim-level field to identify 340B drugs for all dispensing entities submitting claims through the MFP framework. As the draft guidance states, "the use of this field to identify 340B claims is optional," and CMS "encourages its use by covered entities and pharmacies that dispense 340B drugs, but [does] not require it." Leaving this critical data element voluntary perpetuates ambiguity and further compounds the compliance uncertainty manufacturers face. Without this data field, manufacturers lack a basic tool to exclude 340B claims and fulfill the statutory prohibition on duplicative discounts. While a standardized claim-level field would not on its own resolve all challenges associated with identifying 340B claims, it is a foundational component of any effective non-duplication framework and should be implemented in parallel with broader policy and operational support. Requiring this field would promote greater transparency, support program integrity, and provide the minimum necessary visibility for manufacturers to operationalize their obligations under the IRA.

We also encourage CMS to coordinate closely with the Health Resources and Services Administration (HRSA) to ensure that the 340B rebate guidance currently under review at the Office of Management and Budget is finalized to allow maximum flexibility for manufacturers to develop and rely on private market solutions to the de-duplication issue. Given the overlap between CMS and HRSA program requirements, aligned federal policy is essential to avoiding conflicting obligations and enabling effective manufacturer compliance.
Finally, we urge CMS to clarify that manufacturers will not be held liable for errors stemming from incomplete or inaccurate information supplied by covered entities, pharmacies, or third-party administrators. In the absence of mandatory claims-level reporting, manufacturers must be permitted to apply structured safeguards that reflect their limited visibility into downstream dispensing practices. CMS should provide clear assurance that manufacturers who implement reasonable and well-documented processes will not be penalized for circumstances outside of their control.

IV. Negotiation Factors and the Negotiation Process

A. CMS' Required Scope and Information as Part of the ICR Submission Places Significant Burden on Manufacturers

BMS remains concerned with both the scope and burden of information CMS requires as part of the Drug Price Negotiation ICR submission. For example, manufacturers 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 is especially burdensome for manufacturers that may have more than one product on the selected drug list. 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 that are not consistent with how other manufacturers may interpret their obligation, thus creating an inequity in how CMS views this information to determine 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.

BMS appreciates CMS' willingness to streamline definitions in the collection of manufacturer-specific data and support the Agency's proposed changes to remove the questions on acquisition costs and consolidate of other R&D costs. However, we would assert that these proposed changes do not go far enough to ease the burden on manufacturers. 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 is 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 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.**
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 determining 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 (*i.e.*, CMS' proposed "Manufacturer Net Part D Price" is not a standard metric that is reported anywhere throughout the federal programs, is an inappropriate attempt to aggregate price concessions from supply chain entities across the pharmaceutical supply chain, and should also not form the basis of a Medicare price). 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 "negotiation" process and to do so in the least burdensome way possible.

B. CMS Should Consider a Robust Body of Information when Assessing a Selected Drug's Therapeutic Advance and Impact on Unmet Need

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.** As CMS seeks to improve upon this process, we urge the Agency to continue to review experienced HTA markets, and leverage greater flexibilities related to in-market value assessments, such as unlimited word counts on dossiers, transparency in the decision-making process, and more opportunities for an information exchange. Other countries have adopted a more collaborative approach with manufacturers and have implemented key procedural elements, such as structured scoping phases, indication-specific assessments, traceability of outcomes, and structured patient involvement to promote a cooperative process. CMS must demonstrate fluidity in these areas, especially where other markets with longstanding assessment processes offer cooperative procedural elements.

We also believe it is critical for CMS to consider a variety of perspectives throughout the data submission and review process. As we encouraged CMS to do in previous IPAY comments, the Agency should consider an appropriate forum and method for different stakeholders to provide input, rather than using a single submission format for all stakeholders. If CMS attempts to continue to use a single set of questions to collect feedback from a variety of stakeholders, 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. We opine further on stakeholder involvement elsewhere in these comments.

BMS also seeks to provide feedback on some select topics below related to the negotiation factors:

- Forward-Looking Market Data: BMS is strongly opposed to CMS' proposal on the collection of forward-looking market data. CMS suggests this data could be inclusive of forecasted net revenue and volume data for the specified period. However, forward-looking data are forecasts that may not be realized or could evolve based on changes in the market. Furthermore, any consideration of predictive data for use in the process of negotiating an MFP is inappropriate and does not meet the Agency's own requirement that manufacturers submit "complete and accurate" data.[48]
- Cost-Effectiveness Measures: 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 Quality-Adjusted Life Years (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. 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.
- Research Relating to Specific Populations: CMS indicates that priority will be given to studies focusing on special populations (including individuals with qualifying disabilities, patients with End-Stage Renal

[48] CMS, "IPAY 2028"

Disease [ESRD], and Medicare-aged populations) over studies for which these populations were not the primary focus.[49] 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, 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.

- Addressing Unmet Medical Needs: 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 address 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.

C. CMS Should Consult Manufacturers on the 30-Day Equivalent Supply Methodology for a Selected Drug Payable under Part D

BMS understands CMS' desire to convert utilization across a medication's dosage forms and strengths into a consistent 30-day equivalent supply (30DES), but we remain concern with CMS' methodology for selected drugs payable under Part D. While this methodology may yield a meaningful metric for certain Part D drugs which are exclusively in tablet form, taken at a consistent rate through the entire course of therapy, not approved for varying regimens to treat different indications, and not prescribed uniquely to each patient based on their own individual body weight or other personal characteristics, it is important for CMS to recognize that many products do not meet all of these criteria, which will preclude establishment of a single price that can be applied meaningfully to all NDCs. In addition, there are other notable challenges with using a 30-day equivalent supply for pricing, including: weight-based dosing, dosing variation across indications, and dosing titration/loading doses/changes in dosing over course of treatment. And treating supplies for less than 30 days as 30-day supplies is erroneous and creates inconsistency across different dosing regimens. These issues in calculating a 30-day equivalent supply would also preclude meaningful comparisons to therapeutic equivalent products in many cases. For instance, many products are prescribed in combination with other drugs, which may be produced by other manufacturers. In this situation, comparisons of one manufacturer's drug to a single drug from another manufacturer would be further obscured, as neither reflects a complete course of therapy, and neither can simply be substituted for the other within that course of therapy.

Given the significant limitations of the 30-day equivalent methodology, **BMS also strongly urges CMS to consult manufacturers on the methodology to be used for a selected drug at least prior to the "initial offer," but ideally closer to drug selection, to better ensure any limitations are appropriately addressed and accounted**

[49] *Id*. at 107

for in the initial offer. With greater information, and in consultation with the manufacturer, CMS would be able to gain a better understanding of the drug's usage and determine how to make meaningful comparisons to therapeutic equivalents.

D. CMS Should Re-evaluate the Proposed for 30-Day Equivalent Supply Methodology for a Selected Drug Payable under Part B

We appreciate the opportunity to provide feedback on the proposed methodology for calculating the 30-Day equivalent supply in Part B. BMS is concerned that this proposed methodology introduces systemic bias undervaluing Part B products and undermines the intended comparative framework between Parts B and D. While CMS has signaled flexibility in selecting the starting point for determining the maximum fair price under the "negotiation" process, the only detailed methodology currently available for Part B pricing is the one described in this guidance, which is specifically intended for ceiling price calculations. Although CMS has not explicitly stated that this methodology will be used as the starting point, the absence of any alternative frameworks raises concerns that it may serve that role by default. If this ceiling price methodology, particularly the proposed 30DES calculation, were applied as the starting point, it could introduce bias that carries through the "negotiation" process. Therefore, we urge CMS to clarify whether a separate, purpose-built methodology for establishing the starting point will be issued, and, in the meantime, to consider the potential distortions introduced by relying on the ceiling price approach, especially in the context of inter-part comparability.

The proposed 30DES methodology, which equates any supply duration of fewer than 34 days with a full 30-day equivalent, disproportionately affects products administered under Part B. Unlike Part D claims that typically consist of a single prescription filled with a fixed quantity of units (e.g., pills, tablets) over approximately 30 days or more, Part B claims often reflect multiple administrations over shorter intervals (e.g., weekly dosing, or a dosing schedule that varies throughout a month). This leads to a distorted representation of the true cost per 30DES when compared to with Part D drugs. Additionally, not all Part B drugs are dosed the same and will create distortions when making comparisons between Part B drugs. For example, in oncology, for some products it can be common for a patient to receive six administrations of a Part B drug within a 28-day cycle. Each administration generates a separate claim with fewer than 34 days of supply. Under the proposed methodology, this results in the appearance of multiple 30DES units being delivered for what is effectively one month of therapy, thereby deflating the calculated 30-day cost. The more frequent the dosing, the greater the distortion.

Beyond dosing frequency, measuring days between claims in Part B inherently accounts for adherence by factoring delays and skipped treatments into the price as "days supply". This is problematic for comparisons to Part D where the days supply are present in the claims field and price does not account for adherence in its calculation, instead only accounting for the days supply intended, rather than days between the prescription dates. Since the current methodology does not account for the clinical differences in dosing frequency and claim submission between Parts B and D, it undermines the comparability between drugs selected under Part D and their Part B alternatives. The resulting data may misrepresent relative costs, particularly in therapeutic areas where both Part B and Part D-administered drugs are used interchangeably or as alternatives. This imbalance has significant implications for net price determination and subsequent reimbursement decisions. Without adjusting for these structural differences in how claims and dosing are recorded, the calculated net prices may not reflect the true economic burden of treatment.

Therefore, **BMS recommends that CMS re-evaluate the proposed 30DES methodology in Part B to account for its structural differences from Part D.** Adopting a more tailored approach will enhance the precision of price comparisons and ensure that reimbursement frameworks are equitable and clinically relevant across all parts of Medicare.

E. CMS Needs to Significantly Increase Transparency into the Agency's Methodology for Developing an Initial Offer

BMS offers the below solutions to increase transparency in the "negotiation process:"

- Identification of Therapeutic Alternatives: BMS supports CMS' continued consideration of 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. **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 have 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.** Importantly, therapeutic alternatives should be selected based on clinical appropriateness and not narrowed based on least costly alternatives. BMS also requests the opportunity to submit comparative effectiveness evidence data after CMS has identified indications and therapeutic alternatives. Relatedly, and as a practical matter, BMS cautions CMS on the usage of off-label therapeutic alternatives, as well as those in different pharmacologic classes; 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. In ex-U.S. countries, value assessments are typically conducted for a single indication and pricing and access mechanisms are subsequently applied behind the scenes to account for the differential benefit of each indication. But these mechanisms often have data collection and financial flow issues. CMS should expect similar operational challenges to translate varying indication values to a single MFP—for example, oncology therapies can have dozens of indications, and the value story 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. To that end, we would advise the Agency against their proposal on the consideration of health care services under Part A and Part B as therapeutic alternatives; and given the lack of transparency into the identification of these therapeutic alternatives, BMS would, at a minimum, need the CMS to provide clear explanations as to how the Agency would select these alternatives. **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.**
- Starting Point for Initial Offer: BMS remains opposed to CMS' consideration of CGDP payments—and MFPs, when applicable—in using therapeutic alternatives as the starting point for the initial offer. We note that CGDP payments are not a standard metric that is reported anywhere throughout the federal programs and can be highly variable depending upon the mix of drugs a patient is taking, and therefore, should not form the basis of a Medicare price.
- Adjusting the Starting Point Based on Section 1194(e)(2) Factors: BMS appreciates CMS soliciting comment on the emphasis place on section 1194(e)(2) factors. We continue to stress the importance of the Agency considering a robust, holistic body of information in the development of an initial offer. To ensure the proper consideration of information between a selected drug and alternatives,

manufacturers should have insight into CMS' literature review and the opportunity to comment on the accuracy of the proposed value capture. **When considering evidence about alternative treatments and 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 subpopulation benefits. 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 determining the starting point for the MFP offer.** 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.

- Analysis for Selected Drugs with Therapeutic Alternatives: BMS continues to urge 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.
- Adjusting the Preliminary Price Based on Consideration of Manufacturer-Specific Data: For reasons mentioned elsewhere, CMS should place lesser emphasis on manufacturer-specific data, particularly in early years based on inconsistencies in submissions and use of inappropriate price comparators and until CMS can alleviate patient access concerns.

F. CMS Must Make Improvements to Patient Engagement Efforts to Make the Process More Meaningful, Comprehensive, and Transparent

BMS believes that patient and stakeholder engagement are important components of the policy development process for implementation of the IRA's "negotiation" program. While CMS, HHS, the Executive Office of the President, and Congress move forward with the budget and appropriations processes, BMS believes it is important to maintain outreach and engagement activities for this important program. Without dedicated funding, patient and clinician listening sessions and the annual public town hall may not be possible. This would further separate policy making from the very people it aims to affect and removing these important opportunities for feedback and input will make future policy decisions even harder to implement as stakeholders will invariably feel less engaged and more distant from the process.

We appreciate CMS' commitment to improving the public engagement events. However, there are steps CMS could take to facilitate a more meaningful, comprehensive process to engage patients, beneficiaries, caregivers, and consumer and patient organizations. CMS should clarify the appropriate participants and establish clear intentionality and purpose for these roundtables. During previous sessions, it was unclear how CMS selected speakers for roundtable events as there were sessions that were not full to capacity. Communication from the Agency to these stakeholders is a critical component of this engagement and increases transparency into the overall process. CMS should provide more structured discussion topics and clearly defined expectations for each session, allowing participants to more fully understand how their perspectives and information will be used during the "negotiation" process. With this in mind, listening sessions should support bi-directional feedback, encouraging dialogue among speakers and with CMS. These steps would promote participants to more freely share their personal experiences and allow the Agency to show its active engagement and consideration of feedback from stakeholders. CMS should also prioritize creating an environment that is supportive of feedback. For example, the Agency should build in more flexibility for length of statements from participants and giving extra time as needed. We also urge CMS to continue with drug-specific sessions, especially with the potential

introduction of renegotiated drugs into the drug selection process. Separate sessions for each drug are essential to highlight different lived experiences and heterogeneity in treatment effects that would be lost in broader discussions. Finally, CMS should make the entire listening session process as transparent as possible, for example, by sharing the transcripts after the events in a more timely manner. The transcripts, at a minimum, should clearly articulate key insights gained from each session and how CMS will incorporate patient and caregiver experiences into its decision-making process and pricing methodology for selected drugs.

G. CMS Should Release a Confidential Report to Manufacturers to Increase Transparency into the Basis for the MFP Offer

It is critical for manufacturers to understand the context and basis for the MFP offer. **To increase transparency and further CMS' two-way dialogue with a manufacturer of a selected drug, we continue to urge the Agency, as we did in previous IPAY comments, to consider releasing a confidential report for the manufacturer alone alongside the initial offer and justification to better inform a manufacturer's "counteroffer" and subsequent data submissions.** Given the anticipated submissions from members of the public, including academic experts and clinicians, CMS will have a significant amount of information on a selected drug, as well as latitude in determining what is included in an initial concise justification. Manufacturers are unlikely to have enough context to effectively address potential evidence gaps in the initial offer, which would impact manufacturers' abilities to craft an appropriate, evidence-based counteroffer. We therefore ask the Agency to provide a confidential report to manufacturers with details on the Agency's assessment of a selected product, as well as the evidence which was deemed relevant and appropriate from stakeholder submissions. The concise justification and report should, at a minimum, include the following information: (1) evidence sources CMS considered, including third-party assessments the Agency may have formally or informally considered; (2) how each factor was weighted in CMS' MFP determination; (3) how patients and other stakeholders engaged in the process and influenced CMS' decision-making; (4) benefits and impacts that CMS considered; and (5) how CMS came to determine therapeutic advance and unmet need.

H. CMS Should Provide a More Complete and Meaningful Initial Offer and Justification to Improve the Counteroffer Process

BMS reiterates that if CMS does not provide a meaningful justification in the initial offer, then it is impossible for manufacturers to provide a meaningful justification in the counteroffer. We urge CMS to provide a more complete and meaningful initial offer and justification to improve the counteroffer process. This should include a more detailed, formulaic approach to how CMS weighted each factor to give manufacturers more transparency and predictability in the process and for the future.

I. CMS Should Provide the Opportunity for More Meaningful Dialogue with Manufacturers During the "Negotiation" Process

BMS has serious concerns with CMS' process for interfacing with manufacturers of selected drugs. As set forth in the Guidance, manufacturers may have only up to three meetings with CMS—all occurring after the initial MFP is set by the Agency. In our vast experience negotiating with states and payers, CMS' process is highly unusual and arbitrary, and we would encourage CMS to allow for more meaningful dialogue with manufacturers throughout the process, including through appropriate flexibility to have as many meetings as necessary and not place arbitrary limitations on meetings.

BMS strongly believes that CMS should meet with the manufacturer of a selected medicine at multiple points during the "negotiation" process to allow manufacturers to address questions and provide additional

commentary on the value of these medicines, and we note that three meetings, at a minimum, are necessary to thoroughly discuss the value of a selected medicine. Without CMS abiding by standard rules of "negotiation" to which we are bound with other payers and in other markets, it is increasingly difficult for manufacturers to adequately prepare for ongoing negotiations with CMS and to come to a shared understanding on the mutual value that these drugs bring to the Medicare program. CMS should seek to enhance the "negotiation" process by being an active participant and clearly communicating throughout the process. This could, for example, be through an updated offer or counteroffer from CMS directly after each negotiation meeting so that both the manufacturer and the Agency are aligned on their shared understanding of value and are well prepared for the next step (*i.e.*, another meeting) in the "negotiation" process. Another example could be providing clear, detailed justifications for any adjustments to the counteroffer during the negotiation meetings, encouraging discussion between manufacturers and the Agency and allowing manufacturers to address any concerns with the methodology being utilized. **As CMS refines and further standardizes its process, BMS strongly believes that the Agency should be able to increase transparency and certainty in the "negotiation" process by maintaining three meetings, updating the offer after each meeting, and clearly communicating with manufacturers.**

V. MFP Eligible Individuals in 2026, 2027, and 2028

A. CMS Should Take the Necessary Steps to Effectively Monitor Medicare Advantage Plans' Use of Utilization Management to Ensure Enrollees Maintain Access to Care

BMS appreciates the opportunity to provide comments on how CMS can monitor the use of utilization management (UM) for Part B therapies in Medicare Advantage (MA) plans and supports CMS' efforts to ensure that UM policies do not adversely affect beneficiaries' access to care. It's imperative that CMS prioritizes shared decision-making between patients and providers to develop appropriate treatment plans. Generally, BMS supports policies that ensure health plan UM techniques adhere to clinical guidelines, provide timely and transparent responses to patients, and allow for physician-patient choice based on a patient's unique needs and desired outcomes.

UM policy often contradicts expert developed clinical guidelines for treatment. Guidelines are not meant to be restrictive, do not mandate or explicitly support step therapy approaches to maintain a standard of care, and do not exclusively defer clinical recommendations to plans based on cost. Access restrictions, especially on Part B therapies, can set a harmful precedent that may threaten the best interests of patients living with serious diseases that require timely, evidence-based treatment.

Although the intent of UM policy is to manage drug costs, they can also lead to decreased medication adherence, limited treatment options, and delayed access to care, resulting in negative health outcomes. Studies show that delays in care and the need for subsequent interventions to manage disease burden as a result of UM policies such as step therapy can lead to increased overall health care costs to the system and negative outcomes for the patient.[50]

Additionally, UM policies undermine providers' clinical judgment and interfere with the physician-patient relationship. Physicians need the autonomy to make evidence-based treatment decisions together with their

[50] *See* Strand V, Tundia N, Song Y, Macaulay D, Fuldeore M. Economic Burden of Patients with Inadequate Response to Targeted Immunomodulators for Rheumatoid Arthritis. J Manag Care Spec Pharm. 2018 Apr;24(4):344-352 and Avalere Health, Step Therapy Can Lead to Higher OOP Costs for Crohn's Disease Patients (October 2020), available at https://avalere.com/insights/step-therapy-can-lead-to-higher-oop-costs-for-crohns-disease-patients.

patients, with parity across all clinically appropriate options. This policy impedes providers' ability to develop care plans that are tailored to patients' individual medical needs and desired outcomes. These policies also negatively impact providers. Providers have long since advocated that step therapy limits access to preferred, clinically appropriate Part B treatments, are inconsistently based on clinical guidelines, and significantly increase administrative burden.[51]

We encourage CMS to take the necessary steps to effectively monitor MA plans' use of these techniques to ensure enrollees maintain access to medically necessary care. BMS recommends that CMS monitor MA plans' use of these practices to ensure step protocols are based on appropriate clinical guidelines and enforce timelines for plans to respond to step therapy medical exceptions and appeals.

VI. Manufacturer Compliance and Oversight

A. CMS Needs to Address Shortcomings in the Agency's Approach to Monitor Access of the MFP

We refer CMS to our comments in Section 40 which highlight our significant concerns with CMS' MTF process and how manufacturers will provide access to the MFP – including, but not limited to, the significant financial and operational burden, interaction with dispensing entities, and nonduplication of 340B discounts. Additionally, BMS is opposed to CMS' proposal to undertake a "fact-specific" assessment to evaluate whether a manufacturer provided access to the MFP to a dispensing entity. **At a minimum, CMS should not be considering factors, such as "whether the retrospective refund amount….is sufficient to account for commercially reasonable costs the dispensing entity is likely to encounter in the supply chain", that would potentially require manufacturers to be responsible for costs that are beyond the obligations or requirements set forth in the IRA statute.[52]** This could also result in perverse incentives for dispensing entities and other potential stakeholders to attempt to increase profits through arrangements that would increase MFP refund amounts if manufacturers were to be held accountable for these costs in the supply chain. Moreover, any factors in the assessment should be limited to ensuring manufacturers meet their *statutory* obligations in providing the MFP and give manufacturers the opportunity to review and address the Agency's findings to ensure there are no errors given manufacturers are the only party at risk of CMPs.

- Manufacturer Plans for Effectuating MFP: **BMS strongly opposes CMS' proposed change for manufacturers to split their effectuation plans into two sections, with the manufacturer's election to use the MTF PM , the communication plan, the manufacturer's approach to dispensing entities who indicate they anticipate having material cashflow concerns, and information about the plan if the manufacturer does not intend to use the MTF PM due by June 1, and the remainder of the information in the effectuation plan due September 1.** While we recognize an earlier submission date would allow CMS to evaluate a manufacturer's effectuation plan and conduct any needed outreach, BMS implores CMS to give manufacturers additional flexibility, either with the elements of the effectuation plan, the timeline, or both. Given the many operational we have highlighted in our comments, it will be incredibly challenging, if not impossible, for manufactures to submit any aspect of their effectuation plans by June 1. Therefore, CMS should maintain the September 1 submission deadline for manufacturer effectuation plans for initial applicability years 2027 and 2028. Additionally, we continue to stress the importance of protecting manufacturer proprietary information. We recognize CMS intends to limit distribution of manufacturer's redacted effectuation plans to dispensing entities and other applicable stakeholders.

[51] Avalere, " Provider Survey on Part B Step Therapy in Medicare Advantage," available at: https://advisory.avalerehealth.com/insights/white-paper-provider-survey-on-part-b-step-therapy-in-medicare-advantage
[52] CMS, "IPAY 2028," at 165.

However, to the extent possible, CMS should provide manufacturers with an opportunity to review the redacted versions of their effectuation plans to ensure no confidential information is being released. For example. We note that a manufacturer's process for deduplicating 340B claims is proprietary information and should be redacted from the written MFP effectuation plans. This would allow for improved communication between participating stakeholders and facilitate a more transparent, compliant MFP effectuation process.

- Centralized Intake System for Complaints and Disputes Related to MFP Availability and MTF Functionality: Though BMS appreciates the establishment of a complaint and dispute process, we ask CMS to further refine this functionality to ensure sufficient procedural protections, including by establishing a formal appeals process for disputes to provide guardrails and recourse for manufacturers. Additionally, we ask CMS to clarify that is a claim is going through the dispute process that the obligation for manufacturers would be essentially "frozen" until after CMS makes a determination – and relatedly once CMS makes a determination, the 14-day prompt payment window would then restart. CMS must ensure that dispensers and other stakeholders engage in good faith efforts with manufacturers to resolve MFP disputes prior to submitting complaints through CMS' formal process. Finally, BMS appreciates CMS for soliciting comments on the application of the complaints and disputes process for drugs payable under Part B and would recommend that the process be similar as possible to the process for Part D drugs. However, we would request that CMS provide more detail on the effectuation of drugs payable under Part B in order to provide detailed comments on this issue.

B. CMS' Approach to Monitoring for Competition in the Market Violates the Clear Command of the Statute

As we did in our IPAY 2026 and 2027 comments, BMS strongly opposes CMS' extra-statutory notion of "bona fide" marketing and the Agency's continued monitoring for whether "robust and meaningful competition" exists in the market for a given drug. This approach is found nowhere in the statue and would violate the statute's clear command as to exclusion from drug selection and MFP application.
The IRA "negotiation" framework applies only to a single source product, meaning that is a different source exists (i.e., a generic or biosimilar), the product categorically cannot come from a single source. Further, the plain meaning of the statutorily unqualified term "marketed" reveals that Congress did not contemplate extra-statutory concepts related to degree of utilization or "robust and meaningful" competition.
BMS therefore supports CMS taking a position that aligns with the "market date" reported under the MDRP because it presents an established, uniform standard that would help ensure that manufacturers are not inappropriately subject to selection, negotiation, application of an MFP, or an excise tax. Adopting this standard would also help ensure clarity and consistency in the identification of these key dates under Medicare negotiation. BMS urges CMS to use this standard for identifying both: (1) the date on which a generic or biosimilar is first marketed; and (2) the date on which CMS determines that to be the case.

VII. Civil Monetary Penalties

A. CMS Should Implement Safeguards to Protect Against Erroneous and Inappropriate Application of Civil Monetary Penalties

As we noted in our IPAY 2026 and 2027 comments, while dictated by statute, the CMPs associated with the IRA "negotiation" framework are virtually unparalleled in magnitude and strongly warrant CMS implementing special safeguards against erroneous and inappropriate application. BMS appreciates CMS for providing manufacturers with notice of any preliminarily identified deficiency and we urge the Agency to give at least 30 days to cure such deficiency before any sanction is imposed. In addition, CMS should provide manufacturers with a reasonable opportunity to dispute CMS' findings prior to the imposition of any sanction to better ensure that sanctions are

not imposed based on legal or factual errors by the Agency. We refer CMS to our IPAY 2026 comments for further details.

VIII. Part D Formulary Inclusion of Selected Drugs

A. CMS Should Critically Consider the Impact of "Negotiation" on the Part D Program and Prioritize Patient Access to Necessary Medicines

BMS agrees with CMS that the statute requires a selected drug, for which an MFP is in effect, to be covered on all Part D formularies. We note that it is critical for CMS to recommend, and health plans to design, formularies that promote beneficiary access to all medicines, both MFP and non-MFP medicines.
BMS shares CMS' concern 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 UM that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs."[53] BMS urges CMS to proactively ensure that multiple IRA-mandated changes to the Part D program, including MFP implementation and Part D redesign, do not impact beneficiary access to both MFP and non-MFP medicines.

BMS reiterates its concern with burdensome formulary management policies that could impede access to necessary care and medicines, particularly in light of negotiation. We are encouraged by CMS' decision to use its formulary review process to assess formulary placement of selected drugs. However, we implore the Agency to take additional steps to preemptively modernize and strengthen CMS' current formulary review standards for a post-IRA era. Given the potential downstream impacts of "negotiation" on the Part D program, including on plan dynamics and increased UM, we urge CMS to critically examine these impacts and prioritize shared decision-making between patients and providers, not health plans, on the most effective and preferred treatments.

While not contemplated in this Guidance, we also urge CMS to think critically about how Part D redesign will affect patent access to MFP and non-MFP medicines. In fact, BMS asserts that reforms to UM are even more critical in light of Part D redesign. For these new Part D redesign changes to produce the desired outcome for enhanced patient access, the Part D program must maintain its competitive, market-based structure. Health plans have assumed a significantly greater liabilities as a result of the IRA, BMS is concerned they may employ more aggressive UM techniques to restrict patient access to medically necessary care. Our concerns are validated by payer responses to actions they may take due to Part D redesign. Among the respondents, payers reported increasing the use of utilization management tools (96%), increasing the use of formulary exclusions (75%), and increasing scrutiny for Part D formulary exceptions (74%).[54] This point is underscored by research from the highlighting the impact of UM and that many Part D plans embedded step therapy within their prior authorization criteria to obscure CMS' formulary review formulary review process and pose additional barriers to patient access.[55,56] BMS is concerned that without appropriate guardrails and patient protections against UM, many of these trends may be exacerbated under the new Part D benefit design, which would run counter to the intent of the redesign policy.

[53] CMS, IPAY 2028 Draft Guidance, p. 184
[54] Magnolia Market Access, "Inflation Reduction Act Payer Insights Survey" (2024), available at: https://www.magnoliamarketaccess.com/wp-content/uploads/MMA_IRA-Payer-Insights-Survey-4.0_Chartbook_2024.07.31.pdf
[55] ACS CAN, "Step Therapy in Medicare Part D Oncology Drugs," available at: https://www.fightcancer.org/sites/default/files/acs_can_part_d_formulary_analysis_final.pdf.
[56] Avalere Health, "Part D Prior Authorization Policies May Include Step Therapy", available at: https://advisory.avalerehealth.com/insights/part-d-prior-authorization-policies-may-include-step-therapy

While BMS appreciates CMS' commitment to utilize their formulary review process to identify formulary exclusion of selected drugs, less favorable tiering of selected drugs, and more restrictive UM imposed on selected drugs, we ask CMS to convey more strongly to plans the necessary expectation that they do not engage in measures to disadvantage selected drugs and ensure their formulary placement decisions are clinically-driven rather than financially-driven. CMS should also assess any instances where beneficiary cost-sharing increases for selected drugs within the same tier such as due to a shift from copay to coinsurance design for that tier. For example, a selected drug may be placed on Tier 3, the preferred brand tier, but the plan could shift the design of Tier 3 from copay to coinsurance thus increasing beneficiary out-of-pocket costs and limiting access to the selected drug. Recent reports have shown an increase in this shift in beneficiary cost-sharing with several selected drugs having higher copayments and a larger share of enrollees facing coinsurance than copayments for both preferred and non-preferred brand drugs in 2025 compared to 2024.[57,58] These findings are early indications as to how these shifts in plan incentives are already beginning to impact patient cost-sharing and access. Therefore, we encourage CMS to promote greater transparency and plan accountability by committing to public reporting on the occurrence of all the above instances in approved formularies for selected drugs. This reporting should be in addition to publishing data on formularies, tiering, and UM exception requests for selected and non-selected drugs including actual numbers and rates of approvals, denials, and appeals of exception requests. These measures will help ensure that there is a robust assessment of Part D formularies so that MFP products have medical appropriate access vis-à-vis non-MFP products, and that patient access is not impeded due to potential consequences of UM techniques.

Without clear guidance protecting beneficiary access to medicines, BMS is concerned that "negotiation" in the Part D program will have the unintended consequence of altering formulary dynamics that result in narrower formularies with increased formulary exclusions and adverse tiering with more medicines, including those with an MFP, being placed on a higher cost-sharing tier. **BMS urges CMS to critically consider the potential downstream impacts of government "negotiation" on Part D plan dynamics and patient access. We assert that it is necessary for the Agency to contemplate these issues further in the revised IPAY 2028 guidance and future rulemaking process.**

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BMS appreciates the opportunity to comment on the Guidance. We would be pleased to discuss these comments in further detail. Should you have any questions or concerns, please contact Katie Verb, Executive Director, Policy & Reimbursement and Strategic Alliances, U.S. Policy & Government Affairs and Communications, at katie.verb@bms.com

Sincerely,

/s/

[57] KFF, "Medicare Part D in 2025: A First Look at Prescription Drug Availability, Premiums, and Cost Sharing," available at: https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2025-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/

[58] DLA Piper, "Medicare Drug Price Negotiation: Saving money for Medicare, but what about patients?," available at: https://www.dlapiper.com/en/insights/publications/2025/03/medicare-drug-price-negotiation-saving-money-for-medicare-but-what-about-patients

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June 26, 2025

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Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Administrator Klomp:

Boehringer Ingelheim Pharmaceuticals, Inc. (Boehringer) welcomes the opportunity to submit comments in response to the Centers for Medicare & Medicaid Services' (CMS or the Agency) *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028* (Draft Guidance).[1] Boehringer adopts and incorporates by reference the comments submitted on the Draft Guidance by the Pharmaceutical Research and Manufacturers of America. We offer the following comments to elaborate and expand on certain issues raised in the Draft Guidance.

Boehringer is a leading research-driven biopharmaceutical company committed to innovation in areas of high unmet medical need. Jardiance® (empagliflozin), one of Boehringer's products, was a selected drug for initial price applicability year (IPAY) 2026. Two additional Boehringer products—Tradjenta® (linagliptin) and Ofev® (nintedanib)—were selected for IPAY 2027 and are currently undergoing the price-setting process. Accordingly, Boehringer has a significant interest in CMS's implementation of the Inflation Reduction Act (IRA). While Boehringer supports the goal of ensuring patient access to affordable, life-enhancing medicines, we have meaningful concerns relating to aspects of the Draft Guidance as outlined below.[2]

[1] Available at https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.
[2] Boehringer is challenging the "Drug Price Negotiation Program" before the U.S. Court of Appeals for Second Circuit. *See Boehringer Ingelheim Pharm., Inc. v. U.S. Dep't of Health & Human Servs.*, No. 24-2092 (2d Cir.). Boehringer reserves all of its rights with respect to such litigation.

1. To Preserve Patient Access to Selected Drugs, CMS Must Prevent Part D Plans and Their PBMs From Imposing Inappropriate Utilization Management Requirements

CMS must adopt a clear policy preventing Part D plans and their pharmacy benefit managers (PBMs) from imposing utilization management requirements on selected drugs that are not evidence-based and medically appropriate or that create unnecessary barriers to continuity of care. Boehringer has repeatedly alerted CMS that inappropriate utilization management requirements on selected drugs could jeopardize patient access to selected drugs—many of which are used by a significant number of Medicare beneficiaries who rely on long term consistent therapy for chronic conditions.[3] Acknowledging this concern, CMS has indicated in the Draft Guidance that it "will use its formulary review process to assess . . . any instances where Part D sponsors impose more restrictive utilization management (e.g., step therapy and/or prior authorization) for a selected drug compared to a non-selected brand drug in the same class."[4] While Boehringer appreciates CMS's initial steps to address this pressing issue, the formulary development process for calendar year 2026 has exacerbated our concerns and urgent action from CMS is required. In particular, Boehringer fears that without CMS's intervention, Part D plans and their PBMs will impose step-through requirements for patients—including existing patients—prescribed certain selected drugs. This concern is particularly acute in instances where there is more than one selected drug in the same therapeutic class due to uncertain competitive dynamics for such products, as discussed in more detail in section 2 below. Moreover, CMS should require plans to transparently disclose any changes to formulary placement or access policies that are implemented in advance of MFP effectuation to prevent such actions from being mischaracterized as unrelated plan changes. To support enforcement of these protections, CMS should establish a clear and timely process for stakeholders, including manufacturers, providers, and patient advocates, to raise concerns about inappropriate utilization management practices for selected drugs. This would allow CMS to evaluate and respond to emerging issues in real time, reinforcing patient access and treatment continuity.

The effects of imposing inappropriate utilization management requirements on selected drugs could be devastating for Medicare beneficiaries. Many of the selected drugs for IPAY 2026 and IPAY 2027 treat chronic conditions like diabetes mellitus or heart disease that require long-term medication treatment. Often, patients with chronic diseases have become accustomed to (and reliant on) specific treatment regimens. By imposing utilization management requirements such as step therapy, patients may be unable to refill their long-standing prescription for a selected drug and forced to shift to a new drug or undertake the burdensome process to request a formulary exception, causing confusion and potentially harming treatment adherence. To prevent this risk, CMS must adopt a clear policy prohibiting Part D plans and their PBMs from imposing inappropriate utilization management requirements. For example, CMS could add the following language to section 110 of the Draft Guidance: "If a beneficiary is stable on a selected drug, the Part D sponsor shall not require a switch to another therapy unless medically necessary

[3] *See, e.g.*, Comments from Boehringer Ingelheim to IPAY 2027 Draft Guidance (Jul. 2024).
[4] Draft Guidance at 184.

and clinically justified. Beneficiaries switched involuntarily due to formulary changes must be able to reinitiate therapy on the selected drug without additional cost or utilization management burden. If the selected drug is moved to a higher tier, affected beneficiaries shall retain access to the selected drug at the original tier for a minimum continuity period of 12 months." Additionally, to improve data integrity and prevent duplicate discounts, CMS should make mandatory the use of a 340B claims-level indicator for all Part D transactions. Reliance on voluntary reporting leads to inconsistent tracking across plans, impedes proper rebate administration, and risks noncompliance with statutory safeguards. A required 340B identifier would enhance transparency, support regulatory oversight, and better align Part D program operations with Medicaid and commercial practices.

2. CMS Should Establish Clear Formulary Review Policies When There is More Than one Selected Drug in the Same Therapeutic Class to Place the Products Equal Footing

Adopting clear Part D formulary policies for selected drugs in the same therapeutic class (e.g., mandatory tiering for the first 12-month period or requirements for patients currently treated with selected drugs) would help address inefficiencies in the IRA that are otherwise not present in traditional pricing discussions between PBMs and manufacturers. When discussing with a PBM, manufacturers typically receive assurances regarding tier placement and utilization management based on the set price and rebate. This information helps manufacturers determine how their products can remain competitive relative to other products in the same therapeutic class. By contrast, in the IRA context, manufacturers have no insight into how their product may fare relative to other selected drugs in the same therapeutic class, particularly if two such drugs are selected for "negotiation" in the same cycle. While Boehringer recognizes that information-sharing during the MFP-setting process is prohibited by the "Confidentiality of Information" provision in section 1193(c) of the Social Security Act (the Act), CMS can provide similar levels of predictability to manufacturers by adopting formulary review policies that prohibit placing selected drugs in the same class in non-identical tiers or disadvantaging one product over another, for example, through clinically unnecessary utilization management requirements. CMS should consider adopting such policies as "transition" measures that apply through the first year a product is subject to an MFP. By taking these steps, CMS would ensure manufacturers enjoy the same kind of business predictability under the IRA that they currently have in PBM negotiations.

3. CMS Should Formally Incorporate Health Care Provider Perspectives in Planned Engagement Opportunities

Boehringer strongly encourages CMS to broaden the scope of planned engagement opportunities related to selected drugs to explicitly incorporate perspectives from health care providers. Section 60.4.1 of the Draft Guidance discusses CMS's planned engagement opportunities with Primary Manufacturers and interested parties prior to initial offers.[5] Although CMS purports to host these events to "seek input from patients and other interested parties" and "encourages practicing clinicians and researchers, as well as other interested parties, to register to participate,"[6] there has been limited input from health care providers to date. Boehringer

[5] *Id.* at 139.
[6] *Id.* at 140.

encourages CMS to create specific forums for health care providers to share their experiences with selected drugs, such as provider-focused roundtables to parallel patient-focused roundtables. Boehringer also urges CMS to treat clinician and patient preferences equally (e.g., prescribing experience and relative benefits). Health care providers are uniquely positioned to contribute meaningful insights about the relevant medical conditions, selected drugs, and therapeutic alternatives and should be included expressly in CMS's public engagement events.

4. Generics Should not be Primary Comparators

Boehringer urges CMS to avoid using generics as the primary benchmarks when establishing the starting point for the initial MFP offer for a selected drug since pricing selected drugs similarly to generics arbitrarily brings down the MFP and undermines pharmaceutical innovation. The Draft Guidance states that "CMS intends to consider generic drugs and biosimilars when identifying a potential therapeutic alternative(s) to a selected drug."[7] In addition, the Draft Guidance notes that "[i]f there are multiple therapeutic alternatives, CMS will consider the range of [prices] . . . including the prices of generic and biosimilar therapeutic alternatives . . . to determine the starting point within that range."[8] When CMS includes excessive generic or biosimilar products in the therapeutic alternative category, the selected drug's initial MFP offer can be significantly reduced. If a selected drug's MFP is set too close to the generic pricing, it signals to the market that therapeutic areas with mature generics are closed to innovation, disincentivizing manufacturers from pursuing advancements in those specific therapeutic areas (i.e., diabetes, heart disease, depression). Moreover, an approach to identifying therapeutic alternatives based on chemical similarity rather than marked clinical benefit inappropriately devalues products that provide similar therapeutic value to patients.

In the IPAY 2026 and IPAY 2027 cycles, CMS excluded therapeutic alternative(s) with net price(s) or ASP(s) that were greater than the statutory ceiling when determining the starting point for developing the initial offer.[9] Removing such brand-name drugs entirely from consideration for purposes of developing the initial offer fails to adequately account for all appropriate therapeutic alternatives. This policy exacerbates the downward pricing effect of generic or biosimilar therapeutic alternatives by discounting higher-cost branded therapeutic alternatives. To the extent the policy proposed by CMS in the Draft Guidance of examining "the lower of either: (1) the Net Part D Plan Payment and Beneficiary Liability, which reflects TGCDC net of DIR and CGDP or Manufacturer Discount Program payments, as applicable; or (2) the MFP for selected drugs negotiated for a prior initial price applicability year, if applicable," would include the pricing of therapeutic alternatives with prices above the ceiling price, Boehringer supports this evolution. Nevertheless, Boehringer urges CMS to forgo the excessive use of generics as benchmarks when setting the initial MFP offer to avoid any market distortion. If CMS believes it must update the guidance to make this point clear, Boehringer encourages the Agency to make the necessary revisions to clarify its intended approach.

[7] *Id.* at 129.
[8] *Id.* at 131.
[9] *See Id.* at 130 ("CMS used the Part D net price(s) ("net price(s)") and/or ASP(s) of the therapeutic alternative(s) (or a subset of clinically comparable therapeutic alternatives) for the selected drug, as applicable, as the starting point for developing the initial offer unless the net price(s) or ASP(s) was greater than the statutory ceiling and then considered adjustments based on section 1194(e)(2) data and manufacturer-submitted data per section 1194(e)(1) of the Act.").

5. CMS Should Adopt a Policy of Setting MFPs Above the Pricing of Generic or Biosimilar Therapeutic Alternatives to Foster Innovation

Boehringer encourages CMS to adopt a policy of setting MFPs well above the average price of generic or biosimilar therapeutic alternatives to prevent structural unfairness by comparing generics to brand-name drugs. Boehringer is concerned that CMS has over-indexed on generic and biosimilar therapeutic alternatives when setting MFPs for IPAY 2026 and pursuing the IPAY 2027 process. Relying heavily on generics as therapeutic alternatives devalues patents and warps market competition. Furthermore, such low prices complicate manufacturers' ability to develop financial models for products which, in turn, run the risk of their being unable to recoup research and development costs. As a whole, the current over-reliance on the prices of generic and biosimilar products in the MFP-setting process destabilizes future innovation and drug prices. Treating brand-name drugs and generics equally, therefore, risks structural shifts within the pharmaceutical industry that jeopardize future patient access to life-saving drug products. If generics remain in the therapeutic alternative basket, CMS should adopt a policy of setting its initial offer prices well above the starting point to appropriately value innovation of brand-name selected drugs.

6. CMS Should Limit its Assessment of Unmet Medical Need to the Selected Drug and its Therapeutic Alternatives

Boehringer urges CMS to limit its assessment of unmet medical need to the selected drug and therapeutic alternatives for selected drug indications, and to remove consideration of indication(s) that are not treated by the selected drug. In the Draft Guidance, CMS sets out the following policy for assessing unmet medical need: "CMS will consider the selected drug, therapeutic alternatives to the selected drug, *and any existing treatment options* to determine the extent to which the selected drug and its therapeutic alternatives address an unmet medical need at the indication level as of the time the section 1194(e)(2) data is submitted."[10] In practice, Boehringer is concerned that CMS is considering existing treatment options with approved indications *unrelated* to the selected drug when assessing unmet medical need. In these instances, the selected drug does not receive a meaningful benefit for addressing an unmet need *relative to its therapeutic alternatives in each of the identified indications*. Rather, CMS may adjust the starting point for the initial offer *downwards* due to unmet medical need being met by drugs with approved indications that differ significantly from the selected drug. This policy overlooks the meaningful benefits that a selected drug may have with respect to unmet medical need when properly compared with its therapeutic alternatives as contemplated by section 1194(e)(2) of the Act.[11] Thus, to properly assess the value of a selected drug, CMS should limit

[10] Draft Guidance at 134 (emphasis added).
[11] Section 1194(e)(2)(D) of the Act instructs CMS to consider "[t]he extent to which such drug and *therapeutic alternatives* to such drug address unmet medical needs for a condition for which treatment or diagnosis is not addressed adequately by available therapy." (emphasis added). The best reading of the statute is therefore that CMS is limited to comparing a selected drug to its therapeutic alternatives for purposes of determining unmet need in the selected drug's approved indications.

its assessment of unmet medical need to products treating the same indications as the selected drug.

7. Patient-Centric Considerations Such as Dosing Convenience and Pill Burden Should Play a More Significant Role When Setting the Initial MFP Offer

In response to CMS's solicitation of comment "on whether CMS should put greater emphasis on certain section 1194(e)(2) factors when adjusting the starting point to determine the preliminary price,"[12] Boehringer encourages CMS to emphasize patient-centric considerations consistent with section 1194(e)(2)(C) of the Act. Under that section, CMS must compare "effectiveness of [the selected drug] and therapeutic alternatives to such drug, taking into consideration the effects of such drug and therapeutic alternatives to such drug on specific populations."[13] Treatment adherence is a critical component in assessing the "effects" of a drug on a "specific population." And a key driver of treatment adherence is the relative ease of the dosing regimen. Public health research shows that simpler dosing regimens (e.g., single doses vs. multiple doses) improve both adherence and clinical outcomes for patients.[14] Simplified dosing regimens are particularly critical for patients with more than one chronic condition—which include the vast majority of Medicare beneficiaries.[15] Given the particular importance of streamlining treatment adherence for Medicare beneficiaries, CMS should place meaningful emphasis on the dosing convenience and "pill burden" (i.e., total number of pills a patient must take to adhere to the treatment regimen) when comparing a selected drug to its therapeutic alternatives. In instances where a selected drug has a *simpler* treatment regimen than its therapeutic alternatives, CMS should adjust the starting point for the initial offer upward.

Thank you for considering these comments and those submitted by PhRMA. If you require any additional information or have questions, please contact Michael Penn, Head of Public Policy at (203)791-6680 or michael.penn@boehringer-ingelheim.com.

Sincerely,

Robert L. Anderson III

Vice President, Corporate Affairs
Boehringer Ingelheim Pharmaceuticals, Inc.

[12] *Id.* at 133.
[13] SSA § 1194(e)(2)(C).
[14] *See, e.g.*, Karen S. Ingersoll, Jessye Cohen, *The impact of medication regimen factors on adherence to chronic treatment: a review of literature*, 31 J. Behavioral Med. 213 (Jun. 2008) (finding that "the growing literature on the relationship of regimen factors to adherence in diabetes strongly suggests that fewer doses per day improves adherence.").
[15] *See, e.g.*, Matthew L Maciejewski, Bradley G Hammill, *Measuring the burden of multimorbidity among Medicare beneficiaries via condition counts and cumulative duration*, 54 Health Serv. Res. 484 (Feb. 2019) (finding that "[t]he prevalence of two or more [chronic] conditions (e.g., MCC) [among Medicare beneficiaries] was 71.7 percent, with 17.3 percent having six or more chronic conditions.").

Center on Health Policy at BROOKINGS

June 26, 2025

Chris Klomp
Deputy Administrator and Director
Centers for Medicare and Medicaid Services

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp:

Thank you for the opportunity to comment on CMS's draft guidance on the Medicare Drug Price Negotiation Program. This group of experts writes to provide comments on four main areas of the draft guidance.

Section 30.1: Identification of Qualifying Single Source Drugs (Combination Drugs)

We are encouraged to see CMS specifically requesting comment on the role of combination drugs in the identification of the qualifying single source drug (QSSD). To date, CMS has defined a QSSD for drug products as "all dosage forms and strengths of the drug with the same active moiety and the same holder of a New Drug Application (NDA), inclusive of products that are marketed pursuant to different NDAs" (with an analogous definition for biological products). This definition follows on from Social Security Act (the Act) Section 1192(d)(3)(B)'s aggregation provision, instructing CMS to "use data that is aggregated across dosage forms and strengths of the drug, including new formulations of the drug, such as an extended-release formulation." This definition also gives effect to Congress' intent to limit incentives for a form of "product hopping," in which manufacturers would reformulate existing products in an effort to distribute sales across products to reduce the likelihood of being selected for negotiation. If a manufacturer could avoid being selected for the negotiation program by developing an extended-release version of the same active moiety, for example, it would, at best, limit the ability of Congress to achieve its intended goals. At the very least, CMS should maintain its current definition of a QSSD.

In the spirit of defining a QSSD to advance Congressional intent, we also think CMS should go further as it relates to combination drugs. In the 2026 and 2027 cycles of the negotiation program, CMS has treated "fixed combination drugs," defined as "with two or more active moieties/active ingredients," as a distinct product from their component parts for purposes of identifying QSSDs for negotiation program eligibility. But this is not clearly required by statute. Relatedly, we note the guidance's current reference to and reliance on FDA's regulation at 21 C.F.R. § 300.50 defining a "fixed-combination prescription drug" and stating that "two or more drugs may be combined in a single dosage form when each component makes a contribution to the claimed effects," where a "special case" of this rule is when "a component is added to enhance the safety or effectiveness of the principal active component."

CMS should not necessarily follow this regulation, which was first finalized in 1971[1] and serves a very different purpose than does the negotiation program. The role of a combination drug designation is to determine the type and quantity of evidence required for product approval.[2] CMS, by contrast, is aiming to interpret the IRA's statutory instructions to identify a QSSD by aggregating data in a particular way. In our view, CMS is right to conclude that different types of combination drugs ought to be treated differently for purposes of QSSD aggregation. Some combination drugs should be considered as a "new formulation" of the original active moiety, for aggregation purposes, while others should be considered as their own combination for QSSD purposes.

We do not think CMS must determine conclusively in the final guidance the circumstance of every possible type of combination drug. But we do think it is reasonable for CMS to determine that "fixed combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference" should be aggregated with the relevant active ingredient or moiety for QSSD purposes, and to apply its judgment regarding which products fall within this category. CMS can reserve additional classes of combination drugs for later analysis, as it may become necessary. Support for this distinction could be drawn from the "special case" in the FDA regulation referred to by CMS, because FDA itself differentiates between the typical fixed combination drug case and the case when "a component is added to enhance the safety or effectiveness of the principal active component."

In the case in which one of the active ingredients or active moieties is not biologically active against the relevant disease state, such a reformulation with that active ingredient or active moiety is more akin to an alternative mode of delivery, even though FDA may refer to the compound in question as an active ingredient or active moiety. In this case, where the active moiety or ingredient primarily affects the bioavailability or absorption of the other active moiety or active ingredient, this would imply including the combination drug with the products that share the other active ingredient or active moiety. Failure to do so opens the door to adding a benign active ingredient to a product for the purposes of creating a new drug for negotiation considerations, undermining CMS's ability to implement the negotiation program.

Section 50.1: Forward-Looking Market Data

It is reasonable for CMS to solicit forward-looking market data, as such data can potentially affect the negotiating stance taken by the agency. However, because under Section 1194(e) of the Act, "market data" can only be submitted by the manufacturer and not by the public, we urge caution in both collecting and interpreting such data. As one example, a manufacturer might cite a particular date of expected patent/exclusivity expiration and generic or biosimilar entry as a reason for CMS to make a higher offer. But it is also in the manufacturer's interest to work to delay such generic or biosimilar entry, and notable cases (such as involving Humira, in which the first

[1] Food & Drug Admin., *Fixed-Combination Prescription Drugs for Humans*, 36 Fed. Reg. 20037 (Oct. 15, 1971).
[2] In Re Alcon Lab's Inc., 13 U.S.P.Q.2d 1115 (Com'r Pat. & Trademarks 1989) (quoting from a May 10, 1989, letter from Stuart Nightingale, M.D., Associate Commissioner for Health Affairs at FDA).

biosimilars did not enter until six years after AbbVie initially expected)[3] provide reason for concern.

CMS might mitigate these concerns in part by asking the manufacturer to submit additional sources of forward-looking information, such as 10K and 10Q SEC filings, that contain future-looking assessments of opportunities and risks. These filings are subject to considerable scrutiny by investors and analysts. While there is a safe harbor for projections, the provision of misleading information is the subject of lawsuits. The SEC has repeatedly considered the value of such "soft" information and has found it worthwhile to include in filings.

Importantly, future projections are typically, by definition, uncertain and, as a result, rely on subjective factors. CMS might consider relying only on market data supported by actual occurrences. For example, the 2028 draft guidance provides the example of "a substantial WAC price decrease planned for a selected drug to be implemented prior to the first initial price applicability year for the selected drug." If that WAC price decrease had already occurred prior to the onset of the negotiation period but had occurred after the data were gathered on which the selection of the drug was based, CMS might more confidently rely on it.

Sections 60.3.3 and 60.3.4: Factor Adjustment

CMS has solicited comments on whether the agency should place "greater emphasis" on certain Section 1194(e)(1) or 1194(e)(2) factors in determining the preliminary price or adjusting that price. In past cycles of the negotiation program, CMS has received comments that would encourage the agency to adopt a formulaic approach to the negotiation process, and we encourage the agency to maintain its existing approach. As CMS noted in the revised guidance for initial price applicability year 2026, "CMS believes it is important to maintain flexibility when considering how each negotiation factor contributes to the initial offer and final offer, if applicable, which may be impacted by the unique characteristics of each selected drug, the populations each selected drug is intended to treat, and information that may emerge from meaningful discussions with manufacturers, patients, and patient representatives."[4]

The qualitative approach outlined by CMS as part of the 2026 and 2027 cycles of the program is sensible, given the great diversity of circumstances across products subject to negotiation. While many of the Section 1194(e)(1) factors rely on extensive quantitative assessments, consideration on how in the aggregate they might be considered alongside each other may, in part, interact with Section 1194(e)(2) factors. The emphasis CMS places on various factors will, therefore, vary

[3] U.S. House of Representatives Committee on Oversight and Reform, Drug Pricing Investigation: AbbVie—Humira and Imbruvica, at 22 (May 2021), https://docs.house.gov/meetings/GO/GO00/20210518/112631/HHRG-117-GO00-20210518-SD007.pdf.

[4] Ctrs. for Medicare & Medicaid Servs., *Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026*, at 57 (June 30, 2023), https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf; *see also* Ctrs. for Medicare & Medicaid Servs., Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027, at 99 (Oct. 2, 2024), https://www.cms.gov/files/document/medicare-drug-price-negotiation-final-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf.

according to the therapeutic context for the drug, the nature of the disease(s) that the product is used to treat, the populations served, and the financial history of the product, among other details. Negotiation on behalf of the U.S. public must rely on CMS's ability to flexibly take account of the full set of considerations outlined in the statute in developing price offers and the agency's negotiation stance.

We also underscore that this approach is the proper application of Social Security Act Section 1194(b)(1), which directs the agency to develop a "consistent methodology and process" that "aims to achieve the lowest maximum fair price for each selected drug." An overly formulaic process for negotiation would fail to give meaning to the statutory instruction by limiting the agency's ability to achieve the lowest negotiated price. Nor would it be consistent with the instruction in Section 1194(e), which directs the agency to "consider" a wide variety of factors, some of which are by their nature qualitative and therefore could not be given the statutorily mandated "consider[ation]" if the agency were to eliminate the flexibility of its current policy.

Section 130: Renegotiation

In previous work, two of us (R.S. and R.G.F.) have written a white paper[5] (attached to this comment, for reference) articulating policy options for CMS regarding the implementation of Section 1194(f)'s renegotiation provisions. We are encouraged to see so many similarities between our suggestions and the discussion in Section 130 of the draft guidance regarding the implementation of the renegotiation process. For example, we are encouraged to see CMS thinking expansively about the types of evidence that might matter in determining whether there has been a "material change" in a Section 1194(e) factor for purposes of identifying renegotiation-eligible drugs. We have two suggestions for the agency at this time.

First, in determining whether renegotiation is likely to result in a significant change in the MFP, it appears that CMS is proposing to consider both "the likelihood that the new indication or material change would result in a renegotiated MFP that represents a 15 percent or greater change relative to the current MFP" and "whether such a change in the MFP for the renegotiation-eligible drug would have a significant impact on the Medicare Program." Although CMS is proposing to *consider* both criteria, we would encourage CMS to clarify that a product *meeting* either one of these criteria, but not necessarily both, could still be selected for renegotiation. Consider, in particular, a situation involving the likelihood of a smaller than 15 percent change relative to the current MFP that significantly impacted the Medicare Program. It is easy to imagine, for example, how a 10 percent change relative to the current MFP for a drug that is taken by a large number of Medicare beneficiaries could significantly impact the Medicare program.

Second, we do have concern over the nature of the data collection mechanism envisioned in the draft guidance. That is, CMS recognizes that data collection may be needed to inform renegotiation eligibility for selected drugs and for selection of such drugs. As such, where relevant, CMS proposes to "collect a subset of new section 1194(e)(1) data as a voluntary submission from

[5] Rachel Sachs & Richard G. Frank, *Articulating Policy Options Regarding Implementation of the Medicare Drug Price Negotiation Program's Renegotiation Provision* (Jan. 29, 2025), https://www.brookings.edu/articles/articulating-policy-options-regarding-implementation-of-the-medicare-drug-price-negotiation-programs-renegotiation-provision/.

Primary Manufacturers of selected drugs that do not have a change to long-monopoly status," and Manufacturers may "also voluntarily provide new information about section 1194(e)(2) data for CMS' consideration for purposes of renegotiation eligibility and selection."

We are concerned that 1) making these data collection opportunities voluntary and 2) limiting them to manufacturers (excluding other stakeholders) may bias the data collection efforts in a way that is likely to benefit the manufacturers (rather than the public) and deprive CMS of the most accurate and complete data that can be productively used to identify renegotiation-eligible drugs and select products for renegotiation. In our view, data collection should be mandatory for manufacturers, and additional stakeholders should have the opportunity to submit data as well.

First, by making these data collection opportunities voluntary, manufacturers may choose to disclose only information that would tend to result in an increase in the MFP (for example, if their unit costs of production increased, or if new comparative clinical effectiveness data is available that is favorable for their product) and would be less likely to disclose information that would tend to result in a decrease in the MFP (for example, if their unit costs of production decreased, or if new comparative clinical effectiveness data is available that is unfavorable for their product). Making data collection mandatory minimizes these concerns.

Second, another option to respond to this potential concern is to also provide a voluntary data collection opportunity from the public. Other stakeholders may, for example, identify new comparative clinical effectiveness data that might be less favorable to the Primary Manufacturer and would be interested in submitting it to CMS. However, this option would only be useful as it relates to the Section 1194(e)(2) factors. If CMS believed that it would be useful to gather additional information regarding the Section 1194(e)(1) factors, CMS must make this data collection opportunity mandatory for manufacturers. CMS could frame the relevant questions so as to avoid additional data collection burdens on the agency staff. For example, for several of the Section 1194(e)(1) factors, CMS could ask manufacturers only about changes in the information previously submitted, rather than soliciting all of the information anew.

Conclusion

We thank CMS for the opportunity to provide comment on this draft guidance and are available to discuss these issues at any time.

Sincerely,

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Enclosure:

1. Rachel Sachs & Richard G. Frank, *Articulating Policy Options Regarding Implementation of the Medicare Drug Price Negotiation Program's Renegotiation Provision* (Jan. 29, 2025), https://www.brookings.edu/articles/articulating-policy-options-regarding-implementation-of-the-medicare-drug-price-negotiation-programs-renegotiation-provision/.

BROOKINGS

COMMENTARY

Articulating policy options regarding implementation of the Medicare drug price negotiation program's renegotiation provision

Rachel Sachs and Richard G. Frank

January 29, 2025

The Inflation Reduction Act (IRA) of 2022 ↗ included a number of provisions to reform how the federal Medicare program pays for prescription drugs (encompassing both small molecule drugs and biological products) for its beneficiaries. One key provision of the IRA was the creation of a Medicare drug price negotiation program, allowing Medicare to negotiate a "maximum fair price" (MFP) directly with drug manufacturers for a limited number of qualifying single-source drugs each year. The IRA calls for the first set of negotiated prices to take effect in 2026, and the Centers for Medicare and Medicaid Services (CMS) recently completed ↗ the negotiation process for the first set of drugs and published ↗ its explanations for each of the negotiated MFPs. Earlier this month, CMS announced ↗ the second set of drugs selected for the negotiation program, with any negotiated prices taking effect in 2027.

However, the IRA also specifies that other provisions of the negotiation program will not take effect until future years of the program. In particular, the statute articulates a process of *renegotiation* beginning in the 2028 cycle of the program. That means that CMS would seek to renegotiate an MFP for drugs that it had previously selected for the negotiation program and agreed to an MFP in a prior cycle of negotiation. CMS has yet to promulgate guidance for the 2028 cycle of the program and make its views public regarding the structure of the renegotiation process. In this piece, we identify three key questions CMS will face in implementing and operationalizing the

renegotiation process for the program and offer policy options for the agency to consider.

What counts as a "renegotiation-eligible drug"?

As articulated under section 1194(f) of the Social Security Act (42 U.S.C. 1320f-3(f)), the "renegotiation process" applies only to "renegotiation-eligible drug[s]." The statutory definition of "renegotiation-eligible drug" provides three ways in which a selected drug may become eligible for renegotiation.

First, a selected drug "for which a new indication is added" is eligible for renegotiation. Here, CMS must determine under what circumstances a new indication has been added for a drug. CMS' guidance ↗ for the 2027 cycle of the negotiation program distinguishes between an "indication" for a selected drug and the term "FDA-approved indication," allowing the agency to consider situations in which the drug is used for conditions for which it is not currently FDA-approved (off-label use). For consistency, CMS would likely apply this interpretation of the term "indication" in the renegotiation context as well. That is, a drug which received FDA approval for a new indication would be included within this category, but potentially also a drug for which a new indication has been added "in nationally recognized, evidence-based guidelines and listed in CMS-recognized Part D compendia," as stated in the current guidance.[1]

Second, a selected drug that experiences a "change in status" to become either a long-monopoly drug or extended-monopoly drug qualifies as "renegotiation-eligible." These terms—long-monopoly and extended-monopoly—are defined elsewhere in the statute as they relate to the amount of time since a drug was first approved by FDA and are currently fairly mechanical in their application. An extended-monopoly drug has been first approved for at least 12 years and less than 16 years with respect to the initial price applicability year, while a long-monopoly drug has been first approved for at least 16 years.

Third and most notably, the statute (at section 1194(f)(2)(D)) includes as a renegotiation-eligible drug "a selected drug for which the Secretary determines there has been a material change of any of the factors described in paragraphs (1) or (2) of subsection (e)" (emphasis added). Procedurally, this language specifically commits

the question of whether there has been a "material change" to the determination of the Secretary. It is also substantively limited, though, to considering sections 1194(e)(1) and (e)(2).

In general, the 1194(e) factors are those that Congress has specified CMS "shall consider" "as the basis for determining the offers and counteroffers" under the program. Each of these factors has been given operational effect in existing guidance documents and information collection requests from CMS.[2]

The section 1194(e)(1) factors, or "manufacturer-specific data," include the "research and development costs of the manufacturer for the drug and the extent to which the manufacturer has recouped research and development costs," the "current unit costs of production and distribution of the drug," the "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 Food and Drug Administration, and applications and approvals under section 355(c) of title 21 or section 262(a) of this title for the drug," and "market data and revenue and sales volume data for the drug in the United States." Section 1194(e)(1) specifies that these data must be "submitted by the manufacturer."

The section 1194(e)(2) factors, or "evidence about alternative treatments," include "the extent to which such drug represents a therapeutic advance as compared to existing therapeutic alternatives and the costs of such existing therapeutic alternatives," "prescribing information approved by the Food and Drug Administration for such drug and therapeutic alternatives to such drug," "comparative effectiveness of such drug and therapeutic alternatives to such drug, taking into consideration the effects of such drug and therapeutic alternatives to such drug on specific populations, such as individuals with disabilities, the elderly, the terminally ill, children, and other patient populations," and "the extent to which such drug and therapeutic alternatives to such drug address unmet medical needs for a condition for which treatment or diagnosis is not addressed adequately by available therapy." Unlike with section 1194(e)(1), section 1194(e)(2) does not require this information to be submitted by the manufacturer and merely instructs CMS to consider such evidence "as available." Currently, CMS' procedures include consideration of evidence relevant to these factors that are submitted by members of the public (as well as manufacturers).

Given these factors, what should CMS consider to be a "material change"? Non-exhaustively, in our view, CMS should consider at least the following factors to be relevant to the question of whether there is a "material change."

- Section 1194(e)(1)(A): Assuming the manufacturer has not recouped its R&D costs at the time of its initial negotiation, recoupment of R&D costs should qualify as a "material change."
- Section 1194(e)(1)(B): A significant increase or decrease in the manufacturer's unit costs of production and distribution should qualify as a "material change."
- Section 1194(e)(1)(D): If primary patents or FDA-granted exclusivity periods expire or are invalidated and competition has not yet emerged in the form of an approved small-molecule generic or biosimilar, it should qualify as a "material change."
- Section 1194(e)(2)(A): It should qualify as a "material change" if other drugs are approved or existing drugs have new indications approved that render the selected drug no longer a therapeutic advance as compared to existing therapeutic alternatives; alternatively, it should qualify as a "material change" if the costs of those existing therapeutic alternatives change—for example, if a generic or biosimilar is approved and marketed for a therapeutic alternative, or if an existing therapeutic alternative is selected for negotiation and negotiates an MFP that is lower than its previous price.
- Section 1194(e)(2)(B): It should qualify as a "material change" if the prescribing information for the drug changes meaningfully, such as if an accelerated approval indication is withdrawn or a safety warning, such as a newly identified side effect or contraindication, is added.
- Section 1194(e)(2)(C): It should qualify as a "material change" if additional evidence regarding comparative effectiveness becomes available, particularly one that adds significantly to the existing body of comparative effectiveness evidence. For example, if a new head-to-head study is released regarding the selected drug's efficacy relative to its most prominent therapeutic alternative.
- Section 1194(e)(2)(D): It should qualify as a "material change" if a selected drug no longer meets an unmet medical need, which may depend on whether other therapeutic alternatives become available for the conditions at issue.

A significant procedural question underlies these issues. Specifically, what procedures should CMS put in place to allow the agency to determine whether one of the above circumstances has changed? Some questions about changes in circumstances may be answerable based on publicly available information, such as if there is a withdrawal of an FDA-approved indication under section 1194(e)(2)(B). CMS would also be aware, for example, if an existing therapeutic alternative is selected for negotiation and negotiates an MFP that is lower than its previous price under 1194(e)(2)(A) (as CMS is doing the negotiation). In general, though, CMS should consider setting up alternative processes to receive relevant information. One option would be for CMS to require manufacturers of selected drugs to re-submit information about the section 1194(e)(1) factors, as relevant, to determine whether such a "material change" has occurred. Another possibility would be for CMS to maintain an open process for receiving information from the public regarding the 1194(e)(2) factors. In other circumstances, CMS can monitor on its own for these types of developments (such as in the 1194(e)(2)(B) example) and should consider whether additional data sources may be available for use in this area.

Which renegotiation-eligible drugs should be selected for renegotiation?

Section 1194(f)(3) instructs CMS to "select among renegotiation-eligible drugs for renegotiation" as the statute specifies. CMS is directed to select "all" renegotiation-eligible drugs which experience a "change in status" to a long-monopoly drug or extended-monopoly drug, as noted above. But among drugs that qualify as "renegotiation-eligible drugs" due to the addition of a new indication or where there has been a "material change," CMS is directed to select eligible drugs "for which the Secretary expects renegotiation is likely to result in a significant change in the maximum fair price otherwise negotiated" (emphasis added). Procedurally, as with the question of which drugs qualify as eligible for renegotiation, this language is important because it specifically poses the question of when it is "expected" that renegotiation "is likely to result in a significant change" in the MFP to the Secretary.

Under what circumstances should CMS "expect" that renegotiation "is likely to result in a significant change" in the MFP? CMS may wish to establish presumptions regarding when a "material change" would be "likely to result in a significant change" to the MFP without prejudging the results of the renegotiation process. Answers to this

question are likely to be context-dependent and driven by CMS' views of the negotiation process in the first instance. That is, CMS has information about which of the factors in 1194(e) "drove" its determination of the initial offer and resulting agreed upon MFP. In making this determination, it might be the case that the evidence about alternative treatments (the section 1194(e (2) factors) will assume greater importance than the manufacturer-specific data (the section 1194(e)(1) factors) because CMS has stated that its analysis begins with the evidence about alternative treatments in formulating a preliminary price for the initial offer, and then adjusts for the manufacturer-specific data.

As a result, CMS might state that material changes to any of the section 1194(e)(2) factors—such as the approval of a new therapeutic alternative, the introduction of generic or biosimilar competition for a therapeutic alternative, or significant changes in utilization in a certain condition—are likely to be of particular importance here. These types of factors are frequently economically meaningful determinants in the market pricing of a particular drug. To the extent that these types of events would be likely to significantly change the price negotiated in other markets, these types of events should be considered similarly likely to significantly change the negotiated MFP.

As one example, a newly marketed generic or biosimilar version of a therapeutic alternative should reduce the relevant price of that alternative and might, therefore, influence CMS' initial renegotiation offer. In CMS' view, though, whether this is likely to be the case may depend on the utilization of both therapeutic alternatives relative to the selected drug and also the utilization across indications of the selected drug. Focusing on utilization across indications, consider a selected drug with two indications, one which accounts for 90% of the drug's prescriptions and one which accounts for just 10%. The introduction of a generic competitor for a therapeutic alternative for the indication comprising 90% of the drug's utilization may be thought to be more important to CMS' analysis than the introduction of a generic competitor for a therapeutic alternative for the indication comprising just 10%, particularly if the therapeutic alternative for the 90% indication has significant market share as against the selected drug. It is possible, though perhaps less likely, that certain changes to the section 1194(e)(1) factors might have a similar effect.

These same types of considerations would likely be relevant to the question of when CMS would "expect" that the addition of a new indication "is likely to result in a

significant change" in the MFP. A new indication that shifts market share for a particular drug or that impacts competition within a class would be more economically meaningful than new indications that had limited impact on prescribing patterns for the selected or other drug.

What procedures might CMS propose for the renegotiation process?

Section 1194(f)(4) states that CMS "shall specify the process for renegotiation of maximum fair prices with the manufacturer of a renegotiation-eligible drug selected for renegotiation under this subsection" and specifies that the "process (...) shall, to the extent practicable, be consistent with the methodology and process" under the standard negotiation program. CMS should carefully consider its acquisition and use of data as part of this process.

For example, imagine a situation in which a therapeutic alternative for a selected drug newly has generic competition, such that CMS would "determine" that there has been a "material change" to section 1194(e)(2)(A). Further, imagine that the price of this therapeutic alternative was a key analytical piece in forming the initial offer, such that if this therapeutic alternative had a much lower price due to generic entry, CMS "expects renegotiation is likely to result in a significant change" in the MFP. In such a case, CMS ought to consider what information the manufacturer and public have or should have as part of this process. For example, CMS has now published its explanation for each negotiated MFP, and both the manufacturer and the public now have information about what CMS considered to be therapeutic alternatives for the selected drug, and the fact of generic entry would be public. The net price of the generic (and of its reference branded therapeutic alternative) would not be known to the manufacturer of the selected drug, however, it is likely to be known to CMS. To carry out the renegotiation program, what information does the manufacturer and the public need to have, and at what point? What information does CMS need to have, and when? When CMS informs a manufacturer that its drug has been selected for renegotiation, for example, CMS needs to have done so on the basis of information—but must it disclose that information to the manufacturer or specify on what basis the manufacturer was selected? By contrast, all information about whether a selected drug has experienced a change in status to become either a long-monopoly drug or

extended-monopoly drug is likely to be public, such that demonstrating eligibility under 1194(f)(2)(B) or (C) may be easier.

In answering these questions, CMS should consider how it can best use the information it has made available publicly as part of its explanation of the negotiated MFPs, which the IRA instructs it to provide. As part of its public explanation of each negotiated MFP, CMS has now made available publicly the indications, list of therapeutic alternatives for each indication, and list of safety and effectiveness outcomes for each selected drug for the 2026 cycle, in addition to other information CMS used as part of the negotiation process. If CMS decides that a "material change" has occurred if a generic or biosimilar enters for a therapeutic alternative and that it expects a "significant change" in the MFP as a result, CMS should communicate that information to the manufacturer in explaining its selection of the drug for renegotiation. CMS would not, however, need to communicate the relevant net prices of the generic or its reference branded therapeutic alternative to the manufacturer, nor would it typically be able to communicate such proprietary net price information. The fact of generic entry and the typical market impact of such generic entry on price would be sufficient to justify CMS' selection of the drug for renegotiation.

Although the statute does not seemingly require CMS to offer a public explanation here—in other cases, the statute requires a public explanation, as with the explanation of the MFP, but here it seemingly does not—CMS should strongly consider communicating as much of this information as it can publicly as well. CMS could provide the reason for selection, referencing the fact of generic entry, approval of a new therapeutic alternative, or other changes in the relevant comparative effectiveness landscape as relevant. The types of presumptions we articulate above may be more important for CMS as it defines its procedures regarding both the renegotiation program and the disclosure of information publicly.

As CMS prepares to implement the additions made by Congress for the 2028 cycle of the Medicare drug price negotiation program, the operationalization of the IRA's renegotiation program will be a key topic for the agency. Fortunately, CMS has already made important legal and policy decisions in operationalizing the program for the 2026 and 2027 cycles. Our analysis here builds off of CMS' existing framework and provides policy options for the agency to consider.

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Footnotes

1. See Section 50.2 p.241 footnote 121 of the guidance memo entitled: Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027 of October 2, 2024.

2. See, for example, Appendix A of the guidance memo entitled Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027 of October 2, 2024; see also

the Negotiation Data Elements ICR Form (https://www.reginfo.gov/public/do/PRAViewIC?ref_nbr=202411-0938-010&icID=272617 ↗).

June 26, 2025

VIA ELECTRONIC DELIVERY

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244–1850

RE: Medicare Drug Price Negotiation Program: Initial Memorandum, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 202, and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027 and 2028

California Life Sciences (CLS) appreciates the opportunity to comment on the recent draft guidance regarding the Medicare Drug Price Negotiation Program (MDPNP) issued by the Centers for Medicare & Medicaid Services (CMS or the Agency) on May 12, 2025. CLS welcomes the chance to provide feedback on the implementation of the MDPNP and to highlight key considerations when implementing the law. CLS appreciates the steps the agency has taken to establish a dialogue with key stakeholders about the negotiation program and other elements of the Inflation Reduction Act of 2022 (IRA), but we have significant concerns about the effects the implementation of this law will have on California's life sciences ecosystem and our companies' abilities to bring new, lifesaving medicines to patients.

CLS is the state's leading advocacy organization for the life sciences and is proud to represent more than 1,300 organizations, with membership spanning biotechnology, biopharmaceutical, medical device and technology, diagnostic companies, venture capital firms, and research hospitals and universities. CLS and its members are committed to working with the administration to maintain U.S. leadership in life sciences and ensure that American citizens are getting the best access to lifesaving medication. California's life sciences industry generates more than 1 million direct and indirect jobs and over $392 billion in direct economic output for our state on an annual basis, and our members drive innovations in patient care that help save lives.

The process of therapeutic development is a high risk and long-term endeavor. Life sciences innovators are inspired to take on this challenge by their desire to improve the lives and health of patients and their communities. CLS strongly supports policies that both uphold the scientific enterprise and ensure that these products are affordable and accessible to all. The Initial Price Applicability Year for 2028 (IPAY 2028) Draft Guidance dictates how CMS will implement the MDPNP, which will have significant impacts on the future of Medicare, patients, access to medicines, and the future of the life sciences ecosystem. We encourage CMS to incorporate the meaningful feedback provided by the life sciences sector, patient groups, and providers on the IPAY 2028 Draft Guidance.

Formulary Access (Section 80, 110)

CLS strongly believes that CMS must clarify and demonstrate how it will ensure robust beneficiary access to needed therapies, including selected drugs, and institute safeguards that ensure diversity across formularies to meet patient needs. CMS should act to mitigate any way in which the MFP process results in narrower formularies and otherwise provides fewer choices to patients. In addition, CMS should monitor plan coverage and tiering design, clinical appropriateness of utilization management policies, cost-sharing levels, and patient out-of-pocket exposure.

CLS encourages the Agency to redouble its oversight of formulary requirements and to strengthen its policies regarding Part D coverage determinations and appeals as well as tiering exceptions. This is particularly crucial given the widespread and significant reductions in beneficiary access that has resulted since the passage of the IRA. One study that looked at changes in Part D formularies in branded drugs in competitive classes from 2024 to 2025 found that 81.3% of the drugs studied had a decline in coverage.[1] We appreciate the House Committee on Oversight and Government Reform's recent acknowledgment of these access concerns,[2] and encourage CMS to work with the Committee to protect formulary access to all selected drugs. CMS should also protect formulary access to MFP drugs within the six protected classes to ensure that those drugs are not penalized compared to non-MFP drugs within the protected classes.

Stronger oversight is also needed regarding patient access to Part B drugs covered by Medicare Advantage plans, particularly as Part B drugs will be subject to the MDPNP for the first time with IPAY 2028. A recent study should raise alarms about the access barriers Medicare beneficiaries face when they need medicines covered under Medicare Part B. Nearly all (94%) of physicians and providers surveyed said that step therapy requirements limit their ability to prescribe a Part B drug that they have deemed most clinically appropriate for their patients. Of further concern, 74% report that Medicare Advantage plan step therapy requirements for Part B drugs are not always aligned with clinical guidelines and best practices.[3] CMS should increase its oversight of the use of plan step therapy and take all necessary steps to stop practices that are inconsistent with clinical expertise.

Qualifying Single Source Drugs (QSSD) (Section 30.1)

CLS is disappointed to see that CMS maintains an overly broad definition of QSSD, inclusive of New Drug Applications (NDAs) and Biological Licensing Agreements (BLAs) with the same active moiety or ingredient held by the same NDA/BLA holder. CLS remains concerned about the continued use of an extremely broad approach to identifying selected drugs, stating that any form of a drug from the same manufacturer with the same active moiety or active ingredient will be

[1] Patterson JA, Zheng H, Campbell JD. Impacts of the Inflation Reduction Act on 2025 Formulary Coverage in Medicare Part D Plans. Montreal, QC, Canada. Available at: https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session-2/impacts-of-the-inflation-reduction-act-on-2025-formulary-coverage-in-medicare-part-d-plans

[2] Comer Seeks Briefing on Biden Administration's Medicare Part D Redesign Over Concerns of Higher Drug Prices and Reduced Access. Press Release. June 18, 2025. https://oversight.house.gov/release/comer-seeks-briefing-on-biden-administrations-medicare-part-d-redesign-over-concerns-of-higher-drug-prices-and-reduced-access/

[3] https://advisory.avalerehealth.com/insights/white-paper-provider-survey-on-part-b-step-therapy-in-medicare-advantage

swept into the definition of a QSSD. This means that a drug approved only a year ago by the Food and Drug Administration (FDA) could be subject to price-setting even if it has a different trade name and if the new drug represents a significant advancement for patients. CMS' concerning interpretation of the statute will have serious and negative effects on innovations intended to improve patient lives.

However, CLS strongly supports CMS' continued treatment of fixed combination drugs with distinct combinations of active moieties or active ingredients as distinct QSSDs. Specifically, as under the IPAY 2026 guidance, the IPAY 2027 Draft Guidance proposed that if a selected drug is "a fixed combination drug with two or more active moieties/active ingredients," then "the distinct combination of active moieties/active ingredients will be considered as one active moiety/active ingredient for the purpose of identifying potential qualifying single source drugs" This approach is consistent with the QSSD statutory definition, which limits a QSSD to a drug approved under a NDA or BLA and uses the terms "drug product" or "biological product." Fixed dose combination drugs are not merely changes in the "dosage form" or "dosage strength" of an existing drug. Rather, they include the addition of an entirely different molecular entity and constitute distinct drugs that involve significant alterations from existing products. Not only is treating fixed combination drugs as distinct QSSDs consistent with the IRA, but it is supported by the clinical benefits brought to patients.

Generic and Biosimilar Competition/ Removal from the Selected Drug List—CMS's "Bona Fide Marketing" Standard (Section 30.1, 70, 90.4)

A robust market for generic and biosimilar drugs provides patients, Medicare, and other payers with significant savings, while encouraging ongoing therapeutic innovation. Safeguarding incentives for generic and biosimilar development is vital for CMS to maintain long-term savings for the Medicare program and the health care system broadly.

While most brand medicines with an approved competitor are exempt from price setting, the timing for selection in the law predates the typical timeline for generic and biosimilar competition. CLS is concerned that in the Draft Guidance, CMS states it will look at specified data in Medicare and Medicaid to evaluate if a competitor is engaged in "bona fide marketing" – a concept nowhere in the statute and that ignores the reality that insurers and PBMs decide what medicines are covered. This standard for determining the date of marketing of a generic or biosimilar is incompatible with the statute and contrary to sound public policy. CLS disagrees with CMS's plan to use this concept to determine if a marketed generic or biosimilar "counts" as a competitor and encourages CMS to abandon its bona fide marketing standard. As a result, marketed generics or biosimilars will be forced to compete against medicines with government-set prices, significantly reducing the incentive to bring them to market. It is imperative that CMS abandon this standard and instead adopt as its standard the "market date" reported under the Medicare Drug Rebate Program (MDRP). The MDRP "market date" standard should be used for identifying both the date on which a generic or biosimilar is marketed and the date on which CMS determines that a generic or biosimilar has been marketed.

Delayed Selection and Anticipated Biosimilar Entry (Sec. 30.3.1)

To enhance the process for a biosimilar manufacturer to request a delay in the selection of a reference product for negotiation, CLS recommends including meeting the "high likelihood" determination. CLS encourages CMS to make a determination of "high likelihood" based on the most up to date and complete information and believes CMS has the statutory authority for broad discretion in specifying that the manufacturer can submit all relevant information. To ensure that CMS decides a delay request based on the most mature information possible, CMS should set the delay request submission deadline as close as reasonably possible to the selected drug publication date and permit broad supplementation of timely request with late-breaking information or otherwise good cause. Information on the expected timing of licensure and marketing often rapidly changes and may fluctuate based on a range of factors. For CMS to make an informed determination regarding eligibility for delayed selection, it is vital that the Agency rely on all of the most recent available information that informs the likelihood of market entry within the requisite time period.

Furthermore, CLS recommends that CMS provide notice of its delay request determination in advance of the selected drug publication date and establish a dispute resolution process. As it is currently laid out in the Draft Guidance, CMS will not inform a biosimilar manufacturer of an unsuccessful delay request until after the selected drug publication date. This eliminates the ability for a manufacturer to dispute the determination. CLS encourages CMS to provide a preliminary notice of an unsuccessful delay request in advance of the selected drug publication date and establish a process by which the biosimilar manufacturers can dispute an erroneous determination

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Orphan Drug Exclusion (Section 30.1.1)

Recognizing the unique challenges in orphan drug research and development, and the significant unmet medical need for rare disease patients, Congress created an exemption for orphan drugs from the MDPNP. However, CLS remains concerned that the exemption is insufficient and, while well intentioned, undermines the long-standing incentives for orphan drug development as laid out in the Orphan Drug Act of 1983. CLS urges CMS to clarify the scope of the orphan drug exclusion in a manner that maximizes protections for orphan drugs.

Specifically, CMS should clarify that, where an orphan drug loses eligibility for the orphan drug exclusion, the seven- or eleven-year "qualifying single source drug" clock runs from *the date on which the drug lost eligibility for the exclusion*. Clarifying that the seven- or eleven-year clock starts on the date a drug loses eligibility for the orphan exclusion would help maximize protection for orphan drugs in a manner consistent with the statutory framework. Absent such clarification, an orphan drug that loses eligibility for the orphan drug exclusion could be virtually immediately subject to selection for negotiation, simply because it was designated as an orphan drug for a second rare disease or condition or because an indication was approved for a second rare disease or condition, negating the application of the exclusion in the first place. CMS's implementation of the orphan drug exclusion would thereby disincentivize progress in rare disease drug development, which is often predicated upon identification of promising new uses of existing therapies.

Furthermore, CLS requests additional clarification around how "disease or condition" will be defined for the exemption and criteria that CMS will use to determine "conditions" from separate "indications." In addition, CMS should create a process that enables manufacturers to provide evidence that an indication falls within an orphan drug designation to account for situations where CMS is unable to determine eligibility for the orphan drug exclusion based on a review of FDA's orphan drug databases.

Small Biotech Exception (Section 30.2.1)

In recognition of the potential hardships to small and emerging companies who likely do not have significant reserves or multiple products on the market or in the pipeline, the IRA exempted small biotech drugs from negotiation until 2029. Unfortunately, we are concerned that the small biotech exception remains time-limited. It is focused on protecting products that have received approval in the prior decade, not companies that have launched products in more recent years. We trust that CMS and the Administration can work with Congress to extend the exception, so that it applies to small biotech companies that are making investments in future products and are at the forefront of developing new treatments needed by both Medicare beneficiaries and other patient populations.

CLS also continues to urge CMS to establish a dispute resolution process in implementing the small biotech exception. Under such a process, a manufacturer could respond to and appeal a negative determination by CMS—similar to the process that has been instituted for the specified small manufacturer phase-in under the Medicare Part D Manufacturer Discount Program. Specifically, the small biotech manufacturer should have the opportunity to provide additional data or other information to the Agency to support its application for the small biotech exception.

Additionally, we ask that CMS provide flexibility and maintain a dialogue with companies throughout the process to ensure complete and accurate data submissions, while also protecting the confidentiality of the proprietary information that is submitted by a manufacturer. It is also imperative that if a drug has received an exception and the manufacturer's circumstances have not changed in a material way, the manufacturer should not have to re-apply in subsequent years.

Renegotiation (Section 130)

We urge CMS to adopt a more targeted approach to selecting drugs for renegotiation and focus renegotiation on those drugs that have a change in monopoly status as required by statute. Particularly for IPAY 2028, given that prices have recently been set for IPAY 2026 and 2027, it is unlikely that there had been a fundamental change in the negotiation factors that would result in a significant change in the MFP for these drugs.

However, if CMS continues as it proposes, the Agency must provide greater transparency into the criteria and data inputs used to identify drugs selected for renegotiation. Clear insight into the rationale and methodologies for applying the proposed 15% MFP change threshold – and CMS's rationale for the 15% threshold itself – would help manufacturers better understand and prepare for potential renegotiation. Additionally, CMS should streamline data submission requirements, and we request that manufacturers be granted flexibility in the submission of data during the

renegotiation process, recognizing that manufacturers may have new or updated evidence on clinical benefit, market dynamics, or other factors that were not available during the initial round of negotiation.

Qualifying Single Source Drugs (Section 30.1) – Exclusion of Part B Vaccines

CLS urges CMS to exercise its discretion to exclude Part B vaccines from the MDPNP. There are clear gaps in the statutory text of the IRA that make it impracticable and counterproductive for CMS to apply the negotiation framework to vaccines in Part B. Further, while the IRA alters the payment rate for Part B drugs from ASP+6% to MFP+6%, Congress did not amend the existing reimbursement rate for Part B vaccines from their current rates - under Section 1842(o)(1)(A)(iv)- to an amount based on MFP. In the absence of such a change, the current reimbursement framework for vaccines should remain intact. Accordingly, including Part B vaccines in the negotiation program would not result in any financial benefit to Medicare. Moreover, because Part B vaccines are already subject to $0 cost sharing, negotiating these products would similarly not have a further financial benefit for Medicare beneficiaries. Part B vaccines are already subject to a distinct reimbursement methodology designed to ensure affordability and access, and their inclusion in the program would introduce administrative complexity without meaningful cost savings.

Conclusion

CLS appreciates the opportunity to provide feedback to CMS on the Draft Guidance. We remain concerned about the significant and potentially negative impacts the MDPNP will have on companies' investments in research and development, which in turn will harm beneficiary access to future treatments and cures, particularly for rare, hard-to-treat diseases and those areas with high unmet need. We continue to urge CMS to consider these impacts as the Agency works to finalize this Draft Guidance based on stakeholder feedback.

We look forward to continuing to work with CMS to promote beneficiary access to future treatments and cures and ensure a thoughtful and stakeholder-informed approach to implementation of the guidance. CLS welcomes any questions and further discussion on the topics above, and you can contact me at bfisk@califesciences.org.

Sincerely,

Brent Fisk

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June 25, 2025

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: Medicare Drug Price Negotiation Program Draft Guidance
IRARebateandNegotiation@cms.hhs.gov
Hubert H. Humphrey Building,
200 Independence Avenue, SW
Washington, DC 20201

RE: Comment Request (CMS-4210-N); Medicare Program; Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program Draft Guidance; Federal register Number: 2025-08607

Dear Dr. Mohmet Oz,

We write to express deep concern regarding CMS's proposed guidance on the implementation of the Drug Price Negotiation Program (DPNP), particularly the agency's decision not to require the use of a federal claims modifier for affected transactions. This omission undermines program integrity and places patients — especially those dependent on safety-net providers — at increased risk.

ABOUT CANN: The Community Access National Network (CANN) is a 501(c)(3) national nonprofit organization (formerly incorporated under the "Ryan White CARE Act Title II Community AIDS National Network") focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and supports for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking. CANN's coalition-based work is done on behalf of the patient advocacy groups, pharmaceutical partners, and government agencies.

Background: Retrospective Payments and Claims Modifiers - We've Been Here Before

In 2019 the Office of the Inspector General (OIG) audit revealed that CMS inappropriately paid acute-care hospitals **$51.6 million** for outpatient services they provided from January 2013 through August 2016 to beneficiaries who were inpatients of long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and critical access hospitals (CAHs). The overpayments occurred because system edits were not working. However, after CMS modified the edits in May 2019, only $3.4 million (less than 9 percent of the $39.3 million in improper payments for the entire audit period) was

inappropriately paid to acute care hospitals from June 2019 through December 2021.[1]

Both the claims modifier or clearinghouse models offer potential mechanisms to prevent duplicate discounts between CMS and the 340B Drug Pricing Program; **we remain <u>neutral</u> on the specific approach adopted.** Each model presents distinct advantages and implementation challenges: the claims modifier provides a direct, point-of-sale solution, while the clearinghouse model offers a centralized reconciliation framework. Our priority is ensuring the selected method effectively safeguards program integrity, minimizes administrative burden for providers, and maintains access to discounted medications for vulnerable populations.

<u>Claims Modifiers are a Proven Tool to Achieve the Administration's Goals of Reducing Waste, Fraud, and Abuse;</u>

1. Failure to Mandate Claims Modifiers Jeopardizes Patient Access and Transparency

CMS's reliance on "trust" rather than a mandate for claims identification is insufficient as a mechanism for oversight. Patients bear the consequences of systemic inefficiencies and exploitation that arise from this lack of clarity. Without a standardized claims modifier, duplicate discounts—where the same drug unit receives both 340B pricing and Medicaid or Medicare rebates—are allowed to proliferate unchecked. These misallocations distort the healthcare system and, ultimately, reduce funds available for reinvestment into public health services for vulnerable populations.

2. Inconsistent Federal Standards Undermine Program Integrity and Burden Patients

CMS requires use of the "TB" claims modifier for Medicare Part B inflation rebates beginning January 1, 2025, yet it treats use of modifiers as optional under the DPNP. This inconsistent approach breeds confusion and weakens enforcement. Without clear claim identification, pharmacy benefit managers (PBMs) and covered entities can exploit system loopholes, diverting billions away from Medicaid programs and leaving patients to deal with complex, delayed, or inaccurate billing.

3. Responsibility of Manufactures to Means Test

The suggestion that Manufacturers should means test by allowing dispensing entities to choose to voluntarily and proactively indicate on a submitted claim that the claim is 340B-eligible and the MTF would pass along the 340B indication data as applicable to the Primary Manufacturer when the MTF shares the data elements with each Primary Manufacturer will add unnecessary administrative burden to all parties involved.

4. Data Confirms Widespread Duplicate Discount Abuse and Its Financial Toll

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[1] https://oig.hhs.gov/reports/all/2022/cmss-system-edits-significantly-reduced-improper-payments-to-acute-care-hospitals-after-may-2019-for-outpatient-services-provided-to-beneficiaries-who-were-inpatients-of-other-facilities/

IQVIA estimates between $20 and $25 billion in duplicate discounts occur annually. A Government Accountability Office (GAO) audit found a 25% error rate in audited 340B programs, often due to systemic flaws such as the inaccurate Medicaid Exclusion File (MEF). These are not isolated incidents—they reflect systemic issues that CMS's inaction allows to continue.

5. Retrospective Payment Models Create Uncertainty and Delay Care

CMS's proposal to rely on retrospective identification and clawbacks, rather than prospective prevention, shifts undue administrative and financial burdens onto providers—particularly small and rural hospitals. These facilities are often already operating at a loss; nearly 45% of rural hospitals report negative margins, and over 90% depend on 340B savings to continue operations. Delays in payment or complex compliance requirements will result in delayed care, reduced services, or facility closures—placing patients at risk of losing essential access to care.

I. Automation Reduces Manual Oversight

- **Claims modifiers enable automated detection** of duplicate discounts and improper billing.
- Without a standard modifier, agencies must **manually audit records**, cross-reference multiple data sources, or rely on self-reported data—which is costly, labor-intensive, and prone to error.
- Automating compliance through modifiers reduces the need for extensive human review and streamlines oversight operations.

II. Centralized Data = Lower Administrative Costs

- A universal claims modifier creates a **centralized and standardized dataset** for identifying which transactions are eligible for 340B pricing or DPNP pricing.
- This **simplifies data validation** across Medicare, Medicaid, and Manufacturer rebate programs, reducing the complexity and cost of reconciling mismatched data from fragmented systems.

III. Improved Accuracy = Fewer Investigations and Penalties

- Modifier use reduces billing errors and noncompliance, meaning:
  - **Fewer investigations** by the Office of Inspector General (OIG) or GAO.
  - **Fewer whistleblower cases or False Claims Act penalties** requiring lengthy litigation or settlements.
- This leads to **cost savings in legal fees, settlements, and recovery actions**, which are expensive for both government and providers.

IV. Reduces Fraudulent Claims at the Source

- By clearly flagging which claims are 340B-eligible, a modifier helps **prevent improper rebate claims before they occur**, rather than trying to recoup funds after the fact.

- This **proactive compliance model** is far more efficient—and less expensive—than retrospective enforcement.

V. Reduces Burden on State Medicaid Agencies

- CMS currently delegates duplicate discount prevention to **state Medicaid agencies**, many of which are under-resourced.
- A federal claims modifier standard would **relieve states from having to build duplicative infrastructure**, lowering state and federal administrative costs simultaneously.

VI. Enables Risk-Based Oversight Models

- With clean, tagged claims data, CMS and HRSA can adopt **risk-based oversight**, focusing audits and enforcement where problems are most likely—rather than conducting blanket reviews.
- This is more efficient, more targeted, and **dramatically reduces the cost per audit**.

High Administrative Overhead and Time Lag
Retrospective reconciliation involves multiple stages:

- Staff must extract and validate claims.
- Claims are matched retroactively to cost reports or utilization thresholds.
- Discrepancies trigger reviews, recoupments, and possible appeals. This process is:
  - **Slow**: Timeliness is delayed by claims run-out and processing pipelines.
  - **Expensive**: Personnel and contractor costs accumulate.
  - **Error-prone:** High administrative stress increases risk of oversight and inconsistent enforcement.

Bottom Line:
Yes—a standardized, mandatory claims modifier would reduce government oversight costs by enabling automation, improving data accuracy, preventing fraud, streamlining audits, and minimizing administrative burdens at both the federal and state levels.

It's a smart, cost-effective policy tool that supports compliance, reduces waste, and ensures taxpayer dollars are used as intended—to benefit patients, not bureaucratic inefficiency or corporate exploitation.

<u>Opposition Arguments are *not* about Patients</u>

.

1. **Claims Modifiers Do Not Jeopardize Privacy and Are Already in Use**

Contrary to some misinformation, claims modifiers use de-identified digital markers that do not compromise patient privacy. These tools are widely used in Medicare and Medicaid billing processes and are essential for automating compliance and protecting rebate integrity. By failing to extend this existing infrastructure to the DPNP, CMS forces stakeholders to navigate complex, manual, and error-prone alternatives—again to the detriment of patients.

2. Vulnerable Patient Populations Will Suffer Most

When duplicate discounts and exploitative pricing practices reduce available public funds, patients lose access to programs that provide critical medication, preventative care, and emergency services. For example, a legislative analysis in Texas projected a $72 million shortfall in its HIV Medication Program if 340B expansion lacked adequate oversight. This illustrates how poor federal policy choices can directly translate into reduced care or financial hardship for patients.

The Case for a Mandatory Federal Claims Modifier or Clearinghouse Is Clear

CMS must reconsider its position. A mandatory federal claims modifier is a straightforward, existing solution to a complex, high-risk problem. It would:

- Prevent duplicate discounts that siphon funds from safety-net services.
- Provide consistency across state and federal programs.
- Enable automated compliance and enforcement.
- Protect the sustainability of rural and small-scale safety-net providers.
- Safeguard patients from the downstream impacts of financial exploitation.

CMS's decision to "not assume responsibility for deduplicating discounts at this time" effectively abandons the patients and providers most in need of federal protection. Rather than enabling a fairer, more transparent healthcare system, this inaction invites confusion, abuse, and harm.

States Are Hamstrung by Legal Constraints and Inadequate Oversight Tools

At least 12 states have enacted laws restricting the use of 340B claims modifiers or data-sharing with Manufacturers. CMS's decision not to require a federal solution creates a patchwork of rules and a regulatory vacuum. This lack of uniformity enables duplicate discounts that drain state Medicaid programs, undermining services that are critical to patients such as HIV treatment, chronic disease care, and rural hospital services. These are not abstract policy failures—they represent real harms to individuals relying on safety-net systems to survive.

Appropriate CMS guidance would resolve these disparities in state policies via Supremacy Clause application.

Recommendation:

CMS should immediately revise the proposed DPNP guidance to mandate a standardized, federal claims modifier or for all DPNP-related transactions. This reform is essential to protecting patient access, ensuring program compliance, and maintaining the financial sustainability of providers who serve the nation's most vulnerable.

Conclusion: Putting Patients First with a Mandatory Claims Modifier

At its core, this debate is not just about administrative codes, billing systems, or financial reconciliations—it is about people. It is about the cancer patient in a rural town who depends on a safety-net hospital for treatment. It

is about the parent of a child with a rare disease who relies on 340B-discounted medications to stay afloat. And it is about the countless individuals living with chronic conditions who face barriers to care every day.

When duplicate discounts go unchecked and safety-net resources are drained, patients are the ones who suffer—through delayed treatment, reduced services, and closures of the very facilities that serve as their lifelines. Allowing fragmented oversight to continue without a standardized claims modifier creates confusion, fuels inequity, and leaves the most vulnerable at risk.

A mandatory, standardized federal claims modifier is not just a smart policy choice — it is a patient-centered solution. It ensures that public funds are used efficiently, that life-saving medications remain accessible, and that safety-net providers can continue serving communities in need. CMS has the opportunity — *and the responsibility* — to act now, not later, to build a system rooted in clarity, fairness, and care.

We urge CMS to adopt this critical reform and put patients at the center of its policy decisions.

Thank you for the opportunity to comment. We invite you to meet with us to discuss this matter further, we can be reached by email or phone at kalvin@tiican.org , 913-954-8816, or jen@tiicann.org, 313-333-8534.
Sincerely,

Respectfully submitted,

Jen Laws
CEO
Community Access National Network (CANN)

Kalvin Pugh
Director of State Policy, 340B
Community Access National Network (CANN)

June 26, 2025

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Submitted electronically via IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Deputy Administrator Klomp:

As a leading healthcare enterprise serving over 8 million members enrolled in Medicare Advantage Prescription Drug Plans (MAPD) and standalone Part D Prescription plans (PDPs) nationwide, Centene is dedicated to providing high-quality, affordable care to individuals with complex health needs. Our extensive experience operating Medicare Advantage, standalone Part D plans, and integrated Medicare-Medicaid (Duals) plans uniquely position us to provide insights regarding areas that may encourage plans' support and participation in this program.

We commend the Agency for its commitment to improving medication affordability and access for Medicare beneficiaries through the ongoing implementation of the Medicare Drug Price Negotiation Program. Moreover, Centene thanks CMS for the opportunity to submit comments on the Draft Guidance of the Medicare Drug Price Negotiation Program published on May 12, 2025. The draft guidance reflects CMS' thoughtful approach to balancing cost containment with the need to preserve access to clinically appropriate, high-value therapies. We recognize and appreciate CMS' strategies in promoting transparency, ensuring program integrity, and stewarding long-term program sustainability. We look forward to continuing to work with CMS and partnering for the benefit of enrollees in the Part D program. Please contact me if additional information would be helpful or if you have questions about the issues raised in this letter. I can be reached at brittney.a.fairman@centene.com or (202) 253-7949.

Sincerely,

Brittney A. Fairman
Staff Vice President, Federal Public Policy

Comments on Section 60.1 – Establishment of a Single Maximum Fair Price (MFP) for Negotiation and Renegotiation Purposes

We appreciate CMS providing clarity in Section 60.1 of the draft guidance on the establishment of a single Maximum Fair Price (MFP) for each selected drug. Specifically, we understand that CMS intends to negotiate a singular MFP for each selected drug, regardless of dosage form or strength, and that this price will be applied consistently across all steps of the negotiation process and the full applicability period. We support the Agency's intent to align the MFP with existing Medicare payment methodologies. We note CMS' clarification that while the MFP will be singular, the mechanism of payment will vary by benefit design: for Part B, Medicare will pay 106% of the MFP, whereas under Part D, the MFP will serve as a ceiling for negotiated prices, with plans reimbursed up to that amount plus applicable dispensing fees.

CMS is also soliciting comment on how the MFP should apply when a selected drug is reimbursed under a methodology other than Average Sales Price (ASP) or Wholesale Acquisition Cost (WAC), particularly whether Medicare should adopt a "lower of" policy—paying the lower of 106% of MFP or the otherwise applicable amount. While we support the overarching goals of transparency and affordability, we are concerned that applying a uniform MFP may not always lead to cost savings and could disrupt effective market dynamics. In particular:

- **Market Net Prices May Already Be Lower Than MFP**: For several drugs, existing commercial negotiations have already achieved net prices below the MFP's statutory floor. For example, the Institute for Clinical and Economic Review (ICER) and market analysts have noted that Eliquis (apixaban), one of the first ten selected drugs, carries commercial rebates averaging 49% off WAC, effectively bringing the net price well below expected MFP levels.[1]
- **Voluntary List Price Reductions Risk Being Penalized**: CMS should also consider cases where manufacturers have already undertaken significant voluntary price cuts. Novo Nordisk, for instance, announced a reduction in list prices of insulin products—such as bringing the list price of NovoLog (insulin aspart) from $537 to $134 in an effort to improve affordability and preempt negotiation eligibility under the Inflation Reduction Act (IRA).[2] Applying a one-size-fits-all MFP could inadvertently penalize such actions by negating the intended market impact of those reductions.

These examples illustrate that applying MFP as a uniform ceiling may remove incentives for voluntary price reductions and impair plans' ability to secure deeper discounts through competitive negotiations. Moreover, it could unintentionally result in Medicare paying more than the market net price for certain high-utilization, legacy products.

[1] ICER Publishes Special Report on Eliquis and Xarelto Submitted to CMS as Part of Public Comment Process on Medicare Drug Price Negotiations. See https://icer.org/news-insights/press-releases/icer-publishes-special-report-on-eliquis-and-xarelto-submitted-to-cms-as-part-of-public-comment-process-on-medicare-drug-price-negotiations/.
[2] Novo Nordisk Annual Report (2024). See https://www.novonordisk.com/investors/annual-report.html.

Recommendations
To address these concerns, we respectfully recommend that CMS:

1. **Adopt a "Lower-of" Policy**: Allow payment of the lower of the MFP or the net price already achieved through market-based negotiations, particularly under Part D where robust rebate arrangements are prevalent.
2. **Establish an Exclusion Process**: Create a transparent process to exclude selected drugs from the uniform MFP requirement where manufacturers have substantially reduced list prices or where market evidence clearly shows that net prices already fall below the MFP floor.

We appreciate the opportunity to comment on this draft guidance and support CMS' continued efforts to implement a drug price negotiation framework that balances innovation, fiscal responsibility, and patient-centered care. As a national managed care organization committed to improving outcomes for medically complex populations, we believe that thoughtful implementation of this program can enhance care delivery and improve affordability for beneficiaries. By considering the recommendations outlined above, particularly with respect to maintaining flexibility in applying Maximum Fair price, we also believe CMS can reinforce its commitment to sustainability, while ensuring that the Medicare program remains responsive to the evolving needs of current and future beneficiaries.

cancer innovation + regulation initiative

June 20, 2025

Administrator Mehmet Oz, MD, MBA
Deputy Administrator Chris Klomp

Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Oz and Deputy Administrator Klomp:

The Cancer Innovation and Regulation (CIR) Initiative appreciates the opportunity to provide comment on the Draft Guidance implementing the third cycle of the Medicare Drug Price Negotiation Program ("Medicare Drug Price Negotiation Program: "Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191-1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028", May 12, 2025).

The CIR Initiative is an independent research initiative—based at Dana-Farber Cancer Institute and Brigham and Women's Hospital—focused on accelerating innovation for patients with cancer.[1] Overall, we support CMS' ongoing negotiations to lower drug prices for Medicare beneficiaries and American taxpayers. We recommend that the agency use the ESMO-Magnitude of Clinical Benefit Scale (ESMO-MCBS) in assessing section 1194(e)(2) factors relating to the therapeutic value and comparative effectiveness of negotiation-eligible cancer products.

Background to the ESMO Magnitude of Clinical Benefit Scale

The European Society for Medical Oncology (ESMO, representing >40,000 cancer specialists from 177 countries) developed the ESMO-Magnitude of Clinical Benefit Scale (ESMO-MCBS) in 2015 to facilitate improved decision-making regarding the value of cancer therapies.[2] The ESMO-MCBS was developed in a rigorous and transparent process with peer review and feedback from patient representatives, clinicians, statisticians, and researchers. ESMO-MCBS scores for new cancer medicines are incorporated into ESMO's influential Cancer Guidelines and the Pan-Asian Adapted Guidelines, helping to provide patients and clinicians globally with the best care options for their conditions.

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[1] We declare no financial conflicts-of-interest. The opinions expressed in this Letter are those of the authors only and do not represent the position of the authors' institutions or of the ESMO MCBS Working Group (of which the author is a member).

[2] ESMO, representing more than 40,000 oncology professionals and cancer specialists from 177 countries, seeks to improve the quality of cancer care worldwide—from prevention and diagnosis all the way to palliative care and patient follow-up—and promote access to optimal cancer care for all patients. The ESMO-MCBS was revised in 2017 (version 1.1) and further expanded in 2023 to hematologic malignancies in collaboration with the European Haematological Association (EHA).

The ESMO-MCBS tool can be used to score cancer drugs using publicly available outcome data: overall survival, progression- and disease-free survival, quality of life, response rates, and toxicity. Separate scoring forms are provided for the curative (scores range from A to C, with A highlighting high clinical benefit) and non-curative (scores range from 5 to 1, with 5 indicating high clinical benefit) settings. The ESMO-MCBS Scorecards for approved cancer drugs and indications are available online at esmo.org, and these scores have been widely used in the peer-reviewed scientific literature.[3]

Relevance of ESMO-MCBS Scoring for Section 1194(e)(2) Assessment of Therapeutic Alternatives

Section 1194(e)(2) of the Inflation Reduction Act directs CMS to consider evidence about alternative treatments to the selected drug, including the extent to which the selected drug represents a therapeutic advance compared to existing therapeutic alternatives for the selected drug and the comparative effectiveness of the selected drug and its therapeutic alternative(s).

The ESMO-MCBS scoring system is used as part of Health Technology Assessment (HTA) processes in >15 countries around the world[4] and can be similarly leveraged by CMS to guide adjustment of the starting point for the preliminary price offered in negotiations. **In general, cancer medicines with ESMO-MCBS scores of A (for therapies with curative intent) and 4 or 5 (for those with non-curative intent) should be highlighted for high therapeutic value.**

The ESMO-MCBS is a peer-reviewed objective, validated, and structured scoring system to provide reliable and fair evaluation of clinical benefit. This scoring system aligns with section 1194(e)(2) of the Act:

- The ESMO-MCBS does directly account for outcomes that are relevant for evaluating clinical benefit for patients with cancer, including survival, quality of life, and toxicity;
- The ESMO-MCBS does not incorporate any cost-effectiveness or quality-adjusted life year information that is proscribed by the Act; and
- ESMO-MCBS scores are transparent, as they can be independently calculated and verified, and scores for new cancer drugs approved by the US Food and Drug Administration are published online in public Scorecards and incorporated in ESMO's clinical guidelines.

ESMO-MCBS Scores for Selected Drugs for Price Applicability Year 2027

For the four cancer drugs selected for price applicability year 2027, ESMO-MCBS scoring (see enclosed *Table*) illustrates the indications considered as providing vs. not providing high clinical benefit.

This benefit scoring information could be relevant for CMS in adjusting the starting point for these selected cancer medicines (as well as comparison of scoring for therapeutic alternatives). ESMO-MCBS is a potentially useful instrument for informing this section 1194(e)(2) adjustment moving forward.

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[3] See Vokinger KN*, Hwang TJ*, Grischott T, et al. Prices and clinical benefit of cancer drugs in the USA and Europe: a cost-benefit analysis. *Lancet Oncol* 2020;21(5):664-670; Vokinger KN, Hwang TJ, Carl DL, et al. Price changes and within-class competition of cancer drugs in the USA and Europe: a comparative analysis. *Lancet Oncol* 2022;23(4):514-520.

[4] The ESMO-MCBS scoring system is used as part of Health Technology Assessment (HTA) processes in at least 17 countries. In addition, since 2019, the Expert Committee on Selection and Use of Medicines has integrated the ESMO-MCBS as a screening tool for cancer treatments warranting evaluation for listing in the World Health Organization's Essential Medicines List.

Drug	Indication	ESMO-MCBS Score
Acalabrutinib (Calquence)[5]	Previously untreated mantle cell lymphoma (MCL) ineligible for hematopoietic stem cell transplantation (In combination with bendamustine and rituximab)	1
	MCL with receipt of at least one prior therapy	3
	Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)	3
Enzalutamide (Xtandi)	Castration-resistant prostate cancer	**4 (High Benefit)**
	Metastatic castration-sensitive prostate cancer	**4 (High Benefit)**
	Non-metastatic castration-sensitive prostate cancer with biochemical recurrence at high risk for metastasis	3
Palbociclib (Ibrance)	HR+, HER2- advanced or metastatic breast cancer in combination with an aromatase inhibitor as initial endocrine-based therapy	2
	HR+, HER2- advanced or metastatic breast cancer with fulvestrant in patients with disease progression following endocrine therapy	**4 (High Benefit)**
Pomalidomide (Pomalyst)[6]	Multiple myeloma who have received at least 2 prior therapies including lenalidomide and a proteasome inhibitor and have demonstrated disease progression on or within 60 days of completion of the last therapy	**5 (High Benefit)**
	AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV negative	3

The CIR Initiative is available for further discussion of the above scoring and reviewing other drugs/indications, as necessary, for CMS.

Conclusion

The CIR Initiative is committed to ensuring access to and availability of cancer medicines in the US. Thank you for the opportunity to provide input on this important matter. We would be pleased to discuss the ESMO-MCBS and our comments in more detail.

■

ci+r cancer innovation + regulation initiative

Tom Hwang, MD | thwang1@partners.org
Founder, Cancer Innovation and Regulation Initiative

[5] The ESMO-MCBS:H score for the mantle cell lymphoma (MCL) indication (receipt of at least one prior therapy) has been validated by ESMO and will soon be available on the ESMO website.

[6] The ESMO-MCBS:H score for multiple myeloma is undergoing an update review by ESMO (will soon be available on ESMO's website).

CSRO
Coalition of State Rheumatology Organizations

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June 26, 2025

Mehmet Oz, MD
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IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program Draft Guidance - Initial Price Applicability Year 2028

Administrator Oz:

On behalf of the Coalition of State Rheumatology Organizations (CSRO), we would like to provide feedback on the Medicare Drug Price Negotiation Program Draft Guidance for the Initial Price Applicability Year 2028. CSRO serves the practicing rheumatologist and is comprised of over 40 state rheumatology societies nationwide with a mission of advocating for excellence in the field of rheumatology and ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease.

Rheumatologic diseases, such as rheumatoid arthritis, psoriatic arthritis and lupus, are systemic and incurable, but innovations in medicine over the last several decades have enabled rheumatologists to better manage these conditions. With access to the right treatment early in the disease, patients can generally delay or even avoid damage to their bones and joints, as well as reduce reliance on pain medications and other ancillary services, thus improving their quality of life.

Impact of MFP on the ASP and Part B Medications

Rheumatologists and other healthcare practices directly administer Part B biologic products to patients at their in-office infusion suites. These practices engage in the "buy-and-bill" model, whereby the medical practice pre-purchases medications and submits a claim to the health plan for reimbursement once the medication is administered to a patient. This model allows patients to conveniently receive their essential medications at their doctor's office instead of the hospital, reducing their exposure to hospital-based infections—a particularly important consideration for immunocompromised individuals who receive provider-administered drugs. This model is also far more cost effective, with hospital outpatient departments charging an average of 129-211% more for drug administration reimbursement than freestanding physician offices.[i]

However, margins for practices engaged in buy-and-bill are thin. These practices depend on the add-on payment at a bundled rate for administered drugs, which for Medicare Part B is the average sales price (ASP) plus six percent. The ASP is a market-based price that considers the weighted average of all manufacturer sales prices for the drug, including rebates and discounts. The additional six percent add-on helps these

medical practices account for acquisition costs, such as intake and storage, equipment and preparation, staff, facilities, and spoilage insurance.

We strongly advise CMS against including the Maximum Fair Price (MFP) within the ASP calculation for provider administered Part B medications. Inclusion of the MFP will deflate the overall ASP significantly, which then in turn will reduce the ASP base price percentage for provider administered add-on payments. In fact, according to a recent study by Avalere Health and commissioned by the Community Oncology Alliance, incorporating the MFP into the ASP calculation could reduce the ASP so precipitously that the calculated add-on payment for Part B reimbursements in Medicare would be 42-61% lower than the current reimbursement rates. This could also cause ripple effect into the commercial market, driving a 12-18% projected cut to physician reimbursements through the add-on payment.[ii]

Reimbursement rates that do not sufficiently compensate for acquisition costs put healthcare practices at risk. While we understand that theoretically a decreased base price would bring down the total cost per administered medication, such a precipitous drop in calculating Part B provider reimbursement would lead to inadequate, or "underwater," reimbursement, forcing providers into an untenable position. As we mentioned, these buy-and-bill margins are already incredibly thin, so reduced reimbursement for these medications would be unsustainable for private physician practices. Indeed, some practices are already underwater on certain biosimilar medications, forcing providers to choose between administering the drug at an unsustainable financial loss or transferring the patient to another site of service that may be able to absorb the ASP loss, such as the hospital. Driving patients into the hospital for this care will drive up the cost of these services, which is counterproductive to the overall drug affordability goals of the Congress and White House. Ultimately, the patient may lose access to the prescribed medication altogether, which could result in higher healthcare costs as a consequence of loss of control of their disease or the higher costs of an alternative treatment.

CSRO has long supported the *Protecting Access to Cancer and Complex Therapies Act*, sponsored by Senator John Barrasso, MD (R-Wy.), which would address these concerns and stabilize Part B drug reimbursement for providers. We encourage CMS to work with Congress to advance proposals that ensure providers are adequately reimbursed for Part B drug administration.

Manufacturer MFP Models

Through this draft guidance, CMS has also offered two potential processes by which the primary manufacturer can provide access to the MFP for Part B drugs:[iii]

(1) prospectively ensuring that the price paid by the dispensing entity or Part B provider when acquiring the drug is no greater than the MFP; or
(2) retrospectively providing reimbursement for the difference between the dispensing entity or Part B provider's acquisition cost and the MFP.

CSRO has serious concerns regarding Model 2, which would require providers to purchase the drug at a cost much higher than reimbursement and then bare the financial difference until the manufacturer reimbursement is received by the medical practice. This would not be feasible financially for most small rheumatology private medical practices, that do not have the financial flexibility to float these expenses while also faced with inadequate reimbursement if the MFP is incorporated into the ASP. This combination will truly jeopardize the viability of private practice for not only rheumatologists, but for all private practices that buy-and-bill medications. We strongly urge CMS to strike Model 2 from the draft guidance.

PBM Formulary Manipulation

CSRO strongly encourages CMS to monitor whether the medications selected for drug negotiation remain accessible to patients following implementation. While statute requires selected drugs to be covered on every Part D formulary starting in 2026, CMS has indicated that it does not intend to establish tiering or

utilization management requirements.[iv] CSRO is concerned that plans have already adjusted some formularies in anticipation of negotiation, and a recent poll suggests that some payers and pharmacy benefit managers (PBMs) are considering step therapy, prior authorization, and other tactics to steer patients toward non-negotiated, heavily-rebated alternatives.[v]

Even if the MA plans include the selected drugs on their formularies, there is nothing to stop the plan from placing the medication on a fourth tier, requiring patients to "step through" much more expensive drugs before they can access the Medicare negotiated medication. This type of formulary design manipulation will severely limit patient access to the drugs selected for drug negotiation, minimizing the Medicare Drug Price Negotiation Program's influence in making medication more affordable.

Therapeutic Alternatives

The statute instructs CMS to consider available evidence about therapeutic alternatives for the selected medications. CSRO urges CMS to proceed with caution and recognize that not all therapeutic alternatives are therapeutically equivalent, having drastically different clinical outcomes for patients. When healthcare providers evaluate medication substitutions, they typically consider therapeutic *equivalents* – not alternatives. Therefore, we strongly recommend that CMS recognize that only therapeutic equivalents to reviewed drugs are clinically appropriate to consider for substitution.

Deeming medications "therapeutic alternatives" is a one-size fits all approach that disrupts the physician's ability to exercise their medical expertise in concert with their patient. Patients that suffer from complex chronic conditions, such as rheumatoid arthritis and other autoimmune diseases, require careful consideration of exactly how each immunologic medication works for treating their condition. Additionally, continuity of care is essential to successfully manage complex immunologic conditions. Patients may spend months or years of trial and error, working with their physician to find a treatment regimen that successfully manages their condition. Any resulting new treatment plan must carefully balance each patient's unique immunologic profile, medical history, comorbidities, potential drug interactions, adherence challenges, and psychological impact, including medication anxiety or distrust.

Slight deviations in treatment and variations between drugs, even those in the same therapeutic class, may cause loss of disease control, resulting in serious adverse events and higher healthcare costs. Delays or changes in appropriate treatment can cause irreversible or life-threatening disease progression and may render previous therapies ineffective, resulting in needless patient suffering. We urge CMS to carefully consider established clinical standards during its review, as shifting patients to less costly but non-equivalent alternatives could ultimately increase costs for both patients and the healthcare system.

Rheumatologists and our practice partners share your commitment to address high out-of-pocket costs for prescription medications. We respectfully urge CMS to exercise its authority to exclude the Maximum Fair Price from the Average Sales Price calculation and take other necessary precautions to ensure patient access and adequate provider reimbursement. We thank you for your consideration and encourage you to contact CSRO (jfrasco@hhs.com) with any additional questions you may have.

Respectfully,

Aaron Broadwell, MD, FACR
President
Board of Directors

Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs
Board of Directors

[i] Actuarial Research Corporation. "Potential Impacts of Medicare Site Neutrality on Off-Campus Drug Administration Costs." October 2023.
[ii] Avalere Health. "Commercial Spillover Impact of Part B Negotiations on Physicians." September 2024.
[iii] Centers for Medicare & Medicaid Services. "Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028." May 2025.
[iv] Milliman. "Prescribing a Part D formulary for the new IRA world." December 2024.
[v] https://aishealth.mmitnetwork.com/blogs/spotlight-on-market-access/payers-eye-rebate-leverage-um-in-response-to-medicare-negotiated-drug-prices

June 26, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244–1850

By e-mail to IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program Draft Guidance

The Coalition to Stop Flu (the "Coalition") appreciates this opportunity to provide comments on the Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act (SSA) for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 (the "IPAY 2028 Draft Guidance"). Our comments address the importance of influenza vaccines to Medicare beneficiaries and to the Medicare program and explain the legal and policy reasons to exclude flu vaccines from the Medicare Drug Price Negotiation Program (the "Negotiation Program").

I. Introduction to the Coalition to Stop Flu

The Coalition to Stop Flu is a multi-sector advocacy coalition dedicated to ending deaths from seasonal and pandemic influenza, often called "the flu." Our twenty-eight members represent a unified voice for the influenza ecosystem and include public health and patient advocacy organizations; academic, scientific, and research organizations; health care professional organizations; emerging biotech companies; health care distributors; and vaccine, antiviral, and diagnostic manufacturers.

The Coalition's federal policy agenda is aimed at saving lives, saving money, and protecting public health by enhancing the U.S. influenza ecosystem, including through proper authorization, funding, and implementation of federal influenza and adjacent programs. Achieving these shared goals requires strong partnerships between the federal government and external stakeholders and a commitment to innovation.

II. Influenza and the Medicare Program

Influenza is one of our country's most predictable, preventable public health crises. The Centers for Disease Control and Prevention (CDC) estimates that every year in the U.S., influenza results in 6,300–52,000 deaths, 120,000–710,000 hospitalizations, and 9.3–41 million illnesses.[1] People over the age of 65 are at high risk of severe outcomes from the flu, including pneumonia, stroke, heart events, and death. CDC has found that "between 70 percent and 85 percent of seasonal flu-related deaths have occurred in people 65 years and older, and between 50 percent and 70 percent of seasonal flu-related hospitalizations have occurred among people in this age group."[2] Vaccines are

[1] CDC, "About Estimated Flu Burden," https://www.cdc.gov/flu-burden/php/about/index.html (Nov. 13, 2024).
[2] CDC, "Flu and People 65 Years and Older," https://www.cdc.gov/flu/highrisk/65over.htm (Sept. 4, 2024).

the best way to reduce the risk of becoming infected with flu and any of its potentially serious complications.

III. Selection of flu vaccines for the Negotiation Program could result in potential harm to the U.S. population without any benefits to the Medicare program or its beneficiaries.

Flu vaccines are important and unique among the drugs and biologicals covered by Medicare Part B because they play a vital role in protecting Medicare beneficiaries' health; are subject to a special reimbursement method by statute; and face distinct research, development, and manufacturing challenges that could be exacerbated by price negotiation.

As discussed above, flu vaccines are critical to our mission of eliminating flu deaths and saving health care systems, including the Medicare program, from bearing costs of avoidable hospitalizations and other medical care. For these reasons, the Centers for Medicare & Medicaid Services (CMS) recognizes the benefits of flu vaccines and for many years has encouraged Medicare beneficiaries to receive flu vaccines to prevent hospitalizations and death. Medicare quality programs, conditions of participation, and Medicare Advantage Star Ratings all recognize the importance of annual flu vaccination on individual and population health. Despite these efforts, flu vaccines remain underutilized.

Flu and other Part B vaccines also have special reimbursement requirements under the Medicare statute. Federal law requires: (1) Medicare beneficiaries to receive flu vaccines without any out-of-pocket costs, and (2) Medicare to reimburse providers who purchase flu vaccines at 95% of average wholesale price (AWP).[3] The Inflation Reduction Act of 2022 (IRA) did not change the federal laws governing Medicare reimbursement for vaccines.[4] Therefore, even if the flu vaccine price were to be negotiated, Medicare would not pay the negotiated price—it would continue to pay the providers who purchase and administer vaccines at 95% of AWP. As a result, negotiating flu vaccine prices would not result in any savings to the Medicare program or its beneficiaries.

Moreover, flu vaccines have unique research, development, and manufacturing challenges. Unlike other drugs or biologics, flu vaccines' product compositions (i.e., the active ingredient viral strains) are newly developed, licensed, manufactured, and distributed every year through an intricate, labor-intensive process involving many stakeholders, including the Food and Drug Administration (FDA). These stakeholders work together to determine which of the circulating flu strains have the highest likelihood to cause illness in the United States for the next flu season. Manufacturers must continually invest in research and development and innovation, year-over-year, to produce a vaccine that can prevent the right combination of strains each year. The U.S. requires multiple manufacturers to produce vaccines each year in order to maintain a sufficient annual supply of seasonal flu vaccines. However, these challenges contribute to the fragility of the market for flu vaccines and the limited

[3] SSA §§ 1833(a)(1)(B); 1842(o)(1)(A)(iv).

[4] We note that CMS solicits comments regarding "cases where the selected drug is not paid under section 1847A of the Act," specifically "whether it best effectuates the relevant statutory provisions in instances in which payment may be made under Part B for a selected drug on the basis of an amount other than ASP or WAC, for the Medicare Part B payment (and coinsurance) to be based on the lower of 106 percent of the MFP and the otherwise applicable payment amount." Draft 2028 IPAY Guidance, § 60.1, at 109. This would not best effectuate the statute. The relevant statutory provisions are clear: payment for flu vaccines and other Part B vaccines remains unchanged by the IRA's amendments.

number of manufacturers producing these vaccines. If one or more manufacturers exit the market, the supply of vaccines for seasonal flu and pandemics will be at risk. Stable reimbursement is essential to supporting continued investment in new and improved influenza vaccines and to maintaining our flu vaccine manufacturing base.

For all of these reasons, selecting flu vaccines for negotiation will not benefit the Medicare program or its beneficiaries and could lead to potential harms for the entire U.S. population.

IV. CMS has statutory authority to determine that flu vaccines are not subject to negotiation.

CMS should conclude that the ambiguities in the Inflation Reduction Act of 2022 (IRA), coupled with the fact that there is no mechanism for the Medicare program to capture savings from the maximum fair price (MFP) for Part B vaccines, including flu vaccines, provide a basis to determine that Congress did not intend to include Part B vaccines in the Negotiation Program.

There are two key statutory ambiguities that support a decision *not* to include flu vaccines and other Part B vaccines in the Negotiation Program.

A. The IRA does not specify whether or how the maximum fair price ceiling is calculated for Part B vaccines.

Under the IRA, the MFP ceiling sets the limit on the amount Medicare will pay for negotiated drugs.[5] For selected Part B drugs, the ceiling is set at the lowest of: (1) "the payment made under *section 1847A(b)(4)* for the drug or biological product" for the year before the selection; (2) the "applicable percentage" of the average non-Federal average manufacturer (non-FAMP) price for 2021, increased by an inflation factor; or (3) the "applicable percentage" of the average non-FAMP for the year before the selection year (emphasis added).

However, the flu vaccine and other Part B vaccines are *not* reimbursed under Section 1847A(b)(4); they are reimbursed under Section 1842(o)(1)(A)(iv), and the IRA did not amend this section of the statute to change the payment rate. As a result, for flu vaccines and other Part B vaccines, there is no way to determine the first of the three MFP ceiling options, because there is no reimbursement under Section 1847A**.** CMS proposes to address this gap by "default[ing] to the ceiling amount determined under section 1194(c)(1)(C)(ii) of the Act," namely the "applicable percent of average non-FAMP.[6] This approach would not fill the gap in the statute, however. It would instead replace the "lesser of" method comparing the usual reimbursement to non-FAMP that Congress enacted with a fixed benchmark for the MFP ceiling price. There continues to be no way to apply the "lesser of" method that Congress intended to use to a drug that is not reimbursed under Section 1847A(b)(4).

[5] SSA § 1194(c).
[6] IPAY 2028 Draft Guidance, § 60.2.1, at 117.

B. The IRA does not specify whether or how a biosimilar delay rebate is calculated for Part B vaccines.

Eligibility for selection for the Negotiation Program depends, in part, on whether, at the time of selection, a generic or biosimilar has come to market. For a biological, the IRA delays selection from negotiation if a competing biosimilar is highly likely to come to market within two years. But, if a competing biosimilar does not come to market within this time period, the manufacturer must pay rebates for each quarter of delay.

The rebate amount for Part B biologicals is "the sum of the products of": (1) "80 percent of the amount by which" the reimbursement for the biological "under *section 1847A(b)*, with respect to each of the calendar quarters of the price applicability period that would have applied but for" the delay "exceeds" the (delayed) maximum fair price; and (2) the number of separately reimbursable units of the biological "administered or furnished" during the relevant period (emphasis added).

Because flu vaccines (and other Part B vaccines) are not reimbursed under Section 1847A, if a Part B vaccine for which selection for negotiation were delayed in anticipation of the launch of a competing biosimilar, and if the biosimilar did not launch within the two-year window, there would be no way to determine the amount of rebate owed by the manufacturer.

In summary, for flu vaccines and other Part B vaccines, there is no way to determine the biosimilar delay rebate because there is no reimbursement under Section 1847A.

In conclusion, the statutory ambiguities described above suggest that Congress did not clearly intend to include Part B vaccines in the negotiation program and, therefore, give CMS the discretion to exclude flu vaccines and other Part B vaccines from the Negotiation Program.

V. Not subjecting multivalent flu vaccines to negotiation is consistent with the prior guidance and the draft IPAY 2028 guidance around active ingredients and fixed-dose combination products.

The IRA specifies that only qualifying single source drugs (QSSDs) are eligible for negotiation. A biological product must have been licensed for at least 11 years before being considered a QSSD.[7] CMS has indicated in guidance that it will identify QSSDs by reference to active ingredient/active moiety. In the IPAY 2028 Draft Guidance, CMS states, "CMS will identify the active moiety or active ingredient of the drug using public sources such as RxNorm, OpenFDA, FDALabel, and FDA's Active Ingredient-Active Moiety Relationship/Basis of Strength file."[8] The Coalition recommends that CMS also use NLM DailyMed to identify the active ingredients in pertinent drug products.

The IPAY 2026 and 2027 Guidance and IPAY 2028 Draft Guidance also clarify that products that consist of more than one active ingredient – i.e., fixed-dose combination products (even those within a single Biologics License Application (BLA)) – will be disaggregated and treated as distinct for the purpose of identifying QSSDs. In response to comments on the 2027 IPAY guidance, CMS noted,

[7] SSA § 1192(e).
[8] IPAY 2028 Draft Guidance, § 30.1, at 12.

"The policies [on fixed combination drugs] described in section 30.1 of this final guidance apply no differently to vaccines than to other products."[9]

Flu vaccines are multivalent seasonal vaccines that have multiple active ingredients (i.e., viral strains) that change each year. Indeed, FDA sources, such as FDALabel, as well as other public sources, such as NLM DailyMed, identify the viral strains as the active ingredients of multivalent flu vaccines. Multivalent flu vaccines therefore are fixed-dose combination products consisting of annually changing variants of seasonal virus that track the evolving nature of the flu virus. Therefore, as of any given selected drug publication date, a multivalent seasonal vaccine would not qualify as a QSSD because it would be a different fixed-dose combination product from the product approved 11 years earlier.

In summary, flu vaccines are not QSSDs because their active ingredients change nearly every year. Based on the statute, guidance, and the unique nature of seasonal flu, flu vaccines should not be considered eligible for negotiation. If multivalent flu vaccines were to be regarded as QSSDs, notwithstanding the fact that they are fixed-dose combination products that consist of active ingredients that have not been commercialized for the minimum requisite time period, the agency would introduce an arbitrary and inconsistent criterion for evaluating products for selection.

VI. Conclusion

Subjecting flu vaccines to the Negotiation Program would not benefit Medicare or its beneficiaries. To the contrary, it could have negative consequences for continued innovation and the stability of the flu manufacturing base, which ultimately would harm U.S. patients. CMS has the authority to prevent these negative consequences by determining that flu vaccines are not subject to negotiation under the IRA. The Coalition to Prevent Flu urges CMS to exclude flu vaccines from the Negotiation Program.

* * *

Thank you for the opportunity to provide input on these critical issues. If you have any questions or would like any further information, please do not hesitate to contact Niki Carelli, Coalition Executive Director, at niki@daschlegroup.com.

Sincerely,

Tom Daschle
Chairman, Coalition to Stop Flu

[9] 2027 IPAY Guidance, at 15.

I do not understand fully how the program will work. However, it looks to me like I will pay full price for the drug, PBM will reimburse the maximum fair price (or reduced negotiated price). Then later I will receive my rebate when it is determined I dispensed to a Medicare patient. If this is incorrect, please advise me how it will work. If this is correct, how am I as a small, rural, independent pharmacy supposed to stay in business? I pay my drug bill weekly. Then I wait on the PBM to pay me 2-6 weeks later. Now I will have to wait who knows how long to get my rebate money from CMS. This is a terrible deal for pharmacy. Optum is waiting on me to sign a contract regarding Medicare with the new MFP terms. How am I supposed to agree to a contract when the pricing of the drugs are not yet available? I cannot afford to continue to front the money for the PBM's and the feds

Jennifer Coburn

Coburn's Pharmacy, LLC

[redacted]

[redacted]

COMMUNITY ONCOLOGY ALLIANCE

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June 26, 2025

The Honorable Chris Klomp
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

Submitted electronically to *IRARebateandNegotiation@cms.hhs.gov*

RE: Medicare Drug Price Negotiation Program Draft Guidance for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp,

The Community Oncology Alliance ("COA") appreciates the opportunity to provide comments on the Medicare Drug Price Negotiation Program Draft Guidance ("MDPNP") for Initial Price Applicability Year ("IPAY") 2028 and Manufacturer Effectuation of the Maximum Fair Price ("MFP") in 2026, 2027, and 2028.

COA is an organization dedicated to advocating for the complex care and access needs of patients with cancer and the community oncology practices that serve them. COA is the only nonprofit organization in the United States dedicated solely to independent community oncology practices, which serve the majority of Americans receiving treatment for cancer. Since its grassroots founding more than 20 years ago, COA's mission has been to ensure that patients with cancer receive quality, affordable, and accessible care in their own communities where they live and work, regardless of their racial, ethnic, or socioeconomic status.

COA appreciates the work of the Centers for Medicare & Medicaid Services ("CMS") towards the MDPNP's stated goal of lowering drug costs for beneficiaries and appreciates the opportunity to provide comments on the proposed guidance. **However, COA is very concerned with how the program's MFP will impact the ability of community oncology practices, especially those with infusion capabilities and medically integrated dispensing, to provide quality and affordable care to their patients.** As noted in the draft guidance, the supply chain and pricing dynamics of physician-administered drugs ("Part B drugs") are very different than drugs typically covered under the pharmacy benefit ("Part D drugs"). Given these differences and the ways in which Part B providers acquire, administer, and are reimbursed for Part B drugs, **the Part B effectuation process has the potential to be a practice-ending event for many community oncology practices.**

COA is also concerned that in addition to challenges related to drug acquisition and reimbursement, the various ways in which manufacturers of negotiated drugs could

effectuate MFP will create significant administrative burdens and financial challenges for community oncology practices.

Our letter addresses the following topics:

- Release Part B MFP Effectuation Guidance and Incorporate Stakeholder Feedback (Section 40.4)
- Reduced Add-on Payments Under Medicare Part B Due to the Inclusion of MFP in Average Sales Price ("ASP") Calculations (Section 40.4)
- Standardizing MFP Effectuation to Reduce Operational Concerns for Providers (Section 40.4)
- Prospective Model Concerns (Section 40.4)
- Retrospective Model Concerns (Section 40.4)
- Formulary Inclusion of Part D Selected Drugs (Section 110)
- Monitoring Medicare Advantage ("MA") Plans' Use of Step Therapy for Part B Drugs (Section 80)
- 340B Drug Pricing Program Considerations (Section 40.4.5)
- Consideration of Therapeutic Alternatives (60.3.1)
- Patient Access to Innovation (Section 30.1.1, and Section 30.3.1)
- Public Engagement Events (Section 60.4)
- Ceiling for Part B Drugs Not Paid Under 1847(A)(b)(4) (Section 60.2.2.2)

Release Part B MFP Effectuation Guidance and Incorporate Stakeholder Feedback (Section 40.4)

As CMS has not provided a detailed policy on MFP effectuation for Part B drugs in this guidance, we strongly urge CMS to incorporate COA's feedback into this policy when released. A detailed Part B MFP effectuation policy should be released as soon as possible with an additional opportunity for public comment. The supply chain for Part B drugs is complex, with multiple stakeholders involved. Practices need time to plan for cash flow and effectuation concerns and to address these concerns with CMS.

We also recommend CMS be cautious when introducing new stakeholders and processes into the current Medicare Part B reimbursement system. Medicare Part B has complexities that differ from Part D. Under Medicare Fee-for-Service ("FFS"), seven Medicare Administrative Contractors ("MACs") are responsible for processing Part B claims across 12 jurisdictions. Providers also receive reimbursement from Medicare Advantage ("MA") plans that may use different reimbursement structures than Medicare FFS. Introducing MFP effectuation into a system with multiple stakeholders will increase challenges for Part B providers.

Reduced Add-on Payments Under Medicare Part B Due to the Inclusion of MFP in ASP Calculations (Section 40.4)

Of critical concern to Part B providers is the reduction in add-on payments under Medicare Part B due to the inclusion of MFP in ASP calculations. Currently, CMS primarily uses the ASP plus a six percent add-on payment for Part B drugs to reimburse providers for Part B drug administration. The "plus six percent" add-on payment, subject to sequestration, is crucial for the economics of independent community oncology practices, as it covers a range of overhead costs, including complex medication storage, shipping, inventory management, and other related expenses. For many community oncology practices, the add-on payment also helps fund salaries for critically important clinical and office staff, on whom the practices rely on to operate and provide timely, high-quality care to patients with cancer. None of these costs will be reduced by the MFP provisions of the Inflation Reduction Act ("IRA"). Under the IRA, beginning in 2028, providers of selected drugs will continue to receive a six percent add-on payment, but it will be based on the MFP of the drug, which will be significantly lower than the ASP. The statute outlines a formula to

calculate the maximum amount Medicare will pay for negotiated drugs, which will be reduced automatically based on each product's number of years on the market. This is a significant change from current reimbursement levels.

We understand that the change in reimbursement was enacted by Congress, and that is why COA supports the solution previously introduced by United States Senator John Barrasso (R-WY) (H.R. 5391 in the 118th Congress) of creating a "carve out" or pass-through payment to separate MFP from ASP.[1] Under this methodology, manufacturers would provide a refund of the ASP-to-MFP difference to the government, so that providers could keep being paid on pre-IRA ASP basis, while CMS would continue to capture the savings driven by negotiation.

COA understands that Congress would have to act to reverse the IRA change in physician reimbursement. However, in our comments to CMS, we want to ensure that the agency fully understands the negative impact of MFP-based payments on provider viability and acts within its statutory authority to mitigate that impact to the greatest extent possible. To quantify the impact of IRA Medicare negotiation on add-on payments, Avalere analyzed the projected changes to provider reimbursements for a set of physician-administered drugs CMS will likely negotiate when Part B products are included in the program. These include some key oncology and hematology drugs. An earlier published analysis by Avalere estimated that the IRA would lead to a minimum 47 percent add-on payment reduction on average in Medicare FFS for providers who furnish these Part B drugs initially targeted for negotiation.[2]

The analysis was recently updated to reflect expectations of the drugs selected by CMS and also includes estimates of the impact on the commercial market in addition to Medicare FFS. Because MFP is expected to lower ASP calculations, the model shows average ASP erosion across the 10 Part B drugs grows up to 19 percent by the end of 2032, depending on where MFP is set.[3] This, in turn, leads to a minimum of $25 billion in loss of add-on payments for providers between Medicare FFS, MA, and the commercial market between 2028 and 2032.[4] If CMS were to set MFPs for Part B drugs below the ceiling, the total amount of add-on dollars lost by providers who administer the 10 drugs selected for negotiation could increase to $31 billion or even $37 billion, depending on where MFP is set.[5]

Providers administering oncology/hematology products are projected to be hit particularly hard by the decrease in the add-on payment, with providers projected to face a 39 to 64 percent decrease in the Medicare FFS add-on payment, along with a 13 to 21 percent reduction in the commercial and MA add-on payment. Based on Avalere's projections, for just three oncology drugs over five years, add-on payments could be reduced between $12 and $19 billion.[6] This impact is alarming since the fixed costs for handling and administering these drugs will only increase over that same period of time. **As the program is currently designed, community oncology practices will be forced to shut their doors, no longer able to provide care for the patients in their communities.** Not only would patients suffer, but they would likely be forced to seek care at oncology centers affiliated with hospitals and health systems, which would cost Medicare and taxpayers more money given the gross overpayment in these sites of care for the same services provided in community oncology at a fraction (albeit insufficient) of the price.

Community oncology practices operate on extremely narrow margins, with financial challenges growing as reimbursement under the Physician Fee Schedule ("PFS") lags behind inflation. An analysis found that from 2014 to 2023, the conversion factor used to update reimbursement rates under the PFS decreased by

[1] Congress.gov (2023) H.R.5391 - Protecting Patient Access to Cancer and Complex Therapies Act. Available Here
[2] Avalere Health Advisory. "IRA Medicare Part B Negotiation Shifts Financial Risk to Physicians." 29 November 2022. Available Here.
[3] Avalere Health Advisory. "Commercial Spillover Impact of Part B Negotiations on Physicians." 16 September 2024. Available Here.
[4] Ibid.
[5] Ibid.
[6] Ibid.

five percent, while the compounded inflation rate increased by 28 percent. For chemotherapy administration, physician payments in 2023 ($132) and 2014 ($133) are nearly identical despite growing inflation, while the hospital reimbursement rate increased by 11 percent over the same time. For a non-chemotherapy IV infusion, the reimbursement rate for physicians decreased by nearly six percent from 2014 to 2023, while the hospital outpatient reimbursement rate increased by about 20 percent.[7] These findings highlight the current challenges community oncology practices face, which will only worsen under the IRA. Part B negotiation will have ripple effects that extend well beyond the Medicare population, reshaping physicians' behavior and ability to administer life-saving drugs to patients because, despite their best intentions, they cannot keep their practices open without the add-on payment revenue that accounts for practice operations. For practices that can remain in business, they will need to evaluate which products they can stock and administer, thereby increasing the operational and economic burden they face, as well as the impact on patients who may not have access to therapies close to home.

Recommendations

As CMS develops Part B MFP effectuation policies, COA and its members express strong support for MFP effectuation to be operationalized in a way that would reinstate provider reimbursement to ASP plus six percent rather than MFP plus six percent and require manufacturers to pay direct refunds to the government for the difference between ASP and MFP. That is a commonsense solution that would prevent disruptions and added administrative burdens in the supply chain while still preserving the IRA's intent to lower costs for Medicare and beneficiaries. **To ensure that providers are not reimbursed below the acquisition cost for Part B negotiated drugs, we encourage CMS to work with Congress on creating a "carve out" or pass-through payment to separate MFP from ASP. This would address and prevent this type of unintended consequence of the IRA.**

Additionally, CMS has the statutory authority to remove MFP from ASP calculations, based on its precedential removal of Competitive Acquisition Program ("CAP") prices from ASP.[8] This authority is based on CMS's "unit-counting" authority provided by Social Security Act (SSA) § 1847A(b)(2)(B). COA also questions CMS's statutory authority to *include* MFP in ASP calculations. The legislative text of the IRA does not explicitly include MFP in ASP, and doing so would have significant economic and political consequences. Pursuant to the *major questions doctrine*, absent congressional authorization, CMS is not authorized to make changes that start a long-lasting deterioration in the physician-administered drug marketplace. Moreover, including MFP in the calculation of ASP would run counter to the original intent of ASP. ASP was created as a market-based pricing metric intended to reflect actual transaction prices in the commercial marketplace rather than prices set by the government. Congressional records and statutory language from the Medicare Modernization Act of 2003 make clear that ASP was designed to promote reimbursement based on competitive market forces. Including an administratively set price like MFP would shift ASP away from being a market-based benchmark and undermine its foundational purpose of reflecting real-world pricing dynamics.

At a minimum, we recommend CMS continue **to calculate and crosswalk sales and pricing data to ASP calculations and publish both an MFP and an ASP that does not include MFP-based discounts in the quarterly pricing files to minimize disruption outside of Medicare FFS.**

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[7] Centers for Medicare & Medicaid Services. "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." 8 February 2024. Available Here.

[8] Centers for Medicare & Medicaid Services. "Medicare Program; Exclusion of Vendor Purchases Made Under the Competitive Acquisition Program (CAP) for Outpatient Drugs and Biologicals Under Part B for the Purpose of Calculating the Average Sales Price (ASP)." 21 November 2005. Available Here.

Standardizing MFP Effectuation to Reduce Operational Concerns for Providers (Section 40.4)

Under the MDPNP, community oncologists will face challenges under the MFP effectuation process because they will need to manage separate inventories for MFP and non-MFP eligible patients, track different approaches drug-by-drug, and work with multiple vendors for both Part B and Part D drugs. These issues are compounded by complex storage and handling requirements for Part B and Part D drugs, which are particularly important for cancer medications. For practices with medically integrated dispensing, different approaches will also need to be tracked across Medicare Part B and Medicare Part D. The need to track these various approaches will be particularly challenging for independent practices, as they do not have the same level of infrastructure as large health systems or pharmacies.

Under a prospective model, the manufacturer of a selected drug must ensure that the price paid by the dispensing entity or Part B provider when acquiring the drug is no greater than the MFP. Under a retrospective model, the manufacturer must provide reimbursement for the difference between the dispensing entity or Part B provider's acquisition cost and the MFP. Manufacturers can choose either effectuation model based on the current guidance. CMS has stated it intends to align Part B MFP effectuation policy with Part D where possible but has not yet provided detailed guidance on how MFP will be effectuated for Part B drugs. Providers have concerns about effectuation under both models, which are outlined in the sections below.

Recommendations

COA strongly urges CMS to use a standardized approach for MFP effectuation rather than permitting manufacturers to choose an MFP effectuation for each selected drug. Approaches should be standardized for Part B and Part D drugs. The standardized approach does not need to be the same, and will not be the same, for Part B and Part D drugs, given differences in workflows. The chosen approach should have the least magnitude of impact on providers operationally. While a standardized approach will not rectify all of COA's concerns related to the MDPNP, which we provide in more detail below, it will alleviate one of the operational challenges for providers related to the program. **COA is also willing to partner with the negotiation office to understand the full spectrum of challenges that providers would experience in order to design solutions that do not create unintended consequences.**

CMS is considering whether the private market could provide an alternative to the Medicare Transaction Facilitator ("MTF"). If a private market alternative is developed and leveraged rather than the MTF, we ask CMS to **ensure that providers are not financially burdened through additional fees funding any private market alternative, given that CMS has placed providers in the middle of the MFP effectuation process.**

Prospective Model Concerns (Section 40.4)

Under a prospective model, practices are very concerned about managing separate product inventories for MFP and non-MFP-eligible patients, which may particularly impact small practices that do not have the same resources or staffing to track and maintain separate inventories as large practices. These concerns apply to both Part B and Part D drugs.

Under the current model, community oncology providers have agreements with group purchasing organizations ("GPOs") and wholesalers to purchase drugs. Drugs are not purchased based on the patient's payer, but overall. Prospective effectuation would change the dynamics because providers would have to maintain strict inventory management. This, in turn, could change the supply chain and contracting

dynamics. Wholesalers and GPOs may increase their fees to account for this greater complexity, ultimately increasing spending in the health care system or adding further pressures on purchasing physicians.

Community oncology practices will bear a disproportionate operational and financial burden of managing MFP and non-MFP inventories, given the number of oncology drugs likely selected in the first couple of years of Part B negotiations. Where larger practices may have sophisticated inventory management systems and staff to handle this change, smaller community oncology practices face a higher relative resource burden to track and maintain separate inventories. Typically, practices would hire staff to address these burdens; however, in an MFP environment with reduced reimbursement and a lower add-on payment that covers these support staff salaries, this is an unrealistic option for most smaller practices.

Recommendations

To alleviate some of these concerns for Part B drugs, as we noted above, **COA recommends that MFP effectuation be operationalized in a way that would reinstate provider reimbursement to ASP plus six percent and require manufacturers to pay direct refunds to the government for the difference between ASP and MFP.** This would take the onus away from providers to shoulder the financial burden of MFP operationalization and prevent disruptions and added administrative burdens in the supply chain, which is important to facilitate continued patient access to oncology treatments.

If this does not occur, **we urge CMS to provide a transition period for drugs purchased prior to the date that MFP plus six percent reimbursement takes effect (January 1, 2028, for any Part B drugs selected for negotiation) if they were purchased at rates higher than MFP.** CMS should include a provision in the manufacturer agreement for manufacturers with selected Part B drugs requiring the manufacturer to rebate the difference between the physicians' acquisition cost and the MFP as soon as the MFP goes into effect.

CMS should also *guarantee* that providers will be able to purchase drugs selected for negotiation at MFP rather than just providing that as an option. As manufacturers may choose whether to effectuate MFP retrospectively or prospectively, there is no guarantee that providers will be able to purchase the selected drug at MFP, contributing to concerns regarding operating margins.

Retrospective Model Concerns (Section 40.4)

Retrospective Model Concerns for Part B Drugs

Under the retrospective model, providers are put in the middle of drug manufacturers' operations, requiring the dispensing entity to track and manage manufacturers' effectuation plans. These issues will be exacerbated as more drugs continue to be selected for negotiation. A retrospective methodology would require that the MFP be made available to Part B providers by retrospectively transmitting payment for the difference between the dispensing entity's acquisition cost and the MFP (i.e., the MFP refund amount) within a specified window. While in Part D, the 14-day prompt MFP payment window exists in regulation for Part D, it is unclear what that window would be in Part B for Medicare FFS and MA. In this case, a provider would purchase a negotiated Part B drug at a contracted price (which varies by provider and drug), file a claim, and receive a reconciliation payment from manufacturers for any difference between MFP and acquisition cost at some uncertain future time.

A COA practice described that today, Medicare FFS Part B claims are typically reimbursed 18 to 26 days after treatment, while MA claims are reimbursed about 25 to 35 days later. In a retrospective effectuation scenario, providers would have to wait additional weeks for the MFP refund amount from the manufacturer.

Medicare patients account for about 45 to 60 percent of community oncology patients. **Extending the period for recouping the full purchase price of drugs will lead to cash flow issues beyond the challenges of decreased reimbursement in the ASP to MFP transition.** Additionally, practices will have to adapt to new accounts receivable processes and monitor payment to ensure accuracy. This will put further hardship on practices that are already operating on razor-thin margins as they await payment and float the difference in the interim. This change in acquisition cost, reimbursement, and waiting period for the refund amount increases the operational burden and financial stress on practices.

COA is specifically concerned with access implications given the potential for financial strain that oncologists may face when using drugs selected for Part B price negotiation due to the practice of having to float the difference until the reconciliation from the manufacturer is paid. It is also unclear if any such reconciliation amount will fully make up the difference between MFP and ASP-based reimbursement. This gap will be practice-ending for some community oncology providers.

In addition to operational burden and financial stress, it is not clear at this time how manufacturers will calculate the refund amount owed to the provider, how payment should be handled, how providers will be affected by the time lag in recouping their full acquisition price, and whether the refund will be sufficient to cover their costs.[9]

Recommendations

COA supports CMS's efforts to lower drug spending. However, the design of the MDPNP did not consider the ways in which the current system works. COA recommends that CMS consider these operational burdens and associated costs to practices when developing the Part B effectuation guidance. As noted above, COA supports legislation that would remove providers from the middle of the negotiation process and urges CMS to work with Congress to find a resolution that saves both the government and taxpayers money without crippling community oncology providers.

One option to address some concerns regarding retrospective reimbursement is to leverage payment mechanisms already in place to provide the refund. For Medicare FFS claims, MACs could be leveraged to provide Part B providers with refund payments rather than introducing an additional payment mechanism into the existing reimbursement system. CMS should also not require Part B providers to re-enroll in any system to ensure MFP effectuation, as CMS already has Part B provider information from Medicare enrollment.

COA urges CMS to finalize methodologies with the least magnitude of impact on providers operationally. Without urgent consideration, the implementation of MFPs could be economically devastating for community practices. CMS should also consider solutions to minimize the length of time between patient administration and full-cost recoupment.

Retrospective Model Concerns for Part D Drugs

In the CY 2026 Medicare Advantage and Part D Final Rule, CMS finalized its proposal to shorten the prescription drug event ("PDE") submission timeline requirements for drugs selected for negotiation to seven calendar days from receipt of the claim. COA strongly supports this shortened data submission timeline, as this will reduce the amount of time a dispensing entity, including community oncology practices with medically integrated dispensing, may need to wait to receive access to the MFP. However, the

[9] Avalere Health Advisory. Stakeholder Considerations for MFP Effectuation in Part B. 28 April 2025. Available Here.

shortened PDE time does not alleviate COA's concerns about the financial risk associated with MFP effectuation.

Following a PDE submission, manufacturers have 14 days to transmit the refund. This 14-day period to issue a refund is to transmit the refund, not to ensure it has been received by the dispensing entity. If there are delays in excess of the 14-day prompt payment window, as acknowledged by CMS in the Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027 ("Final Guidance for IPAY 2027 and Effectuation of MFP in 2026 and 2027"), cash flow concerns will be further exacerbated.[10]

COA also has concerns about the lack of insight into true operating margins. For retrospective MFP effectuation for Part D drugs, manufacturer refunds will be based on a standardized amount, Wholesale Acquisition Cost ("WAC") minus MFP. As community practices acquire treatments at various price points, it is unclear whether the standardized amount will be sufficient to cover costs, which increases operational pressure on practices.

For Part D drugs, CMS has acknowledged that dispensing entities and manufacturers "may face significant challenges" in establishing a reliable acquisition cost for a selected drug. Although CMS will permit the primary manufacturer and dispensing entity to choose to calculate the MFP refund using actual acquisition rather than a standardized pricing metric, the challenges in determining actual acquisition cost as described by CMS remain.

CMS will also allow dispensing entities to self-identify if they expect cash flow issues for manufacturers to incorporate into their MFP effectuation plans. CMS will also evaluate "the degree to which this pharmacy self-identification process provides useful data for Primary Manufacturers in developing MFP effectuation plans and may reconsider this approach in the future." COA and other stakeholders remain concerned that this MFP effectuation process is not sufficiently detailed to alleviate cash flow concerns by pharmacies and dispensing entities. **A survey of independent pharmacies conducted by the National Community Pharmacists Association shows that more than 90 percent of independent pharmacies may not stock drugs that have been selected for negotiation due to cash flow concerns.[11] This could have a disastrous impact on patient access.**

Recommendations

COA makes the following recommendations to address MFP effectuation concerns for Part D drugs under the retrospective model:

1. Although CMS has shortened the PDE submission period to seven calendar days, we encourage CMS to monitor the impacts of this policy to determine whether a shorter period is needed. We also encourage CMS to **track instances where there are delays in excess of the 14-day prompt payment window and to address these situations swiftly.**

[10] Centers for Medicare and Medicaid Services. "Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027." 2 October 2024. Available Here.

[11] National Community Pharmacists Association. "Independent Pharmacies Reluctant to Stock Drugs in Medicare Drug Price Negotiation Program, New Survey Shows." 15 October 2024. Available Here.; National Community Pharmacists Association. "NCPA to CMS: A Third of Independent Pharmacies Won't Carry Drugs in the Negotiated Price Program, and 60 Percent More are Considering Dropping Out." 27 January 2025. Available Here.

2. To address cash flow concerns, COA recommends CMS **work with dispensing entities and practices to understand whether solutions for mitigating cash concerns suggested by manufacturers in their MFP effectuation plans will be helpful or harmful.**
3. CMS must **address reduced patient access to drugs selected for negotiation if independent pharmacies no longer stock them** and should seek feedback on any solutions developed.

Formulary Inclusion of Part D Selected Drugs (Section 110)

In the draft guidance, CMS states that it does not yet have sufficient information to determine whether changes to its formulary inclusion policies for Part D selected drugs are warranted. For the contract year 2028, CMS will not implement explicit, uniform tier placement or utilization management requirements for selected drugs and instead reminds Part D sponsors of existing statutory and regulatory requirements on formulary design and the formulary review process CMS will undertake.

CMS has noted concerns 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 that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs." COA echoes these concerns. Changes to tiers or utilization management may reduce patient medication adherence or lead to delays in patient care. **Timely access to medication is critical for cancer patients, who may experience disease progression during the time it takes to obtain their medications.**

Recommendations

The tier placement of a drug changes the patient's cost-sharing. While CMS will assess any instances where Part D sponsors place selected drugs on non-preferred tiers and instances where a selected drug is placed on a higher cost-sharing tier than non-selected brand drugs in the same class, we encourage CMS to add an additional step to confirm that any changes in tier placement would not result in higher patient cost-sharing for the selected drug compared to the prior plan year. **CMS should not approve plans where cost-sharing increases for selected drugs, which would run counter to the MDPNP's goal of lowering drug costs.**

Monitoring Medicare Advantage Plans' Use of Step Therapy for Part B Drugs (Section 80)

CMS is soliciting comments on how best to monitor MA plans' use of Part B step therapy practices to ensure compliance with program rules and any data or policy clarifications that may be needed for implementation. COA appreciates that CMS is considering this issue, given its impact on patient access to needed medications.

A recent white paper from Avalere on step therapy in MA found that step therapy is widely used by MA plans and poses challenges for both patients and providers, including by contributing to difficulties in aligning treatment choices with clinical decisions and delays in patient access to medications.[12] Ninety-four percent of physician respondents surveyed for the white paper stated that step therapy limits patient access to their preferred Part B medications. The survey also demonstrated the high burden on providers, with over 60 percent of providers describing the patient burden of step therapy as "high" or "extremely high." Sixty percent of respondents also said that patients often wait weeks to receive their prescribed medication, which can contribute to symptom exacerbation.[13]

[12] Avalere Health Advisory. "Step therapy in Medicare Advantage: Insights from provider experiences." 4 June 2025. Available Here.
[13] Ibid.

Step therapy in MA also contributes to administrative and operational challenges for providers. Ninety-four percent of respondents stated that step therapy for Part B drugs poses a moderate to extremely high burden. Fifty-six percent indicated that policies impact the decisions on what they choose to stock, especially when step therapy protocols across plans vary. Sixty-seven percent of respondents stated that they dedicate staff specifically to managing processes related to step therapy.[14] These concerns are particularly pressing when community oncologists will already face new operational challenges due to the need to track multiple MFP effectuation approaches for both Part B and Part D selected drugs, unless CMS standardizes its approach to MFP effectuation, as COA recommends.

Recommendations

COA encourages CMS to ensure that MA plans do not implement step therapy protocols for Part B drugs selected for negotiation that adversely impact patient access to these drugs. Step therapy policies should not inhibit provider autonomy in prescribing decisions. CMS should closely monitor for any unintended consequences related to step therapy for Part B drugs selected for negotiation, particularly as CMS has already expressed concerns regarding formulary inclusion of Part D drugs.

340B Drug Pricing Program Considerations (Section 40.4.5)

Dispensing entities and Part B providers may purchase drugs through the 340B Drug Pricing Program ("340B" or "340B program") or at MFP but may not access both discounted prices for the same drug units. In the draft 2028 IPAY guidance, CMS reiterated that the agency would not be responsible for preventing duplicate discounts between the 340B program and the IRA.

The duplicate discount risk introduced by the IRA's MFP brings more complexity into the already convoluted 340B program. Hospitals will compare 340B discounts and MFP to identify the most favorable channel to purchase through. This "lesser of" approach that hospitals will take and the risk of duplicate discounts is a risk to the Medicare program and taxpayers and goes against the administration's objectives to lower drug spending and reduce taxpayer risk. CMS must take action to address this risk. If the Health Resources Services Administration ("HRSA") moves into the CMS structure as proposed in the Fiscal Year White House Budget Request, CMS will have clear authority to address this issue. If HRSA does not move under CMS in the future, CMS must work closely with HRSA to address the challenges of 340B and MDPNP overlap.

Community oncology practices are not able to purchase drugs through the 340B program and have historically been at a disadvantage to hospitals who, not only buy drugs at a lower rate but are reimbursed at a greater rate for non-drug services. This dichotomy has led to increased pressure on community oncology practices and practices being forced out of business. The fact that hospitals can now elect to purchase at 340B or MFP based on whichever price is more favorable to them introduces yet another unfair advantage to hospitals. IRA Part B negotiation will drastically cut reimbursement to practices for Part B drugs, disproportionately impacting independent community oncology practices that do not have the drug profits from 340B and higher services payments that are available to hospitals.[15]

COA supports the 340B program for its original intent to provide drugs at a lower price to patients in financial need. However, the growth and fraud of the program need to be addressed. As the 340B program continues to expand, CMS must prioritize ensuring the 340B program's integrity. The program, which already lacks transparency, will become more convoluted when hospitals may "double dip" on discounts

[14] Ibid.,9
[15] Community Oncology Alliance. "COA Prescription For Health Care Reform. Chapter 4: Ensuring Access to Oncology Therapies: Diagnosis, Prescription, and Treatment." 2025. Available Here.

without a method to track and prevent this fraud. Without attention to this issue, existing 340B incentives will be made even more extreme, further disadvantaging the viability of community oncology compared to hospital-based care. COA's Prescription for Health Care Reform further details COA's concerns with and recommended reforms for the 340B Drug Pricing Program, including strengthening 340B participation requirements, requiring transparency and reporting in 340B, and restricting aggressive debt collection practices by 340B hospitals.[16]

Recommendations

CMS must take action and accountability to prevent duplicate discounts. By not doing so, the goals of the agency and administration to lower drug costs are undermined.

Consideration of Therapeutic Alternatives (Section 60.3.1)

The IPAY 2028 draft guidance includes CMS's approach to incorporating therapeutic alternatives into drug price negotiation, including the consideration of off-label use of therapeutic alternatives. When evaluating off-label use, CMS noted it would consider major drug compendia, literature, and accepted standards of medical practice. COA appreciates that CMS is considering off-label use to inform of the range of therapeutic alternatives and urges CMS to consider the nuances and role of off-label medication use in oncology. Off-label use of drugs is very common in cancer treatment, given the complexity and personalization of treatment decisions in oncology.[17] Many cancer drugs, more so than other therapeutic areas, have a variety of both FDA-approved indications, as well as broader use described in national guidelines that would be considered off-label, thus presenting a unique difficulty in identifying relevant therapeutic alternatives for oncology. Furthermore, not only are oncology drugs commonly used off-label, but they also have unique, hyper-specific indications. For other therapeutic areas, drugs are often indicated for a general disease rather than the hyper-specific indications for which oncology drugs are approved. For example, a hypothetical drug is not approved to treat "lung cancer" but to treat metastatic non-small cell lung cancer as a second-line therapy when the patient's tumor is positive for a specific tumor mutation or biomarker. As CMS considers how it will assess utilization and spend in claims for oncology drug indications, the agency must consider the limitations of claims data. In this example, the first challenge is that the ICD-10-CM code for lung cancer does not differentiate between non-small cell and small cell lung cancer. While there is a code for metastatic disease, it is not used consistently to document the stage of the disease. The line of therapy is not available in claims without applying a complex patient journey algorithm to assess prior drug use in each patient. Finally, the result of a biomarker test is also not available in claims.

CMS must take all of this into account when identifying therapeutic alternatives and assessing spend for negotiated oncology drugs. Lack of claims specificity, in addition to oncology drugs having multiple indications and off-label use, will introduce a great margin of error for which CMS must account when setting the MFP. If the MFP is too low because of operational challenges to arrive at the best MFP, oncology providers will not be able to supply the drug to patients for the reasons noted above, ultimately limiting patients' access to cancer therapies.

Recommendations

As CMS considers updates to therapeutic alternative selection in the negotiation process, it is important to consider the challenge of tracking oncology indications, given the complexity and personalization of treatments in comparison to other therapeutic areas. COA supports an approach that prioritizes patient and

[16] Community Oncology Alliance. "COA Prescription For Health Care Reform. Chapter 1: Addressing Hospital Consolidation: Diagnosis, Prescription, and Treatment." 2025. Available Here.
[17] National Cancer Institute. "Off-Label Drug Use in Cancer Treatment." 13 January 2022. Available Here.

provider shared decision-making and allows patients to access the right drugs for their specific disease, stage, and preferences.

COA highly recommends that CMS solicit input from physicians who specialize in the therapeutic area(s) for which selected drugs may treat in order to identify relevant therapeutic alternatives and off-label use. These physicians should specialize in the relevant therapeutic area(s), be licensed in the U.S., and actively treating patients to ensure they are up to date on the latest standard of care and science.

Patient Access to Innovation (Section 30.1.1, Section 30.1, and Section 30.3.1)

Orphan Drugs (Section 30.1.1)

The IRA's orphan drugs exemption protects drugs used to treat *only one* rare disease or condition and allows product sponsors to qualify for an exemption from negotiation selection. However, if the same drug is approved for a second rare disease or condition, the orphan drug exemption no longer applies. As a result, researchers may be disincentivized to pursue follow-on indications for orphan drugs.[18] Without incentivizing the development of treatments for rare and pediatric cancers, these patients will miss out on treatments and cures.

COA supports the inclusion of the ORPHAN Cures Act (H.R. 946 and S. 1862 in the 119th Congress) in the *One Big Beautiful Bill* reconciliation package and believes this will address the risk the IRA currently poses to innovation and treating rare diseases.[19] We are disappointed to see that the Senate Finance Committee's recent bill text does not include the ORPHAN Cures Act.[20]

As manufacturers weigh decisions about drug development and label expansion, their research and clinical trial efforts may shift.[21] This could shift how community oncology practices participate in clinical trials, creating an environment with less clinical trial activity in the community setting and a gap in care for these patients who are underrepresented in research conducted at academic medical centers.

Patients included in clinical trials may also be impacted if community oncology practices are not able to participate in clinical trials, as most oncology patients receive care in the community setting, including a greater proportion of underserved communities (e.g., rural). This lack of representation can lead to sampling bias and undermine the quality of the research.[22] Additionally, community-based real-world evidence efforts capturing patient data in the community setting could be thwarted, placing barriers to attaining data that has previously not been captured. All these factors can compound to a negative impact on patient access to quality care, which can lead to negative health outcomes.

It is imperative for CMS to consider ways to foster innovation in oncology to ensure that patients with cancer receive the best life-saving treatments possible. COA urges CMS to consider that pediatric and rare cancers are more likely to be add-on indications and will be disproportionately impacted by the IRA.[23]

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[18] Chambers D., Clifford K., Enright D., Neumann P. "Follow-On Indications for Orphan Drugs Related to the Inflation Reduction Act." 15 August 2023. JAMA Netw Open. 2023 Aug 1;6(8):e2329006. doi: 10.1001/jamanetworkopen.2023.29006. PMID: 37581890; PMCID: PMC10427936. Available Here.
[19] The White House. "The One, Big, Beautiful Bill." 3 June 2025. Available Here.
[20] Senate Finance Committee. Legislative Text Title VII. 16 June 2025. Available Here.
[21] O'Brien J.M., Motyka J., Patterson J. "How The IRA Could Delay Pharmaceutical Launches, Reduce Indications, And Chill Evidence Generation." 3 November 2023. Available Here.
[22] Collister, D., Song, C., & Ruzycki, S. M. "Fostering diversity in clinical trials: need for evidence and implementation to improve representation." 10 July 2024. *BMJ Medicine*, *3*(1), e000984–e000984. Available Here.
[23] Grabowski, H., DiMasi, J. A., & Long, G. "Post approval Innovation For Oncology Drugs And The Inflation Reduction Act." October 2024. *Health Affairs*, *43*(10), 1400–1409. Available Here.

Definition of a Qualifying Single Source Drug (QSSD) (Section 30.1)

To identify a potential QSSD for drug products, CMS will identify all dosage forms and strengths of the drug with the same active moiety and the same holder of a New Drug Application ("NDA") or Biologics License Application ("BLA"), inclusive of products that are marketed pursuant to different NDAs or BLAs, respectively. COA is concerned that this definition may impact the drug development of new formulations of oncology therapies that provide important benefits to patients and providers. For example, subcutaneous formulations of drugs are often preferred by patients compared to intravenous ("IV") formulations. For providers, subcutaneous formulations reduce treatment time and health care resource utilization.[24] **The QSSD definition may reduce incentives for the development of new formulations of oncology therapies, negatively impacting patient access to cancer care.**

Biosimilar Delay (Section 30.3.1)

CMS should consider how the biosimilar delay timeline may impact the manufacturer's ability and motivation to develop biosimilars. If a drug is selected prior to biosimilar launch, the biosimilar manufacturer will have to consider the MFP in their launch price and may not be able to account for their investments, leading them to slow or end biosimilar development programs. As such, manufacturers who set out with the goal of offering a more affordable alternative cannot offer this lower-cost alternative to patients or the system.

Public Engagement Events (Section 60.4)

COA commends CMS for its intent to hold several public engagement opportunities for IPAY 2028, including 15 patient-focused roundtable events and "one town hall meeting for all selected drugs," to be held in spring 2026. However, COA urges CMS to expand the town hall style meeting based on various stakeholder types. CMS stated that the one town hall meeting would be for all selected drugs, focused on the clinical considerations related to the selected drugs, and would be the appropriate venue for practicing clinicians and researchers, as well as other interested parties. COA acknowledges that, under this guidance, this would be the likely forum that COA members (community oncology practice clinicians, administrators, pharmacists, and other staff) would participate in. However, COA urges CMS to consider that the priorities of Part B providers and dispensing entities, specifically community oncologists, are vastly different from manufacturers.

Recommendations

COA believes a dedicated town hall meeting exclusively for provider groups is needed, given the significant and potentially practice-ending implications of the IRA on community oncology. In addition, one town hall meeting for all selected drugs may not allow for all stakeholders to fully and adequately participate. COA recommends that CMS host public roundtable events for provider advocacy organizations to ensure CMS fully understands the implications the IRA will have on providers, specifically community oncology.

Ceiling for Part B Drugs Not Paid Under 1847(A)(b)(4) (Section 60.2.2.2)

For Part B drugs not paid under 1847A(b)(4) (e.g., those paid at 95 percent of the average wholesale price), COA supports CMS's proposal to default to the ceiling amount calculated via the average non-FAMP

[24] Aguiar-Ibáñez, R., Fotheringham, I., Mittal, L., *et al.* "Differences Between Intravenous and Subcutaneous Modes of Administration in Oncology from the Patient, Healthcare Provider, and Healthcare System Perspectives: A Systematic Review." *Adv Ther* 41, 4396–4417. 3 July 2024. Available Here.

methodology. CMS should ensure that the ceiling amount does not disrupt patient access due to misalignment with provider costs.

Conclusion

Thank you for the opportunity to share our concerns and priorities related to the MDPNP. Our feedback highlights the impact of the MDPNP on community practices and their ability to sustain operations under increasing financial and regulatory pressures.

COA encourages CMS to consider the potential broad and negative impacts of the IRA on cancer care. CMS should take the specific issues outlined in COA's letter into account when developing MDPNP policy in order to protect the quality of care for cancer patients.

COA would appreciate the opportunity to meet with CMS to discuss our concerns or recommendations regarding the comments provided in this letter.

Mark Thompson, MD
Medical Director of Public Policy

Ted Okon, MBA
Executive Director

COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

June 26, 2025

Chris Klomp
CMS Deputy Administrator and Director of the Centers for
Medicare & Medicaid Services
7500 Security Blvd.
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 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Submitted electronically to IRARebateandNegotiation@cms.hhs.gov

Dear Deputy Administrator Klomp,

Thank you for the opportunity to provide comments on the May 12, 2025, memorandum entitled "Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028."

The Council for Affordable Health Coverage (CAHC) has long supported reduced drug costs, greater access to drug therapies, and fostering innovation to help treat and cure disease. CAHC (www.cahc.net) is a broad-based alliance with a singular focus: ensuring all Americans have access to affordable coverage. We are pro-patient, pro-competition, and pro-innovation. Our member organizations include employers, medical providers, patient groups, insurers, agents and brokers, technology companies, pharmaceutical manufacturers, and pharmacy benefit managers.

Briefly, CAHC is concerned that the current guidance perpetuates existing problems with the program while layering new challenges for Medicare beneficiaries, consumers generally, and advocates of an open and transparent government that is responsive to the people. We make the following recommendations in this letter:

1. Prevent the consolidation of markets that empower monopolies and raise prices for all consumers.
2. Follow the law and implement the IRA's drug selection process, and in applying the Orphan Drug Act provisions.
3. Immediately work to fix and operationalize the known problems with Medicare Transaction Facilitator to effectuate drug price controls at the point of sale.
4. Ensure the program is radically transparent and follows good government practices that hold bureaucrat decisions accountable while allowing broad understanding and input.

CAHC has previously commented on the first two years of the Medicare Drug Price Negotiation Program, which only impacted the Medicare Part D program. This year's draft guidance incorporates prescription drugs payable under Medicare Part B, of which CAHC has broad concerns.

Under the current program, health care providers who treat Medicare patients for cancer and other serious diseases will have their reimbursement cut for certain Part B physician-administered drugs. Part B providers are primarily reimbursed based on the product's average sales price (ASP) plus a 6% add-on payment, but under the IRA, the payment will be based on the MFP of the drug, which will be much less than the ASP.

Avalere estimates this could lead to more than a 50% reduction in add-on payments, translating into at least $25 billion in cuts to doctors, $12 billion of which would hit oncologists, specifically.[1] However, this cut to physician reimbursement will be even more dramatic if CMS chooses to include a selected drug's MFP in the calculation of its ASP. Many commercial payers use ASP as a metric for drug reimbursement, so the inclusion of MFP in the ASP calculation will also lower reimbursement for physician-administered drugs in the commercial market. To prevent government price controls from eroding physician reimbursement in the commercial market, CMS must explicitly exclude MFP from the calculation of ASP.

Overall, these massive cuts threaten the financial viability of many oncology practices, especially smaller or rural ones, which may no longer be able to afford cancer drugs priced above reimbursement rates. As a result, these practices may be forced to shut their doors or merge with hospital-based systems. When ASP was adopted in 2005, more than half of all Medicare oncology claims were from doctors in the community. Today, more than half are from more expensive hospitals. The IRA will accelerate this trend. And unfortunately for taxpayers, Medicare pays two to three times as much for hospital treatments than for doctors' services.

Large, metropolitan hospitals may absorb these reimbursement cuts, but smaller oncology practices in rural areas will suffer and may close or join the consolidation trend by joining a hospital. Access to proper care will become even more difficult for cancer patients.

Across markets, if the only choice for more patients is to receive care in a hospital-based setting, the IRA will raise costs for all consumers. For example, one study found hospital prices for the top 37 infused cancer drugs were 86.2% more per unit than in physician offices.[2] Research from AHIP showed hospitals charged 118% more than specialty pharmacies for the same drugs.[3] We encourage CMS to take a broader view of the impact of the IRA and the means it uses, and work with Congress to repeal the seriously flawed drug price provisions of the Inflation Reduction Act.

CMS should exclude MFP from the calculation of ASP to protect beneficiary access to Part B drugs, as the inclusion of the MFP in the calculation of ASP would further reduce ASP and extend provider reimbursement challenges to the commercial market.

In addition to our broad comment on the inclusion of Part B drugs in the negotiation program, we are submitting comments on the following sections of the draft guidance:

1. 30.1 Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028
    a. 30.1.1 Orphan Drug Exclusion from Qualifying Single Source Drugs
2. 40.4 Providing Access to the MFP in 2026, 2027, and 2028
3. 60.4 Negotiation Process
4. 60.5 Application of the MFP Across Dosage Forms and Strengths

[1] Avalere Health. (September 2024). https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians

[2] Employee Benefits Research Institute. (January 2020). https://www.ebri.org/content/cost-differences-for-oncology-medicines-based-on-site-of-treatment

[3] AHIP. (April 2023). https://www.ahip.org/resources/markups-for-drugs-cost-patients-thousands-of-dollars

30.1 Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028

CAHC remains concerned that CMS's interpretation of what constitutes a qualifying single-source drug (QSSD) under Section 1192 of the Social Security Act continues to aggregate distinct and independently approved products that exceed the statute's scope and undermines incentives for innovation. As reiterated in the 2028 Draft Guidance, CMS identifies a qualifying single source drug based on the same active ingredient, aggregating all dosage forms, strengths, routes of administration, and formulations, even when they are approved under different New Drug Applications (NDAs) or biologics license applications (BLAs) and serve different clinical purposes." This interpretation is grounded in CMS's reading of Section 1192(d)(3)(B), which requires aggregation "across dosage forms and strengths of the drug, including new formulations." However, CMS's guidance misinterprets this clause to impermissibly group distinct products that have received separate FDA approvals and may differ substantially in their indications, safety profiles, delivery mechanisms, and target patient populations.

This aggregation practice introduces several harmful consequences. First, it allows CMS to subject newly approved drugs to price negotiation, even if the product in question has not been on the market for the required seven or eleven years, simply because it shares an active moiety with an older product. This undermines the law's explicit eligibility protections for newer therapies.

Second, it collapses clinically distinct products into a single pricing construct, devaluing research and development aimed at expanding indications, improving adherence, or meeting the needs of specialized populations, such as pediatric, elderly, or rare disease patients.

Third, this policy contradicts the regulatory distinction established by the FDA when it approves new NDAs or BLAs for a product with a shared molecule but unique properties or uses. By aggregating across distinct NDAs and BLAs, CMS not only misinterprets the statutory language but also effectively penalizes therapeutic innovation and deters continued investment in follow-on research that can significantly improve patient outcomes.

Additionally, in this section, CMS requested public feedback on aggregating certain fixed-dose combination products. CMS does not have the authority or expertise to assess whether any active ingredient is "biologically active" against the disease states for which the drug is indicated. It would be inconsistent with the FDA's definition of a fixed combination drug if CMS were to make these changes.

Recommendation: CMS should revise its approach to reflect the statutory requirement without exceeding its bounds. Specifically, CMS should treat each NDA or BLA as a distinct qualifying single-source drug unless there is clear and consistent regulatory evidence of interchangeability. Products that differ in route of administration, labeled indication, or target patient population should not be collapsed into a single pricing or selection construct simply because they share a molecular base. This distinction is essential to preserve incentives to innovate and to align the negotiation program with both the letter and the intent of the IRA. If left unchanged, CMS's current approach risks discouraging investment in high-value therapeutic advancements and diminishing access to meaningful new treatment options that improve beneficiary health outcomes. We urge CMS not to finalize any changes to the definition of a fixed combination drug.

30.1.1 Orphan Drug Exclusion from Qualifying Single Source Drugs

The narrow orphan drug exclusion was a vital piece of CAHCs comments on the Initial Price Applicability Year 2026, as the IRA made it clear that companies developing orphan drugs are now at increased risk of market failure – the opposite of what the Orphan Drug Act sought to address through tax, market exclusivity, and other incentives.

While CMS has since acknowledged these concerns and clarified that CMS does not have the authority to change the statutory requirement that prevents a drug with multiple designations from qualifying for the

orphan drug exclusion (ODE), more has to be done to protect and incentivize the development of these treatments. Additionally, since the first two rounds of negotiation, CMS has stopped seeking input on the necessary actions to improve orphan drug development under the current drug negotiation program, a blow to patients with rare diseases.

A recent analysis from the National Pharmaceutical Council found that the percentage of drugs with a first orphan designation that later received a second designation decreased by 48% following the passage of the IRA (12.1% to 6.3%).[4] The impacts of this policy failure are being felt in an already vulnerable population.

Recommendation: The House-passed version of the *One Big Beautiful Bill Act* [5] includes a provision to extend and clarify the exclusion of orphan drugs under Medicare's Drug Price Negotiation Program to allow product sponsors to have one or more orphan drug indications to qualify for the exemption. CMS should work with Congress to expand the orphan drug exemption and continue working with the relevant stakeholders to best understand how to address these issues.

40.4 Providing Access to the MFP in 2026, 2027, and 2028

CAHC remains concerned about CMS's continued reliance on a rigid 14-day payment window for manufacturer refunds to dispensing entities under the Medicare Drug Price Negotiation Program. The 2028 Draft Guidance reaffirms that "[CMS] expects that manufacturers make such payments within 14 days of the date the dispensing entity submitted the claim... whether directly or via a Medicare Transaction Facilitator (MTF)," and further clarifies that the MTF will serve only as a data conduit and "does not expect MTFs to adjudicate claims or handle funds directly."

This approach reflects an ongoing disconnect between CMS's policy timelines and the current capabilities of the pharmaceutical supply chain. The manufacturer-to-pharmacy refund pathway envisioned under this policy does not currently exist in any functional form. CMS acknowledges this reality in the guidance, noting the absence of direct relationships between manufacturers and dispensing entities, and offers two potential payment facilitation options: (1) transmittal of banking information only, and (2) pass-through of MFP refunds.

CAHC supports the pass-through option as the only viable mechanism for ensuring timely and accurate refunds while maintaining system integrity. Despite this policy recognition, CMS has not addressed the most critical challenge: the infrastructure necessary to reconcile and route daily claim-level payments between thousands of pharmacies and manufacturers does not exist, and certainly not at the scale and speed required to comply with a strict 14-day window.

In addition, while the MTF helps with the implementation of the MFP, it does not have the functionality to identify and prevent duplicate discounts, leaving the responsibility of deduplication on manufacturers and covered entities.

The operational complexity of this process, combined with the financial burden it places on manufacturers and smaller, community-based pharmacies, presents a significant threat to beneficiary access and system-wide compliance. Furthermore, the guidance offers no meaningful detail on the operational design or expected capabilities of the Medicare Transaction Facilitator (MTF). As a result, we are concerned MTF will not be operational by January 1, 2026. It is unclear how CMS intends to ensure consistency, dispute resolution, or standardized data exchange among entities with varying technical sophistication and claims systems. These unknowns risk destabilizing pharmacy operations and creating unpredictable delays in drug availability for Medicare beneficiaries.

[4] National Pharmaceutical Council. (May 2025). https://www.npcnow.org/resources/early-signals-ira-orphan-drugs
[5] https://www.congress.gov/bill/119th-congress/house-bill/1

Recommendation: CMS must take immediate steps to provide operational clarity and financial flexibility in the implementation of the MFP payment process.

1. First, the agency should direct the development of a robust facilitator infrastructure modeled on existing transaction platforms, particularly the Coverage Gap Discount Program, which already facilitates similar manufacturer refunds and can serve as a reliable foundation for MFP operations.
2. Second, we are recommending that CMS proactively address 340B duplicate discounts in Part B and D by requiring modifiers and establishing a 340B data clearinghouse. CMS should consider providing civil monetary payment relief for manufacturers operating in good faith when compliance is inhibited by factors outside of the manufacturer's control.
3. Third, CMS should provide a government-funded float or equivalent financial buffer to dispensing entities. This would allow pharmacies to dispense selected drugs at the point of sale without incurring unacceptable cash flow risks. Finally, CMS should formally consider a phased enforcement model that allows for a longer-than-14-day window during initial years and provide regular updates to stakeholders on the MTF's development, capabilities, and readiness benchmarks.
4. Finally, CMS asked for information on whether the Agency should adopt a standardized default refund amount with respect to Part B drugs. Considering the challenges around Part B MFP effectuation, including extended claims processing times, variance in provider acquisition costs, duplicate discounts and the Discarded Drug Refund Program, we recommend CMS adopt a standard default refund amount calculation based on ASP. The amount could be calculated as ASP minus MFP adjusted for add-on payments.

60.4 Negotiation Process

While CAHC appreciates that CMS has made some revisions to the negotiation program based on feedback from the first year of implementation, such as expanding comment periods and reiterating plans for public listening sessions, the negotiation process remains opaque.

In the 2028 Draft Guidance, CMS affirms that it "will continue to host public engagement events... and collect verbal input from patients and other stakeholders," but simultaneously clarifies that "these events are not intended to be decision-making forums." CMS also continues to state that it "will not disclose information related to the offers exchanged, the rationale for CMS's proposed MFP, or the final agreed-upon MFP, except as required by law."

Unfortunately, these disclosures confirm what stakeholders have experienced throughout the program's first year: the most critical elements of the negotiation process remain shielded from public scrutiny. CMS has yet to provide a clear explanation of how it uses stakeholder input; it has not released any analytical basis for how selected drugs were chosen or how maximum fair prices were determined; and it has provided no transparency into who is invited to participate in negotiation sessions or how those participants are selected.

Despite hosting a series of "patient-focused events," CMS has not explained how the feedback collected in those sessions was weighed or used to influence negotiation outcomes. Nor has CMS released a summary or report describing what perspectives were shared, what questions were raised, or whether any agency actions followed.

Additionally, CMS continues to impose sweeping restrictions on manufacturers' ability to speak publicly about their participation in the negotiation process. While Congress rightly directed CMS to protect proprietary information under Section 1198 of the IRA, nothing in the statute requires CMS to operate in near-total secrecy. Prohibiting manufacturers from sharing even basic facts about their role in the process, such as whether or how they responded to CMS's price proposals, chills public debate and erodes stakeholder trust. Transparency is not a threat to the program's integrity; it is a prerequisite for its legitimacy.

CAHC is further concerned that CMS has declined to release regulatory impact analyses or economic modeling conducted by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), even though those analyses could help stakeholders and Congress better understand the expected downstream effects of the program. The agency's persistent refusal to share these materials raises serious concerns about accountability, especially given the program's scope and complexity.

Recommendation: CMS should embrace a more transparent and inclusive approach to stakeholder engagement that reflects best practices in public governance and honors the expectations of the Administrative Procedure Act, even if not formally required. Specifically, CMS should: publish summary justifications for drug selection and MFP determinations; release any non-confidential economic modeling or regulatory impact assessments from ASPE or other sources; lift unnecessary restrictions that prevent manufacturers from discussing their participation in the process; ensure transparency on how and why a particular therapeutic alternative was selected; and convert its public events from passive, listen-only formats to interactive forums that allow meaningful engagement, feedback, and follow-up. A law of this magnitude demands a public process that is as deliberative as it is fair. If CMS expects public trust in the negotiated prices it sets, it must offer the public insight into how and why those decisions are made.

Section 60.5 Application of the MFP Across Dosage Forms and Strengths

CAHC remains concerned about CMS's decision to apply a single Maximum Fair Price (MFP) across all formulations, dosage forms, strengths, and routes of administration for each selected drug, including for drugs that are approved under separate NDAs or BLAs, now for both Part B and Part D drugs. This blanket pricing approach is exacerbated by CMS's overly broad interpretation of QSSD and fails to reflect clinically meaningful differences across formulations that are critical to patient care. Drugs that have the same active ingredient or moiety but are approved or licensed under different NDAs or BLAs, have distinct formulations, oral versus injectable, extended-release versus immediate-release, pediatric versus adult, and often represent significant therapeutic advancements designed to improve safety, efficacy, adherence, or patient-specific outcomes.

Applying one MFP across such diverse products may result in reimbursement levels that do not reflect the actual cost or value of each formulation, further compounding the harm of CMS's interpretation of QSSD. This not only creates potential pricing mismatches at the point of sale but also sends a harmful signal to innovators that the development of tailored or more patient-centric formulations will not be valued or protected under the negotiation framework.

Recommendation: CMS should revise its definition of QSSD to recognize that drug and biological products approved under different applications are different QSSDs and should therefore receive different MFPs. In addition, where there is clear evidence that formulations approved under the same BLA or NDA differ in clinical use, indication, or patient population, CMS should consider creating differentiated MFPs. CMS could establish an exception process that incorporates FDA-approved labeling, drug delivery method, or therapeutic equivalency determinations to justify multiple MFPs for drugs that are approved under the same applications but are not functionally interchangeable. At a minimum, CMS should develop criteria for when separate pricing is appropriate and offer stakeholders the opportunity to submit supporting evidence as part of the negotiation process.

Conclusion

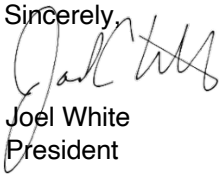
In an Executive Order from April 15, President Trump called for improved transparency of the Medicare Drug Price Negotiation program, efforts to minimize negative impacts of the MFP on pharmaceutical innovation, and expressed support for correcting the "pill penalty," which forces small molecule prescription drugs to be eligible for price controls 4 years before large molecule drugs.

Following the President's directives by preserving incentives for innovation, ensuring operational viability, and embracing transparency are not in conflict with cost control; they are essential to its success.

CAHC continues to support the administration's overarching goal of lowering prescription drug costs and improving affordability for Medicare beneficiaries. However, the policies outlined in the 2028 Draft Guidance raise serious concerns about operational feasibility, regulatory overreach, and unintended consequences for innovation, access, and patient care. As currently written, the guidance risks undermining the very progress it aims to achieve by introducing rigid systems without sufficient transparency, infrastructure, or respect for statutory limits. We urge CMS to revisit several of the assumptions embedded in this guidance and work collaboratively with stakeholders to implement the program in a way that is both sustainable and patient-centered.

We appreciate the opportunity to submit these comments and welcome further dialogue on how to ensure the Medicare Drug Price Negotiation Program is implemented in a manner that supports long-term value, equity, and trust. If you have questions about these comments, please do not hesitate to contact me.

Sincerely,



Joel White
President

June 26, 2025

Chris Klomp
Deputy Administrator and Director
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Requests for Comments on Medicare Drug Price Negotiation Program Draft Guidance

Dear Deputy Administrator Klomp,

On behalf of the Council for Innovation Promotion (C4IP), I appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) draft guidance for the third cycle of negotiations under the Medicare Drug Price Negotiation Program.

C4IP is a bipartisan coalition founded and chaired by former directors of the U.S. Patent and Trademark Office (USPTO) from previous Democratic and Republican administrations — whose board also includes two retired judges from the Court of Appeals for the Federal Circuit. We are dedicated to supporting a strong and effective patent system that bolsters U.S. innovation, strengthens our nation's economic competitiveness, and fuels investment in technology that improves lives everywhere.

Unfortunately, certain aspects of CMS's draft guidance threaten to undermine these goals by devaluing the intellectual property (IP) protections that support life-saving and life-enhancing medical innovation.

Specifically, CMS proposes that certain reformulated drugs — such as those employing new administration routes — may not be treated as separate "Qualifying Single Source Drugs" (QSSDs) under the Inflation Reduction Act if the agency deems the differences not "clinically meaningful." CMS further indicates that reformulations may be excluded from QSSD designation if their added ingredients are "not therapeutically active against the disease state."

The impact of this change would be profound, affecting the meaningfulness of U.S.-granted patent rights. Under CMS's proposal, a newly approved medicine could face price controls on day one — effectively nullifying the value of its patents.

This would directly undermine incentives for follow-on innovation: improvements made after a product's initial approval that build on the original invention to enhance patient care. These advances can significantly improve compliance, convenience, or quality of life, and include a wide range of developments — from new delivery methods to extended-release formulations.

Reformulated therapies fall squarely within this category. These products retain the same active ingredient but incorporate targeted changes to how the drug is delivered — for example, shifting from an intravenous infusion to a subcutaneous injection, modifying the release profile, or adapting the dosage form to improve compliance. Some reformulations also involve updates to inactive ingredients that enhance stability or tolerability. Bringing these therapies to market requires additional research, development, and regulatory engagement — efforts that depend on patent protection to justify the investment.

By collapsing these reformulated products into the same pricing category as their predecessors, CMS would erode their commercial viability, disincentivize follow-on innovation more broadly, and signal that the government may disregard exclusive patent rights whenever they conflict with price-setting objectives.

Consider the example of improved routes of administration for certain immunotherapies, from infused to subcutaneous application, such as Merck's Keytruda and Bristol Myers Squibb's Opdivo. These new products were developed to reduce infusion times, improve patient compliance, and expand access to outpatient and rural settings. They required new clinical trials, FDA review, and demonstrated novelty sufficient to secure independent patent protection.

Yet, under CMS's proposal, these formulations may not qualify as distinct QSSDs, effectively overriding the inventions protected in corresponding patents, and could be bundled with their intravenous predecessors. This practice would disregard the depth of scientific inquiry and the development rigor behind the innovation required to bring them to market.

Advances on version 1.0 of the medicine — such as modified dosing schedules, subcutaneous alternatives to infusions, or formulation changes that improve tolerability — are patient-centered, evidence-based responses to clinical needs. They involve years of research, significant capital investment, and extensive regulatory engagement. The result is improved adherence, expanded access, and better outcomes.

Insulin provides a clear example of how follow-on improvements can lead to substantial long-term benefits. Before insulin was first injected in 1922 to treat diabetes — isolated from the pancreases of cattle — the average lifespan for a person with type 1 diabetes was just under three years. Over the past century, sustained, patent-backed innovation has transformed the therapy, yielding multiple versions: from biosynthetic human insulin to ultra-long-acting and rapid-acting insulins. These advancements have enabled better glycemic control, reduced the risk of hypoglycemia, and supported greater adherence. As a result, people with type 1 diabetes now live well into their 60s, with average life expectancy reaching 68 for women and 66 for men.

Examples like this highlight what is at stake if CMS moves forward with its current approach. There is no justification for collapsing two distinct therapies into a single pricing category. A policy that treats subcutaneous or long-acting formulations as interchangeable with their infused or immediate-release counterparts undermines the IP rights that make such advancements possible. If time-limited exclusivity holds no practical value at launch, it fundamentally distorts the risk-reward calculus for companies evaluating whether to pursue resource-intensive follow-on innovation.

Over time, undermining the enforceability and value of patents would disincentivize the kind of iterative progress that drives sustained therapeutic advancement, delivering more tailored, accessible, and tolerable treatment options to patients. Notably, improved versions of earlier therapies make up over 60% of the World Health Organization's "Essential Medicines" — underscoring the critical role follow-on innovations play in meeting global health needs.

More broadly, if valid patents can be overridden at the government's discretion, it destabilizes the innovation framework as a whole. It weakens incentives for high-risk R&D, deters private investment, and introduces uncertainty across all industries that depend on predictable and enforceable IP protections. Such a precedent would do lasting harm to America's standing as a global leader in medical and technological innovation.

C4IP strongly urges CMS to reconsider the policy direction reflected in the draft guidance and affirm that reformulated drugs with distinct FDA approvals and valid patents must be treated as separate products in the negotiation process. That clarity is essential to sustaining medical innovation, ensuring future breakthroughs reach the patients who need them, and preserving the integrity of the U.S. patent system.

Thank you for the opportunity to comment.

Sincerely,

Frank Cullen
Executive Director
Council for Innovation Promotion (C4IP)

CENTER FOR REGULATORY FREEDOM
PROJECT OF CPAC FOUNDATION
515 KING STREET, ALEXANDRIA VA 22314

M E M O R A N D U M

To: **Hon. Robert F. Kennedy, Jr., Secretary, US Department of Health and Human Services**
Dr. Mehmet Oz, Administrator, Centers for Medicare and Medicaid Services
From: **Andrew Langer, Director, Center for Regulatory Freedom**
Date: **June 26, 2025**
Re: **US Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) request for comments, Docket Number CMS-4210-N, published in the Federal Register on May 15, 2025.**

Below are comments of the American Conservative Union Foundation's (d/b/a. Conservative Political Action Coalition Foundation) (hereinafter "CPAC Foundation") Center for Regulatory Freedom (hereinafter "CRF"), in response to US Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) request for comments, Docket Number CMS-4210-N, published in the Federal Register on May 15, 2025.

CRF is a project of the CPAC Foundation, a non-profit, non-partisan 501(c)(3) research and education foundation. Our mission is to inject a common-sense perspective into the regulatory process, to ensure that the risks and costs of regulations are fully based on sound scientific and economic evidence, and to ensure that the voices, interests, and freedoms of Americans, and especially of small businesses, are fully represented in the regulatory process and debates. Finally, we work to ensure that regulatory proposals address real problems, that the proposals serve to ameliorate those problems, and, perhaps most importantly, that those proposals do not, in fact, make public policy problems worse.

INTRODUCTION

The CPAC Foundation's Center for Regulatory Freedom (CRF) submits these comments in strong opposition to CMS's draft guidance for the Medicare Drug Price Negotiation Program. The proposed policy unlawfully collapses distinct, FDA-approved, patent-protected medicines into pre-existing price-controlled categories, threatening to expropriate private property, destroy incentives for biomedical innovation, and further entrench government overreach into the American healthcare system.

CMS's assertion that it can disregard separate patents and FDA determinations of clinical benefit exceeds any authority granted by the Inflation Reduction Act (IRA) and violates constitutional principles, including the Takings Clause and separation of powers. The agency's aggressive reinterpretation of "qualifying single source drugs" (QSSDs) invites significant legal challenge and economic harm.

This proposed guidance continues the Biden Administration's dangerous march toward centralized, coercive price control regimes reminiscent of failed socialist models abroad. Such policies already have directly contributed to stalled or abandoned drug development programs, undermining America's global leadership in life-saving medical breakthroughs. If left unchecked, CMS's unlawful expansion of its price-setting authority will convert the U.S. pharmaceutical innovation model into a risk-averse, stagnant system that harms patients, seniors, and taxpayers alike.

CRF urges CMS to withdraw this guidance immediately, honor Congress's limited statutory framework, respect the Constitution's protection of private property and innovation, and restore legal and economic integrity to Medicare policy.

CMS's draft guidance for the next cycle of the Medicare Drug Price Negotiation Program presents not only grave policy errors but raises serious legal and constitutional concerns. This guidance would unlawfully expand CMS's price control reach beyond what Congress authorized in the IRA by allowing the agency to dismiss valid patents, FDA approvals, and decades of constitutional precedent protecting private property and innovation.

Under the guise of "negotiation," CMS proposes a regime of coercive price-fixing backed by punitive tax threats, mirroring foreign socialized systems that suppress innovation and ration care. By collapsing new, distinct formulations of existing medicines into prior price-controlled categories—despite their separate FDA approval and new patents—CMS threatens the foundational incentives that make medical advancement possible.

These comments detail the unlawful nature of CMS's proposal, its unconstitutional infringement on private property, the dangerous economic consequences of destroying innovation incentives, and the broader shift toward government-controlled healthcare markets. CRF strongly opposes CMS's continued march toward socialized medicine and demands that this unlawful rulemaking be abandoned.

I. CMS IS UNLAWFULLY NULLIFYING PATENT RIGHTS AND FDA APPROVALS

At the heart of CMS's proposed guidance lies an extraordinary and dangerous assertion of regulatory power: that CMS can unilaterally collapse newly patented, FDA-approved, clinically meaningful medicines into pre-existing price-controlled categories. This proposed treatment of reformulated or re-administered drugs as non-distinct for negotiation purposes is nothing short of administrative expropriation.

CMS proposes to deem reformulations of existing biologics—for example, subcutaneous versions of previously infused products—as lacking "meaningful clinical benefit" if the additive elements do not target the disease directly. Yet these new formulations often address critical patient needs: convenience, accessibility, reduced administration time, and expansion into underserved populations. They involve extensive R&D, rigorous clinical trials, new

manufacturing protocols, and most importantly, the securing of new patents that represent Constitutionally protected intellectual property.

If CMS proceeds, innovators will face a perverse incentive: investing billions in improvements to meet patient needs, only to have their work instantly nullified through bureaucratic fiat. The right to exclude is the essence of patent protection under Article I, Section 8 of the U.S. Constitution. CMS's attempt to sidestep valid patents by asserting subjective clinical equivalency is not authorized by statute and is arguably unconstitutional. The Patent Act and FDA approval processes exist precisely to determine patentable novelty and clinical significance—not CMS.

II. THE IRA DOES NOT AUTHORIZE THIS EXPANSION

Nowhere does the Inflation Reduction Act confer on CMS authority to override patents or FDA approvals to consolidate products for negotiation purposes. The statutory text carefully defines "qualifying single source drugs" (QSSDs) based on FDA approval and exclusivity periods, not subjective CMS judgments about reformulation value. Congress further included narrow carveouts (e.g., for small biotech drugs, biosimilars, and phased implementation) precisely to constrain overreach. CMS's sweeping new interpretation effectively rewrites the statute by regulation.

This constitutes an unlawful agency expansion under basic administrative law principles. The Supreme Court's decision in *West Virginia v. EPA* reiterates that major questions of economic and political significance—such as nullifying billions in intellectual property and chilling an entire sector's innovation—require explicit Congressional authorization. It is not for CMS to arrogate this power under vague statutory language.

III. ECONOMIC CONSEQUENCES: THE DESTRUCTION OF INNOVATION INCENTIVES

The IRA has already begun damaging America's drug development pipeline. As of late 2024, dozens of clinical trials and drug development programs have been shelved due to price control uncertainties. Companies like Pfizer, Eli Lilly, and Bristol Myers Squibb have announced strategic pipeline cuts attributable directly to IRA price-setting distortions. This chilling effect will only accelerate if CMS doubles down on collapsing distinct products into prior price-controlled categories.

The American pharmaceutical model—unlike socialized systems abroad—has long relied on market-based pricing to reward the extraordinary risk and investment inherent in developing new therapies. With $2.6 billion on average required to bring a single drug to market, innovators require confidence in future revenue to justify R&D outlays. CMS's guidance injects radical uncertainty into this calculus, threatening to convert America's most productive sector into a risk-averse, stagnant environment indistinguishable from Europe's rationed, delayed-access systems.

IV. CMS IS ADVANCING A BACKDOOR SOCIALIZED MEDICINE MODEL

CMS's approach mirrors the dangerous path of foreign systems that centralize price setting and prioritize government budgets over patient access. The IRA's so-called "negotiation" is in reality

coercive price-fixing, backed by draconian excise taxes to compel manufacturer compliance—a regime reminiscent of Marxist-era economic coercion, not legitimate market negotiation.

The Biden Administration's IRA regime already redirected $260 billion from Medicare into non-healthcare priorities, distorted Medicare Part D premiums, and awarded billions in new profits to rent-seeking pharmacy benefit managers and insurer allies. With the proposed guidance, CMS is now further weaponizing the IRA as a bludgeon against future innovation in service of centralized economic control.

V. CMS's APPROACH VIOLATES THE CONSTITUTION'S SEPARATION OF POWERS

By creating new price-setting doctrines untethered from statutory text, CMS violates basic constitutional norms. The nondelegation doctrine prohibits Congress from granting unchecked lawmaking power to executive agencies. Here, CMS is functionally legislating major economic policy under the guise of interpretation. Moreover, by interfering with patent rights, CMS raises serious takings clause concerns, as it deprives innovators of the fruits of constitutionally secured property rights without just compensation.

VI. RECOMMENDATION: ABANDON THE GUIDANCE AND RESTORE LEGAL INTEGRITY

The CPAC Foundation's Center for Regulatory Freedom urges CMS to immediately withdraw its proposed guidance. Reformulated, FDA-approved, patent-protected medicines must be treated as distinct QSSDs under any legitimate reading of the IRA. Anything less represents an unlawful and unconstitutional overreach that will devastate the very innovation ecosystem that has delivered more than half of all global medical breakthroughs over the last two decades.

CMS should return to its statutory mandate, respect the constitutional boundaries of its authority, and cease advancing backdoor price control agendas that imperil American leadership in biomedical innovation. We stand ready to assist CMS leadership in pursuing reforms grounded in constitutional fidelity, market principles, and patient welfare.

CONCLUSION

The stakes implicated by CMS's proposed guidance could not be higher. At issue is whether America will preserve the innovation-driven, market-based pharmaceutical ecosystem that has delivered breakthrough cures and treatments for patients worldwide—or whether we will surrender to a centralized, coercive price control regime that dismantles incentives for discovery and undermines constitutional property rights.

By attempting to collapse distinct, patent-protected, FDA-approved medicines into prior price-controlled categories, CMS arrogates authority that neither Congress delegated nor the Constitution permits. The agency's proposed guidance unlawfully strips innovators of core intellectual property protections, violates separation of powers principles, and threatens irreversible harm to America's position as the global leader in medical innovation.

The CPAC Foundation's Center for Regulatory Freedom respectfully urges CMS to abandon this unlawful rulemaking. The Inflation Reduction Act does not authorize CMS to override patents or

FDA determinations. CMS should honor its statutory limits, respect the Constitution, and restore legal, economic, and policy integrity to Medicare. Anything less will chill private investment, delay patient access to breakthrough therapies, and cede American biomedical leadership to our geopolitical adversaries.

CRF stands ready to work with policymakers committed to restoring a healthcare system grounded in constitutional governance, free-market principles, patient choice, and world-leading innovation.

CSL Seqirus

CSL.com
CSLSeqirus.com

June 26, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244–1850

By e-mail to IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program (the "Negotiation Program") Draft Guidance

CSL Seqirus, one of the world's largest influenza vaccine manufacturers, appreciates the opportunity to provide comment on the Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act (the "Act") for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 ("IPAY 2028 Draft Guidance").

Recommendation 1: CSL Seqirus urges CMS to use its discretion to exclude Part B vaccines from the Negotiation Program and articulate this policy in the IPAY 2028 Final Guidance. Due to ambiguities in the statutory language of the Inflation Reduction Act (IRA), CMS has the authority to use its discretion to exclude Part B vaccines from the Negotiation Program. Moreover, negotiating prices for Part B vaccines would not achieve Congress' objective for the Negotiation Program of lowering costs for the Medicare program and its beneficiaries due to the particular statutory mechanism by which Medicare reimburses providers for Part B vaccines and the fact that the statute requires Part B vaccines to be available to beneficiaries without out-of-pocket costs.

Recommendation 2: For selected drugs or biologicals payable under Part B but not paid based on section 1847A(b)(4) of the Act, CSL Seqirus urges CMS not to default to using an alternative methodology for calculating maximum fair price ceiling based on the applicable percent of average non-FAMP, nor any other methodology that is inconsistent with statute. CMS should not implement the methodology described in the IPAY 2028 Draft Guidance to default to the ceiling amount under section 1194(c)(1)(C)(ii) when a Part B drug or biological selected for the Negotiation Program is not reimbursed under 1847A(b)(4) because such methodology is inconsistent with the plain language statutory direction Congress provided in IRA to implement the Negotiation Program.

Below we provide legal analysis and policy considerations that support CSL Seqirus' above recommendations to CMS on the IPAY 2028 Draft Guidance.

Legal Analysis

Congress provided prescriptive details in the statutory text of IRA to direct implementation of key elements of the Negotiation Program for Part B products, including for the calculation of the maximum fair price ceiling and the calculation of a biosimilar delay rebate. The statutory language of IRA specifies that Medicare reimbursement for Part B products under 1847(A) of the Act is the metric, or one of the metrics, to be used as a basis for determining the biosimilar delay rebate or the maximum fair price ceiling, respectively.

However, this prescriptive direction in IRA does not apply to Part B vaccines because, unlike most other Part B products, Medicare reimbursement for Part B vaccines is specified in statute under 1842(o)(1)(A)(iv) of the Act. Although Congress did not explicitly and categorically exclude Part B vaccines from the Negotiation Program in IRA, the fact that the IRA's prescriptive statutory language did not modify payment for products reimbursed under 1842(o)(1)(A)(iv) demonstrates that Congress' intent was that the Negotiation Program would not apply to Part B vaccines. Moreover, although CMS solicits comments on whether the agency should make payment based on the "lower of 106 percent of the MFP and the otherwise applicable payment amount" for drugs and biologicals not reimbursed under section 1847A of the Act," the statute clearly does not authorize CMS to modify the reimbursement method for those drugs, including Part B vaccines.

Further evidence of Congress' intent that the Negotiation Program would not apply to Part B vaccines is found in the fact that any negotiated price for a Part B vaccine would not result in savings for the Medicare program or its beneficiaries. This is because, under sections 1833(a)(1)(B), (b)(1), and (b)(12), and 1842(o) of the Act, Medicare beneficiaries do not pay co-insurance on Part B vaccines and the negotiated price for a Part B vaccine would only be reflected in the price the provider of the vaccine would pay to acquire the vaccine, but not the amount that Medicare would reimburse the provider for purchasing the vaccine. If Part B vaccines were included in the Negotiation Program, there would be no outcome that would meet the policy objectives of the program – that is lower costs for the Medicare program and its beneficiaries. Instead, if Part B vaccines were included in the Negotiation Program, a paradoxical effect of the policy could be to induce artificial purchasing incentives disruptive to the markets for such Part B vaccines.

Given the aforementioned ambiguities in the statutory language of IRA, and the fact that inclusion of Part B vaccines in the Negotiation Program would not benefit the Medicare program or its beneficiaries, CMS has authority to use its discretion to

exclude Part B vaccines from the Negotiation Program. CSL Seqirus urges CMS to do this, and to articulate this policy in the IPAY 2028 Final Guidance.

With respect to CMS' request for comment on an alternate methodology to calculate the maximum fair ceiling prices for Part B products not paid under 1847A of the Act, CSL Seqirus asserts that this approach conflicts with the statutory language of IRA. We note that for selected Part B drugs, statute directs the ceiling price to be the lowest of: (1) "the payment made under *section 1847A(b)(4)* for the drug or biological product" for the year before the selection; (2) the "applicable percentage" of the average non-Federal average manufacturer (non-FAMP) price for 2021, increased by an inflation factor; or (3) the "applicable percentage" of the average non-FAMP for the year before the selection year. The alternate methodology that CMS seeks comment on is to default to a ceiling price based on average non-FAMP, but this methodology does not address the statutory requirement that the ceiling price be the lowest of three pricing metrics, the first of which must be related to payment made under section 1847A. Therefore, CSL Seqirus urges CMS not to default to using an alternative methodology for calculating maximum fair price ceiling based on the applicable percent of average non-FAMP, nor any other methodology that is inconsistent with statute.

Policy Considerations

Flu vaccines are Medicare Part B vaccines but are distinct in a number of ways from other Part B products for which there is high Medicare spend. Flu vaccines are unique because: they are highly-utilized, low-cost products; have demonstrated cost-effectiveness; compete in competitive, "biosimilar-like" markets; benefit both individual and population-level health; and, have product compositions that change every year that require manufacturers to file supplemental biologics license applications (sBLA) with the FDA.

CDC estimates that flu has resulted in between 9.3 million to 41 million illnesses, 120,000 to 710,000 hospitalizations and 6,300 to 52,000 deaths annually between 2010 and 2024. To help prevent flu-related morbidity and mortality, CDC has recommended that, with rare exception, individuals aged 6 months and older receive annual flu vaccines each year since 2010. The Medicare program encourages its beneficiaries to receive annual flu vaccines through public communications, and the importance of flu vaccination as a preventive tool is further reflected in Medicare policies including quality programs and conditions of participation.

Despite strong public health recommendations for individuals 6 months and older to receive annual flu vaccines, flu immunization rates have declined significantly each year since the 2019-2020 flu season, including for individuals aged 65 and older. Reducing flu vaccine prices could affect investments in flu vaccine innovation and, in the long-term, could undermine access to flu vaccines at the population level. These

second and third order effects are counter to long-standing US public health goals and could also harm US pandemic preparedness posture.

Conclusions

CMS has the authority to use its discretion to exclude Part B vaccines from the Negotiation Program, and CMS should articulate this policy in the IPAY 2028 Final Guidance. This approach aligns with congressional intent, would not affect Medicare program or beneficiary costs, and help support long-standing public health goals around vaccine innovation.

CMS should not use average non-FAMP as a “default” for determining the ceiling price for Part B products that are not reimbursed under 1847(A) because this methodology is inconsistent with statute.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, DC 20004

Submitted via email to: IRARebateandNegotiation@cms.hhs.gov

June 26, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary, U.S. Department of Health and Human Services

The Honorable Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services

Director Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Drug Price Negotiation Program Draft Guidance

Dear Secretary Kennedy, Administrator Oz, and Director Klomp:

Thank you for the opportunity to provide comments in response to the Draft Guidance on the Medicare Drug Price Negotiation Program (Negotiation Program) for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 (Draft Guidance) issued by the Centers for Medicare & Medicaid Services on May 12, 2025.

CVS Health serves millions of people through our local presence, digital channels, and our nearly 300,000 dedicated colleagues – including more than 40,000 physicians, pharmacists, nurses, and nurse practitioners. CVS Health offers Medicare Advantage Prescription Drug (MAPD) plans in 46 states and DC. Aetna also offers robust standalone prescription drug plans (PDPs) to individuals in all 50 states and DC. Our unique healthcare model gives us an unparalleled insight into how health systems may be improved to help consumers navigate the healthcare system – as well as their personal healthcare – by eliminating disparities, improving access, lowering costs, and being a trusted partner for every meaningful moment of health.

CVS Health recognizes the complexity of the Negotiation Program requirements and appreciates CMS's proposal to engage the Medicare Transaction Facilitator (MTF) to facilitate the process of making maximum fair price (MFP) available at the point of sale (POS). It is critical that dispensing entities are provided sufficient information to perform the MFP reconciliation process. This includes information on Prescription Drug Event data (PDE) rejects and sufficient key data elements on each claim as outlined in greater detail below. Given the multiple system and process changes that will be required of dispensing entities

as part of the MFP effectuation process, it is important that CMS make the process as transparent, streamlined, and simple for these entities as possible.

Unfortunately, CMS's chosen process to make MFP available to beneficiaries at the point-of-sale places the burden of cash flow delay on pharmacies, which are the most fragile portion of the drug supply process due to existing payment constraints. As CMS evaluates the selected process during the initial 2026 applicability year, it is imperative that alternative methods that would reduce the burden on pharmacy be considered for future year changes to the program. This includes exploring a more sustainable Manufacturer to Pharmacy Benefit Manager (PBM) reimbursement process where the pharmacy would be made whole at POS, and Manufacturers would reconcile the delta between MFP and the negotiated dispenser rate in a similar timeline that plan sponsors make payments to PBMs after a drug is dispensed. There is also an unnecessary bifurcation complicating this arrangement today due to drug benefits existing under the offline medical billing arrangement of Part B and the real-time pharmacy adjudication of Part D. Simplification of this added complexity to the MFP process should be explored in finding an ideal solution to the MFP process.

Today, prescription drug processing in Part B is handled in a different manner than Part D. Therefore, attempts to marry the two processes under the existing MFP process that leverages claims detail to communicate with the MTF and Manufacturers will not work. This concern was highlighted in CVS Health's written comments in 2023[1] and in associated discussions with industry stakeholders and CMS. We ask CMS to explore a process for IPAY 2028 that will enable the same process to take place for Part D and Part B selected drugs while mitigating the cash flow issues that will be experienced by the dispensing entities regardless of size under the current process.

Finally, formularies and utilization management (UM) edits are essential tools to help ensure safe and clinically appropriate drug use and to encourage cost-effective drug choices. Congress was mindful of this in establishing the Negotiation Program, requiring only the inclusion of Part D selected drugs on the formulary but specifically not dictating formulary placement or restricting the use UM tools for the drugs in Part D or step therapy in Medicare Advantage. Congress understood that doing so would undermine the goals of the Negotiation Program to control drug costs. We note that CMS already has in place extensive requirements and guardrails on formulary design in Part D and on the use of step therapy in the MA program. We ask that CMS implement these requirements in accordance with the intent of Congress and the language of the Inflation Reduction Act of 2022 and not impose different or higher standards for the review of UM edits or formulary placement of selected drugs vs. non-selected drugs.

We have included a more detailed discussion of our specific recommendations for each area of concern in the Appendix.

[1] CVS Health Letter, November 13, 2023. RFI Response related to the establishment of a Medicare Transaction Facilitator for the Medicare Drug Price Negotiation Program.

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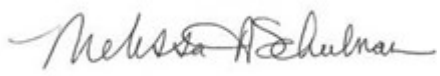
Thank you for considering our comments and recommendations. CVS Health is committed to collaborating with CMS as it continues to implement the Negotiation Program and other policies to promote affordable, comprehensive care and provides beneficiaries with innovative coverage choices to meet their needs. We welcome any follow-up questions you may have and stand ready to support CMS as it works to refine the Negotiation Program to ensure it achieves its intended goals as smoothly and efficiently as possible.

Sincerely,



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Appendix I

Section 30. Identification of Selected Drugs for Initial Price Applicability Year 2028
The Negotiation Program applies to drugs in Part D for IPAY 2026 and 2027, but beginning in IPAY 2028 and beyond, the Program will apply to drugs in both Medicare Part B and Part D. CMS states that it will choose the top 50 negotiation-eligible drugs for IPAY 2028 according to their Total Expenditures under Part B and Part D, and will then select up to 15 negotiation-eligible drugs with the highest Total Expenditures under Part B and Part D. CMS states that, as in IPAY 2026 and 2027, it will determine Total Expenditures under Part D by using "gross covered prescription drug costs" (GCPDC) as defined in 42 CFR 423.308. For Part B drugs that will be included beginning in IPAY 2028, it will determine Total Expenditures by using "Part B claims data" (excluding bundled drugs or those packaged into other payments) to calculate total allowable costs.

We are concerned that CMS' proposed selection methodology for Part B drugs is unclear, incomplete, and could result in overrepresentation of Part D and underrepresentation of Part B drugs in the list of Negotiation Program selected drugs. Specifically, CMS does not define "Part B claims data" or discuss what it encompasses, and therefore it is unclear whether CMS would include only Part B claims in Medicare Fee-for-Service (FFS) or if CMS would also include claims under the Medicare Advantage (MA) program.[2] Since more than half of Medicare beneficiaries are enrolled in MA plans today, failure to include MA expenditures in the "Total Expenditures calculation" would result in dramatically lower Total Expenditures for Part B drugs as compared to Part D drugs, as the Part D Total Expenditures calculation will include Part D claims for the entire Medicare population (i.e., those enrolled in Medicare FFS and also those enrolled in MA plans).

If CMS ranks drugs by combined Total Expenditures under both Part B and Part D without adjusting for the fact that it may consider Part B utilization for less than half of the Medicare population, the resulting drug selection will be heavily skewed to Part D drugs. This is inconsistent with the language of the statute and the intent of Congress, which clearly intended to treat Part B and D drugs in exactly the same way for purposes of eligibility for selection. More importantly, it would also harm beneficiaries and taxpayers by potentially excluding some of the drugs representing the highest expenditures for enrollees and the Medicare program.

We understand that CMS may be relying on Medicare FFS Part B data alone since the agency has direct access to that claims data, whereas Part B drug data under MA must be derived from encounter data. CMS should at a minimum extrapolate from the Medicare FFS Part B utilization and spending data to gross up Total Expenditures under Part B (i.e., CMS should gross up the Part B drug spend by the ratio of total Medicare enrollment (MA + FFS)

[2] While CMS does not define "Part B claims data" one source of information is this Part B claims data set that only includes FFS data. https://data.cms.gov/resources/medicare-part-b-spending-by-drug-methodology

over the FFS-only population that the Part B claims data represents) in order to have Total Expenditure data approximate the Part B drug expenditures for all Medicare beneficiaries. While this approach would assume that Part B drug expenditures under the FFS program and MA program are generally comparable, this is not an unreasonable assumption in the absence of actual data for MA expenditures. While the higher penetration of dual-eligible enrollees in the MA population may slightly increase the MA drug spend, it is also likely that the more effective medical management of conditions in the MA program may decrease MA drug spend, with the net effect being neutral as compared to Medicare FFS spending.

Another reason to add in assumptions about MA expenditures in the Part B Total Expenditures is that the difference in methodologies used to determine Total Expenditures under Part B and Part D already results in a bias towards and overweighting of Part D drugs. This is because CMS has chosen to use gross drug costs to determine Total Expenditures under Part D, but net drug costs to determine Total Expenditures under Part B, since "average sales price" (ASP) takes into account all rebates, discounts and other price concessions provided by manufacturers to purchasers. The failure to consider rebates and other price concessions for Part D drugs will further inflate Total Expenditures under Part D as compared to Part B.

In addition to the inconsistency in methodologies between Part B and Part D drugs, there are also strong public policy reasons to focus on net cost under both Part B and Part D, since this would allow CMS to prioritize the selection of products that cost the Medicare program the most, and where there are fewer discounts and rebates in effect today. It would also remove the perverse incentives under the current approach for manufacturers to offer smaller rebates under Part D than they would if net costs were used as the metric to determine eligible selected drugs in Part D. As demonstrated by the IPAY 2026 process, many of the selected drugs are already highly rebated drugs due to competition from therapeutically equivalent brand alternatives or because generic or biosimilar competitors to the selected drug are about to come to market.

CVS Health Recommendations:

- **CMS should clearly define "Part B claims data," and specifically whether it includes MA plan data in addition to Medicare FFS data.**
- **To the extent "Part B claims data" represents only Medicare FFS data, CMS should revise its methodology to account for Part B utilization and expenditures under the MA program so that Total Expenditures are based on the same enrollee**

populations for Part B and Part D, and Part D drugs are not over-represented in the list of selected drugs.

- **CMS should use net drug costs for Part B and Part D to determine Total Expenditures for drug selection. This would provide a consistent approach across Part B and Part D and exclude rebates and other price concessions from Total Expenditures, resulting in a more accurate reflection of costs for drugs with high Medicare expenditures. This net drug costs methodology would better reflect the intent of Congress and would make the Negotiation Program more effective.**

Section 40.2.2 Dispensing Entity Enrollment in the MTF DM

CMS requires that Part D sponsors include provisions requiring that the pharmacies are enrolled with the Medicare Transaction Facilitator Data Module (MTF DM) in their pharmacy agreements. In the CY2026 MA & Part D Final Rule CMS indicated it they would provide reporting to plans and potentially to PBMs that would inform them of the enrollment status of the pharmacies in their networks.

However, the Draft Guidance does not address the details of this reporting, such as timing of the first reports, the frequency of the reports, the methodology for delivery of the reporting, or the details to be included in the reports. Plans and PBMs need this information to create a robust monitoring plan to ensure pharmacy enrollment.

Additionally, CMS indicated that it would work with Part D sponsors to communicate the MTF DM enrollment requirements to network pharmacies. We note the Draft Guidance does not address the details of the process that CMS envisions for these communications.

CVS Health Recommendations:

- **CMS should work with the National Council for Prescription Drug Programs (NCPDP) Maximum Fair Price (MFP) Task Group to identify the details (such as the data elements, timing, and frequency) that plans and PBMs require from the report on dispensing entity enrollment in the MTF DM to support monitoring pharmacy compliance with this CMS requirement.**
- **CMS should request that NCPDP assist with pharmacy outreach regarding the enrollment requirements, as well as asking the NCPDP MFP Task Group to assist with the creation of an effective message campaign that could be reiterated by plans and PBMs.**
- **CMS should address in the Final Guidance the timing and method that will be used to provide the details of the pharmacy MTF DM enrollment reporting and the messaging campaign.**

Section 40.4 Providing Access to the MFP in 2026, 2027, and 2028

CVS Health has been outspoken through industry calls and public comments detailing that the MFP effectuation reporting process for IPAY 2026 and 2027, that leverages claim-level

data supplied to the MTF DM by Part D plan sponsors, presents administrative challenges that exacerbate the cash flow concerns of dispensing entities.

Overall, the established MFP reconciliation process for IPAY 2026 and 2027 has demanded significant system and process enhancements along with new financial processes for dispensing entities. CVS Health's dispenser-based reporting proposal offered to CMS and dispenser stakeholders was designed to address the core question of Part B drug inclusion, along with other challenges inherent with the claims-based reporting process selected. Instead, the selected arrangement lacks the benefits of a streamlined, dispensing pharmacy-based transactional reporting process.

CMS is soliciting comments on how the effectuation of MFP refund payments for drugs payable under Part B might differ from what is outlined for drugs covered under Part D. The core differences between Part D real-time claims adjudication and Part B offline medical billing render the IPAY 2026 and 2027 claims-based effectuation process unworkable for Part B claims.

For Part D claims, as illustrated in Figure 2 below, the PDE file is sent to the DDPS after plan sponsor approval immediately preceding dispensing. The dispensing entity knows that it will receive payment and that the claim has been accepted by the plan sponsor for Part D in real-time. For Part B claims, the dispensing entities typically contract with a switch vendor that incorporates validation, pre-adjudication edits, and logic that must be satisfied before the switch vendor returns a processed response to the dispensing entity system. These validations of coverage are high-level actions and are not a comprehensive validation that the claim will be paid.

At this point, the drug is dispensed, and the dispensing entity collects any required Part B forms and systematically passes the relevant information, such as sold date, to the switch vendor. The vendor receives this information and performs a series of claim hold validations that ensure compliance with Medicare regulations. It is noteworthy that a claim can be under hold status for prolonged periods. This delay in payment is exacerbated by the addition of the Medicare Transaction Facilitator Payment Module (MTF PM) payment process, regardless of how it is operationalized.

Once cleared, the vendor converts the claim format to the X12 Medical Billing Standard, 837 transaction format, and routes the claim to the correct Medicare Administrative Contractor (MAC) based on claim type and jurisdiction. Medicare receives and processes the claims and provides an 835 to the vendor. The 835-form provided by Medicare must be reformatted and provided to the dispensing entity.

Payments are issued via an electronic fund transfer (EFT) and reconciled by the dispensing entity's internal revenue system. Audits are routinely performed, and payment exceptions are discovered. These matters are worked between the dispensing entity and the vendor to resolve payment exceptions and denials.

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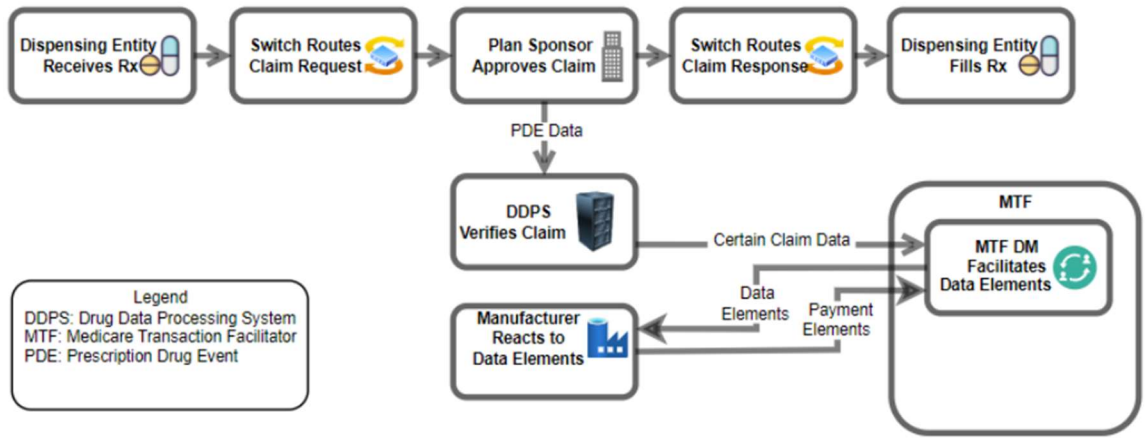
CVS Health Recommendations:

- **For future IPAY years, CMS should explore a process for effectuation that occurs upstream in the payer process that does not place a cash flow constraint on dispensing entities.**
- **CMS should establish a uniform, dispensing entity-based arrangement for IPAY 2028 or, if possible, facilitate an improved process which would:**
  - **Create a single file layout for Part B and Part D MFP selected drugs, avoiding complexities in the IPAY 2028 inclusion of Part B products within the selected drugs.**
  - **Streamline the process and reduce complications that will arise from real-time claim-based reporting such as claim edits, reversals, Medicare Part B MFP claim data reporting while facilitating a basis to identify 340B discounts.**
  - **Provide transparency to dispensing entities for financial reporting and recourse to address MFP reconciliation gaps.**
  - **Limit transactional data to the minimum necessary to facilitate the EFT process.**
  - **Enable batch reporting managed by the dispensing entity to facilitate accurate reporting of the outcome of claims paid at MFP, mitigating the need for payment adjustments by the MTF DM and manufacturer.**
  - **Avoid the scenarios when MTF claim-level data elements lack key reconciliation information, including PDE Rejects that will lead to missing effectuation, overburdened transaction volume, and claim reversal complexities exacerbated by the guidance shortening the PDE window for MFP selected products.**

The diagram in Figure 2 below details the MTF Data Flow for Part D drugs leveraging the claims processing system will not be able to be utilized for Part B selected drugs. This is due to Part B drugs following a non-real time medical payment pathway that does not produce a PDE and therefore does not flow through the Drug Data Processing System (DDPS) verification system. For Part B drug claims to be transmitted to the MTF, a dispenser would have to manually report each claim.

Figure 2: Diagram of MTF Data Flow



Section 40.4.2.1 Primary Manufacturer Participation in the MTF DM

The Draft Guidance states that if a claim has DDPS edits that are on CMS' list of edits directly related to MFP-eligibility or has not yet cleared all of the DDPS edits that are on such CMS list of edits, the MTF DM will not transmit the claim-level data elements to the Primary Manufacturer because it has not been verified that the selected drug of the Primary Manufacturer was dispensed to an MFP-eligible individual.

CVS Health strongly believes that dispensing entities should be notified that the claim is being held up as DDPS edits are cleared and attribute the notice to a specific claim. This will aid in dispensing entity reconciliation while reducing the number of disputes that may need to be raised to the Manufacturer. Since the Manufacturer will not have visibility to this claim as it is being held up, the responsibility to report to the dispensing entity must be placed on the MTF DM.

Section 50. Negotiation Factors

The statute directs CMS to consider certain factors for purposes of negotiating the MFP for a selected drug with the Primary Manufacturer. These factors include data submitted by the Primary Manufacturer, as specified in section 1194(e)(1) of the Social Security Act (Act), and evidence on therapeutic alternatives as specified in section 1194(e)(2) of the Act.

CMS solicits comments on the collection of additional, forward-looking "market data" for the selected drug, and gives as examples (1) the manufacturer's annual forecast of U.S. net revenue, volume by indication, and net pricing for the selected drug itemized by the relevant market channel (e.g., Medicare, Medicaid, commercial or other); and (2) an annual gross-to-net ratio trend for the selected drug across all market channels and market share percentages and volume, by indication.

CVS Health supports CMS' efforts to look beyond current cost data provided by manufacturers in negotiating the MFP, but cautions that forward-looking data is inherently more speculative, and therefore is capable of being manipulated and less reliable. Unless CMS is able to obtain this data from reliable third-party sources or CMS uses data that manufacturers provide for other purposes where they could face penalties for misrepresenting the drug's prospects (e.g., SEC filings), we recommend that CMS continue to rely on current financial data in the negotiation process rather than projections or forecasts.

More broadly, we recommend that, wherever possible, CMS place greater weight on factors and/or data that are less under the control of, or susceptible to manipulation by, the manufacturer of the selected drug, in recognition of the manufacturer's inherent conflict of interest in providing data to CMS that would lead to a higher MFP. For example, the extent to which the development of the drug was funded by the federal government should be given greater weight if this data can be obtained largely from the federal government.

CVS Health Recommendations:

- **CMS should be cautious about relying on forward-looking market data provided by the manufacturer, particularly if the data is speculative and subject to change.**
- **CMS should place greater weight on data obtained from sources other than the manufacturer of the selected drug.**

Section 60. Negotiation Process

60.3 Methodology for Developing an Initial Offer

CMS states that, consistent with the statute, for the purpose of determining an initial offer CMS will identify any therapeutic alternatives, and evaluate the selected drug compared to these therapeutic alternatives, including their comparative effectiveness, impact on specific populations, the extent to which they satisfy an unmet medical need, the extent to which the selected drug represents a therapeutic advance as compared to its therapeutic alternative, and the prescribing information approved by the FDA for each. CMS states that while it believes that pharmaceutical therapeutic alternatives will be the most analogous alternatives to the selected drug when considering treatment effect and price differentials, it is soliciting comments on the possibility and feasibility of considering health care services payable under Medicare Part A or Part B as potential therapeutic alternatives to the selected drug for future rulemaking and on which factors could be used to determine if a health care service could be considered a therapeutic alternative or not.

While CVS Health supports consideration of all relevant factors in setting the MFP, including all therapeutic alternatives to the selected drug, there are significant challenges in ensuring that a comparison between a health service and a drug is fair and appropriate. For example, CMS would need to consider over what time period to measure the cost of a health service or drug, since a health service could be a one-time event (e.g., surgery) whereas the selected drug may need to be taken for a certain period of time, or even indefinitely. Any

comparison between health services and drugs would also need to appropriately account for evidentiary differences in measures of comparative effectiveness, and whether there are sufficient independent, reliable and quantifiable sources for this information. Currently there are well-established and standardized methodologies for comparing the effectiveness of two drugs, but no known or standardized methodology for comparing the effectiveness drugs and health services.

CVS Health Recommendations:

- **We support CMS efforts to explore how health care services might be considered a therapeutic alternative to the selected drug, however CMS should proceed with great caution to ensure that any comparison between health services and drugs are valid and appropriate, considering all relevant factors and methodologies that would quantify comparative effectiveness.**

Section 80. MFP Eligible Individuals

CMS states they do not expect that the MFP of a selected drug will be made available to hospitals, physicians, and providers of services and suppliers with respect to a drug furnished or administered to MFP-eligible individuals enrolled under Part B in 2026 or 2027. However, beginning in 2028, when Part B drugs become eligible for negotiation and renegotiation, CMS says that an MFP-eligible individual includes an individual who is enrolled under Part B or in a MA Plan under Part C if payment is made under Part B for such selected drugs. CMS further notes that the MA plan coverage requirements will apply to selected drugs and is soliciting comments on "how to best monitor MA plans' use of Part B step therapy practices to ensure compliance with program rules and any data or policy clarifications that may be needed for implementation."

As stated in our prior comments on the Negotiation Program and in our comments below on Section 110 related to Part D Formulary Inclusion of Selected Drugs, we are concerned that CMS is applying different and higher standards of review for the formulary placement and use of UM edits for selected drugs, as compared to non-selected drugs, that has no basis in the statute. While the statute requires inclusion of selected drugs on formularies, it does not prescribe where on formularies these drugs should be placed or require different standards for the review of utilization management tools like step therapy placed on selected drugs, nor is there any policy reason to do so.

Data continues to show that MA plans are effective at reducing the use of low-value treatments, including Part B drugs, through tools such as step therapy.[3] Further, CMS already has in place extensive regulatory requirements and guardrails on the use of step therapy in the MA program and on formulary design in Part D, and further standards or guidelines – which would be contrary to the Administration's stated goals of reducing unnecessary and duplicative regulations – are not needed.

[3] https://ascopubs.org/doi/full/10.1200/JCO-24-01907

Specifically, guidance issued by CMS in 2018 requires MA plans to cover all items and services, covered under Medicare FFS while permitting MA plans to utilize step therapy where "an applicable national/local coverage determination is silent on the matter."[4] In this memo, CMS recognizes step therapy as a tool to "achieve the goal of lower drug costs while maintaining access to covered drugs and services for beneficiaries."[5] Further regulations governing MA plans require step therapy protocols to be approved by a P&T Committee that must base its decision making on the "strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other such information as it determines appropriate"; consider whether the inclusion of a Part B drugs in a step therapy program has any therapeutic advances in terms of safety and efficacy; and does not allow step therapy that is stricter than that permitted in an NCD or LCD.[6]

We remain committed to providing access to selected medicines for Medicare patients, in compliance with existing CMS requirements applicable to all Medicare drugs.

CVS Health Recommendations:

- **CMS should not place different and higher standards of review for use of UM edits for selected drugs, which have no statutory basis.**
- **CMS already has in place extensive requirements and guardrails on the use of step therapy in the MA program and the same clinical and cost considerations should apply regardless of whether a drug is a selected drug or not.**

Section 80.1 Direct Member Reimbursements and Access to the MFP for Selected Drugs in 2026, 2027, and 2028

CMS notes that Direct Member Reimbursement (DMR) requests are "unique from typical claims for selected drugs and, therefore, warrant procedures to facilitate access to the MFP for MFP-eligible individuals that differ from how the MFP is normally effectuated for selected drugs." CMS proposes to establish a procedure that "leverages existing Part D plan sponsor procedures for DMRs" to help ensure that the MFP is available to an MFP-eligible individual that submits a covered DMR request. Specifically, CMS says that whether an enrollee submits an in-network or out-of-network (OON) claim for a selected drug, the enrollee must not pay more than the MFP plus any dispensing fees if the individual is in the deductible phase of the benefit, or their copayment or coinsurance if they are in other phases of the benefit. CMS adds that "Primary Manufacturers and Part D plan sponsors may

[4] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf
[5] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf
[6] 42 CFR 422.136 and 42 CFR 422.101(b)

establish a reimbursement process related to DMR requests for MFP-eligible claims as necessary to ensure MFP effectuation for these MFP-eligible individuals."

CVS Health understands that CMS views DMR requests for a selected drug as "exceedingly rare" when considered as a percentage of total claims. However, our experience shows that the actual number of DMR claims is not insignificant, particularly when one considers that each DMR claim must be handled manually by the plan sponsor and within a strict time frame as per CMS guidance. CVS Health is concerned that the Draft Guidance is overly vague and unclear at best, failing to appropriately account for either the administrative burden or financial impact on Part D plans of CMS' proposed approach to DMRs. Each of these concerns is dealt with in turn below.

First, in the Draft Guidance CMS does not address the methodology for calculating the beneficiary cost-sharing, selected drug subsidy, or the population of the PDE for DMR claims. We ask that CMS provide detailed instructions and PDE examples for processing DMR claims for both in-network and OON pharmacies, including:

- The calculation of member cost-share when the cash price paid by the beneficiary is higher than the MFP. We would ask that CMS clarify whether the member cost-share calculation is based on the full submitted amount or the lower of the plan's negotiated rate or the MFP price (MFP + dispensing fee), and whether the OON penalty can be removed from the reimbursement as well.
- The calculation of the Selected Drug Subsidy when the cash price paid by the beneficiary is higher than the MFP. We would expect the selected drug subsidy to be calculated based on the MFP plus dispensing fee in the case of OON claims, and the negotiated price of the selected drug in the case of in-network claims but ask that CMS confirm this and provide examples of different scenarios.
- Details regarding how the PDE data should be submitted, including how the amounts in excess of the MFP/negotiated price are to be reflected in the PDE data (i.e., whether this amount is to be included in the CPP, NPP, PLRO, or other fields).
- Details regarding any differences for claim calculation and PDE reporting for DMRs for PACE, D-SNP, or LIS beneficiaries.

Since most Part D plans receive a disproportionately high number of DMR claims in the first quarter of the year as beneficiaries encounter enrollment and eligibility issues at POS, causing them to pay cash and submit a DMR afterwards, we ask that CMS provide this guidance as soon as possible, and no later than the end of July 2025 if CMS intends for the policy to take effect for IPAY 2026. This is necessary to ensure that Part D plans and their PBMs are able to process DMR transactions accurately when received, and therefore, avoid the cost, administrative burden, and potential beneficiary friction from having to correct claims after the initial processing, including potential payments to or recoupments from beneficiaries.

Secondly, we strongly disagree with CMS' proposed approach of "leveraging" existing Part D procedures to make the MFP available to enrollees that submit DMRs. Not only does this impose financial and administrative responsibility on Part D plans to effectuate MFP, which is directly contrary to the requirements of the IRA and CMS' own repeated statements that the Primary Manufacturer is responsible for effectuating the MFP, but it fails to specify any methodology or standardized process by which manufacturers will be required to reimburse Part D plans for effectuating the MFP on their behalf. In fact, the Draft Guidance does not even require the manufacturer to reimburse the Part D sponsor at all, and it is not clear on what basis any manufacturer would voluntarily agree to do this. CMS seems to be taking the position that because DMR claims are relatively few, neither CMS nor manufacturers should have to deal with them.

Even if manufacturers did agree to reimburse Part D plans, there is no standardized methodology for doing so, which will likely result in each manufacturer, plan and/or PBM taking different approaches, leading to a multitude of methodologies. A diversity of methodologies for reimbursement would not only be inefficient and chaotic, but would also make oversight by CMS challenging, as CMS will have no visibility as to whether the manufacturer is meeting its obligation under the statute to effectuate the MFP by reimbursing Part D plans for the difference between the cash price and the MFP, thereby failing CMS' own statutory obligation to oversee manufacturers' implementation and effectuation of the MFP. Thus, we strongly recommend that CMS create a new standardized process for manufacturers to reimburse Part D plans for any difference between the cash price paid by beneficiaries and MFP, for DMR claims for selected drugs paid by the Part D plan.

CMS could either leverage the MTF to manage this DMR reimbursement process or devise a new process like the one used for the manufacturer payment of the Manufacturer Discount amounts to the plans. Additionally, CMS could request assistance from the NCPDP MFP and/or the NCPDP PDE Task Groups for assistance in developing a new standard process. To facilitate this, CMS would need to provide technical guidance on PDE submission of DMRs to indicate the difference between the MFP and the DMR amount paid to the beneficiary (i.e., the amount in excess of the MFP) in a specific PDE field (either utilizing an existing field, such as PLRO or ERPOSA, or creating a new field utilizing an open filler field location in the PDE file). This would represent the amount the manufacturer owes to the plan.

If CMS leverages the MTF to manage this process, CMS could provide this PDE information to the MTF, which would then include it in its reporting/invoicing process with manufacturers, indicating the information is for a DMR and that the payment is due to the plan. The manufacturer would need to be provided with the payment details for plans for this method. Alternatively, if CMS pursued a process mirroring that for the manufacturer payments of the manufacturer discount program amounts, much of that existing process could be leveraged to provide the reporting to and from the manufacturers that would be necessary for manufacturers to effectuate payment to the plans.

Either of these methodologies would ensure that the manufacturer reimburses the plan for amounts paid to beneficiaries for selected drug claims when the beneficiary paid an amount at POS that was higher than the MFP, and both approaches would also allow CMS to meet its statutory obligation to oversee the effectuation of the MFP , and allow manufacturers to meet their statutory obligation to provide access to the MFP to eligible beneficiaries.

As noted previously, ideally, guidance on the methodology chosen and the above details should be finalized and communicated before the end of July 2025 if CMS intends for the policy to take effect for IPAY 2026, to allow plans and their PBMs enough time to make any necessary changes to adjudication and PDE systems, and to provide CMS with sufficient lead time to prepare the DDPS system and the MTF and/or CSSC to handle any necessary system changes.

CVS Health Recommendations:

- **CMS should provide detailed instructions and PDE examples for processing DMR claims for both in-network and OON pharmacies by no later than the end of July 2025 for a January 2026 implementation.**
- **CMS should develop a standardized methodology for and require manufacturers to reimburse Part D plans for effectuating the MFP on their behalf, providing detailed guidance and instructions as soon as possible, but no later than the end of July 2025 for a January 2026 implementation.**

Section 110. Part D Formulary Inclusion of Selected Drugs

CMS states that for IPAY 2028, it will continue the formulary inclusion policies described in prior Negotiation Program guidance for IPAY 2026 and 2027. Specifically, while CMS will not implement explicit tier placement or utilization management requirements that apply uniformly across selected drugs in all formularies, it will continue to require Part D sponsors to provide justification to support a formulary design that places selected drugs on a non-preferred tier or on a higher tier than a non-selected drug in the same class, or imposes more restrictive UM requirements on selected drugs as compared to non-selected drugs.

As stated in our comments on the draft guidance for IPAY 2026 and 2027, and consistent with our comments on Section 80 above regarding step therapy requirements for Part B drugs, we are concerned that CMS is imposing a higher standard of formulary review for selected drugs as compared to non-selected drugs that not only has no basis in the statute, but for which CMS provides no policy rationale. The statute requires only that selected drugs be included on formularies, and it is notable that Congress chose not to prescribe how or where on formularies these drugs should be placed, balancing the demands of manufacturers against the recognition that formulary flexibility is a critical tool by which Part D plans promote cost-effective drug utilization and that further restrictions would undermine the goals of the Negotiation Program.

While we understand and expect that Part D plans be required to comply with the same restrictions and requirements on formulary design applicable to all Part D drugs,[7] CMS has gone a step further by imposing a higher standard of formulary review for selected drugs. Its proposed formulary review process effectively creates a presumption that Part D plans must justify and overcome any formulary placement or UM edit on a selected drug that is less favorable than for a non-selected drug. CMS provides no policy explanation for why this should be the case, since selected drug status should be irrelevant to CMS' standard formulary review process.

Not only is there no legal basis or policy rationale for giving selected drugs preferential treatment in CMS' formulary review process, CMS' proposed approach will further limit the leverage of Part D plans and their PBMs in negotiations with manufacturers, which have negative effects on beneficiaries and the government from a public policy perspective. Limiting the negotiation leverage of plans and PBMs will result in higher drug costs for enrollees and the government, undermining the goals of the Negotiation Program. The IRA explicitly requires only that selected drugs to be included on a Part D plan's formulary, and any CMS formulary review that focuses exclusively on the placement of selected drugs is beyond the statutory parameters.

Finally, as we discuss in greater detail below in our comments to the Successor Regulation in Section 110.1 of the Draft Guidance, given statutory restrictions on removing selected drugs from a plan formulary, CMS should give Part D plans the maximum flexibility allowed by the statute and successor regulation with respect to formulary placement and UM edits when a generic or biosimilar becomes available. Specifically, Part D sponsors should be permitted to immediately move a selected drugs to a higher tier or impose UM requirements mid-year if a generic or biosimilar becomes available, without the need to provide additional justification or being subject to additional scrutiny that would not apply when similar maintenance changes are made with respect to non-selected drugs.

CVS Health Recommendations:

- **Consistent with the statute and Congressional intent, CMS should not subject Part D plans to a higher standard of formulary review for selected drugs as compared to non-selected drugs.**
- **At a minimum, selected drug status should be irrelevant to CMS' formulary review process, although we believe CMS has the authority and policy basis for providing Part D sponsors additional formulary flexibility with respect to selected drugs.**
- **CMS should allow plans to immediately move a selected drug to a higher tier or impose UM edits when a generic or biosimilar becomes available without having to provide justification not required for non-selected drugs.**

7 See Chapter 6 Part D Manual, Section 30 and the regulatory requirements in 42 CFR 423.272(b) and 120(b), referenced on p.184 of the Draft Guidance.

Section 110.1 Formulary Inclusion Exception Successor Regulation for 2027 and 2028
CMS incorporates section 90 of the Final CY 2026 Part D Redesign Program Instructions (Redesign Instructions) with respect to the successor regulation exception into the Draft Guidance for 2027 and 2028. Accordingly, CMS proposes to allow Part D plan sponsors to remove a selected drug that is a brand name drug or reference product and replace that drug with a generic or interchangeable biosimilar respectively as an immediate substitution as long as certain regulatory notice and timing conditions are met. CMS adds that removals under the formulary inclusion exception cannot be carried over to subsequent years within the price applicability period simply because a selected drug was removed in a preceding year during the price applicability period. Instead, any removal must independently meet the immediate substitution requirements for each plan year.

CVS Health appreciates the availability of the formulary inclusion exception, but as stated in our prior comments, believes that proposed implementation is confusing and unnecessarily restrictive. We are concerned that it may limit the adoption of generic and biosimilar drugs by not allowing the substitution of a generic or biosimilar for a selected drug in a given IPAY if the competitor generic or interchangeable biosimilar is marketed too soon.

For example, we anticipate that generic competitors to the brand drug Entresto may come to market at some point in the next year. If one or more of these generic competitors becomes available in May 2026 and CMS determines in August 2026 that they are being bona fide marketed, Part D sponsors will nevertheless be required to include Entresto on their formularies for 2027 and will not be permitted to remove it through an immediate substitution of the generic. However, if the competitor instead came to market a couple of months later, say in July 2026, Part D sponsors would be allowed to make an immediate substitution. This is an anomalous result, and demonstrates that the immediate substitution rationale, namely, that plans should not have the option to replace a brand with a generic after the formulary is submitted if they could have done so before, does not apply with respect to a selected drug, since plans must include the selected drug as part of their initial formulary submission, even if a generic or biosimilar has become available by then, and even if that generic or biosimilar is included on the formulary as part of the initial formulary submission.

We also note the complexity with CMS' proposed formulary inclusion requirements for the removal of selected drugs with multiple biosimilars. For example, Wezlana (ustekinumab-auub), an interchangeable biosimilar to Stelara, has recently launched. Because this biosimilar launched prior to the CY 2026 Part D formulary submission, according to the proposed approach, coverage of Stelara would be required in CY 2026 as it is a selected drug with an MFP in effect. However, if another interchangeable biosimilar for Stelara is released in the fall of 2025 (after initial CY 2026 formulary submission) we expect, but ask that CMS confirm, that Part D sponsors would be permitted to substitute Stelara with the other interchangeable biosimilar that only becomes available after submission of the 2026 formularies.

These unusual and anomalous outcomes reflect the fact that the timing requirements regarding removal of selected drug status are overlaid on, and do not do dovetail with, the separate and different timing requirements for immediate substitutions, which were devised without taking into account selected drug timing issues. In light of this, we ask that CMS revise the immediate substitution requirements as applied to selected drugs to allow their removal as soon as a generic or biosimilar becomes available, and irrespective of whether this is before or after the initial formulary submission. This is appropriate and consistent with the rationale for immediate substitutions since, as discussed above, Part D plans are required to include the selected drug on their formularies even if a generic or biosimilar becomes available before the date of the initial formulary submission. We also ask that CMS include maintenance changes to remove a selected drug as part of the successor regulation. CMS acknowledged in the Redesign Instructions that it has the authority to do so, and we believe for all the reasons stated above regarding the need for formulary flexibility for selected drugs that this would be in the best interests of beneficiaries and the Medicare program.

Finally, we continue to be concerned that the specific time periods finalized in the current formulary substitution regulations for immediate substitutions and maintenance changes are too limiting and do not provide sufficient time for full evaluation and completion of activities prior to making and implementing decisions regarding the current formulary product, including activities such as evaluation of the new product's attributes (e.g., formulation, interchangeability, pricing), confirmation of sufficient availability in the marketplace, communication of changes, and updating systems. In addition, it is important to note that a new-to-market generic drug may initially have pricing similar to its brand name counterpart due to factors such as market exclusivity and limited competition. In this case, Part D sponsors should have the flexibility to defer removal of the brand drug or reference product until after market condition changes (e.g., market entry of additional competitor products) result in more favorable pricing of the generic. We continue to recommend that a 90-day limitation for immediate substitutions and no limitation for maintenance changes would strike a more appropriate balance.

CMS should also clarify that the 30- and 90-day time frames be based on dates corresponding to formulary reference file addition and formulary submissions. Defining these timelines in this way would allow both implementation and formulary updates to follow the same timing as other monthly updates. This would support Part D sponsors' ability to take full advantage of the formulary flexibility being provided and facilitate member access to the alternative products.

CVS Health Recommendations:

- **CMS should revise the immediate substitution requirements as applied to selected drugs to allow their removal as soon as a generic or biosimilar becomes**

available, and irrespective of whether this is before or after the initial formulary submission.

- **CMS should include maintenance changes to remove a selected drug as part of the successor regulation.**
- **CMS should provide additional flexibility in the timing requirements for immediate substitutions and maintenance changes by allowing 90-days for immediate substitutions and no time limit for removing a brand or reference product as part of a maintenance change.**
- **Clarify that the 30- and 90-day time periods be defined based on dates corresponding to formulary reference file addition and formulary submissions.**

Duke | MARGOLIS INSTITUTE for Health Policy

VIA ELECTRONIC SUBMISSION

Dr. Mehmet Oz
Centers for Medicare and Medicaid Services Administrator
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Dr. Oz:

The Duke-Margolis Institute for Health Policy appreciates the opportunity to comment on the Draft Guidance on the Medicare Drug Price Negotiation Program (Guidance), published on May 12, 2025, by the Centers for Medicare and Medicaid Services (CMS). The Guidance addresses the implementation of the Medicare Drug Price Negotiation Program (Negotiation Program) for initial price applicability year 2028 and manufacturer effectuation of the MFP in 2026, 2027, and 2028, to negotiate maximum fair prices (MFPs) for certain high-expenditure, single-source drugs and biologics.

While Congress exempted the Inflation Reduction Act's (IRA) implementation from a requirement for a formal notice-and-comment rulemaking process until 2029, CMS has described in the Guidance a process for timely public input on how the MFP for a drug will be determined. We appreciate CMS' efforts to solicit comments on most aspects of the Guidance pertaining to the implementation of the Negotiation Program.

The Robert J. Margolis, MD Institute for Health Policy at Duke University generates and analyzes evidence across the spectrum of health policy with the goal of improving health care and health while avoiding unnecessary costs. A core mission of the Institute is to focus on increasing the value of biomedical innovation to patients. The suggestions below are informed by the Institute's experience and research in developing approaches to drug pricing and payment reform that support better evidence, outcomes, and access for patients and better value across the health care system.

Our key comments are as follows:

1. Implement a framework for assessing comparative effectiveness and translating such analyses to prices; And explain how real-world evidence (RWE) should be factored into pricing decisions
2. Clarify and monitor part D formulary practices post-negotiation
3. Evaluate part B negotiation impacts on pricing and utilization

Implement a Framework for Assessing Comparative Effectiveness and Translating Such Analyses to Prices; And Explain How Real-World Evidence (RWE) Should Be Factored into Pricing Decisions

The Guidance for IPAY 2028 reflects a thoughtful and substantive effort by the new Administration to bring greater transparency, detail, and structure to the Negotiation Program. It offers detailed insight into the negotiation process and signals CMS' commitment to incorporating stakeholder feedback. We appreciate the additional clarity it provides on several key features of the program and view it as a meaningful step forward.

As we noted in our comments[1] on the Initial Guidance for IPAY 2026, longstanding concerns remain about how CMS will assess and apply evidence related to a selected drug's clinical and comparative effectiveness. While CMS has made progress in articulating its process and explaining the MFPs for 2026, key questions persist for advancing predictability and clarity—particularly regarding how different types of evidence will be weighted and how they will ultimately influence MFP determination. We recognize that this is a complex and evolving policy area and encourage further progress toward more detailed guidance and explanations over time to strengthen incentives to generate high-quality evidence relevant to Medicare beneficiaries. Accordingly, we are highlighting several key points from our prior letter to advance this goal.

We recommend that CMS build on the Guidance by using our and other comments to outline and then expand on a qualitative framework to govern its negotiation analysis. This framework would detail the most important dimensions of comparative effectiveness for a drug (e.g., key outcomes, safety), how different types of evidence (including real-world evidence, as we further detail below) will be assessed, and how such evidence will influence upward or downward price adjustments. This framework should describe how CMS weighs varying levels of clinical benefit and evidence strength. CMS could indicate what clinical and comparative evidence might support a ceiling price, versus pricing tiers below the ceiling price based on incremental benefits or insufficient evidence. These steps will help reduce uncertainty, increase program consistency, and encourage investment in innovation and evidence development in line with Medicare beneficiary needs. This framework could continue to be revised over time.

Specifically, CMS is now seeking input on whether certain statutory negotiation factors under section 1194(e)(2) should be weighted more heavily than others and is requesting comments on which factors are most compelling and how they could be applied consistently across selected drugs. We recommend that as part of CMS' framework for assessing comparative effectiveness under section 1194(e)2), CMS should clarify how real-world evidence (RWE) development will impact CMS' MFP determinations.

CMS' approach to evaluating section 1194(e)(2) factors involves a broad review of available evidence on the clinical benefit of the selected drug compared to its therapeutic alternatives. This includes CMS-led focused literature review, a review of public and manufacturer-submitted data and analysis, and potentially further evaluation using Medicare claims or other datasets, considering clinical data and information on health care resource utilization.

Historically, most drug assessments have focused on new drugs using premarket evidence, particularly from randomized controlled trials (RCTs), to inform initial coverage and pricing decisions. However, these assessments often lack RWE or RWE-derived insights that result from postmarket analyses. For instance, assessments often lack robust insights into how drugs perform in patient populations outside

of controlled investigational settings and subgroups of patients, leaving important questions about comparative effectiveness and safety unanswered, depending on the drug or treatment indication, when drugs enter the market. This gap is especially important in the context of the Negotiation Program, as CMS has emphasized the significance of understanding clinical and comparative effectiveness in populations that reflect Medicare beneficiaries.

In the IRA context, price negotiation applies to drugs that have been on the market for at least seven years (for small molecules) or eleven years (for biologics). Therefore, CMS has a unique opportunity to promote the development and use of high-quality RWE by leveraging data resources, analytical tools, and mechanisms that exist within the Department of Health and Human Services (HHS) to better understand a drug's impact on the Medicare population, beyond the traditional (generally premarket) clinical trials.

To support this, CMS should establish more explicit qualitative guidance on its approach to assessing real-world data (RWD) quality, relevance,[2] and reliability,[3] and offer examples on the types of RWE that CMS will likely deem meaningful to impact MFP determinations. Providing such further guidance would give manufacturers greater clarity on how to design meaningful RWE that aligns with CMS priorities—leading to stronger, more relevant evidence to inform pricing decisions through the Negotiation Program.

To reduce the time and uncertainty involved in generating strong RWE, CMS should also consider steps to facilitate RWE work that is highly relevant to Medicare beneficiaries. This could include more timely access to CMS data for well-designed analyses of key comparative effectiveness questions, and incorporation of such questions as a component of CMMI's rapid learning initiatives. CMS can play a critical role in advancing the timely development of relevant RWD infrastructure by engaging early in the lifecycle of emerging drugs. This includes working with beneficiary groups, providers, product developers, plans, researchers, and other stakeholders to identify key outcomes of interest, particularly those relevant to real-world clinical benefit assessment, assess existing evidence gaps, and anticipate the types of data that may be needed to support future assessments of drugs' clinical benefit for MFP determinations.

To reduce provider burden, the agency could align these outcomes, where possible, with existing initiatives to advance electronic data exchange and digitally-enabled care, to leverage established data collection systems, minimizing duplication and facilitating more efficient evidence generation in routine care settings. Early engagement can also help facilitate thoughtful planning around data sources and collection methods. Similar to scientific advice processes offered by international HTA organizations like NICE and CADTH, and collaborative initiatives like GETREAL, such consultation could help clarify how the evidence base may be interpreted and inform pricing decisions, encouraging more meaningful and policy-relevant evidence generation.

How CMS approaches the use and interpretation of evidence will not only shape MFP determinations but may also directly influence the types and quality of evidence manufacturers generate. We believe more clarity is needed here. For example, in the 2026 MFP rationales, CMS noted that it *prioritized* direct comparative evidence, such as head-to-head RCTs, and *reviewed* RWE and indirect comparisons. This approach appears to somewhat diverge from CMS' previous high-level guidance on 2026 negotiations, which stated a priority on methodological rigor broadly, rather than specific types of studies. While head-to-head RCTs can be especially informative for assessing comparative benefit under ideal conditions of use, such a rigid hierarchy may not necessarily reflect the most relevant good

evidence on the Medicare population. In many cases, RWE-based comparative studies may be more reflective of actual conditions of use in different groups of Medicare beneficiaries; FDA has supported such studies. In some cases, indirect comparisons or studies using external controls may also offer more reliable insights, particularly when head-to-head evidence is limited or of low quality.

As part of this qualitative guidance, CMS should also provide additional clarity on how it intends to treat postmarket studies that add value to a drug through, for example, demonstrating the additional impact of new formulations and delivery systems that increase patients' ease of use and thus have the potential to improve outcomes, and how much such product improvements could lead to upward MFP adjustments. This is especially important if CMS maintains an expansive definition of "Qualifying Single Source Drugs" (QSSDs), which effectively aggregates all drug versions based on the drug's active ingredient/moiety, including different New Drug Applications (NDAs) and Biologic License Applications (BLAs), for price negotiations, based on the date of the introduction of the first-approved product.

For IPAY 2028, CMS is specifically soliciting comments on how to treat fixed-combination drugs that combine multiple active ingredients for the purpose of determining whether a product qualifies as a QSSD. In particular, the agency raises concerns about combinations where one component lacks independent therapeutic activity against the disease and thus "does not result in a clinically meaningful difference," prompting questions about whether such products should be considered distinct QSSDs eligible to restart the negotiation timeline.

Given the complexity of determining whether an added ingredient creates a clinically meaningful difference, CMS appears to be using biological activity against the disease as a relatively objective proxy for assessing whether a new combination represents a meaningful change. As we commented in the past, to minimize any adverse effects on the development of important RWE that can add significant value to a selected drug—especially with the inclusion of physician-administered Part B drugs in the Negotiation Program—CMS could clarify what types of evidence it aims to encourage in this context, and whether and how such additional evidence related to product improvements could support a higher MFP for the negotiated product "group." This clarification should include cases where it does not treat a fixed combination in which one active ingredient is not therapeutically active against the disease state as a separate QSSD. CMS may determine that maintaining the broad QSSD definition to limit unnecessary fragmentation of closely related products is reasonable. At the same time, valuable product improvements—such as those enhancing adherence or clinical outcomes—should be meaningfully considered under the section 1194(e)(2) factors to avoid discouraging innovation that benefits patients.

We note that CMS appeared to take this consideration into account in the first round of negotiations, as reflected in its 2026 negotiation rationales. Specifically, CMS qualitatively highlighted patient input, including feedback related to ease of use and flexibility in administration—suggesting that innovations that materially improve ease of use for a given active ingredient may be factored into pricing determinations. While these explanations offered helpful insight into CMS' approach, it would be beneficial to provide more explicit guidance on how such patient-centered factors and related postmarket evidence will be evaluated in future rounds.

RWE can play an important role not only in understanding effectiveness and safety but also in another critical component of comparative effectiveness assessments for price negotiations: identifying and characterizing appropriate therapeutic comparators for a given indication. For example, RWE on utilization patterns can help determine which treatments are most commonly used in practice for a

particular condition and type of patient, offering insight into which comparators may be most clinically relevant for Medicare beneficiaries. The 2026 negotiation rationales suggest that CMS placed meaningful emphasis on selecting clinically relevant comparators, likely informed in part by RWD and other evidence on current practice patterns. For instance, warfarin was not included as a comparator for Eliquis and Xarelto for major indications—likely reflecting its declining use and the availability of stronger safety and effectiveness data for alternatives. This suggests an effort to reflect real-world utilization and relevance. To further support transparency and predictability, CMS should consider articulating clearer guidelines on how RWE, including RWD resources within HHS, might inform comparator selection in future price negotiations.

Section 1194(e)(2) Factors and Renegotiations

Finally, postmarket evidence development will also play a critical role in informing renegotiation—a component of the Negotiation Program launching in IPAY 2028. For the first time, the Guidance outlines detailed procedures for determining a drug's eligibility for renegotiation under Section 1194(f) of the IRA, the criteria CMS will use to select drugs for renegotiation, and the process by which those renegotiations will take place.

For reasons other than a change in monopoly status (that is, the addition of a new indication or a material change in the statutory factors), CMS will select renegotiation-eligible drugs by assessing whether renegotiation is likely to result in a significant change to the MFP. This criterion is defined as a change of at least 15% in the MFP, along with an evaluation of whether such a change would have a significant impact on the Medicare program. However, the framework still lacks clarity on how CMS will evaluate the types of evidence or factors that would meaningfully contribute to meeting that 15% threshold. This is particularly important for products that may be on the market for several years before renegotiation eligibility arises.

We recommend that CMS provide additional detail on how postmarket evidence—such as clinical benefit for a new Medicare population (whether demonstrated through a formal new indication or emerging evidence of benefit in a broader or different patient group) or a refined finding of effectiveness in the same population—will be valued in the renegotiation process and translated into an MFP impact, to help align the program with broader goals of RWE development and continued innovation. Without clear expectations, there is a risk that incentives to invest in ongoing evidence generation may be weakened.

Clarify and Monitor Part D Formulary Practices Post-Negotiation

CMS states that for 2028, it will maintain the formulary inclusion policies outlined in the revised guidance for IPAY 2026 and the final guidance for IPAY 2027. The agency explains that, since plan sponsors have not yet submitted formularies for the first year in which MFPs will be implemented (2026) at the time of drafting the Guidance, it lacks sufficient information to assess whether changes to these policies are necessary, but will continue to monitor trends to inform any future updates.

Now, CMS is in the process of receiving more information on 2026 formularies, which begin to inform whether policy changes are needed – with potential implications even for 2026. The IRA's Negotiation Program aims to reduce the net costs of negotiated drugs starting in 2026, in turn, reducing plan financial pressures. Most initially negotiated drugs are in commonly prescribed categories, where competition has already translated into substantial rebates and declining net prices. Indeed, the pre-negotiation net prices for many of the first-year drugs were already far below the maximum prices

based on the minimum statutory discount.[4] Negotiation will also significantly reduce "list" prices for these drugs,[5] potentially lowering beneficiary coinsurance – but out-of-pocket costs and access also depend on benefit design.

In particular, the Part D redesign may alter some of the existing incentives to favor rebates with higher list prices. The pre-IRA design allowed plans to use rebates to keep premiums low while shifting more out-of-pocket burden onto beneficiaries who required high-cost medications, and to Medicare in the form of higher reinsurance payments by reaching the catastrophic phase sooner, through high list prices coupled with substantial rebates.

Now that plans face higher risk in the catastrophic phase of the benefit, the incentive to favor highly rebated drugs persists in the initial coverage phase: the continuing 25% beneficiary contribution in this phase means plans receive a larger portion of rebate allocations than their corresponding liabilities. The importance of rebates will likely decrease for drugs reaching catastrophic coverage, and as more high-cost drugs are negotiated. Previously, manufacturer rebates reduced premiums by attributing the beneficiary catastrophic cost-sharing to the plan. With its elimination, plans and CMS will receive rebate allocations based on their corresponding financial liabilities.[6] As the portion that the plan will be keeping from the rebate will now directly correspond to its financial liabilities in the catastrophic phase, plan incentives to shift costs to the catastrophic phase diminish, and rebate value will align more with list price discounts in that part of the benefit, reducing rebates' impact on lowering premiums.

Consequently, the role of rebates in keeping premiums down will likely lessen under the Part D redesign, but they will remain an important tool in Medicare Part D drug pricing dynamics, and a complex one due to the interactions between negotiated prices and beneficiary and plan liability in different phases of the benefit. Competing, non-negotiated drugs might offer rebates for better formulary placement, while price negotiation will likely constrain list-to-net differences for negotiated drugs as MFPs already reflect reductions from recent net prices. Consequently, the coinsurance percent (and dollar amount) for the negotiated drug could increase if the negotiated drug was not already placed at the non-preferred formulary tier, limiting access to the negotiated drugs and potentially increasing overall costs.

CMS has acknowledged this problem and requires justification for non-preferred placements and utilization management for negotiated drugs, but there has been no further guidance as to how such monitoring and assessment will occur or what the consequences will be for an undesirable assessment. CMS can use emerging data on 2026 formulary designs to clarify expectations or guiding principles for the treatment of negotiated drugs—alongside clear mechanisms for ongoing monitoring and potential response—to support the intention of the Negotiation Program.

Evaluate Part B Negotiation Impacts on Pricing and Utilization

As the Negotiation Program progresses, its impact will evolve—particularly as CMS begins to select higher-priced drugs with smaller rebates. In the initial rounds, limited to Part D drugs, many of the selected drugs treat prevalent chronic conditions with large patient populations. These drugs are subject to considerable competition and thus already carry substantial rebates, which means their MFP ceilings were based on recent Part D net prices. As a result, the negotiated price reductions for this group in the first round were modest, offering limited additional savings beyond current discounts. However, a second category of drugs presents a different dynamic. These drugs often come with higher net prices and smaller rebates resulting from limited competition, and sometimes Part D protected class status. For this group, the ceiling price is based on the minimum statutory discount, which is lower than the

recent Part D net price. Consequently, CMS is likely to achieve more substantial net price reductions and greater Medicare savings from negotiating these products. As the pool of highly rebated drugs may shrink in future cycles, a growing share of selected drugs will likely fall into this second category—where the full potential of CMS' negotiation may be more impactful.

Starting in IPAY 2028, the launch of Part B drug negotiations will introduce related opportunities as well as additional complexities. Unlike Medicare Part D, where drug selection that is based on gross expenditures and rebate structures often play a central role in pricing, the MFP ceiling price will likely be well below recent net prices for more Part B negotiated drugs, especially as drug selection is based on Average Sales Price (ASP) using Part B claims data – that is, net, not gross prices – reducing the likelihood that drugs with large WAC-to-ASP gaps will be selected. This could potentially lead to more significant net pricing impacts than observed for many Part D drugs.

At the same time, we note that CMS' reliance on Part B claims data to guide drug selection suggests that the agency may not be incorporating Medicare Advantage (MA) payment data into its selection analysis. Given that over half of Medicare beneficiaries are enrolled in MA plans, excluding this data may not be representative of total utilization and spending for physician-administered drugs, thereby limiting the pool of Part B drugs selected for negotiation compared to Part D. CMS could potentially extrapolate from FFS Part B claims to approximate total Part B program spending, but this approach may not fully capture drug-specific use patterns within MA as MA beneficiaries may differ from FFS beneficiaries in terms of application of utilization management tools, health needs, care delivery models, and resulting drug utilization. CMS could use MA encounter data and/or non-CMS data sources on MA prescribing of Part B drugs to explore whether such extrapolations are appropriate.

In addition, the negotiated MFPs for Part B drugs are expected to affect the calculation of ASP, which is used to determine provider reimbursement not only in Medicare but also across much of the commercial market. As the MFP is expected to factor into ASP, MFPs may lead to lower ASPs over time. This will not directly affect Medicare reimbursement for negotiated drugs, since Medicare will pay providers based on the MFP. But absent the development of modified commercial payment mechanisms, the impact may be more pronounced in the commercial sector, in particular for community practices that rely on ASP-based reimbursement with lower markups. For commercial plans that base their payment contracts on Medicare prices, adjustments in these payment formulas would be expected. As these shifts unfold, CMS should consider monitoring and assessing the implications of MFP-ASP interactions, including any unintended consequences for access and provider incentives, particularly outside of Medicare.

Within Medicare—where plan sponsors may have incentives to shift utilization toward non-negotiated drugs due to rebate arrangements—a slightly different but similar dynamic may emerge under Part B, as we described above for Part D formularies. Specifically, for negotiated Part B drugs, reimbursement will transition from the traditional ASP+6% formula to MFP+6%. This shift could reduce provider reimbursement margins for negotiated drugs relative to non-negotiated alternatives that remain reimbursed based on ASP, potentially influencing prescribing behavior. That is, providers could receive larger net payments for prescribing a (more expensive) non-negotiated alternative. To ensure the success of the Negotiation Program, mitigate unintended shifts in utilization, and ensure the intended savings for Medicare and beneficiaries materialize, CMS should monitor these prescribing patterns and clearly describe a process for identifying and addressing adverse access or utilization consequences. Establishing a monitoring and response framework would help ensure that reimbursement changes

under negotiation do not inadvertently steer care away from clinically appropriate and less costly treatments.

Conclusion

The Duke-Margolis Institute appreciates this opportunity to provide feedback to CMS on the Guidance and CMS' consideration of our comments. Our recommendations on the use of high-quality evidence and the design of drug payments to improve outcomes in conjunction with the IRA's Negotiation Program can enable CMS to advance its mission of supporting the high-value, evidence-based, and affordable use of pharmaceuticals. Furthermore, we believe that a predictable and transparent process for conducting the negotiations and mechanisms for public input that continues to be refined over time will be important for a sustainable Negotiation Program and outcome. We would be pleased to provide more information on these issues if that would be helpful. If you have any questions, please contact Nitzan Arad (nitzan.arad@duke.edu) for more information. These comments are those of the authors at Duke-Margolis and are not reflective of the view of Duke University leadership, staff, or other affiliated individuals or organizations.

Sincerely,

Nitzan Arad – Area Lead, Duke-Margolis Institute
Mark McClellan – Director, Duke-Margolis Institute

DISCLOSURE
Mark B. McClellan, MD, PhD, is an independent director on the boards of Johnson & Johnson, Cigna, Alignment Healthcare, and PrognomIQ; co-chairs the Guiding Committee for the Health Care Payment Learning and Action Network; and receives fees for serving as an advisor for Arsenal Capital Partners, Blackstone Life Sciences, and MITRE.

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human health care

June 26, 2025

VIA ELECTRONIC SUBMISSION- *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 Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Administrator Oz,

Eisai Inc. ("Eisai" or "the Company") appreciates the opportunity to submit these comments on the draft Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028" ("Draft IPAY 2028 Guidance"). Eisai encourages the Centers for Medicare and Medicaid Services (CMS) to ensure that the continued implementation of the Medicare Drug Price Negotiation Program (MDPNP) minimizes negative implications for patients and does not unduly reduce access to important treatments for patients.

As a company, Eisai's mission is driven by our *"human health care (hhc)"* concept. This concept prioritizes patients and their caregivers, to increase the benefits that health care provides to them as well as to meet the diversity of their healthcare needs. As a dedicated neurology and oncology focused company, everything we do is guided by the principle that patients and their families come first, and we have a responsibility to listen and learn from them. The *hhc* concept is fundamental in our approach to offering innovative therapies and developing new therapies and it inspires our overall mission to ensure that we are empathetic and responsive to patients' needs.

Eisai is aligned with industry comments expressing concern about the implications of the implementation of MDPNP on both patient access to negotiated treatments as well as the potential implications on upfront investments in research and development and continued research to improve and expand indications for medicines. In general, we urge CMS to take an approach to implementation that causes the least disruption for patients and does not undercut continued investments in research and development. We believe this is particularly important as more drugs are included in the MDPNP each year, from both the Medicare Part B and Part D programs.

Below we offer comments on the Draft IPAY 2028 Guidance with a focus on areas of particular impact to patient access and continued research and development of therapies.

Qualifying Single Source Drugs Definition (Section 30.1)

Eisai believes that the approach that CMS has taken with regard to defining a qualifying single source drug (QSSD) and its dosage forms and strengths based on a common active moiety (drugs) or common active ingredient (biologics) is inconsistent with the statute as well as current Medicare and Medicaid definitions of

"single source drugs". Additionally, CMS' current definition of QSSD will unduly impact investment in continued research and development to offer patients improved therapies or therapies for new indications. We therefore strongly encourage CMS to revise their approach to QSSD and limit the definition for a QSSD and its dosage forms and strengths to a unique New Drug Application (NDAs) or Biologics License Application (BLAs), consistent with the statutory text.

Under section 1192(e)(1) of the statute, "qualifying single source drug" is defined in reference to a specific NDA or BLA. Specifically, the statute defines QSSD as products approved under an NDA referring to whether seven years has elapsed since "such approval", or for products licensed under a BLA referring to whether eleven years has elapsed since "such licensure."[1] While we recognize Section 1192(d)(3)(B) of the Act states that CMS shall use data that is aggregated across dosage forms and strengths of the drug, including new formulations of the drug, we believe this is constrained by the plain text of section 1192(e)(1) in the identification of QSSDs to doses, strengths and formulations associated with a single NDA or BLA.

Further, CMS' current definition of QSSD is also inconsistent with other statutory definitions of "single source drug" used by both the Medicare and Medicaid programs and commonly understood for these programs. For example, in the Medicare Part B program, Average Sales Price (ASP) reporting for a "single source" drug is defined with reference to an NDA.[2] CMS provided additional guidance in 2006 to further define "single source" for Part B drug payment as including all products sold under an original BLA or NDA and further memorialized this guidance in section 20.1.2 of Chapter 17 of the Medicare Claims Processing Manual.[3] Eisai believes that had Congress intended for the definition to be different from well-established and implemented definitions already in use, it would have clearly articulated that intention. We believe QSSD should be defined consistently across government programs and be based on a unique NDA/BLA evaluated by the FDA rather than an active moiety or ingredient that is potentially approved across multiple unique applications to the FDA, each going through a separate review.

CMS' current approach also undermines continued research and investment in improving therapies and expanding indications. By sweeping newer formulations of drugs developed under distinct NDAs or BLAs into the definition of a single product, CMS is discouraging the additional investments in research and development that go into updating therapies through material changes to formulation, delivery, or approved indication that have direct impact on patients. Continuing research efforts are critical to patients, improving not only their health outcomes but also their quality of life. Additional research means easier and more convenient administration options, better efficacy and fewer side effects, improved medication adherence, and making treatments available to entirely new patient populations, such as children, rare disease patients, or homebound seniors. Improving these treatments for patients and developing new uses for existing drugs requires years of research and significant investment, and CMS' current interpretation of QSSD will create a disincentive for continued investment to improve therapies for various patient populations.

Finally, we believe that CMS' overly broad approach to defining a QSSD, which will impact many more therapies than required by statute, will have additional negative implications for patients. We continue to be concerned that drugs selected for negotiation will be treated differently by Part D plans, MA plans and providers—including restricted use and or access issues. In particular, Medicare beneficiaries may experience higher out-of-pocket costs, fewer treatment options, and disruptions in coverage as insurers may place

[1] Social Security Act (SSA) § 1192(e)(1)(A) and § 1192(e)(1)(B).
[2] SSA § 1847A(c)(6)(D).
[3] See CMS, Healthcare Common Procedure Coding System (HCPCS) Coding Guidance from 2006 available at Coding Announcement (last accessed June 2025) and CMS, Medicare Claims Processing Manual, Chapter 17, Section 20.1.2 available at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/051807_coding_annoucement.pdf (last accessed June 2025).

selected drugs on less favorable formulary tiers or impose restrictive utilization management to steer patients towards non-selected drugs.

Revising CMS' current definition and approach to determining a QSSD for purposes of selection for negotiation could also be useful in addressing the request for comments on how to group fixed combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) for which the drug is indicated. Basing the definition of QSSD on a unique BLA or NDA, consistent with the single source drug definition used in other parts of the Program as noted above, will likely serve as a clear delineation between therapies that fall into this category.

Providing Access to the MFP in 2026, 2027, and 2028 (Section 40.4)

As CMS begins to contemplate how best to implement MFP for Part B drugs in future years, Eisai suggests that CMS consider leveraging the authority established under Section 1847B of the SSA to offer a specialty pharmacy acquisition and payment model option for negotiated Part B drugs. While this would require additional vetting, the current Competitive Acquisition Program (CAP) authority defined in statute allows CMS to define what drugs and biologics are offered under the CAP by the designated CAP vendor. CMS could use a program facilitator to serve as the designated vendor to purchase negotiated Part B drugs, be reimbursed directly by CMS at the MFP rate, and then ship drugs to providers for administration to patients (i.e., specialty pharmacy distribution or "white bagging"). This could address providers' concerns regarding underpayment and cash flow as providers would no longer incur financial risk for the drugs. A procurement and distribution model for negotiated drugs that follows this paradigm would also supersede the need to determine a standard rebate amount and eliminate the inherent challenges with determining an accurate default rebate amount. As a single Part B drug is purchased by providers across the healthcare system at a range of prices, a default rebate will ultimately undercompensate some provides and overcompensate others.

Exclude MFP from ASP Reporting

These varied net prices in the market are the basis for the established Average Sales Price (ASP) reporting and payment system. The calculated ASP is a volume-weighted average of voluntary prices, rebates, and discounts available to customers that explicitly excludes prices and rebates required by statute, largely mirroring prices and discounts explicitly excluded from Average Manufacturer Price and Best Price reporting. While not explicitly stated in statute, we believe sales of Part B drugs at the negotiated MFP are essentially a government required rate akin to net Medicaid prices, Federal Supply Schedule, and 340B ceiling price all of which are excluded from ASP, therefore sales at MFP should also be excluded from ASP reporting.

Manufacturer-Specific Data (Section 50.1 and Appendix A)

Eisai appreciates CMS' consideration of opportunities to streamline the data collected from manufacturers for the selected drugs as required under section 1194(e)(1). We are especially concerned with the overly burdensome collection of data on research and development (R&D) costs and R&D recoupment, since CMS' approach to the data collection does not align with manufacturer practices and may not fully reflect the actual expenses and efforts of manufacturers in bringing a drug to market and recouping those costs. Currently, CMS' data collection for R&D costs are spread out over multiple categories that do not actually comport with how manufacturers assess R&D investment and also do not offer a way to fully convey the manufacturer's actual process and efforts with regard to R&D. Finally, we are also unclear about how CMS uses the variety of data that is collected for the purposes of negotiations and urge CMS to be more transparent and also consider ways to limit data collection to only what is necessary.

While we are therefore supportive of CMS' efforts to streamline information collected on R&D costs and to

clarify the definition of R&D, we remain concerned that the proposed definition and requirements do not meaningfully reduce unnecessary data collection. Specifically, we continue to be concerned with the inclusion of costs for basic research, post-investigational new drug (IND) costs and failed/abandoned research costs without greater insight into how those are used. Additionally, this information is burdensome as manufacturers will have to rely on information collected many years ago and not necessarily in the manner CMS is requesting it be submitted to meet these data requirements, and it is not clear that this is the best information to support CMS' purposes for negotiations. We therefore request that CMS consider better ways to streamline and reduce the required submission of R&D costs.

Additionally, Eisai also believes that CMS should reduce collection of data for R&D recoupment of costs. Eisai strongly supports reducing this to a single "check-box" response attesting to whether R&D costs have been recouped or not by the manufacturer. We believe that R&D recoupment is not a major contributing factor to the price negotiations and it is not clear how CMS is using data for this in the negotiation process. In order to reduce burden on manufacturers, we request that CMS consider an attestation approach.

Finally, we do not support collection of additional, forward-looking "market data" such as forecasted net revenue and volume data. This type of information is too variable and would complicate manufacturer submissions. We urge that CMS consider opportunities to further streamline and limit data collection, especially given the short turn-around time between selection and data submissions.

Evidence About Therapeutic Alternatives for the Selected Drug (Section 50.2)

Eisai strongly supports greater clarity on how CMS weights the various factors for negotiation and urges CMS to apply greater value to the section 1194(e)(2) factors as they are more relevant to the clinical use and real-world benefit of therapies for patients, caregivers and society. We believe that negotiated prices should weight these aspects more than costs incurred by manufacturers.

Therapeutic Alternative Selection

Eisai encourages CMS to provide more transparency and detail on the selection of therapeutic alternatives for negotiations. We believe it is important to provide early and timely information with manufacturers of selected drugs about which therapeutic alternatives CMS is identifying and relying on for initial offers and continued negotiations. This is especially important given the compressed timeline for data submission and negotiations which make it difficult to ensure CMS is relying on the best information for identifying therapeutic alternatives. We urge CMS to fully inform their selection of therapeutic alternatives using the most clinically relevant information including conversations with, and data submissions from experts with real-world experience including patients, practicing physicians, and pharmaceutical manufacturer(s).

Further, we request that CMS publish the potential therapeutic alternative(s) under consideration for each selected drug when the selected drugs are announced to allow manufacturers to provide the most relevant information to CMS on the identified, proposed therapeutic alternatives—including their appropriateness. This would facilitate information exchange by allowing data submitters to tailor their submissions to CMS.

Establishment of a Single MFP for Negotiation and Renegotiation Purposes (Section 60.1)

CMS proposes to use a 30-day equivalent supply for the basis for negotiations for a single price for a selected drug; however the Agency is requesting comments on use of an alternative basis such as using per-unit to establish single price. Eisai appreciates CMS' consideration of this issue and we strongly encourage CMS to consider adopting flexibility in establishing the basis for the single MFP and working with the primary manufacturer to ascertain the best approach. While in some instances a 30-day equivalent supply may work, in other instances it could lead to significant undervaluing of a drug. However, we also believe that using a per-

unit price could also lead to inaccurate assessments of actual price of the drug in practice. We believe that CMS should consider accounting for the clinical realities and the real-world use of the product in establishing the basis for the single MFP. Specifically, CMS could consider options such as a per unit, per 30-day supply or per course of treatment as approaches to establish the single MFP basis.

Identifying Indications for the Selected Drug and Therapeutic Alternatives for Each Indication- Use of Health Care Service (Section 60.3.1)

Eisai does not think that CMS should consider non-drug health care services as therapeutic alternatives and believes this move would be premature. While Eisai understands that certain health care services could be clinically appropriate therapeutic alternatives, it is not clear how CMS would evaluate how services would be selected and compared to drug therapies. We also note that many health care services are acting as complementary therapies with medicines and that it may be challenging to distinguish therapeutic alternatives from complementary therapies and/or supplementary therapies. We are therefore concerned that adding health care services as therapeutic alternatives could also lead to inappropriate selection of therapeutic alternatives in some instances.

Developing a Starting Point for the Initial Offer (Section 60.3.2)

Eisai has concerns with CMS' approach to establishing an initial offer based on the prices of therapeutic alternatives, particularly for drugs with multiple therapeutic alternatives. First, we reiterate the need for greater transparency and earlier communication about the therapeutic alternatives that CMS is considering with regard to price negotiations for a selected drug. We believe that the negotiations must be based on the value of the selected drug compared to therapeutic alternatives in terms of real-world clinical use and advantages. We therefore encourage CMS to provider earlier information about the potential therapeutic alternatives CMS is considering and their weight in CMS' price assessments to ensure meaningful feedback and input from clinicians, patients and manufacturers on those alternative therapies and their value.

We do not agree with CMS' approach of using prices for therapeutic alternatives net of Coverage Gap Discounts or Manufacturer Discount Program (MDP) discounts. Both coverage gap discount payments and MDP payments were/are required under statutory Part D plan design and not reflective of a true market price for the drugs. We believe incorporating these discounts into the prices used for therapeutic alternatives does not represent the fair full value of the pricing inputs.

Additionally, Eisai is concerned with CMS' stated approach of using a starting point within a range associated with the prices for multiple therapeutic alternatives. We are concerned with then developing a potential starting point based on a weighting by utilization of the therapeutic alternatives. Without greater transparency and insight into CMS' selection, weighting and process, we are worried that this approach may significantly undervalue the clinical benefits and other advantages of the selected drug as compared to certain of the therapeutic alternatives. Since therapeutic alternatives are not made public in advance, this approach and the use of ranges for the starting point is both unpredictable and lacks transparency.

We appreciate CMS' consideration of alternative approaches to developing a starting point for selected drugs with one or more therapeutic alternatives. However, we do not support a starting point that utilizes unit costs of production and distribution, or other price points not informed by clinical value to patients.

Part D Formulary Inclusion of Selected Drugs (Section 110)

Eisai appreciates CMS' recognition of the potential negative effects of Part D plan formulary placement and utilization management decisions for selected drugs on patient access. We appreciate CMS' commitment to monitoring formulary placement and actions for selected drugs and for requiring justification from Part D

sponsors when a selected drug appears to be disadvantaged on a formulary compared to similar non-selected brand drugs. However, we urge CMS to consider new steps to specifically collect additional information from plans and to more actively monitor utilization management practices of Part D plans with regard to selected drugs. Finally, we especially encourage CMS to ensure selected drugs that are in a protected class are not disadvantaged compared to other non-selected drugs in the same protected class.

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Eisai appreciates the opportunity to provide comments on the Draft IPAY 2028 Guidance and the consideration of these comments. Eisai would be pleased to answer any questions regarding the recommendations raised in this letter or provide additional information if needed.

Sincerely,

Amanda Bartelme
Executive Director, Policy

SUBMITTED ELECTRONICALLY

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

June 26, 2025

The Honorable Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016.

Submitted electronically via regulations.gov

Re: Draft Guidance on the Medicare Drug Price Negotiation Program for the initial price applicability year (IPAY) 2028

Dear Administrator Dr. Oz:

Families USA is a nonprofit consumer advocacy organization that, for more than 40 years, has been working to ensure that everyone has access to high quality, affordable health care and can achieve their best health. Central to this goal is ensuring access to affordable prescription medication, particularly for older adults and people with disabilities who rely on Medicare. We thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Draft Guidance for the Medicare Drug Price Negotiation Program for the initial price applicability year (IPAY) 2028 (from here on referred to as the draft guidance).

President Trump, bipartisan lawmakers, and health care consumer advocates have long identified the need to lower the cost of prescription drugs for the American people, and robust implementation of the Medicare Drug Price Negotiation Program provides an excellent opportunity to make real progress on that goal for patients and families. Families USA supports CMS in its work to vigorously negotiate the prices of selected medications to be as low as possible, continuing to improve the affordability of lifesaving and life-sustaining drugs for older adults and people with disabilities. Our comments seek to uphold and strengthen the success of this effort, both by pointing to potential threats that could weaken CMS authority through exemptions and limitations, and by encouraging use of the best data sets, transparent processes, and an evidence-based cost-effectiveness approach to pricing. We also appreciate and encourage CMS' proposed opportunities for ongoing consumer engagement and input on this critical program.

As you know, the U.S. is experiencing a prescription drug affordability crisis. From January 2022 to January 2023, prices increased on average 15% for roughly 4,200 drugs, and some drug prices increasing over 3000%.[1] These price increases *far* outpace the rate of inflation.[2] Almost 30% of Americans report having difficulty affording their medications,[3] which often leads to skipping doses, rationing, or not filling a needed prescription at all—all of which can be detrimental to health outcomes, and even life-threatening in many cases. For example, medication non-adherence (not taking your prescription as prescribed) results in 125,000

deaths a year.[4] Families USA and our partners around the country have documented and collected many individual patient stories detailing struggles with the cost of needed medications, which we would be happy to share with CMS to illustrate the importance of its commitment to lower drug costs.

The high cost of prescription drugs is not only unaffordable for people across the country but is also a major source of increasing health care spending for the federal government. National prescription drug spending reached $449.7 billion in 2023 alone, increasing 11.4% from the year before and growing faster than total national health expenditures.[5]

The Inflation Reduction Act (IRA) established the Medicare Prescription Drug Negotiation Program (from here on referred to as the Negotiation Program), finally giving Medicare the authority to negotiate fair prices for prescriptions drugs and ultimately lower the cost of drugs for our nation's seniors and the federal government.[6] The Congressional Budget Office (CBO) estimates that when taken together, the drug pricing provisions from the IRA will save the federal government $237 billion over a decade.[7] Further, CMS found that the Negotiation Program would have generated $6 billion of savings in 2023 alone, had the negotiated prices for the first ten drugs been in effect at that time. [8] The first round of price negotiations is complete and the second is well underway. This administration now has the opportunity and responsibility to continue strong implementation of the Negotiation Program by setting the course for future rounds of robust negotiations that will continue to result in historic savings for seniors, people with disabilities, and the Medicare program.

Families USA provides comments on several sections of the draft guidance which we believe will ensure the third round of negotiations are successful in reducing high and unreasonable drug prices in the Medicare program:

- **Sections 30.1 and 30.1.1:** *Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028* and *Orphan Drug Exclusion from Qualifying Single Source Drugs*
- **Sections 30.3 and 30.4:** *Selection of Drugs for Negotiation for Initial Price Applicability Year 2028* and *Publication of Selected Drug List*
- **Section 60.3:** *Methodology for Developing an Initial Offer*
- **Section 60.4.1:** *Engagement with Primary Manufacturers and Interested Parties Prior to Initial Offers*
- **Section 130:** *Renegotiation of Maximum Fair Price for Initial Applicability Year 2028*

Section 30.1: *Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028* and ***Section 30.1.1:*** *Orphan Drug Exclusion from Qualifying Single Source Drugs*

The Negotiation Program is designed to ensure fair, competitive, affordable drug prices are accessible to seniors and people with disabilities across the country through the Medicare program. To achieve this, CMS must negotiate prices for a full array of high-cost drugs that do

not already face robust competition in the drug market. The IRA included a limited but meaningful set of criteria for drugs to be exempt from negotiation in order to strike an appropriate balance between ensuring lower costs for patients and supporting investments in innovation and prescription drug development by pharmaceutical companies. **Families USA is therefore concerned by growing efforts to broaden these exemptions which would undermine this historic program by further limiting the number of drugs eligible for negotiation; we appreciate that this guidance continues to follow and reiterate the existing statute.**

As is accurately detailed in the draft guidance, the IRA states that in order to qualify as a single source drug for the Negotiation Program (in addition to other qualifications), a small molecule drug must be on the market for seven years and a biologic must be on the market for eleven years.[9] In doing so, the IRA ensures that drug companies are given an ample window of time to cover the costs of research and development before their drugs are eligible for negotiation. Any efforts to extend those exclusivity windows would significantly limit the number of drugs that CMS is able to negotiate. For example, if the eligibility requirement was lengthened for small molecule drugs from seven to eleven years, more than half of the drugs CMS negotiated in the first round would not have been eligible for negotiation, continuing to expose our nation's seniors to unaffordable prices.[10]

Furthermore, the IRA currently allows drugs with a designation for *only one* rare disease or condition to be exempt from negotiation.[11] These "orphan drugs"—drugs that treat small populations of people with rare diseases or conditions—provide lifelines for people with very limited treatment options.[12] Drug companies receive a variety of supports from the federal government, allowing them to successfully invest in orphan drug development. Those supports include market and patent exclusivity, expedited access to certain markets, and 25% tax credits on qualified clinical trials,[13] and they help to lower the costs for drug manufacturers to do the research and development needed to get orphan drugs on the market. Drug manufacturers then leverage and exploit these supports from the government by unscrupulously increasing drug prices year after year. Orphan drugs are no exception: Research shows orphan drugs are on average between five and 25 times more expensive than non-orphan drugs, putting an excessive cost burden on consumers, and in some cases making these drugs inaccessible. [14] Orphan drugs are quickly becoming a larger share of the drug market. In 2023, 43% of new drugs received orphan drug indications.[15] And from 1990 to 2022, 491 novel orphan drugs received approval, 15% of which have been approved for multiple rare conditions and 20% of which have approval for *both* rare and common conditions.[16] Exempting additional orphan drugs that have designations for multiple uses would further chip away at the list of drugs eligible for negotiation and it would also leave seniors and people with disabilities on the hook for high and unreasonable prices for their lifesaving and sustaining medications.

Families USA opposes any administrative or legislative effort to undermine current negotiation eligibility guardrails, which ensure that CMS is able to negotiate competitive and fair prices for as many drugs as possible. Further extending the length of time drugs must be on the market before becoming eligible or excluding additional high-cost drugs like orphan drugs with multiple orphan designations, as is being proposed by some lawmakers, only serves to threaten CMS's ability to fulfill the goal of the Negotiation Program of achieving the lowest fair price for currently high-priced drugs.

Section 30.3: *Selection of Drugs for Negotiation for Initial Price Applicability Year (IPAY) 2028* and ***Section 30.4:*** *Publication of Selected Drug List*

IPAY 2028 is a landmark year for the implementation of the Negotiation Program since, for the first time, both drugs payable under Medicare Part B *and* drugs covered under Medicare Part D will become eligible for negotiation and a Maximum Fair Price (MFP). This is a critical next step in the implementation of the Negotiation Program, as it will ensure seniors and people with disabilities can afford their drugs at the pharmacy counter *as well as* those delivered by physicians in a doctor's office. **While Families USA congratulates CMS on reaching this moment in implementation, we believe the draft guidance's language around how to determine which drugs are high-expenditure drugs under Part B is vague and needs further clarification.**

Under Part D, CMS uses Prescription Drug Event (PDE) data, which includes prescription drug expenditures under Part D for beneficiaries using Traditional Medicare and Medicare Advantage (MA) plans to determine high-expenditure drugs under that program.[17] Families USA is supportive of this approach. However, the draft guidance proposes that CMS will use Part B claims data to determine the highest-expenditure drugs paid under that arm of the Medicare program [18] Part B claims data does not include claims for physician-administered drugs through the Medicare Advantage program.[19] This means that the database used to determine the drugs administered at a physician's office that Medicare spends the most on—and should be subject to negotiation[20]—does not include data on the drug spend from the part of Medicare in which more than half of Medicare beneficiaries receive their care. This raises particular concerns given that spending in Medicare Advantage is directly tied to the solvency of the Medicare trust fund.[21] We worry that the Part B claims data will not adequately capture the drug expenditures for Medicare Part B payable drugs within the MA program. Measuring the highest-expenditure drugs payable under Part B without including the costs of those drugs under the MA program would be an incomplete measure of their financial burden on the federal government, seniors, and people with disabilities across the country. As a result, **Families USA recommends that CMS identify one or more data sources that include both Traditional Medicare and MA expenditures for drugs payable under Part B to use when compiling their list of the highest-expenditure drugs that determine which drugs are eligible for negotiation.**

The draft guidance also proposes to publish a list of the top 50 high-expenditure drugs that were considered for negotiation, along with the final fifteen that will be negotiated.[22] **Families USA supports CMS's proposal. Publishing this list will improve transparency into the decision-making process and provide policymakers, researchers, advocates, and consumers more information on potential drugs for future years.**

Section 60.3: *Methodology for Developing an Initial Offer*

The IRA requires that CMS develop and apply a consistent methodology and process for negotiation with drug manufacturers to arrive at an MFP. A vital step in the negotiation process is how CMS arrives at the initial price that it offers to drug manufacturers. The law lists nine factors that CMS is required to consider when calculating an initial and final MFP offer.[23] However, the IRA does not provide direction for how CMS should prioritize, weight, or define each of these factors.[24] What is made clear by the law, and reiterated in this draft guidance, is that the negotiation program's aim is to achieve "the lowest maximum fair price for each selected drug."[25]

The draft guidance outlines a plan to reach the initial MFP offer for IPAY 2028.

First, CMS will identify therapeutic alternatives for the selected drug subject to negotiation. Then, as laid out in the draft guidance, to determine the starting point for the initial MFP offer, CMS will use the lower of either:[26]

- For drugs covered under Part D:
    - Net Part D Plan Payment and Beneficiary Liability of the therapeutic alternatives, which reflects the total gross covered drug cost, net of direct and indirect renumeration, and coverage gap discount program payments, or
    - MFP for IPAY 2026 or 2027 selected drugs (if applicable as therapeutic alternatives).
- For drugs payable under Part B:
    - Average Sales Price (ASP) of therapeutic alternatives,[27] or
    - Wholesale Acquisition Cost (WAC)[28] of therapeutic alternatives.

In other words, CMS will use whichever is lower of the Part D Net price or the previously negotiated MFP, and whichever is lower of Part B WAC or ASP, for therapeutic alternatives in creating a starting point for the initial price offer on drugs being negotiated.

Second, CMS will adjust the initial price offer based on statutorily defined factors, including but not limited to: therapeutic advance represented by the drug and costs of existing therapeutic alternatives; prescribing info for the drug and therapeutic alternatives; comparative effectiveness of the drug and therapeutic alternatives; and unmet medical needs that the drug and therapeutic alternatives address. These adjustments will help CMS to arrive at a preliminary price.

Third, CMS will adjust the preliminary price based on a number of statutorily defined manufacturer-specific data.

We strongly support CMS adjusting the MFP offer based on comparative effectiveness research, such as patient-reported outcomes and patient experience data as well as the manufacturer-specific data. However, as noted in our comments submitted in April 2023 and July 2024[29] pertaining to the first two rounds of drug negotiation, **we continue to be deeply concerned with CMS's approach that anchors the initial price point to a price of therapeutic alternatives even though drug prices are often not based on clinical benefit**.[30]

In the proposed guidance, CMS acknowledges this point, stating that "the therapeutic alternative(s) for a selected drug may not be priced to reflect its clinical benefit."[31] Prescription drug prices in America are vastly skewed by drug companies manipulating the U.S. drug market to keep competition off the market and raise prices year after year on drugs that have already been released.[32] This behavior is a better measure of the drug company's ability to game the drug system, rather than the drug's continued benefit to consumers. In addition, substantial evidence demonstrates that drug prices in the U.S. are significantly higher than the prices paid in comparable countries: For example, the Government Accountability Office (GAO) reported that Part D net prices were at least two to four times higher than publicly available prices in comparable countries (2020) and the HHS Assistant Secretary for Planning and Evaluation (ASPE) reported that Part B spends 2.05 times as much on prescription drugs than it would spend using the prices from comparable countries (2020).[33] We are deeply concerned that Part D net prices and the Part B ASP or WAC do not reflect the true value of these medications and relying on them as fundamental starting points for drug negotiation will undermine the Negotiation Program and its ability to achieve meaningful cost savings for the federal government, seniors, and people with disabilities.

Based on these concerns, **Families USA strongly encourages CMS to avoid using the price of therapeutic alternatives as a starting point for developing an MFP initial offer. Instead, we encourage CMS to employ a cost-effectiveness approach to develop a preliminary price range, which could then be adjusted to arrive at an MFP. Specifically, we recommend CMS establish non-biased, cost-effectiveness targets or thresholds which can then be adjusted based on comparative effectiveness research, the prices of therapeutic alternatives, and other manufacturer-specific data.**

To calculate these targets, CMS should determine an upper and lower bound price per unit of health gained (as well as cost per condition-specific measure of clinical benefit) that it deems appropriate.[34] This should also reflect the opportunity cost of the treatment in relation to the treatment's added net benefits for Medicare patients over time.[35] We believe the cost effectiveness approach outlined above more closely ensures that the MFP calculated by CMS truly reflects the therapeutic value of the drug subject to negotiation and, importantly, avoids

relying on prices that are all too often the result of widespread market failures and pharmaceutical industry gaming.

Section 60.4.1: *Engagement with Primary Manufacturers and Interested Parties Prior to Initial Offers*

The draft guidance includes a continued commitment from CMS to "host public engagement events to seek input from patients and other interested parties...to better understand patients' experiences with the conditions and diseases."[36] The public engagement events include "15 patient-focused roundtable events, which will be open to patients, patient advocacy organizations, and caregivers."[37] **Families USA strongly supports CMS in their commitment to continue the patient-focused roundtables that they have held in both the IPAY 2026 and 2027 negotiations as a way to incorporate consumer experiences and better understand the real-world implications of the prices set by drug companies. We also encourage CMS to hold additional roundtable events for the drugs selected for renegotiation, so they can consider any and all updated information about whether the existing MFP accurately and fairly represents the value to patients or if the drug remained unaffordable and inaccessible.**

We note that this draft guidance does not include information about conflict-of-interest disclosure for the patient-focused roundtables or other public engagement opportunities.[38] The listening sessions for the IPAY 2026 negotiation process included many participants who worked at or were otherwise affiliated with organizations that receive funding from drug manufacturers, and many of these speakers failed to disclose their conflict of interest since the disclosure was voluntary.[39] In the final IPAY 2027 guidance, CMS decided to "revise the conflict-of-interest disclosure request and require potential speakers in the patient-focused roundtable events and the town hall meeting to include information about the existence and nature of conflicts of interest."[40]

In order for CMS to accurately assess the needs and interests of consumers, and for that information to inform the negotiation process in a meaningful way, any and all potential conflicts of interest held by those speaking at patient-focused events should be clearly disclosed. Without this safeguard, drug manufacturers are incentivized to leverage their patient networks to obscure the true experience of consumers. In many cases, drug manufacturers may actually co-opt consumers' and patients' voices to advocate for the ability to continue abusing the drug supply chain and increasing prices, including through nefarious practices such as false threats of patients losing access to certain medications.[41]

CMS should reiterate the requirement that conflict-of-interest disclosure be mandatory for all patient-focused roundtable events for this IPAY 2028 negotiation cycle and beyond so they may discern which participants have specific ties to drug manufacturers and better understand the influences behind the experiences and interests presented in those sessions.

Section 130: *Renegotiation of Maximum Fair Price for Initial Applicability Year 2028*

IPAY 2028 is a crucial negotiation year because it provides the first opportunity for CMS to renegotiate previously negotiated MFPs. The renegotiation process is an opportunity to address changes in a drug's monopoly status, indications, or manufacturer information that would result in a meaningful change to the MFP. CMS should robustly employ this process only when it serves to ***continue lowering*** the price of the negotiated drugs and achieve the lowest MFP possible, as is the goal of the Negotiation Program.[42]

The draft guidance outlines the process with which CMS will identify renegotiation-eligible drugs as well as choose drugs for renegotiation from the eligible list.

First, the IRA[43] defines a renegotiation-eligible drug as a drug previously selected for negotiation which: 1) has a new indication, 2) experienced a change in drug monopoly status from not a long or extended monopoly drug to an extended monopoly drug, 3) was not a long monopoly drug and now is a long monopoly drug, or 4) the Secretary has determined there was a material change to factors including manufacturer-specific information or information on alternative treatments. An extended monopoly drug is defined as a drug for which twelve but not more than sixteen years have elapsed since approval, excluding vaccines and any drug with a price agreement for IPAY before 2030.[44] A long monopoly drug is defined as a drug for which more than sixteen years has passed since approval, not including vaccines.[45]

Second, once CMS has determined the renegotiation-eligible drugs, it will select drugs to renegotiate. Statute requires CMS to select for renegotiation all drugs that are eligible due to a change in their monopoly status.[46] Statue also requires that, of all the other eligible drugs, CMS will select all drugs where renegotiation is "likely to result in a significant change in the maximum fair price otherwise negotiated."[47] The draft guidance puts forward two criteria to determine if the renegotiation is likely to result in a significant change: 1) if the new indication or material change would likely result in a new MFP with a 15% or more change to the current MFP, or 2) if the new MFP would have a significant impact on the Medicare Program. Once CMS has determined which drugs it will renegotiate, it will publish the renegotiation list on the same schedule as the IPAY 2028 negotiation list.

Third, CMS will follow the same negotiation process it outlines in their draft comment for the renegotiation process.

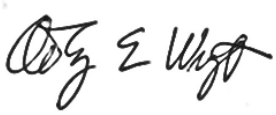
Families USA congratulates CMS on reaching this momentous step in the drug negotiation program. Since the renegotiation process ensures that the MFP remains the *lowest* fair price, CMS should *only* be renegotiating an MFP if there is substantial evidence that if they do not act, the price will no longer be fair and competitive. **We encourage CMS to take this opportunity to robustly renegotiate the prices to be as low as possible, continuing to improve the affordability of these lifesaving and life-sustaining drugs for older adults and people with disabilities.**

Conclusion

Families USA greatly appreciates CMS taking this important step in continuing implementation of the Medicare Drug Negotiation Program by releasing this draft guidance for IPAY 2028. This historic health care reform promises to drastically reduce the excessive cost of prescription drugs and ensure that older adults and people with disabilities who rely on Medicare for health coverage have access to affordable, life-saving medications. Families USA thanks CMS for the work it has done since the IRA's passage to start lowering drug costs for people across the county and we look forward to continuing to work in partnership with CMS on the implementation of this program, as well as other efforts to lower the high costs of prescription drugs.

Thank you for taking time to review this comment. Please contact Hazel Law, hlaw@familiesusa.org, with any questions.

Sincerely,



Anthony Wright
Executive Director

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[7] "Price Negotiation: CBO estimated that price negotiation will lower average drug prices paid by Medicare and will reduce the budget deficit by $25 billion in 2031: Part D spending will be $14 billion lower than it would have been, Part B drug spending will be $9 billion lower, and other federal spending will be $1 billion lower on net." Congressional Budget Office. (February 2023). How CBO Estimated the Budgetary Impact of Key Prescription Drug Provisions in the 2022 Reconciliation Act. cbo.gov. https://www.cbo.gov/system/files/2023-02/58850-IRA-Drug-Provs.pdf.

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[18] Center for Medicare. (May 2025). Draft Guidance on the Medicare Drug Price Negotiation Program, Page 8. Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

[19] 42 U.S.C. 1395w–4. https://www.ssa.gov/OP_Home/ssact/title18/1848.htm#ft283.

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[25] 42 U.S. Code § 1320f-3 (b)(1). https://www.law.cornell.edu/uscode/text/42/1320f-3.; See also, Center for Medicare. (May 2025). Draft Guidance on the Medicare Drug Price Negotiation Program, Page 108. Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

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[43] H.R.5376 - Inflation Reduction Act of 2022. https://www.congress.gov/bill/117th-congress/house-bill/5376/text.

[44] 1194 (c)(4)(A), https://www.congress.gov/bill/117th-congress/house-bill/5376/text.

[45] 1194 (c)(5)(A), https://www.congress.gov/bill/117th-congress/house-bill/5376/text.

[46] H.R.5376 - Inflation Reduction Act of 2022. https://www.congress.gov/bill/117th-congress/house-bill/5376/text.

[47] SSA Section 1194(f)(3)(C); See also, [47] Center for Medicare. (May 2025). Draft Guidance on the Medicare Drug Price Negotiation Program, Page 194. Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

Flatiron Health, Inc.
233 Spring St, 5th Floor
New York, NY 10013

June 26, 2025

Center for Medicare & Medicaid Services (CMS)
Center for Medicare Department
7500 Security Boulevard Baltimore, Maryland 21244-1859

Re: Flatiron Health response to Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Mr. Klomp,

Flatiron Health ("Flatiron") is pleased to offer 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 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 ("Draft Guidance"). Flatiron provides healthcare technology products and other related services that form the cornerstone of a platform to advance and accelerate cancer research in the United States, the United Kingdom, Germany and Japan. Flatiron's vision is to realize the full potential of real-world data (RWD) and real-world evidence (RWE) for the development of new and innovative oncology treatments, and to build a world where technology and science close the gap between care and research.

Flatiron commends and appreciates the opportunity to comment on the Draft Guidance as CMS continues to refine its framework for the Medicare Drug Price Negotiation Program (MDPN). As a leader in oncology-related RWD and RWE generation, Flatiron supports CMS in its efforts to foster innovation and incorporate timely, methodologically rigorous evidence into the MPDN framework. Below, we provide a set of general comments for consideration.

General Comments:

Flatiron appreciates CMS' receptiveness and enhancements to transparency and stakeholder feedback on this Draft Guidance. As such, we are pleased to offer several suggestions where we believe the Draft Guidance can further support the use of high quality evidence generation approaches in evaluating therapeutic alternatives, while advancing technological innovation and efficiency at scale, transparency, inclusion, and collaboration across the healthcare ecosystem.

1. Promoting the use of high-quality RWD and RWE in Evidence Generation for the MDPN Program

Flatiron strongly supports CMS' commitment to leveraging RWE in the evaluation of therapeutic alternatives under Section 1194(e)(2) of the Inflation Reduction Act. When curated through rigorous, transparent methods, RWD/RWE can provide valuable insights into how medicines perform in real-world settings, especially in populations underrepresented in traditional clinical trials. By embracing the submission of high-quality RWE in the MDPN program, CMS can more effectively evaluate the clinical and economic value of selected drugs in real-world settings where Medicare beneficiaries receive care.

To promote the broader use of high-quality RWD in the MDPN program, **Flatiron recommends that CMS clearly affirms that high-quality, methodologically sound RWD/RWE is acceptable to support use cases cited as evidence for alternative treatments in Section 50.2 of the Draft Guidance.** Specifically:

- *Assessing therapeutic advance and relative cost*: RWD/RWE can be used to assess comparative effectiveness in a number of ways, including assessing treatment sequencing, time to progression, treatment-related toxicity, and total cost of care in real-world settings. These metrics complement clinical trial endpoints and provide a fuller picture of comparative therapeutic value. We also note that RWD can also serve as a control arm in a clinical trial supporting comparative effectiveness research. This is especially important when assessing rare or complex conditions where recruitment into a placebo control arm is not feasible or ethical.
- *Supplementing FDA-approved prescribing information*: RWE can help contextualize the use of a selected drug and its alternatives outside of labeled indications (e.g., off-label use, sequencing patterns), helping CMS understand how prescribing patterns evolve over time in response to new evidence.
- *Comparative effectiveness in specific populations*: Historically, less than five percent of cancer patients participate in clinical trials[1]. Flatiron's oncology RWD datasets include populations often excluded from pivotal trials, including the elderly, disabled, and terminally ill patients. Our large RWD datasets can enable efficacy evaluations in such subpopulations not reflected in clinical trials, including comparative studies of real-world outcomes, toxicity, and quality of life metrics across these groups.
- *Addressing unmet medical needs*: RWE can reveal areas where available therapies are not effective in the real world (e.g., early discontinuation, lack of durable benefit), thereby identifying therapeutic gaps and informing unmet need assessments.

[1] Unger, et al. National Estimates of the Participation of Patients With Cancer in Clinical Research Studies Based on Commission on Cancer Accreditation Data. Journal of Clinical Oncology. 42(18); https://doi.org/10.1200/JCO.23.01030

2. Strengthening Transparency on Data Quality and Evidence Generation Rigor in the MDPN Program

Flatiron applauds and supports CMS' intent to prioritize methodologically rigorous research, including both randomized and observational studies for consideration in the MDPN program. Through this prioritization, we believe CMS has a unique opportunity to confirm a harmonized vision across HHS on the importance of data quality and methodological standards for the generation of RWD/RWE. **Flatiron encourages CMS to highlight the importance of methodology, validation and transparency practices for RWD used in RWE generation in the Draft Guidance to support credibility, reliability, and acceptability of the evidence used in the MPDN program.** To achieve this, we recommend that CMS consider inclusion of specific quality frameworks in the Draft Guidance that are appropriate for both structured and unstructured data, such as the ISPOR SUITABILITY Checklist[2] that outlines approaches for data delineation and determining fitness-for purpose, Flatiron's machine learning extraction evaluation framework[3] and large language model extraction evaluation framework (VALID framework)[4] for unstructured EHR data, the ISPOR PALISADE Checklist for health economics and outcomes research[5], and the ISPOR HARPER framework that outlines reproducibility practices used for generating RWE[6].

We also recommend CMS provides explicit clarity in Section 50.2 of the Draft Guidance on its expectations for evidence generated from RWD, including:

- *Evaluating RWD sources*: Flatiron recommends CMS clarify specific criteria that CMS will use to evaluate RWD sources, including any frameworks CMS intends to use to evaluate RWD sources, including the appropriateness of disease-specific and disease-agnostic RWD sources in specific use cases.
- *Defining "rigor":* Flatiron notes there are many dimensions to rigor as it relates to RWD sources and study designs. We recommend that CMS explicitly clarify how rigor should be defined for evidence generation approaches under the MPDN program, including details related to specific study designs, modes of data collection (e.g., for specific endpoints), and whether outcome adjudication be required for all endpoints in all studies.
- *Comparative effectiveness and relevance of the selected drug and its therapeutic alternative(s)*: Flatiron recommends that CMS clarify how it intends to consider evidence for selection of therapeutic alternatives. For example, does CMS intend to weight

[2] Fleurence RL, Kent S, Adamson B, et al. Assessing real-world data from electronic health records for health technology assessment: the SUITABILITY checklist: a good practices report of an ISPOR Task Force. *Value Health*. 2024;27(6).
[3] Ibid at 1.
[4] Estevez, et al. Ensuring Reliability of Curated EHR-Derived Data: The Validation of Accuracy for LLM/ML-Extracted Information and Data (VALID) Framework. https://arxiv.org/pdf/2506.08231
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[6] Wang SV, Pottegård A, Crown WH, et al. HARmonized Protocol Template to Enhance Reproducibility of Hypothesis Evaluating Real-World Evidence Studies on Treatment Effects: A Good Practices Report of a Joint ISPE/ISPOR Task Force. *Value Health.* 2022; 25(10):1663–1672.

selection of an alternative drug based on an evidence-driven argument higher than arguments based on expert feedback and current therapeutic guidelines? An integrated data-driven and expert-informed approach would be incredibly valuable here.

- *Priority populations for the MPDN program*: Flatiron takes note that CMS intends to prioritize "research and real-world evidence relating to Medicare populations, including individuals with disabilities, patients with end-stage renal disease (ESRD), and Medicare-aged populations" in the MPDN. We recommend that CMS clarifies specific study designs that would be acceptable for consideration, including whether CMS would favor head-to-head comparisons of subgroups with unmet need, or studies where outcomes are stratified by subgroup but without direct comparison. Additionally, we note that our research[7] has demonstrated that RWD from the US has the potential to be used in health technology evaluations that support pricing and reimbursement decisions in the UK, where UK data are unavailable or sparse. Should CMS seek additional data outside of the US for use in the MPDN program, Flatiron would be pleased to share our perspective on transportability of data from other countries.

3. The Role of Artificial Intelligence in RWD Curation and Evidence Generation

As part of our core mission to improve and extend lives by learning from the experience of every person with cancer, Flatiron has developed and validated artificial intelligence (AI), machine learning (ML), and large language model (LLM)-based technologies that enable scalable, accurate extraction of structured variables from unstructured text found in patients' electronic medical records (EHR), including physician notes, pathology reports, and radiology narratives. These tools support the generation of fit-for-purpose datasets that reflect cancer patients' experience in the real world, with increased speed, reproducibility, and cost-effectiveness. Importantly, our research[8,9,10,11] has demonstrated that these methods can match or exceed human abstraction in precision and consistency for selected variables in oncology. Further, we have advanced a ML-extraction performance framework[12] that articulates minimum evaluation standards necessary to understand the quality of ML-extracted RWD for target populations and to expose hidden biases of an information extraction tool for researchers that can ultimately be used to define a minimum quality threshold when using ML-extracted RWD for different use cases.

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[7] Kent, et al. Evaluating transportability of overall survival estimates from US to UK populations receiving first-line treatment for advanced non-small cell lung cancer: a retrospective cohort study. BMJ Open. 2024 Dec 7;14(12):e085722.
[8] Ibid at 1 and 4.
[9] Benedum C, et al. Replication of Real-World Evidence in Oncology Using Electronic Health Record Data Extracted by Machine Learning. Cancers. 2023;15(6). doi:10.3390/cancers15061853
[10] Adamson, et al. Approach to machine learning for extraction of real-world data variables from electronic health records. Front Pharmacol. 2023 Sep 15:14:1180962.
[11] Cohen, et al. Large Language Model Extraction of PD-L1 Biomarker Testing Details From Electronic Health Records. AI in Precision Oncology. 2025; 2(2). https://doi.org/10.1089/aipo.2024.00
[12] Estevez, et al. Considerations for the Use of Machine Learning Extracted Real World Data to Support Evidence Generation: A Research Centric Evaluation Framework. *Cancers* 2022, *14*(13), 3063; https://doi.org/10.3390/cancers14133063

We encourage CMS to explicitly acknowledge the acceptability of AI/ML- and LLM-derived RWD submitted as part of the manufacturer evidence package under Section 1194(e)(2) of Inflation Reduction Act. This would help align CMS' approach with the broader U.S. federal AI strategy and FDA's own recent guidance promoting the responsible use of AI/ML in regulatory decisionmaking. In particular, CMS should consider:

- Recognizing AI/ML-curated datasets as eligible sources of real-world evidence when supported by robust validation;
- Clarifying evaluation criteria for AI-derived data, including transparency, traceability, bias assessment, and model performance; and
- Encouraging publication of acceptable quality frameworks, including tools like Flatiron's internal validation protocols and peer-reviewed methodology papers.

4. Fostering Innovation and Transparency through Multi-stakeholder Collaboration

We strongly commend and support CMS efforts to consult subject matter experts and academic literature in its evidence review process for the MPDN program. We encourage CMS to go a step further by establishing new, formal dialogue channels that include multiple stakeholders, including leading data organizations, life science companies, and academic researchers. Regarding the use of RWE in the MDPN program, **Flatiron recommends CMS consult subject matter experts on a variety of topics, including RWD quality and methods for mitigating bias in RWD.**

Mechanisms that could bring such diverse stakeholders and perspectives together include forming **a standing technical advisory panel** on real-world data and AI quality standards; hosting **public workshops or listening sessions** jointly hosted by CMS and other HHS agencies including the FDA and NIH, and other stakeholders to develop cross-agency alignment on the use of RWE in drug research, evaluation, and decision-making; and **pilot programs** to evaluate innovative approaches to using evidence in regulatory and reimbursement decision-making in the Medicare population.

Conclusion

Flatiron Health remains committed to supporting the CMS' goal to ensure that drug pricing in the United States reflects real-world value grounded in rigorous and inclusive evidence. We believe that high-quality RWD and innovative RWEgeneration approaches represent a unique opportunity to accelerate achieving this goal. RWE represents a critical lever for improving scalability and inclusion in therapeutic value assessment. We welcome continued collaboration and are happy to provide additional data or insight at your request.

Sincerely,
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July 26, 2025

Chris Klomp
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
Attn: PO Box 8016

Sent via electronic mail

Re: Comments on *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028*

Dear Deputy Administrator Klomp:

Genentech appreciates the opportunity to provide comments on the *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028* (the "draft guidance"). The draft guidance provides the Centers for Medicare & Medicaid Services (CMS) a critical opportunity to modify policies that stifle innovation and disrupt robust market competition. We believe CMS and Genentech have aligned goals in seeing the Inflation Reduction Act (IRA) implemented to reduce patient costs, prudently spend taxpayer funds on needed medicines, prevent government overreach, and maintain or improve the innovation ecosystem in the United States.

Genentech pioneered the biotech industry and revolutionized how we treat some of the world's most complex health problems. Today, as a member of the Roche Group, we remain dedicated to pursuing breakthrough research, developing life-changing medicines, unlocking advances in data and technology, and partnering across society to take on systemic issues that stand in the way of

better health care for all. In 2024, Roche and Genentech collectively invested nearly $15 billion globally in research and development. Our efforts have resulted in the delivery of 27 new medicines over the last fourteen years, providing hope to patients facing life-threatening and difficult-to-treat conditions, including cancer, multiple sclerosis, and hemophilia. We market more than 40 approved medicines in the United States and are actively pursuing 70 investigational medicines. Furthermore, we have been granted 40 FDA Breakthrough Therapy Designations for medicines with the potential to provide a substantial improvement over currently available treatments.

As Genentech has commented with respect to the draft guidance for previous IPAYs, this draft guidance, as currently drafted, fundamentally threatens the U.S. market's established balance of innovation and competition; a system that effectively controls costs through robust competition among brand, generic, and biosimilar medicines. This dynamic has resulted in a 90% generic and biosimilar prescription usage rate and an estimated $3.1 trillion in savings over the last decade.[1] However, the IRA's government price-setting mechanism risks dismantling this framework by imposing prices so low they could deter generic and biosimilar manufacturers from entering the market, thereby stifling the primary driver of long-term drug cost reduction.

The draft guidance contains multiple policies that create significant uncertainty for manufacturers and disincentives for continued innovation. By replacing market competition with government price setting, the IRA's approach endangers the very system that has successfully delivered both medical innovation and affordability. This draft guidance not only retains the flawed framework of the previous administration but adds additional uncertainty by failing to outline the agency's proposals for important details regarding the inclusion of Part B drugs into the Medicare Drug Price Negotiation Program (the "program"). However, this Administration has an opportunity to mitigate these issues.

Below, we provide the following comments and recommendations on how, through this draft guidance, CMS can better:

- adopt methods that more accurately effectuate a Maximum Fair Price (MFP) and limit dispenser/provider impact;
- avoid discriminatory metrics when setting prices;
- preserve incentives for innovation, including for orphan drugs;
- remove barriers to ensure the continuance of a robust biosimilar market; and
- protect patient access to medicines by implementing safeguards for both selected and non-selected drugs.

[1] AAM. (2024). The U.S. Generic & Biosimilar Medicines Savings Report, 2024. Available at: https://accessiblemeds.org/resources/reports/2024-savings-report/

I. CMS should adopt a more accurate method to effectuate an MFP and use methodologies that limit dispenser/provider impact.

As a general matter, we note our continued concerns with effectuation through a Medicare Transaction Facilitator (MTF) as merely a facilitator of information exchange. While we note the solicitation of comments on private market solutions to the MTF function, we **suggest CMS adopt an MFP effectuation model that relies on rebates, similar to the Part D Coverage Gap Discount Program (CGDP)** where CMS would pass-through pre-funded MFP refund amounts to dispensers/providers on behalf of Primary Manufacturers at the time of claim adjudication. This approach offers three key advantages: it ensures pharmacies and providers are paid promptly, reduces cash flow concerns, and leverages a proven, seamless system. By having CMS pass through pre-funded MFP refund amounts directly to dispensers/providers and invoicing manufacturers later, the agency can replicate what has been a seamless and effective system. **We urge CMS to commit to this proven framework for future implementation years.**

While we recognize that CMS faces the complex challenge of determining an MFP effectuation methodology that accurately considers the multitude of drug packaging, dosage, and routes of administration, we remain concerned that the agency's chosen methodology creates unnecessary financial risk for dispensers and providers. CMS must develop a system that ensures dispensers and providers do not face financial strain when ensuring the MFP price is made available to eligible Medicare patients, and we are concerned that CMS's 30-day equivalent calculation fails this standard. We discuss these and other concerns in more detail below.

A. CMS should abandon its 30-day equivalent calculator for a single MFP and instead adopt a per unit MFP calculation.

The fundamental flaw in CMS's current methodology for calculating a single MFP lies in its reliance on a "30-day equivalent supply" approach, which has already proven to be fundamentally flawed in its application to Part D drugs. This approach systematically undervalues medicines, particularly those with patient-specific variable dosing based on the patient's condition or those requiring dosing frequency adjustments to optimize the therapeutic effect. By relying on an average supply over a fixed period, the model fails to accurately capture the true use and value of drugs like insulin, where dosing changes based on patient need, or treatments that feature different initial and maintenance dosing regimens.

Extending this flawed 30-day equivalent methodology to Part B drugs for 2028 will only compound these existing concerns and demonstrate the model's complete unsuitability for drugs administered in clinical settings. The 30-day approach is particularly inappropriate for Part B drugs—such as cancer and autoimmune therapies—where dosing is highly individualized based

on patient body weight, indication, or progression of treatment. Forcing these variable treatments into a fixed 30-day framework obscures necessary dosing variations and will lead to significant pricing inaccuracies that could compromise patient care and provider reimbursement.

To resolve these critical valuation and operational challenges, **CMS should abandon the 30-day equivalent supply model entirely. The most effective solution is to move to a per-unit pricing methodology to establish a single ceiling price and MFP for all selected drugs.** A straightforward price per unit (e.g., per milligram) would bypass the complex data conversion and reconciliation issues of combining two disparate claims systems. Most importantly, it would accurately accommodate the variable dosing inherent in Part B medicines, ensuring the price reflects the drug's value as administered. While a per-unit approach should be the default, **CMS should retain the flexibility to work with manufacturers on a drug-by-drug basis to determine the most appropriate methodology for each unique product.**

B. CMS should require the submission of NDC codes for reimbursement for selected drugs under Part B FFS and on MA claims effective for IPAY 2028.

Under the current Medicare Part B system, physician-administered drugs are reimbursed based on a Healthcare Common Procedure Coding System (HCPCS) code, not the drug's specific National Drug Code (NDC). This HCPCS-based approach creates a fundamental data gap: since NDCs are not required on Part B claims, the payment rate for a single HCPCS code may potentially represent a blended price across various drug strengths and package sizes, making it difficult to identify the specific product that was administered to the patient.

This lack of product-level specificity makes the HCPCS-based system wholly inadequate for accurately setting an MFP because a single HCPCS code can represent multiple different drugs, only one of which might be a selected drug subject to the MFP. Without the NDC on the claim, it is impossible to determine if a patient received a selected drug, which specific selected drug it was, or how to apply the MFP refund correctly. Relying on HCPCS codes alone would thus increase the likelihood of inaccurate MFP effectuation and could prevent providers from obtaining reasonably accurate access to the negotiated price.

To ensure the MFP program can function as intended, **CMS should require the submission of NDCs on all Medicare Part B Fee-for-Service (FFS) and Medicare Advantage (MA) claims for selected drugs, effective for IPAY 2028.** This would provide the necessary product-level detail to accurately identify when a selected drug is administered and calculate the correct refund amount. We note that this is not an unprecedented burden, as providers are already required to report NDCs for purposes of the Medicaid Drug Rebate Program and in other specific Medicare circumstances, making it a feasible step necessary for the successful implementation of the MFP.

C. CMS should establish a Standard Default Rebate Amount (SDRA) as a true default option for MFP effectuation; the SDRA for Part B should be [(ASP+6%) - (MFP+6%)] to preserve provider financial stability.

To reduce stakeholder burden and create a more efficient system, the SDRA must be established as a true default, not merely an option that requires mutual agreement. CMS's current approach contains an inherent contradiction: while the agency acknowledges that, for Part D drugs, a WAC-based SDRA is reliable, it simultaneously undermines this position by indicating that its use is contingent on an agreement between manufacturers and dispensers. This requirement negates the very purpose of a "default" and forces both parties into the entity-by-entity negotiations the SDRA was specifically designed to prevent. While this is a significant burden for manufacturers for Part D, this burden will increase significantly when CMS effectuates the MFP in Part B given the enormous volume of Part B prescribers. To remedy this contradiction and minimize stakeholder burden, **CMS should explicitly state that manufacturers can assume the SDRA is the sufficient and applicable refund amount for a selected drug.**

CMS is also soliciting comments on how to set an SDRA formula for Part B drugs, which arguably represents a more complex reimbursement environment. Unlike Part D drugs, there is not as clear of a pricing metric that would work for the vast majority of providers for Part B drugs. Provider acquisition cost can be significantly further below WAC than pharmacy acquisition cost, making WAC a poor choice for a Part B SDRA. However, we suggest below a method that would ensure sustainable provider reimbursement while at the same time ensuring the MFP price is made available in the marketplace. **We believe that establishing an SDRA formula for Part B drugs of [(ASP + 6%) - (MFP + 6%)] would meet both of the state goals above and be an easily predictable and calculable metric for MFP effectuation.**

D. CMS should exclude MFP units from ASP calculations.

To ensure the stability of provider payments, we urge CMS to confirm the exclusion of MFP units from ASP calculations. Beginning in 2028, CMS will base payments for selected Part B drugs on the MFP instead of the ASP, which will lead to a drastic reduction in Medicare reimbursement for these provider-administered medicines. The negative effects may also spill over into the commercial market, where ASP is a key benchmark for reimbursement, leading to an estimated 18 percent reduction in add-on payments for provider-administered selected drugs.[2] Oncology practices would be disproportionately affected, facing reimbursement cuts of at least half for certain medications.[3] Furthermore, small and rural providers, who operate on narrower

[2] A recent survey of commercial insurers showed that they reimburse for 72 percent of covered lives in the physician office based on a medicine's ASP. ASP is also the basis of Medicaid reimbursement for provider-administered medicines in many states. *See*, Avalere Health. (September 2024). Commercial Spillover Impact of Part B Negotiations on Physicians. Available at: https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians

[3] Ibid.

margins, would be the least equipped to handle these reductions, likely leading to more practice closures and consolidations and a subsequent decrease in patient access to community providers.

Importantly, CMS has clear legal authority to exclude the MFP from ASP reporting requirements. Under section 1847A(b)(2)(B) of Social Security Act, Congress expressly authorizes CMS to define the "units" for purposes of implementing ASP statute. Drawing from precedent set with the Part B Competitive Acquisition Program (CAP), CMS previously exercised this authority to exclude CAP drug units from the ASP after determining that their inclusion would undermine the program's design. In justifying that decision, CMS explained: "We believe it is appropriate to implement this exclusion from the ASP calculation because this exclusion is necessary for implementing the CAP, a program that the Congress has expressly identified as an alternative to the ASP payment methodology."[4]

A parallel rationale applies here. The MFP framework operates as a distinct statutory alternative to ASP, accompanied by a comprehensive and separate pricing methodology. **Accordingly, CMS has both the legal authority and policy justification to exercise its unit-level definitional discretion to exclude MFP-priced units from the ASP calculation.** Doing so would mitigate the risk of disproportionate reimbursement reductions to providers and safeguard beneficiary access to medically necessary therapies.

E. CMS should adopt a 30-day payment timeline for manufacturers to make MFP available to providers for Part B drugs.

Genentech supports prompt payment for providers, but we also stress the importance of valid and accurate payments. To facilitate this, **we urge CMS to adopt a 30-day payment window from the receipt of claims data to make MFP available to providers for Part B drugs.** We think this is an appropriate timeline because this timing aligns with CMS's own timelines to reimburse providers under the Part B program.

F. CMS should require mandatory MTF payment module participation by dispensers.

With only limited time before implementation and with substantial concerns remaining regarding MTF implementation, **we believe the payment module should be mandatory for all dispensers to avoid a situation where manufacturers who opt to use the MTF-facilitated payment process are forced to operate outside that process with potentially thousands of dispensers.** If it remains voluntary for dispensers for IPAY 2026, CMS should require dispensers to commit to their choice (opt-in or opt-out) for a full year, and CMS should continue to commit to a system that is mandatory for dispensers in future years.

[4] 70 Fed. Reg. 70478, 70479 (Nov. 2005).

Additionally, to the extent CMS retains the 14-day payment window for Part D drugs, this window should only apply to payments made under the MTF-facilitated payment process. That is, **if a manufacturer chooses to opt-out of the MTF payment facilitation process, the manufacturer and the dispenser with whom it enters into an agreement should be able to determine the appropriate time window for payment.**

G. Additional policies are needed to ensure 340B de-duplication.

Compliance with the duplicate discount prohibition is a condition of covered entities' eligibility for the 340B Program.[5] However, in its fiscal year 2023 covered entity audits, HRSA uncovered duplicate discount errors in nearly 25 percent of cases examined.[6] Duplicate discounts are the direct result of a lack of uniform requirements in place for covered entities and MCOs, a lack of data transparency, and a lack of oversight and effective enforcement mechanisms to ensure compliance. To improve program compliance and integrity with regard to the duplicate discount prohibition, CMS itself has—for several years—acknowledged the value of greater claims transparency to improve program integrity.[7]

We reiterate that **a more workable solution would be an independent entity that serves as a clearinghouse for all claims data, facilitating the exchange of necessary information to identify 340B claims, prevent duplicate discounts, and resolve other issues or disputes.** Such a mechanism would be a much-needed improvement to the patchwork of data systems that are inconsistent and opaque, and would bring a level of transparency needed to address the inefficiencies of our healthcare system while still protecting patient and other confidential information.

Although mandated by CMS, we also note the still-low compliance with JG and TB modifiers and encourage CMS to hold covered entities (CEs) accountable. **We urge CMS to expressly clarify that, in cases where a claim is missing the required modifier and the manufacturer verifies that the dispensing entity is a 340B-covered entity, the manufacturer may withhold payment until the dispensing entity provides sufficient documentation demonstrating 340B eligibility.** We also encourage CMS to continue to explore ways to improve identification of 340B claims at the point of sale. We believe this is best accomplished through the use of mandatory claim modifiers (e.g., TB modifiers). CMS should also **require MA plans to report claims data more frequently for selected Part B drugs and to require MA plans to mandate**

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[5] See 42 U.S.C. § 256b(a)(4) ("In this section, the term 'covered entity' means an entity that meets the requirements described in paragraph (5)" of section 340B(a), which includes both the duplicate discount and diversion prohibitions described in subsections (a)(5)(A) and (a)(5)(B), respectively.).
[6] HRSA. Program integrity: FY 2023 Audit Results. https://www.hrsa.gov/opa/program-integrity/fy-23-audit-results
[7] CMS. Best Practices for Avoiding 340B Duplicate Discounts in Medicaid. January 2020. https://www.hhs.gov/guidance/sites/default/files/hhsguidance-documents/cib010820_142.pdf .

340B covered entities to identify 340B-eligible claims through the use of mandatory modifiers. Until a more effective solution is implemented, we appreciate CMS's acknowledgement that all parties—manufacturers, TPAs, and other stakeholders—must work together to address any unlawful duplication of MFP and 340B discounts.

II. CMS should continue to avoid discriminatory metrics in setting prices under the Negotiation Program.

Consistent with the need to ensure the Negotiation Program maintains a patient-centric focus, we thank CMS for continuing to acknowledge the potential discriminatory nature of cost-effectiveness measures that treat extending the life of individuals who are elderly, disabled, or terminally ill as of lower value. Such metrics fail to capture the societal value placed on health outcomes, particularly the added value of life-extending treatments. We reiterate below prior comments submitted to the agency on certain discriminatory metrics CMS should avoid.

We recommend that **CMS explicitly prohibit the use of certain value assessment methods that rely on "cost per generic health metric" analyses or thresholds, given their inherently high risk of discriminatory impact on vulnerable and marginalized patient populations, particularly patients with disabilities.** Value assessment tools that use cost-effectiveness analyses relying on generic health metrics that compare across diseases and patient populations carry a significant risk for discrimination against persons with disabilities who are systematically undervalued by these metrics and comparisons.

Cost per generic health metric analyses—such as quality adjusted life years (QALYs), equal value life years (evLYs), and healthy years in total (HYT)—can, in the context of the Negotiation Program, lead to discriminatory outcomes. These methodologies may systematically undervalue treatments for conditions that disproportionately affect individuals with higher levels of disability, older patients, and patients with terminal illnesses. It is imperative that healthcare evaluation and policy reflect a comprehensive understanding of value that aligns with societal preferences and ensures equal access to care for all patient populations.

A. CMS should continue to require Negotiation Program ICR respondents to indicate whether their submission contains information from studies that use QALY metrics.

CMS states that it plans to remove the requirement for respondents to indicate in their submissions to the Drug Price Negotiation ICR whether a study includes the QALY metric for IPAY 2028. While we understand and support the agency's desire to simplify the submission process for manufacturers and others, **we believe it is important for CMS to continue taking steps to proactively ensure that information submitted in the ICR process does not inadvertently rely on the QALY metric.** The current requirement provides CMS a clear and

simple method to ensure it is not drawing conclusions from studies using QALYs, especially when it is likely reviewing a large amount of information (some MFP explanations cite nearly 300 sources). While CMS has expressed concern that some stakeholders may not be familiar with QALY metrics, many respondents are fully capable of identifying them. In fact, the risk of inadvertent inclusion may increase among those less familiar with these methodologies, further underscoring the importance of requiring an explicit attestation.

The current requirement prompts all respondents to consider whether their submission relies on QALY data, thereby serving as a critical safeguard. Eliminating it could result in missed opportunities for CMS to fully comply with its statutory obligation to exclude QALY metrics from its pricing determinations. Therefore, **we urge CMS to reconsider eliminating the attestation requirement, as it serves as a crucial safeguard against the submission of data from third parties that relies on these significantly flawed measures.**

III. CMS should revise the Draft Guidance to better preserve incentives for innovation.

A. CMS should adopt a narrower QSSD definition for consistency with the statute and maintain a consistent approach to fixed-dose combinations to preserve incentives for innovation.

CMS is soliciting comments on how the addition of drugs payable under Part B in IPAY 2028 may impact its current policy for defining a qualifying single source drug (QSSD) in the context of fixed combination drugs. CMS is considering grouping certain fixed combination drug products where it deems that one active ingredient / moiety does not contribute to a clinically meaningful difference. Irrespective of the implications that Part B drugs may have on CMS's administration of this policy, we fundamentally disagree with CMS's current interpretation of the QSSD definition. We are concerned that CMS is both maintaining an overly broad interpretation of the QSSD definition and simultaneously advancing new policy proposals that further depart from the plain text of the statute and from FDA's established scientific and regulatory framework.

Specifically, CMS states that a QSSD includes all dosage forms and strengths of a drug with the same active moiety or active ingredient, even if they are marketed under different NDAs or BLAs. We strongly disagree with this policy. The statute makes no reference to either active moiety or active ingredient, and instead sets forth a QSSD definition that is expressly tied to individual NDAs or BLAs. The statutory language imposes two distinct requirements:

(1) First, unique dosage forms, strengths, and routes of administration of a given drug or biologic may only be treated as a single QSSD (i.e., "aggregated") if they are approved under a single NDA or BLA. The statutory definition of a QSSD repeatedly refers to

"such approval" or "such licensure" in the singular, indicating that Congress intended aggregation to be limited to products under a *singular* marketing application.

(2) Second, the statutory requirement for time elapsed before selection must be met independently by each NDA or BLA. That is, seven or eleven years "have elapsed since the date of such approval [licensure]". This clear articulation demonstrates that Congress did not intend the pre-selection timeline to be based on the date of the first approval of an "active ingredient" or "active moiety," particularly where the approval was under a different NDA/BLA.

Moreover, the aggregation of dosage forms and strengths compelled by the "use of data provision" applies as part of the process for identifying "negotiation-eligible drugs," i.e., after a product is determined to be a QSSD. Taken together, these provisions demonstrate that CMS's current approach—aggregating products across NDAs or BLAs based on shared active moieties or ingredients—exceeds the statutory definition of a QSSD and should be revised.

Beyond its maintenance of an overly broad definition of a QSSD, CMS is contemplating a new and different approach to aggregating certain fixed-combination products. CMS is soliciting comments on how it could approach aggregating products that contain one of the ingredients in a fixed combination product with other products that contain one but not all of the ingredients of the fixed combination —namely when it believes one of those ingredients does not provide a "clinically meaningful difference".

Genentech believes these efforts are misguided. First, there is no statutory basis for CMS's proposed approach. The IRA statute does not provide any definition for the terms "therapeutically active" or "biologically active" or "clinically meaningful difference", nor does it grant CMS authority to interpret or apply them. These terms have established meanings within the context of scientific and regulatory evaluation—particularly in determining the safety and efficacy of drug components—which is the exclusive domain of the FDA. CMS's attempt to redefine or operationalize these terms for the purpose of implementing a drug price negotiation program represents a fundamental shift in their intended use. This recharacterization distorts their scientific meaning to serve a policy objective and, in doing so, encroaches upon FDA's jurisdiction and expertise. Scientific determinations of therapeutic contribution or clinical significance must remain with the agency expressly charged by statute with evaluating them: the FDA.

Second, CMS's proposed approach to fixed-combination products is inconsistent with the FDA's established regulatory framework, including the agency's regulations, and exceeds the boundaries of CMS's policy role. Specifically, FDA's fixed-combination regulation states that "[t]wo or more drugs may be combined in a single dosage form when *each component makes a*

contribution to the claimed effects and the dosage of each component (amount, frequency, duration) is such that the combination is safe and effective for a significant patient population[.]"[8] This regulatory standard reflects the FDA's scientific judgment that, for a fixed-combination product to be approved, each active moiety or active ingredient must meaningfully contribute to the product's therapeutic effect.

Accordingly, all components in an FDA-approved fixed-combination drug are, by definition, "therapeutically active" and "biologically active." FDA's scientific determination of these characteristics is not discretionary; it is embedded in the regulatory criteria for approval. CMS's attempt to override or reclassify these components—by asserting that certain ingredients do not result in a "clinically meaningful difference"—directly contradicts FDA's regulatory determinations.

In short, **CMS should not move forward with its suggested aggregation of certain fixed-dose combination products.**

B. CMS should toll the pre-negotiation period while a given orphan drug qualifies for the orphan drug exclusion.

Consistent with our comments to the IPAY 2026 and IPAY 2027 draft guidances, we remain concerned that an overly narrow interpretation of the statutory exclusion could discourage investment in bringing additional indications of orphan drugs to market, particularly ones that treat a small number of patients or take significant additional time to develop. The draft guidance continues to require that all dosage forms and strengths of the QSSD meet the criteria for the ODE. Under this interpretation of the statute, loss of ODE status for any single drug product or biological product with shared active ingredient or active moiety (across multiple NDAs/BLAs and irrespective of the time post-approval) would result in the loss of such exclusivity for all products with that active ingredient/active moiety, all the way back to the time of initial licensure/approval, undercutting the incentives for further drug development in orphan disease areas—incentives that have led to significant scientific breakthroughs and benefitted countless patients over the last several decades. To address this issue, **CMS should clarify that, for a product that initially qualifies for the orphan drug exclusion, the 7- or 11-year period prior to negotiation eligibility starts only upon loss of the orphan drug exclusion.**

C. CMS should take steps to ensure its process for establishing the MFP does not undercut incentives for biopharmaceutical innovation.

We remain concerned that CMS's proposed methodology to develop an initial offer, as outlined in the draft guidance would undercut incentives to undertake the most difficult and riskiest

[8] 21 C.F.R. § 300.50(a).

research and development efforts. As a guiding principle, we believe that **CMS should implement the Negotiation Program to achieve both of the following overarching and equally important goals: (1) delivering cost savings to Medicare and its beneficiaries to promote access to therapies today, and (2) maintaining incentives to invest in the innovations that can deliver meaningful benefits to patients in the future.** Consistent with prior comments, **we urge CMS to amend its proposed MFP methodology to:**

- Establish an MFP at the ceiling price for products that, over the course of the product's lifecycle, have: (1) provided therapeutic advancements and/or (2) treated previously unmet medical needs.
- For selected drugs that do not meet one or both of the above criteria, establish the MFP by considering evidence regarding the comparative effectiveness of the drug to determine whether the selected drug provides benefits compared to therapeutic alternatives.

- To avoid unintended consequences of setting MFPs too low, only use the manufacturer specific factors[9], enumerated in Section 1194(e)(1) of the Social Security Act, when a product provides fewer benefits than its therapeutic alternatives.

For more detail on each of these points, we refer CMS to our comments to the IPAY 2026 draft guidance.

D. CMS Should Re-Evaluate the Threshold for Identifying Renegotiation-Eligible Products.

The Inflation Reduction Act (IRA) establishes the criteria for identifying and selecting drugs for the Negotiation Program beginning for IPAY 2028. According to Section 1194(f)(2) of the Social Security Act (SSA), a drug is "renegotiation-eligible" only if:

1. Its monopoly status changes (for IPAY 2028, from short-monopoly to long-monopoly);
2. A new indication is added; or
3. The Secretary determines a "material change" has occurred in the factors listed in SSA § 1194(e).

For criteria (2) and (3), the Secretary can only select drugs where renegotiation is expected to significantly change the maximum fair price (MFP). Regarding this "significant change" criterion, CMS proposes a "holistic inquiry" requiring a drug to meet two conditions: (1) renegotiation is likely to result in an MFP change of 15 percent or greater; and (2) this expected change would significantly impact Medicare (e.g., spending, beneficiary cost-sharing). CMS justifies the 15 percent threshold by drawing a parallel to the maximum statutory price reduction applicable when a drug transitions from short- to long-monopoly status. In CMS's view, a 15

[9] As a general matter, CMS must only use the factors enumerated by statute and may not consider extra-statutory factors or data.

percent expected MFP change is sufficiently "significant" to meet the statutory standard under §1194(f)(2)(B).

However, using CMS's own logic, a higher threshold would be more appropriate. CMS treats the 15 percent figure as a meaningful benchmark because it mirrors the ceiling price reduction applied in monopoly status transitions. But that rationale lacks clear statutory grounding when applied to the material change and new indication criteria. There is no indication in the statute that price reductions resulting from non-monopoly-related changes must be judged against the same standard as those triggered by monopoly transitions.

That said, if CMS is determined to anchor its "significant change" threshold to the statutory ceiling price adjustments associated with monopoly status, a 35 percent threshold would be more appropriate than 15 percent. For drugs selected prior to IPAY 2030, a change in monopoly status triggers a 35 percent change in the non-FAMP ceiling, not 15 percent. Section 1194(c)(4)(B)(ii) excludes drugs for IPAYs 2026–2029 from the "extended-monopoly drug" definition if the manufacturer has an agreement. CMS acknowledges that no drug will change to extended-monopoly status for renegotiation eligibility in 2028. Thus, for IPAY 2028, only drugs changing from short-monopoly to long-monopoly status can be selected based on monopoly status.

Setting the expected MFP change threshold at 35 percent for drugs with a new indication or a material change in Section 1194(e) factors would align with the non-FAMP applicable percentage difference between short-monopoly (75 percent) and long-monopoly (40 percent) drugs, achieving the consistency CMS aims for in defining a "significant change." In this draft guidance, CMS has not adequately explained how its proposed 15 percent threshold aligns with the statutory non-FAMP ceilings for IPAY 2026-2029.

Genentech strongly suggests that CMS reconsider its 15 percent threshold and instead adopt a 35 percent threshold starting in 2028, extending it through 2030, because the only monopoly status changes for selected drugs during this period will be from short-monopoly to long-monopoly.

V. CMS should remove barriers for successful generic and biosimilar market/competition.

A. CMS should confirm that selected drugs for IPAY 2028 will not be subject to an MFP if there is generic or biosimilar entry by March 31, 2027.

Genentech disagrees with CMS's interpretation of section 1192(c)(1), which suggests that a generic or biosimilar drug must be approved and marketed by November 1, 2026, to exempt a

selected drug from an MFP for IPAY 2028. However, **we believe the statute requires that if a generic or biosimilar is approved and marketed by March 31, 2027—at least nine months before January 1, 2028—the selected drug should not be subject to an MFP for IPAY 2028.** Specifically, Section 1192(c)(1) states that "each negotiation-eligible drug included on the list published . . . *with respect to an initial price applicability year* . . . shall be *referred to* as a 'selected drug' with respect to *such year* and *each subsequent year* beginning before the first year that begins at least 9 months after the date on which the Secretary determines at least one drug or biological product" has been approved or licensed and marketed pursuant to such approval or licensure.[10] In other words, the statute indicates that if CMS determines a generic or biosimilar has launched by March 31, 2027, the drug should no longer be categorized as a "selected drug" for the IPAY beginning January 1, 2028, rendering the MFP inapplicable.

This approach would foster competition by encouraging the market entry of generics and biosimilars, ensuring biosimilar entry is not erroneously competing against a brand drug with an MFP. It also provides CMS with a nine-month window to terminate the selection of a branded drug once a generic or biosimilar has entered the market.

B. CMS should adopt a standard for biosimilar marketing that tracks the statutory QSSD definition.

We reiterate our comments from previous comments regarding the "robust and meaningful competition standard" when investigating whether a drug has generic or biosimilar competition. The statute defines a QSSD as a product without a marketed generic or biosimilar, among other requirements. In determining whether a product has a marketed generic or biosimilar, we appreciate that CMS would want to investigate whether the generic or biosimilar is truly offered for sale. However, CMS has exceeded the bounds of the statute by proposing to establish a "robust and meaningful competition" standard and to impose requirements that the product be "widely available" or show up in the Prescription Drug Event (PDE) data. **We strongly urge CMS to focus on the statutory standard of whether the generic or biosimilar is merely marketed—that is, made available for sale—and not to adopt these standards that exceed CMS's authority under the statute.**

Specifically, the statute does not allow for imposition of CMS's "bona fide" qualifier. The statute defines a QSSD as a drug product "that is not the listed drug for any [generic] drug that is approved and marketed under section 505(j) of the FDCA and a biological product "that is not the reference product for any [biosimilar] biological product that is licensed and marketed under section 351(k)" of the PHSA. Additionally, when determining when a drug is no longer considered a selected drug, the statute uses the term "marketed" without the "bona fide"

[10] § 1192(c)(1) (emphasis added).

qualifier. CMS's utilization of the "bona fide" qualifier is vague and implies a higher standard for marketing than Congress intended.

VI. CMS should implement safeguards to preserve access (formulary placement and cost sharing) to both selected and non-selected drugs.

We support the agency's goal of ensuring that selected drugs are covered under Part D; however, we have concerns about *how* these products may be covered, and the resulting consequences for patients. Under the current system, manufacturers often provide rebates and, in some therapeutic classes, such rebates are very common and serve as a considerable source of revenue for plans. In these classes, we can expect a plan may nominally include a (lower-price, lower-rebate) selected drug on its formulary—thereby technically complying with the statutory requirement—while implementing utilization management techniques (e.g., step therapy or tiering) that adversely affect patient access to the selected drug. At the same time, we are also concerned that patients taking non-selected drugs could be worse off than today as plans face increased liability under the Part D benefit beginning in 2025. Under this scenario, plans may restrict access (via increased utilization management, higher patient out-of-pocket costs, or non-coverage) for non-selected drugs, for which coverage is not required. Unfortunately, the draft guidance does not adequately address these issues and may actually exacerbate them. Indeed, research has shown that nine in 10 Part D plans say they intend to increase access restrictions on drugs in the coming years because of the IRA.[11]

We appreciate CMS's commitment to closely monitor Part D plan formulary requirements, but **we urge CMS to provide additional specificity around the requirements for coverage of both selected and non-selected drugs**, and in doing so, implement safeguards to ensure that plans cannot disrupt care for patients or otherwise make them worse off than under current formulary guidelines.

Thank you for the opportunity to provide input on the draft guidance. We would welcome the opportunity to answer any questions CMS may have regarding our comments.

Sincerely,

Dan Neves
Senior Director, Federal Policy
U.S. Policy and Evidence

[11] Magnolia Market Access. (2024). IRA Payer Insights Report Chartbook Summary of Key Findings. Available at: https://www.magnoliamarketaccess.com/wp-content/uploads/MMA_IRA-Payer-Insights-Survey-4.0_Chartbook_2024.07.31.pdf

GILEAD
Creating Possible

June 26, 2025

Via email (IRARebateandNegotiation@cms.hhs.gov)

Mr. Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028

Dear Mr. Klomp:

Gilead Sciences, Inc. (Gilead) appreciates this opportunity to comment on the above-captioned memorandum providing draft guidance (Draft Guidance) regarding the "Medicare Drug Price Negotiation Program" (MFP Program) under sections 11001 and 11002 of the Inflation Reduction Act (IRA) for Initial Price Applicability Year (IPAY) 2028 and the effectuation of the Maximum Fair Price (MFP) in IPAYs 2026, 2027 and 2028.[1]

Gilead is a research-based biopharmaceutical company that discovers, develops, and commercializes innovative medicines in areas of unmet medical need. We endeavor to transform care for people with life-threatening illnesses around the world. Our portfolio of products and pipeline of investigational drugs includes treatments for human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), liver diseases, cancer, inflammatory and respiratory diseases, and cardiovascular conditions. Our portfolio of marketed products includes a number of category firsts, including complete treatment regimens for HIV infection available in a once-daily single pill, the first oral antiretroviral pill available to reduce the risk of acquiring HIV infection in certain high-risk adults, and the first Hepatitis C virus (HCV) treatment to provide a complete regimen in a single tablet. Most recently, Gilead launched Yeztugo® (Lenacapavir), a twice-yearly injectable HIV-1 capsid inhibitor for the prevention of HIV as pre-exposure prophylaxis (PrEP) to reduce the risk of acquiring HIV in adults and adolescents weighing at least 35kg, making it the first and only twice-yearly option available in the United States for people who

[1] Memorandum from Chris Klomp, CMS Deputy Administrator and Director of the Center for Medicare to Interested Parties (May 12, 2025), https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

need or want PrEP.[2] Gilead is committed to ensuring that people have access to groundbreaking medicines like these.

HIV is a deadly infectious virus that causes chronic disease and is uniquely challenging to treat. Small molecule medicines that treat HIV have unique clinical and pharmacological qualities that must be considered when selecting the most appropriate treatment regimen for a person with HIV. There is a longstanding recognition in Medicare that patients need access to the particular HIV medication that was prescribed to them, and that one HIV product cannot simply stand in for another. Gilead strongly encourages CMS to work with Congress, as directed by President Trump's Executive Order on "Lowering Drug Prices By Once Again Putting Americans First," to correct the IRA's disparate treatment of small molecules by passing the Ensuring Pathways to Innovative Cures (EPIC) Act. Until that time, CMS should set the MFP for small molecules at the statutory ceiling. It is particularly important that CMS use the statutory ceiling for the MFP for medicines that treat HIV.

We appreciate the efforts of the Centers for Medicare & Medicaid Services (CMS) to provide Draft Guidance to pharmaceutical manufacturers and to solicit comments from interested parties. The comments herein are intended to further build on suggestions included in the comments of the Pharmaceutical Research and Manufacturers of America (PhRMA), the Biotechnology Innovation Organization (BIO), and the National Pharmaceutical Council.

Consistent with our prior comment letters filed in response to CMS' initial guidance regarding the implementation of the MFP Program for IPAY 2026 and 2027[3] and the Negotiation Data Elements Information Collection Request (ICR),[4] we remain concerned that the MFP Program could hinder continued biopharmaceutical innovation, particularly with respect to newer and longer-acting HIV treatments, as well as the discovery of an eventual cure and an end to the HIV epidemic.

Gilead's specific comments can be summarized as follows:

- CMS Should Use the Statutory Ceiling Price for Small Molecules, Particularly Medicines that Treat HIV. Until the IRA's disparate treatment of small molecules ("Pill Penalty") is remedied, as directed by President Trump's Executive Order on "Lowering Drug Prices By Once Again Putting Americans First," CMS should use the statutory ceiling price for small molecule prescription drugs. That will mitigate the distortion and undermining of investment in such critical and needed prescription drugs. In particular, the statutory ceiling price should be used to determine the MFP for HIV treatments, given that antiretrovirals have unique clinical and

[2] Gilead, Press Release, Yeztugo® (Lenacapavir) Is Now the First and Only FDA-Approved HIV Prevention Option Offering 6 Months of Protection (June 18, 20025), Yeztugo Lenacapavir Is Now the First and Only FDA Approved HIV Prevention Option Offering 6 Months of Protection.

[3] Letter from Gilead to Dr. Meena Seshamani, re: 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 (April 14, 2023) ("IPAY 2026 Comments"); Letter from Gilead to Dr. Meena Seshamani, re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Section 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 (June 28, 2024) ("IPAY 2027 Comments").

[4] May 22, 2023 Letter from Gilead to William Parham, re: Information Collection Request for Negotiation Data Elements under Sections 11001 and 11002 of the Inflation Reduction Act (CMS-10847, OMB, 0938-NEW).

pharmacological qualities that must be considered when selecting appropriate regimens for persons with HIV and to ensure there is future innovation to further improve HIV treatments and offer a potential cure.

- CMS Should Treat Fixed Combination Drugs as Distinct Qualifying Single Source Drugs (QSSDs). Gilead supports CMS' continued treatment of fixed combination drugs as distinct QSSDs. Not only is such treatment consistent with the statutory language, but it is also supported by the clinical benefits these medicines bring to patients. This is particularly true when treating infectious diseases like HIV, which require multiple drugs that attack different parts of the viral lifecycle to suppress viral replication and slow the progression of disease. In many cases, fixed combination drugs also allow for simplification of dosing frequencies, reduce pill burden, and lower the risk of selective non-adherence. Treating fixed combination drugs as distinct QSSDs improves incentives for developing critical lifesaving medications and spurs new scientific discoveries, improving patient access to combination products that lead to better outcomes and fewer hospitalizations, potentially saving overall healthcare costs.

- CMS Should Clarify that Drugs Covered Under Part B as "Additional Preventive Services" are Not QSSDs and are Not Eligible for Selection. CMS recently established national coverage for pre-exposure prophylaxis (PrEP) using antiretroviral therapy to prevent HIV under the statutory benefit category for "additional preventive services" (referred to as "DCAPS"). CMS used the corresponding payment authority for such services to establish a new payment methodology. Because DCAPS are paid for under Medicare Part B as additional preventative services, not drugs, DCAPS do not qualify as QSSDs. CMS should therefore clarify that it will not select such "additional preventive services" under the MFP Program or include DCAPS utilization when calculating a ceiling price for a selected drug with both DCAPS and non-DCAPS utilization, as doing so would be incongruent with the statutory scheme and create disincentives that threaten access to this key component of HIV prevention.

- CMS Should Give Substantial Weight to Certain Section 1194(e)(2) Factors When Developing Initial Offers and Further Foster Stakeholder Engagement. Gilead urges CMS to give substantial weight to certain Section 1194(e)(2) factors such as patient outcomes and clinical appropriateness, when considering potential therapeutic alternatives and developing initial offers. This is particularly important for HIV, for which the selection of an appropriate therapy is a complex and individualized determination. CMS should also broaden the definition of unmet medical need to consider patient subpopulations within the disease that have high disease burden, which would better align with FDA's existing definition of this term. Gilead also strongly encourages CMS to ensure that patient input is meaningfully considered during the MFP determination process.

- CMS Should Use the Statutory Ceiling Price As A Starting Point for the Initial Offer and Not Use Domestic Reference Prices from Other Programs or Cost-Based Pricing, Which Undervalue Innovation. As opposed to domestic reference prices from other healthcare programs, which do not reflect the Medicare program's structure and population, or cost-based (or "cost-plus") pricing, which can limit patient access, the statutory ceiling price offers the best starting point permissible under current authority to maintain incentives for continued innovation.

- Gilead Strongly Opposes Inclusion of Manufacturer Discount Program Payments and 340B Pricing in Manufacturer Net Price Metrics. Congress' original intent in the IRA was to create a clear separation between MFP discounts and Part D statutory discounts. CMS's inclusion of Manufacturer Discount Program payments when considering prices of the selected drug and its potential therapeutic alternatives undermines Congress' intent by incorporating the Part D statutory discounts into the MFP determination. Gilead also urges CMS not to include 340B pricing in Manufacturer Net Medicare Part D Price Metrics and Manufacturer Net Commercial Price Metrics, because doing so would discourage sub-ceiling discounts and inappropriately base Medicare prices on prices intended for safety-net populations.

- CMS Should Abandon Its Non-Statutory Bona Fide Marketing Standard. CMS' proposal to apply a bona fide marketing standard deviates from the statute, which requires only that a generic drug be "approved and marketed." CMS should follow the statutory language and consider only whether a generic has been introduced or delivered for introduction into interstate commerce. If CMS retains the bona fide marketing standard, Gilead is encouraged that CMS is considering a broader range of data. It is important that CMS not overly rely on Prescription Drug Event (PDE) data, which reflects only Part D claims and does not capture the full scope of generic drugs covered by the statutory language.

- Gilead Supports a Larger Role for the Medicare Transaction Facilitator (MTF), but Additional Safeguards, Guidance, and Controls are Necessary to Improve Effectuation of the MFP.
    - CMS should implement additional safeguards and processes to ensure that manufacturers have access to necessary data in a timely, efficient, and consistent manner to verify whether an MFP or a 340B discount is owed with respect to a particular claim. Gilead offers a number of recommendations to CMS, including adoption of a claims clearinghouse model to validate claims, prevent duplicate discounts, and leverage efficiencies to prevent duplication of efforts and disputes.
    - Gilead also believes that private market solutions, such as a 340B rebate model, could ultimately efficiently and effectively identify and prevent 340B/MFP duplicate discounts and support compliance with other statutory requirements that involve identifying 340B claims, such as the prohibition against Medicaid duplicate discounts and the exclusion of 340B units from the Part D inflation rebate program. We urge HHS to stop opposing these efforts.
    - *Mandatory* timely use of a 340B Claim Indicator by dispensing entities is an additional approach that could help prevent duplicate discounts between the 340B and MFP Programs.
    - In light of the substantial time and efforts required for a manufacturer to verify the MFP-eligibility of a claim, and to reduce the potential for duplicate discounts and fraud, CMS should extend the period before a manufacturer is required to pay the MFP discount from 14 days to 38 days.

Our more detailed comments on the Draft Guidance are set forth below. We hope that CMS will consider these comments when developing further guidance.

I. Recognizing Congressional Efforts to Address the Disparity Between Large and Small Molecules in the IRA, CMS Should Use the Statutory Ceiling to Determine the MFP for Small Molecules, Particularly Medicines that Treat HIV

A. Given that Investment in Small Molecules is Critical, CMS Should Use the Statutory Ceiling as the MFP for Small Molecules Until the Government Passes the EPIC Act to Correct the IRA's Disparate Treatment of Small Molecules

The IRA includes a penalty that gives small molecule drugs a shorter period of exemption from a maximum fair price (9 years) compared to large molecule drugs (13 years). In March this year, the EPIC Act was introduced in Congress to address this disparity by delaying selection of small molecules. Additionally, the Executive Order "Lowering Drug Prices By Once Again Putting Americans First," issued on April 15, 2025, recognizes this "pill penalty," and that it "threatens to distort innovation by pushing investment towards expensive biological products, which are often indicated to treat rarer diseases, and away from small molecule prescription drugs, which are generally cheaper and treat larger patient populations."[5] The Order directs the Secretary to "work with the Congress to modify the Medicare Drug Price Negotiation Program to align the treatment of small molecule prescription drugs with that of biological products, ending the distortion that undermines relative investment in small molecule prescription drugs, coupled with other reforms to prevent any increase in overall costs to Medicare and its beneficiaries," as proposed in the EPIC Act.[6] Gilead is pleased the administration and EPIC Act co-sponsors acknowledge this issue and understand that it is critical that Congress equalize the timelines to ensure that small molecule drugs have the same period as other drugs prior to potential MFP determination.

Until the government corrects the IRA's disparate treatment of small molecules, CMS should use the statutory ceiling to set the MFP for small molecule drugs. Small molecule investment is critical given that such molecules can, for example: (1) cross cell membranes and even the blood-brain barrier, reaching targets inside cells to facilitate clinical benefit for hard-to-treat diseases;[7] (2) play a critical role in treatment of RNA viruses;[8] (3) help patients remain adherent to their treatment because they can be easier to take and often preferred by patients, keeping them healthier;[9] and (4) reduce costly health care utilization and other opportunity costs,

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[5] Executive Order 14273, Lowering Drug Prices By Once Again Putting Americans First, 90 Fed. Reg. 16441 (April 15, 2025), https://www.whitehouse.gov/presidential-actions/2025/04/lowering-drug-prices-by-once-again-putting-americans-first/.

[6] *Id.*

[7] Mikitsh JL, Chacko AM. Pathways for small molecule delivery to the central nervous system across the blood-brain barrier. Perspect Medicin Chem. 2014;6:11-24. Published 2014 Jun 16. doi:10.4137/PMC.S13384; Banks WA. Characteristics of compounds that cross the blood-brain barrier. BMC Neurol. 2009;9 Suppl 1(Suppl 1):S3. Published 2009 Jun 12. doi:10.1186/1471-2377-9-S1-S3.

[8] Li S, Li H, Lian R et al. New perspective of small-molecule antiviral drugs development for RNA viruses. Virology. June 2024;594. doi:10.1016/j.virol.2024.110042.

[9] Balkrishnan R. Predictors of medication adherence in the elderly. Clin Ther. 1998;20(4):764-771. doi:10.1016/s0149-2918(98)80139-2; Wertheimer AI, Santella TM, Finestone AJ, Levy RA. Drug delivery systems improve pharmaceutical profile and facilitate medication adherence. Adv Ther. 2005;22(6):559-577. doi:10.1007/BF02849950.

by requiring travel to fewer in-person visits and decreasing the burden on caregiver costs, lost wages, and other hurdles.[10]

Estimates by the University of Chicago expect the pill penalty will result in a $232 billion reduction in research and development (R&D) for small molecule medicines over the next 20 years, leading to nearly 80 fewer small molecule medicines.[11] Recent research has shown that IRA's disparate treatment of small molecules is already having an impact on R&D. A study of post-approval clinical trials found a 47.3% reduction in clinical trial starts for small molecules after the passage of IRA, compared to a 32.9% reduction for biologics.[12] Another study of small and mid-sized biopharmaceutical companies found that early stage clinical research for small molecules dropped almost 70% after passage of IRA.[13] Preserving incentives for innovation is necessary for the development of lifesaving treatments for those with cancer, mental illness, neurological conditions, and many other devastating illnesses.

B. To Prevent Further Exacerbating Disadvantages For Small Molecules, CMS Should Confirm In The Final Guidance That It Will Include MA Plan Utilization When Determining Medicare Spending For Part B Drugs For Eligibility In The MFP Program.

If CMS excludes utilization of Part B drugs by Medicare beneficiaries enrolled in Medicare Advantage (MA) plans, CMS would further exacerbate the MFP program's built-in disadvantages for small molecules. This is because small molecules are generally covered under Part D, biologics are typically paid for under Part B, and spending on drugs covered under the latter would be effectively be undercounted.[14] In Section 80 of the Draft Guidance and on the May 2025 Manufacturer Group Monthly Technical Call, CMS states they "expect Primary Manufacturers to provide access to the MFP...to MFP-eligible individuals enrolled under Part B, *including an individual who is enrolled in a Medicare Advantage plan under Part C.*" (Emphasis included in CMS slide presented on May 29). However, CMS does not clearly address the agency's consideration of utilization of (and Medicare spending on) drugs paid for under Part B by individuals enrolled in MA plans when identifying drugs eligible for MFP. The Draft Guidance provides that "CMS will determine Total Expenditures by using Part B claims data to calculate total allowed charges (meaning the amount that is inclusive of the beneficiary coinsurance and

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[10] Boswell KA, Eaddy M. Associating Medication Adherence with Improved Outcomes: A Systematic Literature Review. American Journal of Pharmacy Benefits. 2012;4(4)e97-e108; Lloyd J, Maresh S, Powers CA, et al. How Much Does Medication Nonadherence Cost the Medicare Fee-for-Service Program? Medical Care. 2019;57(3):218-224. DOI: 10.1097/MLR.0000000000001067.

[11] R. Phillipson, Y. Ling, R. Chang, The Impact of Price Setting at 9 Years on Small Molecule Innovation Under the Inflation Reduction Act, University of Chicago, October 2023.

[12] Zheng H., Patterson J., Campbell J. (2025). The Inflation Act and Drug Development: Potential Early Signals of Impact on Post-approval Clinical Trials. *Therapeutic Innovation & Regulatory Science*, 1-9.

[13] Schulthess, D.G., O'Loughlin, G., Askeland, M. et al. (2025). The Inflation Reduction Act's Impact Upon Early-Stage Venture Capital Investments. *Ther Innov Regul Sci.* Available at: https://doi.org/10.1007/s43441-025-00773-3.

[14] Note that there are common exceptions to these coverage and reimbursement patterns in practice (*e.g.*, drugs that are usually self-administered.) CMS, Medicare Benefits Policy Manual (Pub. 100-02), Ch. 15, § 50.2.C (issued Jan. 16, 2025).

Medicare payment for the covered Part B item or service)," but does not specify whether such claims data will be inclusive of MA plan claims.[15]

In 2024, 54% of all eligible Medicare beneficiaries were enrolled in Medicare Advantage, and that share is growing.[16] Excluding utilization by these beneficiaries when determining Medicare spending on drugs paid for under Part B would significantly underrepresent the Medicare spending on these drugs, skewing selection heavily in favor of Medicare Part D drugs. Nothing in the statute suggests that Congress would have intended such an aberrant result. Including MA plan utilization in determining Medicare spending would also be consistent with statements CMS has made in its guidance for implementing Part B inflation penalty rebates, in which CMS has expressed support for a policy that includes MA units in the calculation of Part B inflation rebates, although the agency has not done so yet due to "operational considerations."[17] Additionally, CMS includes all Part D spending from Medicare Advantage Prescription Drug Plans when aggregating Part D drug spending for drug selection.

To help address disparities between the treatment of large and small molecule medicines in the IRA, Gilead requests that CMS confirm in the final guidance that it will include MA plan utilization when determining Medicare spending for Part B drugs and the sources of data that CMS will use to make such determination (e.g., MA plan encounter data or a system for MA plans to report quarterly unit data by HCPCS code and estimating cost for this utilization using applying the ASP-based reimbursement used in Medicare part B).

C. CMS Should Use the Statutory Ceiling to Determine the MFP for Medicines That Treat HIV, Given the Importance of Their Unique Clinical and Pharmacological Qualities When Selecting an Appropriate Regimen for an Individual With HIV.

Gilead strongly urges CMS to use the statutory ceiling to determine the MFP for medicines to treat HIV — a deadly infectious virus that causes chronic disease and requires individualized treatment. Antiretrovirals have unique clinical and pharmacological qualities that need to be considered when selecting the most appropriate regimen for a person with HIV. CMS should also use the statutory ceiling price to determine the MFP for medicines that treat HIV because future innovation that can improve HIV treatments and offer a potential cure would be at stake if incentives for research and development are reduced.

HIV infection and treatment are clearly distinguishable from other therapeutic areas. Viral suppression stops HIV infection from progressing and maintains an undetectable viral load, effectively eliminating the risk of sexually transmitting the virus to an HIV-negative partner.[18] The

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[15] Section 30 note 6, Draft Guidance.

[16] Nancy Ochieng, Juliette Cubanski & Tricia Neuman, Kaiser Family Foundation, A Snapshot of Sources of Coverage Among Medicare Beneficiaries (Sept. 23, 2024), https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/.

[17] CMS, Medicare Part B Drug Inflation Rebates Paid by Manufacturers: Revised Guidance, Implementation of Section 1847A(i) of the Social Security Act § 50.8.5 (Dec 14, 2023). This policy remains in places as of the most recent final rule codifying the program in regulation. Calendar Year 2025 Physician Fee Schedule Final Rule, 89 Fed. Reg. 98251 (Nov. 1, 2024).

[18] Eisinger RW, Dieffenbach CW, Fauci AS. HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable. JAMA. 2019 Feb 5;321(5):451-452.

importance of medication adherence, risk of transmission, and HIV drug resistance means that the HIV landscape poses unique challenges for both individual persons living with HIV and at the community level for public health.

HIV is a uniquely challenging virus to treat. Effectively targeting viral replication requires combining multiple drugs with different mechanisms of action.[19] Effectively managing HIV infection requires vigilance to avoid creating treatment-resistant mutations, which reduce the efficacy of antiretroviral therapy (ART) and may create the need for varied combinations of medications. HIV drugs have unique clinical and pharmacological qualities that need to be considered when selecting the most appropriate regimen for a person with HIV.[20]

Effectively treating HIV requires an individualized, tailored approach, meaning that there is often no true "therapeutic alternative" to a particular HIV medicine.[21] Indeed, the U.S. Department of Health and Human Services (HHS) Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV states that "selection of a regimen should be individualized" for a particular patient based on factors such as virologic efficacy, toxicity, potential adverse effects, pill burden, dosing frequency, drug–drug interaction potential, resistance-test results, comorbid conditions, and childbearing potential."[22] In recognition of the fact that there is often no meaningful "therapeutic alternative" for many HIV medicines, CMS should set the MFP for such medicines at the statutory ceiling price.

Moreover, treatment history and needs are complex for older adults with HIV and thus are a particular concern for the Medicare population. Studies show that, as people with HIV age, they are more likely to develop additional health issues and tend to develop them earlier than people who do not have HIV.[23] This often means they must take multiple medications and may be more prone to drug-drug interactions from medications for different conditions.

There is longstanding recognition under the Medicare program that patients need access to the particular HIV medication that was prescribed for them, and that HIV products are not interchangeable. Indeed, Congress and CMS have a longstanding record of recognizing the need for individualized treatment and how critical it is to maintain robust access for drugs in Medicare's six protected classes, including antiretrovirals. When Congress established Medicare Part D, it

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[19] HHS, Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv.
[20] HHS, Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv.
[21] *See* 42 U.S.C. § 1320f-3(e)(2).
[22] HHS, Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv; *see also*, HHS, NIH, Office of AIDS Research, Glossary of HIV/AIDS-Related Terms, 2025, 10th Edition, Information on HIV/AIDS treatment, prevention, and research (defining HIV "Treatment Regimen" as "A structured treatment plan designed to improve and maintain health. Recommended regimens for the initial treatment of HIV generally include a combination of three or more antiretroviral (ARV) drugs from at least two different HIV drug classes."), https://clinicalinfo.hiv.gov/sites/default/files/glossary/Glossary-English_HIVinfo.pdf Accessed 6/16/2025.
[23] Collins LF, Armstrong WS. What It Means to Age With HIV Infection: Years Gained Are Not Comorbidity Free. JAMA Netw Open. 2020;3(6):e208023. doi:10.1001/jamanetworkopen.2020.8023; Gross, AM, et al. Methylome-wide analysis of chronic HIV infection reveals five-year increase in biological age and epigenetic targeting of HLA. Molecular Cell. 2016, 62(2). 157-168.

recognized that robust access to certain medicines is central to the wellbeing of beneficiaries who need those therapies, and that their prescribers need the ability to choose among the full range of treatment options.[24] The protected classes were codified in statute as part of the 2008 Medicare Improvements for Patients and Providers Act (MIPPA) and strengthened by the Affordable Care Act.[25] The Medicare Part D Manual also recognizes the importance of the protected classes, stating that "CMS instituted this policy because it was necessary to ensure that Medicare beneficiaries reliant upon these drugs would not be substantially discouraged from enrolling in certain Part D plans, as well as to mitigate the risks and complications associated with an interruption of therapy for these vulnerable populations."[26]

With respect to the antiretroviral protected class, CMS has acknowledged the "number of multiple drug combinations and adjunctive therapies involved," the frequency with which drug protocols are subject to change, and "the role that changing drug resistance plays in determining the selection of among the different antiretroviral drugs."[27] CMS affirmed its long history of support for the protected classes as a permanent part of the Part D program in the 2019 final rule on modernizing Medicare Part D.[28]

At this time, 81.6% of people living with HIV have been linked to care, but only 65.1% of the diagnosed population has achieved viral suppression.[29] The HIV viral suppression rate in the U.S. is the lowest among comparable high-income countries.[30] Implementation of price controls that disrupt care for patients who are successfully suppressing their virus will only make these statistics worse. Whether a person is starting therapy for the first time or has been treated for decades, ensuring unrestricted access to optimal antiretroviral therapy is essential for the patient, and is critical to achieving the public health goal of decreasing transmission and, ultimately, ending the HIV epidemic.

Additionally, supporting innovation in HIV treatment is critical to ending the HIV epidemic. HIV treatment has evolved from multi-tablet regimens with complex dosing schedules to single-tablet regimens taken orally once a day and long-acting injectables that reduce dosing

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[24] Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173 (Dec. 8, 2003); 149 Cong. Rec. S15887 (Nov. 25, 2003) (emphasizing that one purpose of Medicare Part D is to ensure broad medication coverage for patients, especially those "who need exactly the right medicine for them"); 149 Cong. Rec. at S15887-88 ("Victims of HIV/AIDS are somewhat unique since the treatment for HIV/AIDS varies with the individual. To be clear, no low-income Medicare beneficiaries who have HIV/AIDS will be denied access to the drugs they need in Medicare Part D").

[25] Section 176 of Medicare Improvements for Patients and Providers Act of 2008, Pub. L. 110-275, July 15, 2008(amending Social Security Act (SSA) § 1860D-4(b)(3)(G)); Section 3307 of the Affordable Care Act, Pub. L. 111-148, March 23, 2020 (amending SSA § 1860D-4(b)(3)(G)(i)(II)).

[26] Medicare Prescription Drug Benefit Manual, Pub. No. 100-18, Chapter 6 – Part D Drugs and Formulary Requirements, § 30.2.5 (Rev. 18, January 2016), https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf.

[27] Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; Proposed Rule, 79 Fed. Reg. 1918, 1944 (Jan. 10, 2014).

[28] 42 C.F.R. § 423.120(b)(2)(vi)(C).

[29] Data from https://map.aidsvu.org/profiles/nation/usa/continuum-of-care#2-4-Achieving-Viral-Suppression, Accessed 5/22/25.

[30] KFF, HIV Viral Suppression Rate in the U.S. Lowest Among Comparable High-Income Countries, https://www.kff.org/hivaids/slide/hiv-viral-suppression-rate-in-u-s-lowest-among-comparable-high-income-countries/ Accessed May 29, 2025.

frequency. Reduced dosing frequency, the ability to take the medicine with food, and other administration simplifications can assist patients with adhering to a treatment regimen. Current and future investments in research and development aim to further reduce dosing frequencies, improve drug administration technology, and pursue a potential cure for HIV. Price controls threaten incentives for developing critical lifesaving HIV medications and new scientific discoveries. Accordingly, we urge CMS to set the MFP for such medicines at the statutory ceiling price to avoid inhibiting the continued progress that has been made against this deadly and infectious disease.

II. CMS Should Continue to Treat Fixed Combinations of Active Moieties/Active Ingredients as Distinct QSSDs – Particularly If the Combination of the Components Results In a Clinically Meaningful Difference

As Gilead has emphasized in its prior comment letters, the statute makes clear that fixed combination products are distinct QSSDs.[31] Specifically, the statute limits a QSSD to a drug approved under a new drug application (NDA) or biologics license application (BLA) and uses the terms "drug product" or "biological product" — which refer to the finished product, not an active ingredient or active moiety — in the QSSD definition. The QSSD definition also requires "at least 7 years" to have elapsed from the date of "such approval" to the selected drug publication date for a drug product and "at least 11 years" from the date of "such licensure" to the selected drug publication date for a biological product, further supporting that a QSSD encompasses a single drug product approved under a single NDA (including all sNDAs) or a single biological product approved under a single BLA (including all sBLAs). Accordingly, products with different approvals cannot be treated as the same QSSD. As discussed below, this is particularly true for fixed combination products.

Treating fixed combination drugs as distinct QSSDs is consistent with Section 1192(d)(3)(B) of the Act, which describes the data CMS will use to determine whether a QSSD satisfies the criteria for a negotiation-eligible drug. That provision states that in determining whether a QSSD is a "negotiation-eligible drug," CMS "shall use data that is aggregated across dosage forms and strengths of *the drug*" — *i.e.*, a single drug — "including new formulations of *the drug*, such as an extended release formulation."[32] Because different fixed combination products comprise multiple active moieties or active ingredients that may be included in other drugs, they cannot be new formulations of a *single* drug, as required by the statutory language referencing "new formulations of ***the*** drug."

Moreover, fixed combination drugs are *not* merely changes in the "dosage form" or "dosage strength" of an existing drug.[33] Rather, they include the addition of an entirely different

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[31] *See* IPAY 2026 Comments and IPAY 2027 Comments, *supra*, note 3.

[32] 42 U.S.C. § 1320f-1(d)(3)(B) (emphasis added).

[33] The statute uses the word "including" as a bridge between "dosage forms and strengths" and "new formulations," it makes clear that "new formulations" are a *subcategory* of "dosage forms and strength" changes. *See, e.g.*, *Hincapie-Zapata v. U.S. Att'y Gen.*, 977 F.3d 1197, 1202 (11th Cir. 2020) ("Sometimes the listed examples are broader than the general category and need to be limited in the light of that category. For example, the phrase 'any American automobile, including any truck or minivan,' would not naturally be construed to encompass a foreign-manufactured truck or minivan." (citation, quotation marks, and brackets omitted)). Further reinforcing this reading,

molecular entity and constitute distinct drugs that involve significant alterations from existing products. As we have commented previously, Congress did not intend "new formulations" to include significant changes such as combinations – otherwise it would not have chosen, as the sole example of a "new formulation," an extended release formulation that merely constitutes a slight alteration of dosage form. Combination products treat conditions in novel ways and are expensive and timely to research and develop and require complex chemistries, unlike extended-release formulations. Formulating novel combination products requires multiple approaches and becomes increasingly sophisticated – development of one single combination product may necessitate many attempts given the components of physical compatibility, dosage strength, pill size, solubility, permeability, and stability differences. To ensure that all of the medicines in a pill are delivered to a patient and made bio-available, Gilead typically develops and tests between five and ten formulations of our medicines before identifying a combination that works for patients. Combination products represent important scientific advancements in patient care. Treating combination products as new formulations would stifle innovation and harm patients.

Gilead therefore strongly supports CMS' continued treatment of fixed combination drugs with distinct combinations of active moieties or active ingredients as distinct QSSDs, as articulated in the IPAY 2026 and 2027 Guidance, and now again in the Draft Guidance. We appreciate that CMS states in the Draft Guidance that "treating distinct combinations of active moieties/active ingredients as one active moiety/active ingredient for the purpose of identifying potential qualifying single source drugs is generally appropriate."[34] CMS further states, however, that "there may exist fixed combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference."[35] CMS seeks input on how the addition of drugs payable under Part B may impact the fixed combination policy described in the Draft Guidance and how it might consider grouping such fixed combination products with products containing at least one but not all active moiety(ies)/active ingredient(s) into the same potential QSSD for both drugs payable under Part B and/or covered under Part D.

Gilead urges CMS to maintain its current, clear policy that fixed combination drugs with distinct combinations of active moieties or active ingredients are distinct QSSDs. Determining whether a particular active ingredient or active moiety "does not result in a clinically meaningful difference" is vague and unwarranted additional standard. FDA's definition of fixed dose combination already recognizes the clinical contribution of each component. FDA treats fixed-dose combination drugs as new drug products requiring robust review and approval to ensure patient safety and efficacy. FDA requires the submission and review of original NDAs or BLAs, as opposed to a supplemental application, even when a combination drug consists only of

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the only listed example of a new formulation in the statute — "extended release formulations" — involves precisely that kind of change.

[34] Section 30, Draft Guidance.

[35] Section 30, Draft Guidance. CMS provides the example of including active moiety/active ingredient X to a different active moiety/active ingredient Y, but active moiety/active ingredient X does not result in a clinically meaningful difference because it affects the bioavailability of active moiety/active ingredient Y, but is not therapeutically active against the disease state for which active moiety/active ingredient Y is indicated. *Id.*

previously approved active moieties.[36] FDA's requirement for an original NDA or BLA ensures that the agency can assess the complete and extensive evidence developed for fixed combination drugs.[37] Such applications are subject to user fee requirements and a lengthy review period in recognition of the significant FDA resources necessary for review of NDAs or BLAs for combination drugs.[38]

If CMS were to nevertheless revise its existing approach, depending on how broadly CMS began grouping drugs containing at least one but not all of the same active moieties/ingredients, this change could result in very different drugs being grouped into the same QSSD. For example, individual components, when combined into a single tablet regimen (STR) to treat HIV or HCV, clearly "result[s] in a clinically meaningful difference" compared to only one or two of the components. If CMS were to treat all STRs containing at least one, but not all, of the same active moieties/ingredients as the same QSSD, this could inappropriately group STRs to treat HIV or HCV with their components, ignoring the critical role that each of the multiple components in a single drug plays in attacking different parts of the viral lifecycle to suppress the virus and stop spread of disease. HHS has recognized that "[m]onotherapy or the treatment of HIV is not recommended outside of a clinical trial. The optimal regimen for initial treatment of HIV includes multiple antiretroviral (ARV) drugs from at least two different HIV drug classes."[39] Complete regimens are critical to achieving viral suppression and requires the use of combination ARV regimens that generally include three active drugs from two or more drug classes.[40]

Single tablet regimens represent meaningful advances in highly active antiretroviral therapy (HAART).[41] For example, with the first HIV drug (AZT, azidothymidine), sequential monotherapy and incomplete virological suppression resulted in the emergence of multiple resistance mutations, with long-term treatment consequences in the early years of HIV treatment. HAART regimens, first used in the mid-1990s, consisting of two nucleoside reverse transcriptase

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[36] FDA, *Guidance for Industry: Submitting Separate Marketing Applications and Clinical Data for Purposes of Assessing User Fees*, at 3 (Dec. 2004) ("Every . . . combination of two or more different active ingredients should be submitted in a separate original application.").

[37] For example, as the FDA notes, "[a]n NDA or ANDA is generally the appropriate marketing authorization pathway for a drug-led combination product," and an "NDA for a drug-led combination product must contain, among other things, a demonstration of the safety and effectiveness of the product for the conditions prescribed, recommended, or suggested in the proposed labeling." FDA, *Guidance for Industry and FDA Staff: Principles of Premarket Pathways for Combination Products*, at 12 (Jan. 2022). FDA goes on to note that "[t]o appropriately ensure the safety and effectiveness of a combination product in a single application, such application should enable a substantially similar evaluation to that which would be applied to each constituent part if they were reviewed under separate applications . . . including consideration of data and information that would be reviewed under the separate applications." *Id.* at 6.

[38] FDA, PDUFA Reauthorization Performance Goals and Procedures Fiscal Years 2018 Through 2022, https://www.fda.gov/media/99140/download.

[39] HHS, AIDSinfo, HIV/AIDS Glossary: Monotherapy, https://clinicalinfo.hiv.gov/en/glossary/monotherapy

[40] HHS, Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV: Treatment Goals (updated Jan. 28, 2016), https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/treatment-goals; *see also* Office of AIDS Research, Glossary of HIV/AIDS-Related Terms (10th ed. 2025) (defining HIV "Treatment Regimen" as "A structured treatment plan designed to improve and maintain health. Recommended regimens for the initial treatment of HIV generally include a combination of three or more antiretroviral (ARV) drugs from at least two different HIV drug classes."), https://clinicalinfo.hiv.gov/sites/default/files/glossary/Glossary-English_HIVinfo.pdf.

[41] *See* HIV.gov HIV Timeline, 1981-2024, https://www.hiv.gov/hiv-basics/overview/history/hiv-and-aids-timeline Accessed 6/16/2025.

inhibitors (NRTIs) plus a protease inhibitor (PI) or non-nucleoside reverse transcriptase inhibitor (NNRTI), were capable of virological suppression (<400 copies ml−1), and widespread uptake quickly led to dramatic reductions in morbidity and mortality in the developed world. Studies have demonstrated the efficacy of triple-drug therapy. For example, the ACTG 320 study found that a three-drug combination of the protease inhibitor indinavir and two NRTIs reduced viral loads to very low levels for up to one year in people who had previously been taking single-drug therapy, and also showed that adding at least two new drugs when switching therapy is more effective than adding a single new drug.[42] The strategy of using two NRTIs plus a potent third agent still forms the cornerstone of current treatment principles, and is now referred to as combination ART.[43]

The synergistic potential of components of a complete regimen may be necessary to achieve treatment goals. As an example, Biktarvy® (bictegravir, emtricitabine, and tenofovir alafenamide) is indicated as a *complete regimen* for the treatment of human immunodeficiency virus type 1 (HIV-1) infection in adults and pediatric patients weighing at least 14 kg, who have no antiretroviral treatment history; or to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no known or suspected substitutions associated with resistance to bictegravir or tenofovir.[44] Biktarvy® exhibits synergistic in vitro antiviral effects in pairwise combinations with tenofovir alafenamide, emtricitabine, or darunavir and maintains potent antiviral activity against HIV-1 variants resistant to other classes of antiretrovirals.[45] In contrast, other drugs that include certain active moieties/active ingredients of Biktarvy® may only be indicated *in combination with other antiretroviral agents* for the treatment of HIV-1 (*e.g.*, Emtriva® (emtricitabine only)[46] and Descovy® (emtricitabine and tenofovir alafenamide only)[47]).

III. CMS Should Clarify that Drugs Covered Under Part B As "Additional Preventive Services" are not QSSDs and Thus are Not Eligible for Selection

CMS recently adopted a coverage policy and payment methodology for drugs covered as "additional preventive services" (DCAPS) under section 1833(a)(1)(W)(ii) of the Social Security

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[42] NIH, Antiretroviral Drug Discovery and Development (last rev. Feb. 5, 2024), https://www.niaid.nih.gov/diseases-conditions/antiretroviral-drug-development.

[43] Tseng A, Seet J, Phillips EJ. The evolution of three decades of antiretroviral therapy: challenges, triumphs and the promise of the future. Br J Clin Pharmacol. 2015 Feb;79(2):182-94. doi: 10.1111/bcp.12403. PMID: 24730660; PMCID: PMC4309625.

[44] Biktarvy® Highlights of Prescribing Information, https://www.gilead.com/~/media/files/pdfs/medicines/hiv/biktarvy/biktarvy_pi.pdf.

[45] Tsiang M et al. Antimicrob Agent Chemother 2016; 60:7086–97, https://pmc.ncbi.nlm.nih.gov/articles/PMC5118987/.

[46] Emtriva, Prescribing Information § 1, https://www.gilead.com/~/media/files/pdfs/medicines/hiv/emtriva/emtriva_pi.pdf ("EMTRIVA® is indicated *in combination with other antiretroviral agents* for the treatment of HIV-1 infection.") (emphasis added),

[47] Descovy, Prescribing Information § 1.1, https://www.gilead.com/~/media/Files/pdfs/medicines/hiv/descovy/descovy_pi.pdf ("DESCOVY is indicated, in *combination with other antiretroviral agents*, for the treatment of HIV-1 infection in adults and pediatric patients weighing at least 35 kg. It's also indicated, in *combination with other antiretroviral agents* other than protease inhibitors that require a CYP3A inhibitor, for the treatment of HIV-1 infection in pediatric patients weighing at least 14 kg and less than 35 kg.") (emphasis added).

Act (SSA).[48] Under SSA § 1861(ddd)(1), additional preventive services are services that identify medical conditions or risk factors and that the Secretary determines are: (1) reasonable and necessary for the prevention or early detection of illness or disability; (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

In October 2024, CMS established a National Coverage Determination (NCD) for pre-exposure prophylaxis (PrEP) Using Antiretroviral Therapy to Prevent Human Immunodeficiency Virus (HIV) Infection.[49] This national policy "covers furnishing HIV PrEP using antiviral drugs, including the supplying or dispensing of these drugs and the administration of injectable PrEP."[50] Therefore, CMS' NCD covers all PrEP medications as additional preventive services under Medicare Part B.

Subsequently, CMS established payment for DCAPS, developing a specific payment methodology that treats such drugs as "additional preventive services" and not as separately payable Part B drugs. In particular, CMS clarified the unique nature of the DCAPS benefit category and reimbursement scheme:

> *[T]he authority at section 1833(a)(1)(W)(ii) of the Act provides for payment for additional preventive services, including drugs. This authority differs from the authority used to pay for drugs that are separately paid as drugs and biologicals under other Part B payment authorities.* Specifically, payment for most drugs separately payable under Part B is authorized at section 1833(a)(1)(S) of the Act and outlined at section 1842(o)(1)(C) of the Act, and those payments are generally made according to the methodology described at section 1847A of the Act, which typically reflects a payment limit based on the Average Sales Price (ASP). In addition, *because drugs covered as additional preventive services (hereinafter, DCAPS; we will use the term ''DCAPS drugs'' for the ease of the reader) are not described in section 1842(o)(1)(C) of the Act, provisions under section 1847A of the Act would not apply, including requirements for manufacturers to report ASP data to CMS on a quarterly basis* (see sections 1847A(f) and 1927(b)(3)(A)(iii) of the Act).[51]

The statutory definition of QSSD include "a drug or biological product for which payment is made under part B...."[52] Although DCAPS are technically drug products, they are not payable under Part B as drugs—they are covered and paid for as additional preventive services. Therefore, CMS should not consider DCAPS to be "drug[s]...for which payment is made under Part B" and

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[48] *See* Calendar Year 2025 Physician Fee Schedule Final Rule, 89 Fed. Reg. 97710, 98221 (Dec. 9, 2024).
[49] CMS, Preexposure Prophylaxis (PrEP) Using Antiviral Therapy to Prevent Human Immunodeficiency Virus (HIV) Infection, Final Decision Memorandum, CAG-00464N (Sept. 30, 2024), https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&ncaid=310.
[50] *Id.*
[51] 89 Fed. Reg. at 98221 (Dec. 9, 2024) (emphasis added).
[52] Section 1320f-1(e)(1) of the Social Security Act.

should not consider Part B utilization of such drugs when identifying selected drugs for any initial price applicability year.

Moreover, CMS should not include DCAPS utilization when calculating a ceiling price for a selected drug with both Part B (DCAPS) and Part D (non-DCAPS) utilization. For a drug that is selected under the MFP Program that has utilization under both Part B and Part D, any utilization under Part B due to its coverage as an additional preventive service should be excluded from ceiling price calculations. Calculating a single combined amount based on DCAPS utilization in Part B and non-DCAPs utilization in Part D would not only be inconsistent with statute, but also introduce operational complexities for both CMS and dispensing entities, and consequently reduce access to necessary prevention services for Medicare beneficiaries. In particular, the "volume-weighted average of the Part B amount" for HIV PrEP DCAPS cannot be compared to a Part D amount for a drug covered for HIV treatment that is "the sum of the plan-specific enrollment weighted amount." Additionally, deductibles and coinsurance are waived under Part B for DCAPS, but apply under Part D for HIV treatment. Setting an MFP for a drug with no patient cost sharing would not improve patient affordability.

This also is sound policy given the importance of HIV Prevention and the potential of the MFP Program to create disincentives that threaten public health. PrEP is a key component of HIV prevention as demonstrated by evidence that PrEP using antiretroviral therapy, when used according to the FDA label, can reduce the risk of acquiring HIV for those at increased risk of HIV.[53] HIV prevention avoids future health care utilization and other costs associated with infection.[54,55] Therefore, CMS should not treat DCAPS as QSSDs or include DCAPS utilization when calculating a ceiling price for a selected drug with both Part B (DCAPS) and Part D (non-DCAPS) utilization.

IV. CMS Should Not Use Domestic Reference Prices from Other Programs or Cost-Based Pricing, Which Undervalue Innovation

To support the continued need for innovation and avoid creating disincentives for such innovation, Gilead strongly recommends that CMS *not* use domestic reference prices from other programs that do not reflect the Medicare program's structure or enrollee population. Given that there are no other domestic programs covering drugs for beneficiary populations that are comparable to Medicare, a drug's value would not be reflected in prices used in non-Medicare programs.

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[53] For example, data show that ≥99.9% of participants who received Yeztugo in the Phase 3 PURPOSE 1 and PURPOSE 2 trials remained HIV negative. Gilead, Press Release, Yeztugo® (Lenacapavir) Is Now the First and Only FDA-Approved HIV Prevention Option Offering 6 Months of Protection (June 18, 20025), Yeztugo Lenacapavir Is Now the First and Only FDA Approved HIV Prevention Option Offering 6 Months of Protection.

[54] Cohen, J.P., Anupindi, V.R., Doshi, R. et al. Estimation of Lifetime Costs Among Insured Persons with HIV in the United States. PharmacoEconomics Open (2025). https://doi.org/10.1007/s41669-025-00584-0

[55] D'Angelo, S., Bates, L., and Honeycutt, A., 2023. Memorandum on the Updated HIV Incidence Assumptions for the PrEP Cost Calculator. Available at: https://hivhep.org/wp-content/uploads/2024/02/PrEP_Cost_HIV_Incidence_Updates_Memo_20231128.pdf [Accessed 23 June 2025].

Additionally, Gilead urges CMS *not* to use starting points based on any type of cost-based pricing (sometimes termed "cost-plus" or "fair profit") pricing, including consideration of "whether R&D costs have been recouped and margin on unit cost of production and distribution."[56] Doing so will limit patient access to innovative therapies, create incentives for inefficient cost management, and lower the reimbursement which is critical to funding research for future innovation. Cost-based pricing does not sufficiently allow innovators to recover their R&D costs, as it does not accurately capture these investments.[57,58] As such, cost-based pricing can have the effect of limiting patient access to future innovations, including potential cures, because manufacturers are less incentivized to invest in R&D.[59] Global health organizations also recommend against countries using cost-based pricing due to its lack of transparency and the lack of consensus on what cost inputs ought to be included; additionally, there is little evidence and country experience using cost-based pricing.[60]

Unit cost and distribution-based pricing promotes inefficient drug development if R&D costs are considered. Cost-based pricing would incentivize inefficiency because manufacturers are not rewarded for streamlining their processes.[61] This can result in high-cost manufacturers commanding higher prices than their more efficient counterparts. Moreover, it can undermine the sustainability of health care systems by driving up costs through incentives for inefficient production.[62]

Unit cost and distribution-based pricing do not drive investment toward highest value areas. Cost-based pricing misdirects innovators with incentives that are not necessarily aligned with patient-centric or societally-oriented unmet need (e.g., areas with high R&D costs or lowest risk of failure), rather than the highest value areas (i.e. those of most benefit to patients and health

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[56] Section 60.3.2, Draft Guidance.

[57] Towse, A., Hernandez-Villafuerte, K. and Shaw, B., 2018. A critique of the paper "The estimated costs of production and potential prices for the World Health Organization Essential Medicines List". [online] Available at: https://www.ohe.org/publications/critique-paper-estimated-costs-production-and-potential-prices-world-health/ [Accessed 31 Mar. 2025].

[58] WHO, 2020. Evidence and recommendations. In: WHO guideline on country pharmaceutical pricing policies [Internet]. [online] World Health Organization. Available at: https://www.ncbi.nlm.nih.gov/books/NBK570143/ [Accessed 16 Apr. 2025].

[59] Towse, A., Hernandez-Villafuerte, K. and Shaw, B., 2018. A critique of the paper "The estimated costs of production and potential prices for the World Health Organization Essential Medicines List". [online] Available at: https://www.ohe.org/publications/critique-paper-estimated-costs-production-and-potential-prices-world-health/ [Accessed 31 Mar. 2025].

[60] WHO, 2020. WHO Guideline on Country Pharmaceutical Pricing Policies. Geneva: World Health Organization.

[61] Schlander, M., Hernandez-Villafuerte, K., Cheng, C.-Y., Mestre-Ferrandiz, J. and Baumann, M., 2021. How Much Does It Cost to Research and Develop a New Drug? A Systematic Review and Assessment. Pharmacoeconomics, 39(11), pp.1243–1269. 10.1007/s40273-021-01065-y.

[62] Bell, E., Berdud, M., Cookson, G. and Hodgson, S., 2023. Delivering the Triple Win: A Value-Based Approach to Pricing. [online] Office of Health Economics. Available at: https://www.ohe.org/publications/delivering-triple-win-value-based-approach-pricing/ [Accessed 10 Apr. 2025].

systems).[63] Thus, future innovations are likely to deliver less health gains to patients and less progress in areas of unmet need.

While Gilead continues to oppose government price setting in all forms, we suggest that, if CMS must select a drug and is unable or unwilling to provide the ceiling price, it should utilize value-based pricing instead of these other pricing approaches. In contrast to cost-based pricing, value-based pricing has the capacity to increase patient access and account for patient experiences, while also supporting healthcare system sustainability and promoting innovation.[64]

Finally, in the Draft Guidance, "CMS is soliciting comments on possible alternative approaches to determine a starting point for a selected drug with one or more therapeutic alternatives, including (1) considering a starting point between (a) the Part B ASP/WACs, the Net Part D Plan Payment and Beneficiary Liability, or the combined Part B and D amount discussed above for the therapeutic alternatives and (b) the statutory ceiling; or (2) considering a starting point between (a) the Part B ASPs/WACs, the Net Part D Plan Payment and Beneficiary Liability, or the combined Part B and Part D amount discussed above for therapeutic alternatives and (b) unit cost of production and distribution of the selected drug."[65] Gilead opposes CMS using starting points that are expressed as a range, because ranges are inconsistent, arbitrary, and subject to distortions. In particular, ranges based on the Net Part D Plan Payment and Beneficiary Liability for therapeutic alternatives are subject to distortions resulting from Part D plan sponsor behavior that may be a reaction to other MFPs. Given the drawbacks to and concerns about these other sources, Gilead urges CMS to use the statutory ceiling price.

V. Gilead Strongly Opposes Inclusion of Manufacturer Discount Program Payments and 340B Pricing in Manufacturer Net Price Metrics.

A. CMS Should Not Include Manufacturer Discount Program Payments in Manufacturer Net Medicare Part D Price Metrics or the Calculation of Net Part D Plan Payment and Beneficiary Liability

Gilead has concerns about CMS' proposal to include Manufacturer Discount Program Payments in its consideration of selected drug's sales data and determination of the value of its therapeutic alternative(s). In the Appendix of the Draft Guidance, CMS includes two Manufacturer Net Medicare Part D Price Metrics ("Manufacturer net Medicare Part D average unit price" and "Manufacturer net Medicare Part D average unit price – best"), reported at the NDC-11 level, that include "coverage gap discounts for calendar years prior to the calendar year date specified in the applicable information collection and discounts under the Manufacturer Discount Program for the same calendar year as specified in the applicable information collection, and other supply chain

[63] Bell, E., Berdud, M., Cookson, G. and Hodgson, S., 2023. Delivering the Triple Win: A Value-Based Approach to Pricing. [online] Office of Health Economics. Available at: https://www.ohe.org/publications/delivering-triple-win-value-based-approach-pricing/ [Accessed 10 Apr. 2025].

[64] Bell, E., Berdud, M., Cookson, G. and Hodgson, S., 2023. Delivering the Triple Win: A Value-Based Approach to Pricing. [online] Office of Health Economics. Available at: https://www.ohe.org/publications/delivering-triple-win-value-based-approach-pricing/ [Accessed 10 Apr. 2025].

[65] Section 60.3.2, Draft Guidance.

concessions (e.g., wholesale discounts)...not reflected in the sum of the plan-specific weighted amounts calculation and utilization, that may differ from the PDE data."[66] Additionally, CMS proposes to use the "Net Part D Plan Payment and Beneficiary Liability," defined as "Part D total gross covered drug cost (TGCDC) net of DIR and CGDP and/or Manufacturer Discount Program payments," for purposes of valuing therapeutic alternative(s) with regard to selected drugs and developing initial offers.[67]

The Manufacturer Discount Program payments are part of the Medicare Part D benefit structure, like the deductible or the government contribution. It is not part of the price of the drug from the manufacturer to the Medicare Part D plan or any other customer. Moreover, Congress specifically provided that Medicare Part D statutory discounts (i.e., discounts under the new Manufacturer Discount Program) are not owed on selected drugs.[68] Including Medicare Part D prices net of Manufacturer Discount Program payments, either when considering prices of the selected drug or when evaluating its potential therapeutic alternatives, would undermine Congress' intent in creating a clear separation between MFP discounts and Part D statutory discounts, because it would effectively incorporate the Part D statutory discounts into the MFP determination.

B. Gilead Opposes Inclusion of 340B Pricing in Manufacturer Net Medicare Part D and Commercial Price Metrics Because It Would Discourage Sub-ceiling Discounts and Inappropriately Base Medicare Prices on Prices Intended for Safety-Net Populations

The definitions in Appendix A of the Draft Guidance for Manufacturer Net Medicare Part D Price Metrics and Manufacturer and U.S. Net Commercial Price Metrics provide that those metrics include "other supply chain concessions (e.g., wholesale discounts)" but do not specifically reference whether discounts to 340B covered entities are included or excluded.[69] The 340B statute specifically provides that manufacturers may offer voluntary discounts to covered entities that are below the 340B ceiling price.[70] Congress and CMS also have excluded these voluntary discounts from the Medicaid Best Price and Average Sales Price (ASP) determination.[71]

Gilead therefore urges CMS to clarify that 340B prices should not be included in the following metrics:

- "Manufacturer net Medicare Part D average unit price,"
- "Manufacturer net Medicare Part D average unit price – best,"
- "Manufacturer U.S. commercial average net unit price,"
- "Manufacturer U.S. commercial average net unit price – net of patient assistance program," and

[66] Appendix, "Market Data and Revenue and Sales Volume Data," at 213, Draft Guidance.
[67] Section 60.3, Draft Guidance. CMS further notes that given that the CGDP ended in December 2024 and the Manufacturer Discount Program took effect in 2025, the Net Part D Plan Payment and Beneficiary Liability will be determined using PDE data records to remove Manufacturer Discount Program payments rather than CGDP payments, as applicable and as available. *See* footnote 97, Draft Guidance.
[68] *Id.*
[69] Appendix A, Draft Guidance.
[70] 42 U.S.C. § 256b(a)(10).
[71] SSA § 1927(c)(1)(C)(i)(I); SSA § 1847A(c)(2)(A).

- "Manufacturer U.S. commercial average net unit price – best."

Gilead believes that 340B prices should not be included in any of these metrics because doing so would discourage manufacturers from providing sub-ceiling discounts and could inappropriately base Medicare prices on prices intended for safety-net populations. Moreover, the U.S. Net Commercial Price metrics explicitly exclude Medicaid fee-for-service and Medicaid managed care.[72] Because the 340B ceiling price is based on metrics from the Medicaid program,[73] and the Manufacturer U.S. Net Commercial Price metrics explicitly exclude Medicaid prices, it would be inappropriate to include 340B discounts in these metrics.

VI. CMS Should Give Substantial Weight To Certain Section 1194(e)(2) Factors Such as Patient Outcomes and Clinical Appropriateness and Improve Stakeholder Engagement

A. When Considering Potential Therapeutic Alternatives and Developing Initial Offers, CMS Should Give Substantial Weight to Section 1194(e)(2) Factors Such As Patient Outcomes and Clinical Appropriateness

In its Draft Guidance, CMS states that it will prioritize clinical appropriateness in the selection of therapeutic alternatives;[74] however, Gilead urges CMS to identify therapeutic alternatives based solely on clinical appropriateness, which, as noted above, is complex and individualized for HIV. The statute's reference to "therapeutic" alternatives makes clear that such alternatives should be selected based on their therapeutic use, and not based on cost.[75] Clinical appropriateness should be determined through review of clinical guidelines, and input from clinical experts, manufacturers, providers, and other stakeholders.

The agency reiterates in the Draft Guidance that it will consider the effects of the selected drug and its therapeutic alternative(s) on specific populations (e.g., individuals with disabilities, the elderly, other patient population) and the extent to which the selected drug and its therapeutic alternatives address an unmet need.[76] We believe that CMS should recognize subpopulations based on treatment experience and/or specific and difficult forms of a disease when considering "unmet medical need."[77] CMS's definition should be broadened to consider patient subpopulations within the disease that have high disease burden – such as specific and difficult forms of a disease – and unmet need. In those cases, a medicine may help to close disparities between populations. For example, lower income populations are more likely to be infected with HIV and may also face greater difficulties in adhering to medicines. Notably, CMS's definition of "unmet medical need"[78] is much narrower than the definition the FDA uses. FDA defines unmet medical need as "a

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[72] *Id.*
[73] 42 U.S.C. § 256b(a)(2).
[74] Section 60.3.1, Draft Guidance.
[75] Only then, *after* the therapeutic alternatives are identified, can CMS consider their cost as a factor in determining the MFP. SSA § 1194(e)(2).
[76] Section 60.3.3.1, Draft Guidance.
[77] See Gilead comment letter on IPAY 2026.
[78] *See* Appendix A, p. 214, Draft Guidance (A circumstance in which the relevant disease or condition is one for which no other treatment options exist, or existing treatments do not adequately address the disease or condition.").

condition whose treatment or diagnosis is not addressed adequately by available therapy" that includes either "an immediate need for a defined population" or "a longer-term need for society."[79] Broadening the definition of unmet medical need to consider patient subpopulations within the disease that have high disease burden would better align with this existing FDA guidance.

B. Gilead Encourages CMS to Facilitate Patient Input and Ensure Such Input is Meaningfully Considered

Gilead strongly encourages CMS to ensure that patient input is meaningfully considered during the MFP determination process. CMS should continue making efforts to solicit information about the patient experience and should give substantial weight to the factors that patients care most about when assessing the value of a drug. Patients can best express the value that HIV medications bring to them, and CMS should consider this patient perspective in its reviews and explanations of the agency's decision making.

CMS indicates that it intends to host public engagement events to seek input from patients and other interested parties.[80] Gilead is encouraged to see CMS' interest in patient views on disease conditions and areas of value in the "Negotiation Data Elements." Gilead strongly encourages CMS to ensure that this patient input is meaningfully considered during the MFP determination process. Although it is encouraging that CMS seeks information about the patient experience, the IPAY 2026 MFP explanations did not suggest that CMS was meaningfully using feedback from patients. Each product received a one sentence summary of patient input in the explanations, and CMS did not explain how this input impacted its assessment of the Section 1194(e)(2) factors. Moving forward, CMS should commit to a transparent explanation of how input from all public engagement events impacts its evaluation process, particularly regarding the Section 1194(e)(2) factors. Such transparency should include, but not be limited to, describing CMS's safeguards for making sure discriminatory cost-effectiveness measures, including those based on quality-adjusted life years (QALYs) or similar measures, are not considered in the agency's decision making procedures. Otherwise, patients and other stakeholders will question the utility of participation in CMS' process and doubt the fairness of the MFPs. We encourage CMS to give substantial weight to the factors that patients care most about when assessing the value of a drug. Patients can best express the value that HIV medications bring to them, and CMS should consider this patient perspective in its review of the Negotiation Data Elements.

Gilead believes CMS can continue to adopt further best practices for patient engagement to incorporate feedback from individuals who may have concerns about stigma associated with their disease. To receive a greater amount of patient-centered evidence directly from patients, their caregivers, and providers, CMS should prioritize more robust and meaningful engagement methods to improve patient-centricity of the program throughout the MFP determination process. We also advise CMS to consider the format it follows for the public sessions to ensure it is conducive to beneficiary input and maximizes the feedback that can be solicited from patients. Patient and caregiver engagement opportunities should offer a diversity of formats, scheduling options, and provide reasonable assurances of privacy for those who do not wish to interact in openly public forums.

[79] FDA, Guidance for Industry Expedited Programs for Serious Conditions – Drugs and Biologics (2014)
[80] Section 60.4.1, Draft Guidance.

VII. CMS Should Abandon Its Non-Statutory Bona Fide Marketing Standard

Under the statute, a drug or biological product may not be selected for negotiation where a generic or biosimilar product is "marketed" by the selected drug publication date or during the negotiation period. For purposes of determining "marketed," as under the IPAY 2026 and 2027 Final Guidance, CMS has created a "bona fide marketing" standard.[81] As we commented previously, applying a "bona fide marketing" standard to determine whether a generic or biosimilar has been marketed conflicts with the statute and is unduly restrictive. The statute provides that a drug does not qualify as a QSSD if an FDA-approved generic drug is "approved and marketed" or a biologic is "licensed and marketed."[82] The "bona fide marketing" standard deviates from the plain meaning of "marketed" and imposes requirements not found in the statute, replacing a clear statutory rule with an amorphous totality of the circumstances analysis that creates considerable uncertainty and delay in determining the effect of a generic or biosimilar on whether the listed drug or reference product qualifies as a QSSD. As directed by the statute, CMS must consider only whether the generic or biosimilar has been "marketed"—i.e., introduced or delivered for introduction into interstate commerce.

We remain disappointed that CMS proposes to continue to follow this standard in lieu of what the statute demands. However, to the extent CMS retains the bona fide marketing standard, which it should not, Gilead is encouraged that CMS is considering a broader range of data. We support the use of Average Manufacturer Price (AMP) data as well as the additional data CMS is considering reviewing for drugs payable under Part B and covered under Part D (*e.g.*, ASP data, Medicaid State Drug Utilization Data, and/or data from a nationally representative and commercially available database).[83] As we commented previously, CMS should not overly rely on PDE data. Congress provided that a drug does not qualify as a QSSD if it is "the listed drug for *any* drug that approved and marketed under section 355(j)."[84] Congress did not limit the relevant universe of generic drugs solely or instruct CMS to rely on those included in PDE data, which reflects only Part D claims. CMS should begin its analysis with a broader range of data and allow manufacturers to submit additional data as needed to demonstrate that a generic or biosimilar has entered the market.

CMS also provides examples in the Draft Guidance of circumstances where CMS would consider the bona fide marketing standard to be met.[85] Gilead is concerned that these examples are subjective, lack predictability, and introduce new requirements that are not listed in the statute. For example, it is unclear how CMS will determine whether a generic/biosimilar has "high and consistent" PDE utilization, AMP sales, and/or ASP sales, or if such data is low, whether the generic/biosimilar manufacturer "has successfully launched their product, and there is no evidence of agreements limiting distribution of the generic or biosimilar product."[86] These are highly

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[81] CMS considers a drug to be marketed when the totality of the circumstances, including Medicare Part D prescription drug event (PDE) data and average manufacturer price (AMP) data for a specified period, establish the drug is the subject of "bona fide marketing"

[82] SSA § 1192(e)(1)(A)(iii) & (B)(iii).

[83] Section 30.1, Draft Guidance.

[84] SSA § 1192(e)(1)(A)(iii) (emphasis added).

[85] Section 30, Draft Guidance.

[86] Section 30.1, Draft Guidance.

subjective assessments as to whether sales are "high and consistent" or whether a launch has been "successful" and could result in an incorrect determination that the generic/biosimilar is not "marketed" simply because initial market uptake is slow. The statute also makes no mention of agreements regarding distribution of the generic/biosimilar product as relevant to whether such generic/biosimilar is "marketed," in contrast to other provisions of the IRA where Congress directly addressed such agreements,[87] demonstrating that Congress did not intend CMS to delve into such considerations when determining whether a generic or biosimilar is "marketed."[88]

That CMS' ultimate determination would be "based on the totality of the circumstances and not on the presence, or absence, of any single factor" creates further uncertainty about how this bona fide marketing standard would be applied and if it would be wielded consistently.[89] Gilead thus urges CMS to abandon this misguided standard.

VIII. Gilead Supports a Larger Role for the MTF, but Additional Safeguards, Guidance, and Controls are Needed to Improve Effectuation of the MFP and Prevent 340B Duplicate Discounts

Under the statute, a Primary Manufacturer that provides access to the MFP for a selected drug is not required to provide a 340B ceiling price on that same selected drug claim if the MFP is lower than the 340B ceiling price.[90] Hence, the 340B nonduplication provision makes clear that the price concessions are not cumulative. Gilead supports the 340B Program as one way to ensure broader access to medicines for uninsured, low-income patients. We are concerned, however, based in part on our experience with the 340B Program, that unless further guidance is provided and sufficient guardrails are put in place, it will be difficult, if not impossible, to identify and prevent duplicate discounts consistent with the IRA's 340B nonduplication requirement. The 340B Program has experienced unprecedented growth in recent years; by one estimate, purchases under the 340B Program totaled over $124 billion in wholesale acquisition cost (WAC) dollars, representing year-over-year growth of 16.5%.[91] Five year growth of the 340B program was 129.4%, more than triple the growth rate of non-340B sales.[92] Today, the 340B Program is the second largest federal healthcare program in terms of prescription drug sales, behind only Medicare Part D.[93] This magnifies the need to ensure duplicate discounts are avoided.

CMS acknowledges in the Draft Guidance that it has received numerous requests from interested parties for CMS to assume responsibility for nonduplication of the 340B ceiling price and MFP. Gilead is disappointed that CMS states that it "will not, at this time, assume responsibility for nonduplication of discounts between the 340B ceiling price and MFP."[94] While

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[87] SSA § 11002(f)(2)(C)(iv).

[88] *See, e.g., FCC v. NextWave Personal Comm'ns, Inc.*, 537 U.S. 293, 302 (2003) ("[W]here Congress has intended to provide regulatory exceptions to provisions of the Bankruptcy Code, it has done so clearly and expressly....").

[89] Section 30.1, Draft Guidance.

[90] Section 1193(d)(1) of the Social Security Act.

[91] IQVIA, The 340B Drug Discount Program Grew to $124B in 2023 (2024), https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2024/iqvia-update-on-size-of-340b-program-report-2024.pdf.

[92] *Id.*

[93] BRG, Measuring the Relative Size of the 340B Program (June 2022), https://www.thinkbrg.com/insights/publications/measuring-relative-size-340b-program-2020-update/.

[94] Section 40.4.5, Draft Guidance.

CMS states it is continuing to explore the feasibility of incorporating 340B-related transactional data from 340B covered entities or their third party administrators (TPAs) into the MTF process in the future, we urge CMS to act quickly and adopt concrete solutions. Below we reaffirm and build upon recommendations we previously provided regarding actions or approaches that CMS could take to ensure such discounts are not duplicated.

In particular, Gilead supports the use of a single, neutral MTF to perform the following dual roles: (1) to provide claims-level data elements to manufacturers, facilitating the validation of MFP-eligible claims and preventing diversion; and (2) to administer retrospective MFP discounts from manufacturers to dispensing entities. Our recommendations if adopted would help to enhance the role of the MTF and improve MFP effectuation and compliance with the 340B nonduplication requirement.

A. Additional Guidance, Safeguards, and Processes, such as a 340B Claims Clearinghouse, are Needed.

CMS is *required* under the statute to "establish[] procedures to carry out the provisions of [the MFP Program] . . . with respect to . . . [MFP]-eligible individuals,"[95] and the 340B nonduplication requirement is a core component of MFP effectuation because it determines whether 340B covered entities are owed the MFP for drugs dispensed to MFP-eligible individuals. Therefore, CMS cannot simply refuse to facilitate the implementation of this requirement. Given the importance of a robust process to validate claims, as we have previously commented, we again urge CMS to adopt a claims clearinghouse model to validate 340B claims and prevent duplicate discounts.[96]

CMS could refer to the Oregon Medicaid program's model as an example of a claims clearinghouse, while building in additional components to ensure data accuracy.[97] Under this model, 340B claims must be identified and sent to the state rebate vendor for each calendar quarter within thirty days after the end of that quarter, and the state rebate vendor uses the 340B claims files to match up the original paid encounter and exclude the claim from the quarterly drug rebate process.[98] If there is an error and a validation fails, the claim is sent back to the trading partner for correction.[99]

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[95] SSA § 1196(a)(3).

[96] June 28, 2024 Letter to Dr. Meena Seshamani, 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 in 2026 and 2027; March 10, 2023 Letter from Gilead to Dr. Meena Seshamani, re: Medicare Part D Drug Inflation Rebates Paid by Manufacturers: Initial Memorandum, Implementation of Section 1860D-14B of Social Security Act, and Solicitation of Comments; April 14, 2023 Letter from Gilead to Dr. Meena Seshamani, re: Medicare Drug Price Negotiation Program: Initial Memorandum, Implementation of Sections 1191-1198 of the Social Security Act for Initial Applicability Year 2026, and Solicitation of Comments.

[97] Oregon Health Authority, Retroactive 340B Claims File Instructions, https://www.oregon.gov/oha/HSD/OHP/Tools/340B%20Claims%20File%20Instructions%20and%20Design.docx.

[98] *Id.*

[99] *Id.*

CMS could consider using the MTF or a Third-Party Administrator (TPA) to manage the clearinghouse, similar to the agency's use of a TPA for the Part D Coverage Gap Discount Program and the new Manufacturer Discount Program. The TPA could collect 340B claims information from providers and provide it to manufacturers for validation. If a manufacturer reviews the claims data and as a result, disputes the 340B status of a particular prescription, and the covered entity agrees that the claim was inappropriately billed (either as a 340B claim or non-340B claim), that manufacturer should have the ability to submit data to the clearinghouse to update the claim information.

If CMS implements a clearinghouse model, Gilead encourages CMS to set forth clear, applicable requirements for all 340B stakeholders. CMS also should establish penalties for covered entities that do not submit claims data to the clearinghouse in the specified time frame or underreporting 340B claims over a specified time period. For example, CMS, in consultation with HRSA, could provide that a covered entity's repeated failure to comply could result in losing eligibility for participating in either Medicare or the 340B program. Additionally, if CMS establishes a clearinghouse, Gilead encourages HHS to employ the same clearinghouse to comply with other statutory requirements that involve identifying 340B claims, such as the prohibition against Medicaid duplicate discounts and the non-duplication prohibitions applicable to Medicare inflation rebates. To ensure accuracy of data reporting, covered entities should report all 340B sales, not just Medicare sales. Additionally, manufacturers should be able to receive 340B claims data from the clearinghouse. This would allow verification that the total number of 340B claims reported by each covered entity match the 340B discounts provided to that covered entity on each drug.

Using the same TPA to administer both the MFP discount program and a 340B clearinghouse would provide valuable efficiencies. The TPA could obtain Medicare Part D PDE data from CMS in addition to 340B claims information from covered entities, and use this information to remove 340B claims identified in time from the MFP invoices provided to manufacturers (unless the MFP is lower than the 340B ceiling price, in which case the amount invoiced to the manufacturer would be reduced to equal the difference between the MFP and the 340B ceiling price).

While Gilead is optimistic about the role that a 340B claims clearinghouse could play in preventing prohibited 340B duplicate discounts broadly, we recognize that significant work must be done for such a clearinghouse to be implemented effectively. In this context, it is critical that a clearinghouse receive accurate and timely data to identify MFP-eligible claims and prevent diversion of product subject to the MFP discount to individuals that are not MFP-eligible individuals. Until and unless CMS and HRSA require and enforce timely identification of 340B claims before an MFP discount is paid, another process will be necessary to ensure non-duplication of 340B and MFP payments.

B. Gilead Supports the Option for Manufacturers to Voluntarily Use Private Market Solutions Instead of the MTF For Aspects of MFP Effectuation, Particularly to Prevent 340B Duplicate Discounts.

In Section 40.4 of the Draft Guidance, CMS notes that while Primary Manufacturers and dispensing entities participating in Part D plan networks will be required to enroll in the MTF DM

(and CMS expects that Primary Manufacturers and dispensing entities will use the MTF platform to support access to the MFP for selected drugs beginning 2026), CMS notes that "it is possible that the private sector could develop alternative solutions for sharing verified data or for routing refund payment form manufacturers to dispensing entities." As a result, CMS solicits comments on potential private market solutions that could offer an alternative to the MTF and the extent to which interested parties perceive the need for ongoing MTF support. We believe it is important that CMS continues to invest in the MTF such that manufacturers can choose between a private solution and the MTF for various capabilities.

Gilead appreciates the potential option to use a private market solution as an alternative, or potentially an additive, to the MTF. As CMS acknowledges in the Draft Guidance, manufacturers will require data from covered entities to validate 340B claims.[100] We also support CMS' proposal that, if a drug is identified as 340B after a MFP discount has been paid, the manufacturer can pay the covered entity the difference between the MFP and the ceiling price and not also be required to replenish at the 340B ceiling price.[101] However, there is not yet an established process for all covered entities to provide this data to manufacturers in a timely, efficient, and consistent manner.

Therefore, private market solutions such as a 340B rebate model—in which the manufacturer offers the 340B price through a rebate after receiving limited claims level data—can facilitate manufacturers obtaining such data from covered entities to verify that a particular purchase is 340B-eligible. HRSA issued guidance permitting ADAPs to use a rebate model in 1998.[102] We therefore believe an expansion of such models to other covered entities could ultimately efficiently and effectively identify and prevent 340B/MFP duplicate discounts and support compliance with other statutory requirements that involve identifying 340B claims, such as the prohibition against Medicaid duplicate discounts and the exclusion of 340B units from the Part D inflation rebate program. Despite these evident program integrity benefits and the fact that the 340B statute permits manufacturers to provide the 340B ceiling price in the form of a rebate,[103] HRSA has thus far opposed manufacturer efforts to implement 340B rebate models for covered entities other than ADAPs.[104] We urge HHS to revisit this position, which undermines a timely, effective, and free to the government solution to effectuating the multiple statutory prohibitions on 340B duplicate discounts.

C. CMS Could also Mandate Timely Use of a 340B Claim Indicator for Dispensing Entities to Help Identify Duplicate Discounts.

Mandatory timely use of a 340B Claim Indicator by dispensing entities is an additional approach that could help prevent duplicate discounts between the 340B and MFP Programs. As currently contemplated in the list of MTF Data Module (DM) Claim-Level Data Elements contained in Table 2 of the Draft Guidance, the 340B Claim Indicator "Assists the manufacturer

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[100] Specifically, CMS "anticipates this will include utilizing data available from covered entities and their 340B TPAs, and other prescription drug supply chain stakeholders." Section 40.4.5, Draft Guidance.

[101] Section 40.4.5, Draft Guidance.

[102] 63 Fed. Reg. 35239, June, 29, 1998.

[103] 42 U.S.C. § 256b(a)(1).

[104] *See, e.g.*, Letter from Carole Johnson, Administrator, HRSA to Joaquin Duato, CEO, Johnson & Johnson (Sept. 17, 2024) ("Because J&J's rebate proposal, if implemented, violates J&J's obligations under the 340B statute, it subjects J&J to potential consequences, such as termination of J&J's Pharmaceutical Pricing Agreement (PPA).").

in assessing applicability of section 1193(d)(1) of the Act," but will only be available "as *voluntarily* reported by dispensing entity."[105] In the absence of a claims clearinghouse another clear process for manufacturers to access 340B claims data, such as private market rebate models, we strongly urge CMS to make reporting of the 340B Claim Indicator **mandatory** for dispensing entities and limit the timeframe for claiming 340B discounts to ensure accuracy of those claims indicators. As CMS has acknowledged, the IRA includes an express 340B nonduplication requirement: manufacturers of selected drugs only are required to provide the lower of the MFP *or* the 340B ceiling price—but not both—when a covered entity dispenses a selected drug to a Medicare beneficiary that is a "patient" of the covered entity.[106] None of the other Claim-Level Data Elements in Table 2 are sufficient to identify whether a unit was purchased at the 340B price, making the 340B Claim Indicator a critical data element to identify and prevent duplicate discounts.

Research has shown that covered entities do not consistently include 340B modifiers on insurance claims where use of such modifiers is not mandatory. For example, a 2023 study found that "[m]odifier usage reached 90% in some segments when reporting was mandatory, fell below 20% when it was optional, and dropped below 1% when it was impractical."[107] It is therefore critically important that CMS establish a uniform, mandatory standard for reporting 340B units to facilitate compliance with the 340B nonduplication requirement. Unless CMS mandates use of a 340B Claim Indicator, identification of 340B units in MTF Claim-Level Data from the PDE Record will be incomplete as 340B modifiers will not be used consistently, undermining the intent of the statutory prohibition against duplicate MFP and 340B discounts.

Gilead further recommends that – if the agency chooses to rely on a claims modifier – CMS should require that all covered entities and contract pharmacies identify a patient as 340B-eligible at the point of sale and dispense product purchased under the 340B Program to that patient. Covered entities should also be required to affirmatively identify individuals who are not eligible for 340B through use of a different claims modifier. This identification requirement would help ensure that a pharmacy knows the 340B status of a particular unit of drug at the time the product is dispensed and has included an appropriate 340B indicator as appropriate on the claim. This would facilitate accurate claims information submitted in real-time and prior to adjudication and could also help to ensure that beneficiaries are able to receive any benefits the covered entity provides to 340B patients (e.g., lower cost sharing) at the point of sale. If point of sale identification is not possible, CMS could establish a system for pharmacies to determine 340B status before the MTF determines whether an MFP discount is owed and resubmit the 340B identification field without rebilling the claim. This would allow the pharmacy to correct claims while avoiding updated billing changes after dispense, such as when the applicable payer changes or a payer's coverage rules change.

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[105] MTF DM Claim-Level Data Elements, Table 2, Draft Guidance (emphasis added).
[106] SSA § 1193(d).
[107] Rory Martin, *et al.*, Can 340B Modifiers Avoid Duplicate Discounts in the IRA?, IQVIA White Paper (Feb. 2023), https://www.iqvia.com/locations/united-states/library/white-papers/can-340b-modifiers-avoid-duplicate-discounts-in-the-ira.

Research shows that 340B claims modifier usage was higher when the 340B status of the claim was known prior to or at the point of sale.[108] The requirement to identify a patient as 340B-eligible at the point of sale should also apply regardless of the insurance that the patient presents at the time of dispense, to encourage pharmacies to adopt and employ consistent processes that will improve the accuracy of 340B identification. Additionally, with respect to Medicare Part D claims, CMS also should require pharmacies to populate the 340B identifier on the claim at the point of sale to identify the claim as either 340B or not 340B and require Part D plan sponsors to deny claims that do not have the field populated with one of these values.

D. CMS Should Give Manufacturers More than 14 Days to Pay MFP Discounts and Confirm Payment to the MTF.

In the Draft Guidance, CMS proposes that the MFP must be passed through to the dispensing entity within 14 days of the MTF sending claim-level data elements to the manufacturer that verify that the selected drug was dispensed to an MFP-eligible individual.[109] This time limit is far too short. Identifying claims subject to the 340B nonduplication requirement is a resource- and cost-intensive process, and 14 days is wholly insufficient for manufacturers to perform even basic due diligence on the claims, particularly given the limited data that manufacturers would receive from the MTF. As we have urged previously, CMS should give manufacturers at least 38 days to provide the MFP discount to the dispensing entity (and sufficient data) to adequately validate the MFP-eligibility of claims. This would be consistent with the time that manufacturers have to pay Medicaid rebates and Medicare Part D Manufacturer Discount Program.[110]

For drugs in certain therapeutic classes, including HIV, verification by manufacturers also is important to help avoid fraud stemming from the availability of significant statutory discounts. Gilead, for example, has been subject to fraudulent schemes by providers to exploit the 340B program. In 2020, Gilead brought an action in United States District Court for the Southern District of Florida against two networks of healthcare providers in Florida engaged in schemes to defraud Gilead's charitable free-drug medication assistance program (MAP) for critical pre-exposure prophylaxis (PrEP) HIV medications. The scheme allowed the providers to secure substantial profits for each bottle of PrEP medication purchased at 340B prices and purportedly dispensed to enrollees in Gilead's MAP; defendants were alleged to have obtained even greater fraudulent profits when they sought reimbursement from Gilead for dispensing PrEP medication that they illicitly repurchased from recruits for as little as $10, when they did not actually dispense the prescribed medication, or when they illegally resold the already-dispensed PrEP medication on the black market.[111] A subsequent consent decree, default judgment, and permanent injunction in 2022 and 2023 resolved these (and other) allegations and permanently enjoined the providers involved. However, Gilead has recently seen similar fraudulent behavior involving 340B and Gilead's copay

[108] *Id.* (The "340B status of a drug must be known at the point of sale to the patient in order to apply the modifier to the claim prior to adjudication. While this is possible for pharmacies that identify 340B transactions at the point of sale, which may occur in entity-owned pharmacies and often in those that use physical inventory, the drug's 340B status is unknown for pharmacies using the 340B replenishment model and virtual inventory which is used by almost all contract pharmacies.").

[109] Section 40.4.5 and 40.4, Draft Guidance.

[110] CMS, Manufacturer Release No. 89 (Mar. 10, 2014); CMS, Revised Medicare Part D Manufacturer Discount Program Final Guidance § 80.2.3 (Dec. 20, 2024).

[111] First Amended Complaint, *Gilead Sciences, Inc.; Gilead Sciences Ireland UC*, v. *AJC Medical Group, Inc. et al.*, Case No. 20-cv-24523-AMC (S.D. Fla.) (March 14, 2022).

assistance program, in addition to the primary payer. While Gilead's legal action against these fraudulent schemes helps protect Gilead's ability to provide free life-saving HIV medications to eligible individuals, the action demonstrates the time-consuming difficulty manufacturers face in identifying, investigating, and taking action with respect to fraud committed in connection with the 340B program. The 2020 Florida lawsuit alone took over 18 months--and 899 filings on the docket--to resolve once filed (not including the time to investigate and prepare). Timeframes that essentially prohibit any eligibility verification by the manufacturer will only encourage such fraud and drain resources that could better be spent on developing innovations for this nation's seniors.

In the absence of sufficient time to validate claims and adequate claim-level data (including the 340B Claim Indicator), the availability of the proposed dispute resolution process as contemplated in Section 90.2.2 of the Draft Guidance also will be of limited value to manufacturers. The Draft Guidance states that "[t]he disputing party will need to submit evidence supporting its position when making the report."[112] Manufacturers, however, may not be able to feasibly provide such evidence, given the limited time frame for manufacturers within which the MFP must be passed through to the dispensing entity and limited data available to manufacturers. Thus, CMS should provide sufficient claim-level data to manufacturers and extend the timeframe within which the MFP must be passed through to the dispensing entity.

E. CMS Should Permit Use of the "Standardized Default Refund Amount" in All Circumstances.

Gilead appreciates that the Draft Guidance would establish a "standardized default refund amount" (SDRA) and that CMS acknowledges that the use of WAC to calculate an SDRA "offers a reliable refund amount for both manufacturers and dispensing entities."[113] We encourage CMS to explicitly permit the use of the "Standardized Default Rebate Amount" as a sufficient methodology for offering the MFP in all circumstances or, at a minimum, in all circumstances except where dispensing entities alert the Primary Manufacturer that their acquisition costs were greater than WAC and provide the acquisition cost prior to the MTF DM transmitting the claim-level data elements to the Primary Manufacturer to initiate the 14-day prompt MFP payment window. Without such notice from dispensing entities, manufacturers do not have sufficient information to make an adjustment to the "Standardized Default Rebate Amount," given that dispensing entities often purchase through wholesalers and distributors, and thus the manufacturer may not have visibility into the acquisition cost of the dispensing entity. If CMS does not adopt this approach, we urge the agency to cap the rebate amount and clarify the limited situations when a refund amount other than the SDRA is appropriate.[114]

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Gilead hopes CMS will incorporate these suggestions into its revised final guidance and implement the MFP Program with a goal of ensuring that it does not disincentivize biopharmaceutical

[112] Section 90.2.2, Draft Guidance.
[113] Section 40.4.1, Draft Guidance
[114] Section 90.2, Draft Guidance.

innovation, which could hinder finding a cure for HIV and ending the HIV epidemic. If you have any questions, please do not hesitate to contact Abra Yeh at abra.yeh@gilead.com.

Sincerely,

Rekha Ramesh
Vice President, U.S. Policy
Government Affairs
Gilead Sciences, Inc.

Global Coalition on Aging

June 25, 2025

Chris Klomp, MBA
Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Drug Price Negotiation Program Draft Guidance

Dear Deputy Administrator Klomp:

The Global Coalition on Aging (GCOA) is the world's leading business voice on aging-related policy and strategy, aiming to reshape how global leaders approach and prepare for the 21st century's shift in population aging. Through research, public policy analysis, and advocacy, GCOA supports the advancement of innovative policy and market solutions, as well as efforts to ensure that global aging is a path to health, productivity, and economic growth.

Based on the communities we serve, we remain concerned about the ongoing implementation of the Medicare Drug Price Negotiation Program (MDPNP) and current Draft Guidance for initial price applicability year (IPAY) 2028, which threatens to disrupt continuity of care for Medicare beneficiaries by negatively impacting access to necessary treatments and diverting resources away from critical research and development of new treatments.

According to the most recent census data from 2020, 16.8% of the U.S. population are age 65 and older and, from 1920 to 2020, this age group grew five times faster than the general population – thanks, in part, to continued innovation of and access to medicines that help extend lifespans and improve quality of life.[1] As the U.S. population ages, it is essential to have policies and systems in place that support and promote healthy aging, leading to better outcomes for older adults. Medicare is one such system established to help older Americans access and receive care.

Approximately 90% of people enrolled in Medicare are over the age of 65. We are concerned about how the IPAY2028 Draft Guidance will affect access to medicines for seniors and individuals with disabilities now and in the future.[2,3] Older adults are disproportionately impacted by chronic conditions – including diabetes, heart disease, HIV, and cancer - and rates of chronic conditions in older Americans are set to double by 2050.[4]

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[1] United States Census Bureau: The Older Population: 2020 (May 2023)
[2] Centers for Medicare & Medicaid Services (CMS): Medicare Monthly Enrollment (January 2025)
[3] Centers for Medicare & Medicaid Services (CMS): Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 (May 2025)
[4] Frontiers in Public Health: Projecting the chronic disease burden among the adult population in the United States using a multi-state population model (January 2023)

A majority of the drugs recently selected for IPAY2027 are used to treat chronic conditions such as diabetes, asthma, COPD, cancer, and other conditions – highlighting the negative consequences the MDPNP stands to have on access to treatments for those and other chronic conditions and, as a result, opportunities for healthy aging in the U.S.[5]

Prioritize Patient Engagement

As CMS continues to evaluate and implement the MDPNP, patient and caregiver perspectives and input must be meaningfully incorporated into the process. Since the MDPNP was first established through the passage of the Inflation Reduction Act (IRA) in 2022, CMS has provided limited information about how patient and caregiver engagement is incorporated into the negotiation process. An analysis of the first round of Medicare negotiations revealed that CMS received approximately 12 minutes of evidence for each selected drug or therapeutic alternative per listening session, with just over half of the speaker slots filled. Of these speakers, 57% were below the Medicare age, indicating a lack of engagement with the patients whom the MDPNP will most impact.[6]

While we recognize the changes that CMS has made to improve patient engagement opportunities since the program's implementation began, the IPAY2028 Draft Guidance continues to fall short in ensuring that all patients and advocates have meaningful opportunities to provide input about the process and drugs selected for negotiations. CMS continues to withhold information about how negotiations are conducted, the process for determining prices, and how the patient perspectives shared during engagement opportunities are incorporated into the calculations of maximum fair prices (MFPs). **CMS must provide timely insight into how negotiations are conducted and commit to transparency throughout the implementation of the program.**

Additionally, CMS has not taken adequate steps to protect beneficiary access to medicines selected for price setting. A recent analysis found that for nine of the first ten drugs selected for negotiation for IPAY2026, the average out-of-pocket cost increased by 32 percent.[7] CMS must ensure that patients are not experiencing unintended consequences, such as higher out-of-pocket costs and additional administrative barriers, through the use of utilization management tactics to access care as a result of the MDPNP.

Recognize Patient Preferences & Promote American Innovation

One area of concern within the IRA is the unnecessary distinction in negotiation timelines between small and large molecule drugs under the MDPNP, often referred to as the "pill penalty." This distinction makes small-molecule drugs – typically taken as pills, syrups, or in inhaled forms – eligible for negotiation four years earlier than large-molecule drugs. Due to this discrepancy, investment is being diverted away from research and development of small-molecule drugs.

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[5] Centers for Medicare & Medicaid Services (CMS): HHS Announces 15 Additional Drugs Selected for Medicare Drug Price Negotiations in Continued Effort to Lower Prescription Drug Costs for Seniors (January 2025)
[6] National Pharmaceutical Council (NPC): Lessons from a Quantitative Analysis of the First Round of CMS Patient Listening Sessions for IRA's Medicare DPNP (November 2024)
[7] Pioneer Institute: Pioneer Institute Launches Tracker Showing Drug Price Controls Are Raising Out-of-Pocket Costs for Medicare Patients (May 2025)

Since the IRA was introduced in 2021, there has been a nearly 70 percent reduction in early-stage funding for the development of small-molecule drugs, impacting the ability of treatments to reach new patients and manufacturers to reinvest in new research and development.[8]

Small-molecule drugs are the only molecules that can cross the blood-brain barrier, making them a critical and effective part of treatment for conditions that disproportionately impact older adults, such as cancer and neurological diseases. Due to the ability for patients to take these treatments at home and the lower costs and travel burden typically associated with small-molecule drugs compared to large-molecule drugs, small molecules are often preferred by older adults and people diagnosed with chronic conditions.[9] A recent survey found that 91 percent of respondents considered being "able to take the medicine at home" important or extremely important when evaluating the benefits of a new medicine to address an unmet need.[10]

Through the bipartisan Ensuring Pathways to Innovative Cures (EPIC) Act (S. 832/H.R. 1492), members of Congress have recognized the importance of small-molecule drugs, proposing changes to the IRA to correct the distinction between negotiation timelines for small and large-molecule drugs.[11,12] Additionally, the Trump administration has similarly signaled support for ending this discrepancy through an Executive Order in April 2025, noting how it "threatens to distort innovation by pushing investment towards expensive biological products, which are often indicated to treat rarer diseases, and away from small molecule prescription drugs, which are generally cheaper and treat larger patient populations."[13] **As such, CMS should exclude drugs that would be exempt from negotiation under the EPIC Act in IPAY2028 and future rounds of negotiation.**

The U.S. is a leader in biopharmaceutical innovation. A RAND Corporation study found that at the end of 2022, the U.S. had more total new drugs sold (74 percent of all new drugs) compared with any other individual country in the study.[14] However, analyses show that future revenue on drugs subject to negotiations may decrease by as much as 28 percent as a result of the IRA and MDPNP.[15] From 2014 to 2018, U.S.-based businesses produced twice as many chemical or biological entities as Europe and Japan, respectively.[16] China and other countries are emerging as competitors in the global biopharmaceutical market, with China's global share of clinical trials increasing from 10 to 15 percent over five years.[17]

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[8] Information Technology & Innovation Foundation: The Inflation Reduction Act Is Negotiating the United States Out of Drug Innovation (February 2025)
[9] Global Coalition on Aging (GCOA): The Inflation Reduction Act & Small Molecule Development: Policy Brief (June 2025)
[10] Partnership to Fight Chronic Disease (PFCD): Preserving Accessibility and Incentives for Development of Small Molecule Medicines for Chronic Diseases
[11] U.S. Senate: S.832 (March 2025)
[12] U.S. House of Representatives: H.R.1492 (February 2025)
[13] The White House: Executive Order: Lowering Drug Prices By Once Again Putting Americans First (April 2025)
[14] RAND Corporation: Comparing New Prescription Drug Availability and Launch Timing in the United States and Other OECD Countries (February 2024)
[15] Charles River Associates: Impact of Medicare Price "Negotiation" Program on small and large molecule medicines (May 2024)
[16] Information Technology & Innovation Foundation (ITIF): Not Again: Why the United States Can't Afford to Lose Its Biopharma Industry (February 2024)
[17] IQVIA: Rethinking Clinical Trial Country Prioritization (July 2024)

Without adequate revenue to spur research and discovery, as well as incentives to innovate and discover new treatments, the American pharmaceutical industry will fall behind other countries, leaving patients without the care they need and stunting the growth of a vital U.S. industry. By removing disincentives for the development of small-molecule drugs, CMS can secure future new and incremental innovations of small-molecule drugs and continue to elevate the United States as a leader in drug development.

Protect Access to Treatments

As the MDPNP continues to progress and more drugs are subject to MFPs set through Medicare negotiation, local pharmacies and community health centers may be unable to stock and store these treatments due to a loss of revenue. As a result, these critical providers may be forced to choose between providing needed treatments to patients or closing their doors. A recent survey conducted by the National Community Pharmacists Association (NCPA) found that more than 90 percent of independent pharmacies may not sell prescription drugs subject to federal price negotiations.[18] This will be particularly harmful for people living in rural communities who are more likely to receive care from these facilities. As of 2020, 77 percent of community pharmacies serve populations of 50,000 people or fewer.[19]

Many diseases that once burdened aging populations have evolved into manageable chronic conditions due to modern, safer, and more effective treatments, allowing many patients to live longer, healthier lives. HIV is one such condition that has turned from a death sentence to a manageable chronic condition, in part due to innovations in new treatment options. People living with HIV work in close consultation with their health care provider to determine individualized treatment regimens to minimize symptoms and achieve viral suppression. Recognizing the importance of continuity of care for people living with HIV and treatment adherence for both achieving better individual health outcomes and broader public health goals, Medicare has declared antiretrovirals, which are one type of treatment for HIV, as one of 6 Protected Classes.[20]

For people living with and at risk of HIV, not being able to access their prescriptions will be devastating. Interruptions to an individual's HIV treatment regimen can lead to impacts both at personal and public health levels, with the potential for more significant and widespread consequences than in other therapeutic areas.

Ultimately, barriers to timely access to effective HIV treatments could lead to the progression of costly resistant viruses and could further complicate HIV care for older adults living with HIV who have comorbid conditions.

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[18] National Community Pharmacists Association (NCPA): Report for Fall Survey of Independent Pharmacy Owners/Managers (October 2024)
[19] National Community Pharmacists Association (NCPA): NCPA Releases 2020 Digest Report (October 2020)
[20] Centers for Medicare & Medicaid Services (CMS): Medicare Prescription Drug Benefit Manual Chapter 6 – Part D Drugs and Formulary Requirements

Global Coalition on Aging

One simulation modeling study published in 2024 projected that by 2030, 45 percent of people living with HIV who are treated with antiretrovirals will be living with two or more comorbidities.[21] **CMS should follow its precedent of preserving beneficiaries' access to medicines within the 6 Protected Classes and exclude HIV drugs from the negotiation process within the MDPNP.**

CMS has solicited comments on the use of price ranges informed by concerning metrics and frameworks, such as domestic reference prices or cost-plus pricing. Due to the unique population that Medicare serves, CMS should not use starting points based on domestic prices from other programs that do not benefit the 90% of Medicare's beneficiaries who are over the age of 65. CMS should not refer to domestic or foreign drug prices associated with discriminatory value metrics, such as the Quality-Adjusted Life Year (QALY) methodology, which devalues the lives of older Americans and people living with disabilities. Through an IRA provision, the law itself notes that the QALY and other similar value-based metrics must not be used within the MDPNP.[22]

We urge you to support efforts to prioritize aging Americans by committing to meaningful and transparent patient engagement throughout the MDPNP implementation process, promoting American innovation, and protecting access to treatments that enable people to live longer, healthier lives. More specifically, CMS should exclude HIV treatments and drugs that would be exempt from negotiations under the EPIC Act in IPAY2028 and future guidance for the MDPNP.

Thank you for allowing us to share our concerns. We applaud your commitment to finding solutions that ensure continued access to treatment for patients, prioritize innovation of new treatments, and support opportunities for healthy aging.

We would be happy to discuss these concerns further or address any questions you may have.

Thank you,

Michiel Peters

Michiel Peters
Head of Advocacy Initiatives
Global Coalition on Aging

[21] PLOS Medicine: The forecasted prevalence of comorbidities and multimorbidity in people with HIV in the United States through the year 2030: A modeling study (January 2024)
[22] U.S. Congress: H.R.5376 – Inflation Reduction Act of 2022 (August 2022)

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June 25, 2025

Mehmet Oz, MD, MBA
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Draft Guidance for the Medicare Drug Price Negotiation Program: Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Administrator Oz:

Global Liver Institute (GLI) would like to express our sincere gratitude for the opportunity to provide feedback on the draft guidance for the Medicare Drug Price Negotiation Program for Initial Price Applicability Year (IPAY) for 2028. We were given the chance to participate in the recent CMS-hosted roundtable and appreciate the strides taken to ensure that patients impacted with liver diseases could contribute to the discussion.

Patient-centered care leads to improved outcomes[1], greater treatment adherence[2], and higher morale for clinical staff[3]. We thank you for uplifting patients' voices by including their perspectives in the IPAY process. Your inclusion of patients in the negotiation process aligns with those goals and must continue to ensure that cost-saving policies do not come at the expense of patient health and access.

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[1] Yu C, Xian Y, Jing T, et al. More patient-centered care, better healthcare: the association between patient-centered care and healthcare outcomes in inpatients. *Front Public Health*. 2023;11:1148277. Published 2023 Oct 19. doi:10.3389/fpubh.2023.1148277

[2] Dilles T, Mortelmans L, Loots E, et al. People-centered care and patients' beliefs about medicines and adherence: A cross-sectional study. *Heliyon*. 2023;9(5):e15795. Published 2023 May 2. doi:10.1016/j.heliyon.2023.e15795

[3] Lewis SE, Nocon RS, Tang H, et al. Patient-centered medical home characteristics and staff morale in safety net clinics. *Arch Intern Med*. 2012;172(1):23-31. doi:10.1001/archinternmed.2011.580

As a 501(c)3 nonprofit committed to solving the problems that matter to liver patients and improving the lives of individuals and families impacted by liver disease, GLI has long engaged in issues of access to high-value, high-quality care. We serve as a bridge between the impactful policies and the real-world experiences of the people they affect – including patients all over the country and the providers who serve them. In addition to providing comment on CMS rulemaking regarding Drug Price Negotiation Program for IPAY 2027, we have held Externally-Led, Patient-Focused Drug Development meetings with the FDA, partnered with key Congressional offices on priority legislative initiatives, and collaborated to establish ICD-10 codes to more accurately represent liver disease diagnoses. These efforts reflect our commitment to ensuring that federal health programs, including Medicare, are responsive to the needs of the communities we serve.

We commend several aspects of the IPAY process so far: CMS's facilitation of patient listening sessions ensured meetings were productive and efficient, the closed-door environment allowed for honest and comfortable dialogue, and the inclusion of both clinicians and patients in town halls allowed for a comprehensive understanding of treatment realities. Additionally, the availability of both written and verbal feedback opportunities, and clear communication about meeting purposes, contributed to the accessibility and transparency of the process.

To further strengthen these efforts, we encourage greater care in the selection and identification of meeting participants. While it is important that a variety of perspectives are represented, it is essential to ensure that those in the room suit the purpose of the meeting, and that the entities they represent are clear in order to avoid harm to patient trust, health, or understanding. Therefore, we urge CMS to fully vet participants to be sure that their participation is well-intentioned and does not undermine the perspectives of lived experience shared by others.

Additionally, we recommend CMS improve communication and clarity around how input from these meetings will be incorporated into future decisions. It is essential that patients know their advocacy is received and valued, and this can be accomplished through outlining how their advocacy impacts outcomes. We request that the CMS team reports the specific factors and evidence incorporated into calculations of maximum fair price (MFP) ceilings to demonstrate the clear role of patient testimony and public engagement in the larger process. Given the populations affected by the therapies affected, reports of this information should be linguistically accessible and readily available in multiple formats. This transparency will not only honor the stories told but also will help future participants ensure that they provide salient information in the future.

Beyond just clarity on intention, it is imperative that the current process for comment submission and participation be easily accessible and understandable to the average patient who may not be well versed in the advocacy realm and regulatory processes. Simplifying these processes and collaborating with networks like the National Health Council and the Council of Medical Specialty Societies could broaden participation and better reflect the diverse patient and provider experience.

Thank you again for your commitment to ensuring patient voices are heard and respected throughout this process. Please do not hesitate to contact Alyssa Davenport, Policy Director at adavenport@globalliver.org or Lily Benig, Associate Director of Science and Public Health at lbenig@globalliver.org if you or your staff would like to discuss these comments in greater detail. We are grateful to be able to work alongside CMS both in past and future endeavors.

Sincerely,

Larry R. Holden
President & Chief Executive Officer
Global Liver Institute

About Global Liver Institute

Global Liver Institute (GLI) is a 501(c)3 nonprofit organization founded in the belief that liver health must take its place on the global public health agenda commensurate with the prevalence and impact of liver illness. GLI promotes innovation, encourages collaboration, and supports the scaling of optimal approaches to help eradicate liver diseases. Operating globally, GLI is committed to solving the problems that matter to liver patients and equipping advocates to improve the lives of individuals and families impacted by liver disease. GLI holds Platinum Transparency with Candid/GuideStar, is a member of the National Health Council and NORD, and serves as a Healthy People 2030 Champion. Follow GLI on Facebook, Instagram, LinkedIn, and YouTube or visit www.globalliver.org.

GSK Comment Letter
Response to IPAY 2028 Draft Guidance

June 26, 2025

VIA ELECTRONIC SUBMISSION –

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Director Klomp:

GSK appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS, or the Agency) IPAY 2028 Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 (hereinafter, Draft Guidance).

As CMS finalizes this Draft Guidance, GSK appreciates CMS's willingness to solicit comments and offer listening sessions to understand stakeholder impacts and concerns related to implementation. While GSK is a member of PhRMA and supports their comments on this issue, we respectfully submit these more targeted comments in response to CMS's Draft Guidance.

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 is deeply concerned with the potential negative effects on innovation and patient access that could result if the Draft Guidance is finalized as proposed. In particular:

- Improving prioritization of the clinical value of selected drugs relative to therapeutic alternatives when determining initial offers, not the selected drug's unit cost of production and distribution.
    - Ambiguous and opaque selection criteria for therapeutic alternatives and how factors will be weighted in the determination of initial offers remain unclear, resulting in significant financial uncertainty that could harm innovation.
- Aggregating products for purposes of identifying a potential Qualifying Single Source Drug is an overly broad and simplistic approach neglects to consider clinically meaningful differences that do not hinge on the product's active moiety/active ingredient. This will impact future decision making and likely result in a decline in innovation.

- Failing to require covered entities to identify 340B units in claims submissions will exacerbate significant abuses in the 340B drug discount program, increasing the likelihood of duplicate discounts, without saving patients money or improving health outcomes for vulnerable populations.
- Aligning MFP effectuation policies across Part D and Part B fails to account for the unique administrative and financial burden of Part B MFP effectuation on providers, and may result in Part B providers declining to stock certain drugs or choosing to refer patient to health systems, further exacerbating access concerns for Medicare patients.

These are just a few among many examples demonstrating that implementation of the Negotiation Program, as currently proposed, is likely to result in serious and widespread barriers to patient access. Such outcomes run counter to CMS's core policy objective of promoting timely and equitable access to prescription drugs for Medicare patients. GSK strongly urges CMS to recalibrate its implementation strategy, shifting away from a framework that is narrowly focused on lowering Medicare spending, and instead adopting a patient-centered approach that prioritizes access to innovative therapies for vulnerable Medicare populations.

We respectfully submit the additional comments below (see appendix) to address our concerns with these proposals and to highlight issues of paramount interest to GSK and the patients we serve.

GSK appreciates the opportunity to comment on the IPAY 2028 Draft Guidance. Please contact Molly Burich Molly.M.Burich@gsk.com if you have any questions about the topics discussed in our comments or if GSK can provide any further information.

Sincerely,

Molly Burich
Head of Public Policy
US Government Affairs, Public Policy and Patient Advocacy

Appendix

I. Section 60.3.2 – Developing a Starting Point for the Initial Offer
Section 60.3.3 – Adjusting the Starting Point Based on Section 1194(e)(2) Factors

Recommendation: GSK recommends that CMS not use the unit cost of production and distribution of the selected drug and should place greater weight on the clinical therapeutic advances over alternatives when determining initial offers.

Comment: CMS seeks comments on alternative methods for determining the starting point for selected drugs that have multiple therapeutic alternatives. CMS highlights two potential approaches: 1) setting the starting point between therapeutic alternatives and the ceiling price; and 2) setting the starting point between therapeutic alternatives and unit cost of production and distribution of the selected drug. CMS is also interested in feedback on whether it should place greater emphasis on specific negotiation factors as well as on its methodology for applying those factors consistently across selected drugs when adjusting starting points during the negotiation process.

GSK strongly opposes CMS's proposal to adopt a starting point that is based on the unit cost of production and distribution of the selected drug. This metric is wholly inadequate for assessing a drug's therapeutic value and does not capture the substantial investment, scientific innovation, and risk inherent in the development of complex therapies—particularly biologics reimbursed under Part B. Moreover, focusing narrowly on current production and distribution costs disregards additional costs associated with bringing a drug to Medicare patients, including government-required taxes, fees, and discounts. This approach would devalue innovation and contradict the purposes of the program.

Furthermore, in response to CMS's solicitation regarding whether the agency should place a greater emphasis on a particular negotiation factor, GSK asks that CMS consider placing greater weight on whether a drug represents a clinical therapeutic advance over therapeutic alternatives, as this factor most concisely captures the value of a drug for Medicare patients.

GSK also supports CMS's clarification that it will not use evidence from comparative effectiveness research in a manner that treats extending the life of an individual who is elderly, disabled, or terminally ill as of lower value, and will not use QALYs.

II. Section 50.1 – Manufacturer-Specific Data

Recommendation: GSK urges CMS to not finalize requiring manufacturers to submit "forward looking" data as part of the collection and consideration of additional market data during the negotiations process.

Comment: In the Draft Guidance, CMS seeks comment on the collection and consideration of additional market data that is "forward-looking" and overlaps with the period in time between selection and start of the IPAY. According to CMS, this information can assist the agency as it considers anticipated net pricing and volume change during the negotiation process. CMS provides two examples of the type of data that might be included: (1) annual US net revenue

forecast, volume by indication, and net pricing by market channel, and (2) annual gross-to-net across all market channels and market share by volume and by indication. According to CMS these data are consistent with section 1194(e)(1)(E) language relating to "market data and revenue and sales volume data for the drug in the United States." The Draft Guidance points to an example scenario of a substantial WAC price decrease planned for a selected drug prior to the initial price applicability year as information that could be informative during discussions with manufacturers.

GSK opposes CMS's proposal to also consider additional market data that is "forward looking" during the negotiations process. CMS does not have the statutory authority under Section 1194(e) to require the submission of forecasted data. Neither does CMS have the authority to consider this data as part of the negotiation process. In addition, CMS does not need to create unnecessary risks with potential breaches of highly sensitive, confidential information that this proposal produces.

If CMS finalizes requiring manufacturers to submit "forward looking" data, CMS should request future production and distribution costs associated with the selected product rather than projected revenue or profit data. Costs for producing and distributing products are not static, therefore CMS should evaluate over a multiple year period of time. Manufacturers' costs may increase due to investments in capital products to ensure safe and efficient production, changes in inflation, possible tariffs, and other costs. CMS should incorporate these variable costs into its assessment if it insists on requiring "forward looking" data.

Furthermore, we note that manufacturers are already subject to extensive data submission obligations under the negotiation process. Imposing additional, non-statutory data requirements would only further heighten the administrative burden for manufacturers.

Recommendation: GSK strongly recommends CMS allow manufacturers to respond with a single response for a manufacturer's research and development (R&D) costs and simple (Yes/No) attestation for recoupment.

GSK is concerned with CMS' approach to collecting research and development cost information for selected drugs. Manufacturer decisions on research and development are conducted at a portfolio level and are not followed at a product level. The expectation is for approved therapies to subsidize the many expensive failed trials inherent in clinical development. CMS' requirement for reporting R&D costs mandates reporting more data than is necessary to determine recoupment and does not account for current practices and the complex nature of bringing safe and effective treatments to the market.

GSK recommends adopting a single response for R&D costs and a simple (Yes/No) attestation for R&D recoupment. Further, manufacturers should only report additional information if they respond "No." Supplemental information is necessary to ensure CMS provides an upward adjustment to price offers if the manufacturer selects "No". CMS does not need more information for determining price offers if the manufacturer reports it has recouped R&D costs.

The IRA requires CMS to consider R&D costs to the extent they have been recouped, and this approach achieves the statutory obligation.

III. Section 60.3.1 – Identifying Indications for the Selected Drug and Therapeutic Alternatives for Each Indication

Recommendation: GSK urges CMS to not finalize its proposal to consider a product's off-label use for purposes of identifying indications for a selected drug in IPAY 2028. GSK also opposes any future consideration of non-pharmaceutical healthcare services as potential therapeutic alternatives to the selected drug.

Comment: In the Draft Guidance, CMS states that, for purposes of identifying indications for a selected drug in IPAY 2028, it may consider off-label use if such use is included in evidence-based clinical practice guidelines and the off-label use is a medically-accepted indication payable under Part B or covered under Part D, taking into consideration the major drug compendia, authoritative medical literature, and/or accepted standards of medical practice. CMS also seeks comment on whether to consider non-pharmaceutical healthcare services as potential therapeutic alternatives to the selected drug in future rulemaking.

GSK recommends CMS refrain from considering products' off-label use as a price comparator when establishing MFP. Using a product's off-label use, as opposed to a product's approved indication, is too broad a framework for CMS to establish a comparative pricing alternative. CMS should consider the ramifications of comparing products that are not fully equivalent – including generic products – and how that practice could stifle future therapy innovation.

GSK also opposes any future consideration of non-pharmaceutical healthcare services as potential therapeutic alternatives to the selected drug. First, the statute is focused on Part B and Part D drugs and does not contemplate that CMS would consider non-pharmaceutical therapeutic alternatives in this context. Furthermore, and as CMS states in the Draft Guidance, "pharmaceutical therapeutic alternatives will be the most analogous alternatives to the selected drug when considering treatment effect and price differentials." There are material differences between pharmaceuticals and non-pharmaceutical healthcare services, making comparisons between the two a case of apples and oranges. Moreover, broadening the scope of potential therapeutic alternatives to include health care services risks opening a pandora's box of "evidence about alternative treatments" that the agency may consider, and for manufacturers to respond to, and would only serve to further complicate this component of an already convoluted negotiation process.

We also stress that therapeutic alternatives should be based solely on clinical appropriateness. Clinical guidelines are the most appropriate and useful source of information in therapeutic alternative selection. Existing evidence, including clinical trials and pre-/post-approval real-world evidence, should also be considered in decisions on therapeutic alternatives, with the recognition that registration of clinical trials may have used comparators that were appropriate at the time but are no longer relevant due to advances in treatment and new standards of care.

CMS should also directly engage clinical experts to inform therapeutic alternative selection, as well as patient experiences.

GSK also recommends that CMS establish a transparent framework which outlines the therapeutic alternatives selected by the agency and an explanation detailing how such therapeutic alternative met CMS's selection criteria. This is necessary to ensure that proper comparisons are selected and evaluated as therapeutic alternatives.

IV. Section 30.1 – Identification of Qualifying Single Source Drugs (QSSD) for Initial Price Applicability Year 2028

A. QSSD Definition

Recommendation: **CMS should not continue to aggregate products for purposes of identifying a potential QSSD based only on the product's active moiety or ingredient. This over-broad and overly simplistic approach neglects to consider clinically meaningful differences that do not hinge on the product's active moiety/active ingredient. Rather, CMS should adopt a clear case-by-case or multi-dimensional approach to identification of potential QSSDs that appropriately aligns with FDA statutory authority and clinical expertise.**

Comment: In the Draft Guidance, CMS proposes to continue identifying potential QSSDs by aggregating all dosage forms and strengths of a drug or biological product with the same active moiety / active ingredient and the same holder of an NDA or BLA, respectively, including products that are marketed pursuant to different NDAs or BLAs. CMS proposes to identify the active moiety or active ingredient of the drug using public sources and to "consult with FDA as appropriate to, for example, clarify whether a suffix or prefix in an ingredient name represents a genuine difference in active ingredient."

While CMS has a legitimate interest in recognizing genuine, clinically meaningful differences for purposes of identifying individual QSSDs and avoiding unwarranted exclusion of drugs from selection under the Negotiation Program, **CMS should not continue to aggregate products for purposes of identifying a potential QSSD based only on the product's active moiety or ingredient. This over-broad and overly simplistic approach neglects to consider clinically meaningful differences that do not hinge on the product's active moiety/active ingredient.** These clinically meaningful differences would be evident in a case-by-case approach or even in a multi-dimensional approach that considers other factors involved in the FDA's consideration of different NDAs and BLAs including significant new research and development, new clinical studies, substantially different indications and clinical profiles, and other relevant factors involved in product approvals. **CMS should adopt a clear, case-by-case or multi-dimensional approach that appropriately defers to FDA statutory authority and clinical expertise.** Especially as the scope of the Negotiation Program expands over the coming years, continued identification of potential QSSDs based only on active moiety/active ingredient could

have a severe chilling effect on innovation, particularly within the context of known active moieties/active ingredients, limiting development of transformative products.

Recommendation: **CMS should not revise its approach to fixed dose combination products for identifying QSSDs.**

Comment: CMS proposes to continue to treat drugs with fixed combinations of two or more active moieties/active ingredients (fixed combination drugs) as one active moiety/active ingredient for the purpose of identifying potential QSSDs and aggregate all dosage forms and strengths of the fixed combination offered by the same NDA/BLA holder. However, CMS suggests that there may be some fixed combinations "for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference." CMS offers the example of the addition of a different active moiety/active ingredient to the original active moiety/active ingredient where the added active moiety/active ingredient "affects the bioavailability" of the original active moiety/active ingredient "but is not therapeutically active against the disease state" for which the original active moiety/active ingredient is indicated. CMS is soliciting comments on whether the addition of drugs payable under Part B may impact the agency's current policy on fixed combination drugs and how CMS might consider further aggregating some fixed combination drugs with products containing at least one but not all of the active moieties/active ingredients into the same potential QSSD, including both drugs payable under Part B and covered under Part D.

In acknowledging this potential problem with its current policy for fixed combination drugs, CMS seems to recognize the relevance of factors other than the active moiety/active ingredient of a drug—for example, the possibility that the addition of a new active moiety/active ingredient may not represent a clinically significant innovation. Instead of doubling down on "further aggregation" of products into single potential QSSDs, CMS should take this opportunity to reflect on the absence of its own statutory authority and scientific expertise to make determinations involving "biologically active" moieties/ingredients or "clinically meaningful differences." CMS should develop an approach that recognizes and defers to the clear statutory authority and clinical expertise of FDA in these matters given the potential for significant clinical innovation not only in formulation changes, but also among and between different NDAs and BLAs that coincidentally share the same active moieties/active ingredients.

Regarding fixed combination products, CMS suggests that the agency might consider further aggregating some of these with products containing at least one but not all of the active moieties/active ingredients into the same potential QSSD where CMS finds no "clinically meaningful difference" among the products. CMS provides no details regarding how it would make such determinations. Instead, CMS presents an example of a fixed combination drug where one of the components "affects the bioavailability" of the other but is not "therapeutically active against the disease state" for which the original active moiety/active ingredient is

indicated. CMS indicates that, in this situation, the Agency would find no "clinically meaningful difference" produced by addition of the component that impacts bioavailability.

This proposed CMS policy does not align with the FDA's definition of fixed-combination products at 21 C.F.R. § 300.50 which states that "[t]wo or more drugs may be combined in a single dosage form when *each component makes a contribution to the claimed effects*." Rather, the example CMS provides of how the agency would apply the proposed policy is in direct tension with the FDA's definition. FDA could very well find, based on clinical studies and other information gathered through the approval process, that a fixed combination drug where one component increases the bioavailability of another component that is therapeutically active against the disease state is one where each component makes a contribution to the claimed effects. It is unclear on what basis CMS has authority or expertise to conclude otherwise.

Importantly, CMS's approach may risk undermining FDA's regulatory determinations related to exclusivity. Under statutory frameworks such as the Orphan Drug Act, FDA has granted exclusivity both to a base product and to a fixed-combination version where an added component, such as one that enhances bioavailability, provides a clinical benefit. These decisions reflect the FDA's scientific judgment that certain combinations warrant independent regulatory recognition. By adopting a separate and more narrowly defined framework for assessing clinical contribution, CMS may introduce conflicting signals about how therapeutic innovation is evaluated, raising concerns about regulatory predictability and alignment across agencies.

This concern is further compounded by CMS's approach to fixed-dose combination products that include two or more active moiety/active ingredients along with an added component that enhances bioavailability. While the Draft Guidance suggests that some combinations may be grouped with a single-active counterpart if the added component is not biologically active against the disease state, it fails to address how CMS will handle scenarios where multiple components could independently qualify for selection under the IRA. The ambiguity is heightened when one of those components is excluded due to biosimilar/generic competition, while the others remain eligible. Attempting to dissect such products based on a narrow, component-by-component assessment produces a fragmented and unworkable framework. Consequently, treating such products in a way that departs from FDA's regulatory approach risks creating confusion, inconsistency, and unpredictable outcomes. Greater alignment with FDA's established fixed dose combination framework is essential for coherent implementation and regulatory integrity.

Again, this is an over-broad, overly simplistic approach that relies exclusively on active moiety/active ingredient and neglects to consider other clinically relevant factors. Moreover, a policy under which CMS conducts an unspecified, independent analysis, one that is not aligned with FDA's approval framework, introduces significant uncertainty for industry and threatens to undermine regulatory coherence. This misalignment could discourage investment in combination therapies and disrupt innovation, particularly for products designed to improve delivery, access, or adherence.

V. Section 30.3 – Selection of Drugs for Negotiation for Initial Price Applicability Year 2028

Recommendation: GSK recommends CMS maintain separate top 50 Part B and Part D spending lists and not combine drugs spanning Parts B and D for purposes of determining QSSDs.

Comment: In the Draft Guidance, CMS proposes to rank the list of negotiation-eligible drugs identified by combined Total Expenditures under both Part B and Part D in descending order, such that the negotiation-eligible drug with the highest Total Expenditures under Part B *and* Part D will be listed first. CMS states that if a negotiation-eligible drug appears on both high-spend lists, it will receive only one ranking for purposes of selection, *according to its combined total expenditures* under both Part D and Part B.

GSK opposes this approach. The best reading of the underlying statute calls for keeping the Part B and Part D High-Spend lists separate and not combining them for purposes of determining total expenditures and associated ranking. As an initial matter, the statute's definition of QSSD distinguishes between a "covered part D drug … [and] a drug or biological product for which payment may be made under part B…" It does not envision a QSSD that would span both Parts. Furthermore, pursuant to the statute, CMS is directed to create two separate lists of 50 high-spend drugs – i.e., CMS must create a list of 50 Part B High-Spend drugs and a separate list of 50 Part D High-Spend drugs. Drugs that are negotiation-eligible are defined as appearing on *either* the Part B or Part D list, but not both. Although the statute does not expressly dictate how to calculate the final total expenditures used to rank negotiation-eligible drugs in order to identify selected drugs (to be determined by the Secretary), the most accurate reading of the statute calls for keeping the Part B High Spend Drug list and the Part D High Spend Drug list separate, such that a drug's Part B and Part D total expenditures are not combined for purposes of this ranking. Had Congress intended for CMS to combine Part B and Part D expenditures, as CMS had proposed, it would not have gone through the effort of mandating the creation of these two separate lists. We further note that this reading is also more consistent with the larger statute, which consistently distinguishes between Part B and D for other aspects of the program (e.g., the definition of a QSSD refers to either a "covered part D drug (as defined in section 1860D–2(e))" *or* "a drug or biological product for which payment may be made under part B of title XVIII").

VI. Section 40.4.5 Nonduplication with 340B Ceiling Price

Recommendation: GSK recommends CMS mandate covered entities to identify 340B units under Part D and other key information in their claim submissions, allow manufacturers to shift to a rebate model, and apply civil monetary penalties to non-compliant covered entities.

Comment: In the Draft Guidance, CMS states that it will not at this time assume responsibility for preventing duplicate discounts between the 340B ceiling price and MFP. CMS states that it intends to provide Primary Manufacturers with a process to identify applicable 340B-eligible

claims through the reporting of claim-level payment elements to the MTF. CMS also states it is continuing to explore the feasibility of incorporating 340B-related transactional data from 340B covered entities or their Third-Party Administrators (TPAs) identifying eligible claims, including ways to incorporate asynchronous 340B data into MTF processes in the future.

GSK is concerned that CMS has failed to adequately take the necessary steps to safeguard against duplicate discounting, as is required by statute. The statute clearly requires that the 340B status of a claim be known before a manufacturer is required to provide any MFP discount. Often, 340B claims – in particular those from contract pharmacies -- are not identified until weeks or even months after dispensing. Not having claims identification is likely to subject manufacturers to duplicate payments contrary to the statute, particularly without an extended MFP processing cycle time. Given that manufacturers currently lack the data needed to identify these claims, CMS should prioritize efforts on the 340B non-duplication requirement, such that a manufacturer is not required to provide both a 340B discount and the MFP for a given unit of a selected drug.

For instance, we note that an identification mechanism that is voluntary for 340B covered entities will not serve as a realistic solution since covered entities have no compelling reason to report their 340B claims. Indeed, covered entities are actively promoting legislation at the state level that would ban the identification of a claim as 340B-eligible. As such, GSK recommends CMS require covered entities to identify 340B units in their claim submissions. Covered entities should be required to identify 340B units through the use of a modifier (CMS already requires the TB modifier to identify 340B claims for purposes of Part B inflation rebates). We ask that CMS also consider requiring that covered entities use an additional modifier for non-340B claims, which would further facilitate identification of 340B claims and lower the risk of duplicate discounts.

Covered entities should also be required to provide additional 340B detailed claims data, including but not limited to, the Prescriber ID (i.e., NPI) along with Provider and Pharmacy NPI ID (with the file location) as part of the MTF data requirements.

Further, CMS should require covered entities to share 340B claims data with manufacturers (via the MTF/clearinghouse) and consider permitting the establishment and use of a private sector solution to shift 340B discounts to a rebate model, using asynchronous data referenced in the Draft Guidance. These data metrics and sharing practices will allow manufacturers to determine the appropriate payment due (based on 340B status) and prevent duplicate discounts. Furthermore, CMS should adopt a Civil Monetary Penalty (CMP) framework as an enforcement mechanism to ensure covered entities comply with these requirements.

VII. Section 40.4 – Providing Access to the MFP in 2026, 2027, and 2028

Recommendation: GSK recommends CMS adopt a standardized Part B MFP effectuation model that addresses unique challenges for Part B providers while reducing administrative burden and minimizing beneficiary access barriers.

Comment: In the Draft Guidance, CMS states that it is not currently including detailed policy on providing access to the MFP for selected drugs payable under Part B for IPAY 2028. CMS states that, to the extent appropriate and feasible, it intends to align the policies and operations for providing access to the MFP for selected drugs payable under Part B with those for selected drugs covered under Part D. For example, CMS states that the MTF could be expanded to support MFP effectuation for drugs payable under Part B beginning with IPAY 2028. CMS also solicits comment on how effectuation for Part B drugs may differ from Part D drugs, as well as recommendations regarding various aspects of Part B effectuation, including the most effective means for the MTF PM to facilitate MFP refund payments for drugs payable under Part B to Part B providers, whether the MTF DM should include a standard default refund amount (SDRA) among the claim-level data elements and how such refund amount could be calculated, and other related claim-level data, workflow, and payment flow considerations.

CMS's implementation of MFP effectuation for Part B drugs starting in IPAY 2028 presents several unique operational and policy challenges that differ meaningfully from Part D. It is critical that CMS's MFP effectuation policy for IPAY 2028 be tailored to address these differences in order to avoid serious disruptions in patient access. Unlike Part D, Part B MFP effectuation will involve provider-administered drugs furnished in physician offices or outpatient hospital settings, with retrospective reimbursement relying on complex claim submissions and manual processing through Medicare Administrative Contractors (MACs) or Medicare Advantage (MA) plans. This structural divergence makes MFP effectuation under Part B significantly more resource-intensive and less predictable.

Providers will face substantial administrative and financial burdens under Part B MFP effectuation. For one, providers will be expected to administer the same drug—often with a higher level of administrative oversight and documentation—while receiving lower reimbursement tied to the MFP. Furthermore, Part B providers already experience significant delays in final payment due to MAC and MA plan claim adjudication processes. Payment from MACs typically takes 60-90 days, as MACs often identify errors in claim submissions and/or require additional information to process a claim. The delay in payment is even worse in the MA context. Adding MFP effectuation on top of this process risks delaying reimbursement even longer, which is particularly untenable for small or independent practices that already operate on thin margins and limited staff to navigate the additional complexity. There is a risk that providers may respond by either seeking coverage under the pharmacy benefit (via white bagging under MA plans) for selected drugs or shifting patients to external infusion centers or health systems causing further delays and increasing access fragmentation and burden for patients. In addition, this is a more expensive site of care for the Medicare program, so this policy could inadvertently drive-up cost to the program in one aspect while seeking to implement an overall effort to lower cost to the same program.

Furthermore, to ensure equitable and sustainable implementation of MFP provisions across Part B and Part D, CMS should also consider establishing a standardized TPA process to manage data collection, price reconciliation, and refund calculation for both Part B and Part D, particularly through the MTF. Without such standardization, the inherent structural differences

between the two parts of the program will continue to create inconsistency, confusion, and unintended patient access barriers—particularly for providers operating under the more administratively burdensome Part B framework.

Recommendation: CMS should exclude MFP from ASP calculations to prevent significant patient access barriers for Part B drugs.

Comment: The IRA is silent on inclusion of MFP into ASP, which is the basis of provider reimbursement in other markets (especially with commercial payers). Unlike Part D dispensers, the MFP may have a direct impact on Part B dispensers' reimbursement in other markets. Inclusion of MFP into ASP will drastically reduce payment, while providers must maintain the same financial costs and burden for administering products in-office. CMS has statutory authority to institute the exclusion and failure to do so will result in providers receiving substantially lower reimbursement from payers beyond Medicare. Inevitably, this will impact patient access to critical medications. GSK recommends CMS clarify exclusion of MFP from ASP.

VIII. Section 40.4.3 – MTF Payment Facilitation

Recommendation: GSK urges CMS to require all Part B providers/dispensers to use the MTF PM if the manufacturer chooses to participate in the MTF PM.

Comment: In the Draft Guidance, CMS states that it intends to provide the MTF to facilitate payment exchange for drugs payable under Part B that are furnished or administered to MFP-eligible individuals. CMS is also soliciting comments to understand how the payment flow for Part B claims may differ from the one outlined for Part D drugs. CMS reiterates that the MTF PM's ministerial role is to facilitate MFP payment passthrough from the Primary Manufacturer to the dispensing entity.

As an initial matter, GSK appreciates CMS's development of the MTF payment functionality though the MTF PM, as well as CMS's MTF PM policy with respect to Part D MFP effectuation. In particular, GSK commends CMS for providing manufacturers with the option of either passing MFP rebate amounts to dispensing entities through the MTF PM or using their own processes, and also clarifying that should a manufacturer elect to participate in the MTF PM, any applicable rebate amount will flow to the dispensing entity through the MTF PM, without requiring the dispensing entity to affirmatively opt in to the MTF PM participation. This will greatly alleviate manufacturer burden and facilitate MFP effectuation under the Program.

For purposes of Part B MFP effectuation, GSK urges CMS to consider also requiring all providers/dispensers to use the MTF PM if the manufacturer chooses to participate in the MTF PM for payment facilitation, as it does in the Part D context. The need for such a requirement in the context of Part B MFP effectuation is even more salient, given the infeasibility of establishing different payment flows with all providers billing under Medicare Part B. Furthermore, a standardized MFP rebate framework across Part D and Part B, to the extent practicable, will alleviate burden on manufacturers.

IX. Section 80 – MFP-Eligible Individuals in 2026, 2027, and 2028

Recommendation: GSK recommends CMS stringently monitor MA plans utilization management practices for Part B drugs in IPAY 2028 and leverage any lessons learned from selected Part D drugs from IPAY 2026 and 2027.

Comment: CMS is soliciting comments on how best to monitor MA plans' use of Part B step therapy practices to ensure compliance with program rules and any data or policy clarifications that may be needed for implementation.

As in the Part D context, it is common practice for MA plans to impose utilization management protocols, including step therapy and prior authorization, on Part B drugs. GSK is deeply concerned that MA plans will be incentivized to disadvantage certain Part B drugs by inappropriately leveraging utilization management practices, such as step therapy, to steer utilization away from these drugs, potentially at the expense of clinical appropriateness and patient stability.

It will be vital for CMS to closely monitor MA plan formulary placement and coverage policies to ensure compliance with all applicable coverage requirements for Part B drugs. In this vein, CMS should also extend it formulary review processes outlined for Part D drugs in its IPAY 2026 Revised Guidance and IPAY 2027 Final Guidance to the Part B context, to the fullest extent applicable. For example, CMS should clearly outline its intent to conduct rigorous formulary and coverage policy review to assess instances where MA plans impose more restrictive utilization management (including step therapy and/or prior authorization) for certain Part B drugs compared to another drug in the same class.

Furthermore, we note that when CMS allowed MA plans to impose step therapy requirements on Part B drugs in 2019, it also adopted corresponding patient protections via regulation at 42 CFR § 422.136. For example, MA plans may only apply step therapy to new administrations of Part B drugs, must establish policies and procedures to educate and inform health care providers and enrollees concerning its step therapy policies, and must ensure that, prior to implementation, the MA plan's step therapy policy has been reviewed and approved by the MA plan's pharmacy and therapeutic (P&T) committee. In its final guidance for IPAY 2028, CMS should emphasize its intent to closely monitor MA plan policies for compliance with these protections with respect to drugs payable under Part B.

We also note that CMS has also clarified that "[a]ll Part B drugs must be covered by the MA plan when medically necessary, for example, when a stepped drug is not effective or appropriate for the patient, *the patient must be allowed direct access to an alternative Part B drug*."[1] As such, we urge CMS to closely review MA plan step therapy exceptions processes, to ensure that vulnerable patients are able to promptly receive the Part B drug determined to be medically

[1] *See* Modernizing Part D and Medicare Advantage To Lower Drug Prices and Reduce Out-of-Pocket Expenses Final Rule, 84 Fed. Reg. 23832, 23858 (May 23, 2019).

necessary by their provider. Even minor delays in treatment caused by MA plan administrative processes can be disastrous for these patients.

GSK also urges CMS to take a dynamic approach with respect to strengthening its monitoring and enforcement. For example, should the agency find that Part D plans have engaged in harmful utilization management practices in IPAY 2026, CMS should issue formal rulemaking to address these concerns in the Part D program. Furthermore, instead of waiting to see how MA plans respond to the application of MFP to selected Part B drugs in IPAY 2028, CMS should leverage lessons learned in the Part D context and proactively issue rulemaking in advance of IPAY 2028 that adopts more comprehensive utilization management transparency requirements and guardrails against MA plans for drugs payable under Part B.

X. Section 130.2 – Selection of Drugs for Renegotiation for Initial Price Applicability Year 2028

Recommendation: GSK recommends CMS define "significant change" for purposes of renegotiations as an expected positive or negative change of at least 35% rather than 15%

Comment: Per the underlying statute, drugs that newly qualify as long-monopoly products must be selected for renegotiation. For all other drugs, CMS proposes to apply a two-part standard to determine selection: whether renegotiation is likely to lead to a change of 15% or more in the current MFP, and whether such a change would have a significant impact on the Medicare program or beneficiary out-of-pocket costs. CMS proposes to conduct a holistic review based on "the totality of the information available and the circumstances of the renegotiation-eligible drug," and notes that these determinations are not subject to administrative or judicial review. CMS seeks feedback on the proposed selection criteria, the applicability of the current negotiation process to renegotiation, and options to increase transparency throughout the renegotiation timeline.

For the first criterion for selection of renegotiation-eligible drugs, CMS proposes that a change of at least 15% in the current MFP is the threshold for a "significant change in the otherwise negotiated MFP." CMS identifies the 15% proposal based on the "range" of the differential statutory percentage reductions applied in calculating the MFP ceiling price for a selected drug based on its monopoly status at section 1194(c)(3)(A) – (C) of the statute. It is not clear why, or on what authority, CMS intends to establish a percentage criterion for "significant change" in the otherwise negotiated MFP, especially in the context of the proposed holistic review of the totality of information and circumstances. Moreover, there is no apparent connection at all between the statutory range of percentage reductions and the choice of 15%.

If CMS intends to establish a specific percentage criterion, GSK recommends that CMS define "significant change" in the otherwise negotiated MFP as an expected change of at least 35% which would reflect the differential percentage change in the ceiling price between a selected drug with short- and long-monopoly status. CMS should make clear that this differential

percentage should include upwards or downwards movement. For instance, if a selected drug obtains approval for a new indication, that should result in an upwards adjustment, particularly if that new indication addresses an unmet need or represents a therapeutic advance. As CMS notes in this discussion, the renegotiation process requires a substantial investment of resources by both CMS and the Primary Manufacturer. CMS should define "significant change" in the otherwise negotiated MFP in a way that warrants this substantial investment of resources. A 15% expected differential in the otherwise negotiated MFP would not remotely warrant the investment.

XI. Section 130.3 – Data Collection to Inform Renegotiation Drug Eligibility, Selection, and Renegotiation of the MFP for Initial Price Applicability Year 2028

Recommendation: GSK urges CMS to not require manufacturers to complete restatements of previously submitted information as part of any renegotiation process.

Comment: CMS proposes to collect information from Primary Manufacturers and other interested parties to: determine which selected drugs are renegotiation-eligible (for other than automatically selected renegotiation-eligible drugs) in accordance with sections 1194(f)(1) and (2) of the Act; select drugs for renegotiation in accordance with section 1194(f)(3) of the Act; and renegotiate the MFP of drugs selected for renegotiation in accordance with section 1194(f)(4) of the Act.

The proposed information collection regimens associated with each CMS decision point would impose significant administrative burdens for manufacturers. The proposal to require submission of section 1194(e)(1) factor data for renegotiation in entirely new ICRs is particularly burdensome. As CMS acknowledges, there is a relatively short timeframe between the original negotiation and renegotiation processes and associated information collections. CMS should revise the information collection process to require manufacturers of drugs selected for renegotiation to update previously submitted ICRs rather than complete restatements of previously submitted information. CMS should also look for other opportunities to reduce the administrative burden of information collection for both manufacturers and CMS.

XII. Section 60.2.2 – Determination of the Sum of the Plan-Specific Enrollment Weighted Amounts, the Payment Amount Under Section 1847A(b)(4) of the Act, and the Combined Part B and Part D Amount

Recommendation: CMS should substantially simplify and increase transparency in its approach to including Part B drugs for IPAY 2028 and subsequent years by adopting a unit-based approach rather than relying on calculation of a 30-day equivalent supply of the selected drug.

Comment: To determine the MFP ceiling price for a selected drug, CMS proposes to calculate a single "combined Part B and Part D amount" for a selected drug that would be a volume-weighted average of the Part B amount, generally 106% of ASP, and the Part D amount, which is the "sum of the plan-specific enrollment weighted amount." CMS proposes to calculate these two amounts separately for each of the NDC-9s associated with HCPCS codes present in Part

B claims data and present in Part D PDE data for each selected drug per 30-day equivalent supply. CMS would then weigh the amounts for the NDC-9s separately based on their respective utilization in Part B and Part D to calculate the single combined amount. CMS proposes to identify the NDCs that are assigned to a HCPCS code and calculate a payment amount for each of them by allocating HCPCS code-level utilization (Part B claims) across each NDC-11 assigned to a HCPCS code that describes a selected drug using ASP data. CMS proposes to then compare the single combined Part B and Part D amount to the applicable percent of the lower of the CY 2021 (inflation-adjusted) or CY 2025 average non-FAMP per 30-day equivalent supply and choose the lowest of these as the MFP ceiling price.

CMS proposes to use the "30-day equivalent supply" as the common denominator in calculating the single combined Part B and Part D amount for a selected drug. For Part D, CMS would continue to use the same process established at 42 C.F.R. § 423.104(d)(2)(iv)(A)(2) to determine the 30-day equivalent supply using the days' supply reported in PDE data. For Part B, CMS proposes an alternative methodology to calculate the 30-day equivalent supply. For a given Part B claim for a selected drug's HCPCS code, CMS proposes to identify any subsequent Part B claim or PDE record for that same beneficiary and selected drug. CMS would then calculate a "days between service amount" by counting the days between the first claim and first subsequent claim (either Part B or Part D) for the same beneficiary and same selected drug. CMS then proposes to use this "days between service amount" to calculate the 30-day equivalent supply in the same way it does for Part D—if the number is less than 34, then 30-day equivalent supply is 1; if greater than 34, then 30-day equivalent supply is the number of days divided by 30.

For the 30-day equivalent supply calculation and other calculations that require comparability between Part B and Part D units (e.g., weighted average between Part B and D claims, average non-FAMP), CMS proposes to translate the HCPCS J-code units into PDE units and attribute them to the relevant NDCs. CMS proposes to then use NDCs and the 30-day equivalent supply as the common denominators to allow for direct comparison between the HCPCS code-based Part B payment amounts and Part D calculation of the sum of plan-specific enrollment weighted amounts.

IPAY 2028 is the first year that CMS will select drugs for which payment is made under Part B in addition to Part D covered drugs. The complexity of CMS's proposals for incorporating Part B drugs into the agency's policies to select and establish the MFP for selected drugs is apparent even in the abbreviated summary provided above. **CMS should substantially simplify the approach to including Part B drugs for IPAY 2028 and subsequent years. Given that "days' supply" is not reported in Part B claims data, the most straightforward and transparent approach would be to use "units" of the selected drug as the common denominator rather than attempting to calculate a 30-day equivalent supply based on a combination of Part B and Part D claims data.** In addition to unnecessary complexity and reduced transparency, the proposed use of a 30-day equivalent supply of a selected drug introduces additional opportunities for potential error and bias. It is very unlikely that there will be temporal alignment between Part B claims and Part D PDE data, which could lead to

significant mismatching in the data used to calculate a 30-day equivalent supply. In contrast, the units of a selected drug are publicly available and readily identifiable at the NDC-11 package level, and the component NDC-11s within a HCPCS J-code are similarly identifiable.

There is also potential bias in the use of ASP data, which includes information on all sales to all purchasers within the U.S., to allocate units among the different NDC-11s within a HCPCS J-code. The mix of sales among NDC-11s across all purchasers in the U.S. could be very different from the mix in the Medicare beneficiary population. Rather than allocating "billing units" among the NDCs within a HCPCS code using ASP data, CMS should collect actual data on Part B claims to identify the NDC-11 associated with the billed HCPCS J-code. CMS already requires this information on claims for dual-eligible Medicare/Medicaid beneficiaries. This would allow CMS to standardize data between Part B and Part D at the NDC-11 and HCPCS billing unit level rather than resorting to a complex and potentially inaccurate calculation of an estimated 30-day equivalent supply under Part B for each NDC-11 that is assigned to a HCPCS J-code.

XIII. Section 90.2 – Monitoring of Access to the MFP in 2026, 2027, and 2028

Recommendation: GSK requests CMS clarify factors it will consider when conducting fact-specific assessments and ensure manufacturers will not be required to provide a rebate greater than SDRA.

Comment: When assessing whether a Primary Manufacturer provided access to the MFP to a dispensing entity with respect to a selected drug, CMS states that it will undertake a fact-specific assessment that will consider the following, among other factors, as applicable: whether the retrospective refund amount authorized for payment or paid by the Primary Manufacturer is sufficient to account for commercially reasonable costs the dispensing entity is likely to encounter in the supply chain, the invoice amount from the dispensing entity (if available), the delta between the MFP refund amount provided and the SDRA (if available), and any agreements or communications between the dispensing entity and the Primary Manufacturer regarding the availability of the MFP to the dispensing entity.

GSK is concerned that the factors CMS outlines for its fact-specific assessment are overly broad and would result in manufacturers providing a rebate that is greater than what is required by the statute. The statute only requires manufacturers to "provide access" to MFP to eligible individuals, pharmacies and other relevant dispensers, and hospitals, physicians, and other providers, where applicable for selected Part D and Part B drugs.[2] There is nothing in the statute that requires manufacturers to provide a rebate that takes into account the "commercially reasonable costs the dispensing entity is likely to encounter in the supply chain." Consideration of this factor would in practice allow additional costs borne by the dispensing entity to be factored into the MFP and MFP effectuation, and would represent an impermissible expansion of CMS's statutory authority.

[2] Section 1193(a)(1) of the Social Security Act.

We ask that CMS clarify in the final guidance that, when assessing whether a manufacturer provided access to MFP to a dispensing entity, it will not consider extraneous factors such as whether a rebate is sufficient to account for commercially reasonable costs to the dispensing entity is likely to encounter in the supply chain, which lacks grounding in the statutory text. CMS should further clarify that, for purposes of MFP effectuation, the expectation is that manufacturers will not be required to provide a rebate that is greater than the SDRA, which is the difference between the dispensing entity's acquisition cost (i.e., in the Part D context, WAC) and MFP.

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June 25, 2025

Department of Health and Human Services
Centers for Medicare & Medicaid Services
IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Program; Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program Draft Guidance; Comment Request (IPAY 2028)

Halozyme, Inc. (Halozyme) appreciates the opportunity to submit comments on the Draft Guidance for Implementation of Sections 1191 – 1198 of the Social Security Act (SSA) for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 (IPAY 2028 Draft Guidance). At Halozyme, we are focused on innovative and disruptive solutions that provide new therapeutic options that could significantly improve the patient treatment experience. We have two subcutaneous (under the skin) drug delivery technologies that significantly streamline treatment and can offer patients potential benefits including reduced side-effects, improved effectiveness, a more comfortable experience, improved convenience, and reduced treatment time.

In finalizing the Draft Guidance, we urge CMS to adhere to the definition of qualifying single source drug (QSSD) adopted in the IPAY 2026 and 2027 guidance documents for fixed combination products for clinical, scientific, legal, and policy reasons. This approach would align with the important clinical benefits that fixed combinations offer for patients and healthcare providers (HCPs) alike.

I. Executive Summary

CMS should maintain the definition of QSSD adopted in the IPAY 2026 and 2027 guidance documents for fixed combination products. The addition of Part B drugs to the Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program (the Program) does not justify the creation of a new QSSD policy for a subset of fixed combination products. Specifically, CMS should not adopt its proposal to disregard active ingredients that it views as "not therapeutically active against the disease state," or alternatively, not "biologically active" or causing "clinically meaningful differences," in identifying QSSDs (the Proposal). This Proposal lacks an adequate basis, because the statute has not changed, and the QSSD definition applies equally to Part B and D drugs. The Proposal also raises legal and policy issues, as noted below.

If CMS decides to deviate from its IPAY 2026 and 2027 approach to identifying QSSDs, CMS should find that Halozyme's human hyaluronidase is an active ingredient with biological and therapeutic activity that provides clinically meaningful effects in fixed combination products, and therefore that fixed combinations of human hyaluronidase and antibodies should be considered distinct QSSDs from the individual active ingredients.

In particular, subcutaneous fixed combination products containing Halozyme's human hyaluronidase and specific antibodies provide meaningful

therapeutic advantages for patients and the public health. For example, these products can reduce side effects, improve efficacy, reduce patient burden associated with receiving treatment, and reduce HCP burden. These products also have been demonstrated to reduce overall cost to the healthcare system and patients. When compared to an antibody given intravenously as a single component product, subcutaneous delivery of a fixed combination containing Halozyme's human hyaluronidase and the specific antibody can enable, for example:

- Meaningfully lower incidence of infusion-related reactions, a potentially life-threatening side effect;
- Meaningfully lower incidence of serious adverse events (SAEs) that result in hospitalization and death;
- Meaningfully improved overall survival;
- Improved patient comfort and decreased emotional distress associated with treatment;
- A reduction in patient treatment time and patient costs related to the site of treatment care;
- A reduction in infection risk by eliminating the need for an intravenous access device (e.g. a port) in some patients;
- A reduction in cancer patients' exposure to infections by reducing the length of time spent in hospital infusion centers;
- A reduction in HCP resources and time required for treatment preparation and administration; and
- A reduction in the chance of a dosing error by the use of a fixed dose combination that does not require the pharmacist to calculate the dose based on individual patient weight.

This evidence demonstrates that subcutaneous delivery of a fixed combination with Halozyme's human hyaluronidase results in clinically meaningful benefits. Accordingly, if CMS finalizes the Proposal despite the concerns explained in this comment, CMS should find that Halozyme's human hyaluronidase is biologically active and therapeutically active when combined with an antibody in a fixed combination product, given its clinically meaningful, beneficial effects on patient feeling, safety and/or effectiveness, and its pharmacological activity.

More fundamentally, the Proposal is flawed as a matter of law. The Proposal creates multiple definitions of "biological product," which conflicts with the statute, *Loper Bright Enterprises v. Raimondo*, and the President's memorandum issued on April 9, 2025, which directs the repeal of unlawful regulations that contravene *Loper Bright*. The Proposal also conflicts with FDA's approval of Halozyme's human hyaluronidase combinations as fixed combination products under 21 C.F.R. § 300.50 and the SSA's orphan-drug exclusion from QSSD status. Further, the Proposal diverges from precedent without reasoned explanation and is arbitrary and capricious for creating inconsistent definitions of biological product across agencies.

Finally, the Proposal is flawed as a matter of policy. The Proposal discourages the development of fixed combination products that benefit patients and can reduce the cost of care. It also undermines government efficiency by requiring CMS to conduct a fact-intensive assessment of fixed combination aggregation issues and disrupts research and development planning by creating uncertainty about which fixed combination products will be aggregated.

For the foregoing reasons, Halozyme urges CMS to retain its IPAY 2026 and 2027 approach to QSSD aggregation of fixed combination products.

II. Background

A. Statutory Definition of QSSD for Biological Products

Under the statute, a QSSD is eligible for selection into the Program.[1] For biological products, the IRA defines QSSD as follows:

> "(B) BIOLOGICAL PRODUCTS.—A ***biological product***—
>
> > "(i) that is licensed under section 351(a) of the Public Health Service Act and is marketed under section 351 of such Act;
> >
> > "(ii) for which, as of the selected drug publication date with respect to such initial price applicability year, at least 11 years will have elapsed since the date of such licensure; and
> >
> > "(iii) that is not the reference product for any biological product that is licensed and marketed under section 351(k) of such Act."[2]

Since issuing the draft version of the IPAY 2026 Guidance, CMS has interpreted "biological product" in this provision to mean "active ingredient" or combination of "active ingredients."

Specifically, to identify QSSDs, CMS aggregates all dosage forms and strengths of a biological product with the "same active ingredient" and the same BLA holder, inclusive of products that are marketed pursuant to different BLAs.[3] Then, to determine the date of licensure for a potential QSSD that is a biological product licensed under more than one application, CMS uses the earliest date of licensure of the application assigned to the BLA holder for the active ingredient.[4]

B. CMS's IPAY 2026 & 2027 Guidance: Recognition That Fixed Combinations Are Separate QSSDs

In the IPAY 2026 and 2027 Guidances, CMS indicated that, "[i]f a drug is a fixed combination drug with two or more active moieties / active ingredients, the distinct combination of active moieties / active ingredients will be considered as one active moiety / active ingredient for the purpose of identifying potential qualifying single source drugs."[5] There are several important aspects of this interpretation:

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[1] SSA § 1192(c)-(e).

[2] SSA § 1192(e)(1)(B) (emphasis added).

[3] *See* IPAY 2026 Final Guidance at 99; IPAY 2027 Final Guidance at 168; IPAY 2028 Draft Guidance at 11.

[4] *See* IPAY 2026 Final Guidance at 101. *See* IPAY 2027 Final Guidance at 170. *See* draft IPAY 2028 Guidance at 14.

[5] *See* IPAY 2026 Final Guidance at 100. *See* IPAY 2027 Final Guidance at 169.

- CMS included a footnote stating that "[f]or purposes of the Negotiation Program, the term 'fixed combination drug' has the meaning specified in 21 C.F.R. § 300.50,"[6] which is FDA's regulation governing fixed-combination drugs for humans.

- In IPAY 2026 and 2027, CMS rejected comments disagreeing with this approach to fixed combination products.[7] For example, some commenters had opposed this policy on the theory that "by allowing strategic development by manufacturers of combination products that would not differ significantly from the original single product, not contribute directly to the drug's therapeutic effect, and provide minimal additional patient benefit."[8] In other words, these comments suggested a conceptually similar approach to the Proposal.

- As recently as October 2024, CMS rejected this idea. In responding to these comments, CMS stated that it "believes that a fixed combination drug is distinct in its composition from the individual active moieties / active ingredients" and reaffirmed "its approach on fixed combination drugs, which treats the distinct combination of . . . active ingredients as one . . . active ingredient for the purpose of identifying qualifying single source drugs."[9]

- CMS also explained that it identifies "active ingredients" using the RxNorm database. This database does not distinguish between active ingredients based on their perceived biological or therapeutic activity or their specific pharmacological function in the product.[10]

C. CMS Seeks Comment on Proposed Reversal in the IPAY 2028 Draft Guidance

Despite its prior approach in the IPAY 2026 and 2027 final guidance documents, CMS included the following Proposal in the IPAY 2028 Draft Guidance:

> CMS believes that treating distinct combinations of active moieties / active ingredients as one active moiety / active ingredient for the purpose of identifying potential qualifying single source drugs is generally appropriate. However, CMS acknowledges that there may exist fixed combination drugs for which one of the active ingredients or active moieties contained is ***not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference***. An example might include the addition of active moiety / active ingredient X to a different active moiety / active ingredient Y, where active moiety / active ingredient X ***affects the bioavailability*** of active moiety / active ingredient Y but is ***not therapeutically active against***

[6] *See* IPAY 2026 Final Guidance at 100, fn. 34. *See* IPAY 2027 Final Guidance at 169, fn. 63.

[7] *See* IPAY 2026 Final Guidance at 13; IPAY 2027 Final Guidance at 14.

[8] IPAY 2027 Final Guidance at 14.

[9] *See* IPAY 2026 Final Guidance at 13-14. *See* IPAY 2027 Final Guidance at 14-15.

[10] *See* CMS, *Frequently Asked Questions: Medicare Prescription Drug Price Negotiation Program for Initial Price Applicability Year 2026* (link). *See also* IPAY 2026 Final Guidance at 13-14; IPAY 2027 Final Guidance at 16.

> ***the disease state*** that active moiety / active ingredient Y is indicated for. In this example, the addition of active moiety / active ingredient X does not result in a clinically meaningful difference. CMS is soliciting comments on whether the addition of drugs payable under Part B may impact the fixed combination drug policy described in this draft guidance. In particular, CMS is soliciting comments on how CMS might consider grouping such fixed combination drug products with products containing at least one but not all of the active moiety(ies) / active ingredient(s) into the same potential qualifying single source drug for both drugs payable under Part B and/or covered under Part D, including input on terminology that could facilitate the effectuation of such a policy.[11]

The IPAY 2028 Draft Guidance provides no further details on this Proposal, nor does it explain how CMS intends to implement this Proposal, if adopted.

III. Halozyme's human hyaluronidase is biologically and therapeutically active and results in clinically meaningful differences.

If CMS adopts the Proposal, antibody-human hyaluronidase fixed combination products qualify for fixed combination treatment. The human hyaluronidase in these fixed combinations is biologically and therapeutically active and results in clinically meaningful differences compared to single-entity antibody products.

A. Human hyaluronidase is biologically and therapeutically active.

Halozyme's human hyaluronidase is biologically active because it increases permeability of tissues in the subcutaneous space through the degradation of hyaluronic acid, thus enabling a large volume of drug to be administered by subcutaneous drug delivery. Human hyaluronidase has a different molecular target than the antibody or antibodies with which it is sometimes co-formulated. Hyaluronidase targets and degrades hyaluronan, and a co-formulated antibody targets a specific antigen (e.g., expressed on the surface of certain cancer cells). The hyaluronidase increases the dispersion and absorption of the co-administered antibody when administered subcutaneously.

Human hyaluronidase's specific enzymatic activity is to split the glucosaminidic bond between C1 of an N-acetylglucosamine moiety and C4 of a glucuronic acid moiety and degrade hyaluronan.[12] When combined with an antibody, human hyaluronidase effectively "opens up" space in the subcutaneous region (usually in the abdomen) to allow the other drug to be injected under the skin rapidly and without tissue damage. Without human hyaluronidase, rapid subcutaneous delivery subcutaneous delivery of an antibody or antibodies is limited to just ~2 milliliters, significantly restricting the use of subcutaneous delivery as many drugs to be effective require higher doses. Subcutaneous delivery of multiple antibodies used to treat cancer, neurological disease, and immune disease today is only possible because of coformulation with human hyaluronidase. With Halozyme's human hyaluronidase, today's approved fixed combination products range in volume from 5 mL to 23 mL, delivered in as little as 20 seconds for 5 mL, 3 minutes for up to 15 mL, and 10 minutes for 23 mL. The combined

[11] IPAY 2028 Draft Guidance at 13.

[12] *See, e.g.,* Hylenex, Prescribing Information, § 12.1 (link).

antibody is dispersed in the subcutaneous space and is then absorbed by the patient's body. The patient's hyaluronic acid levels then return to normal, typically within 24 hours.

FDA has recognized that human hyaluronidase is an active ingredient, which FDA defines as "any component that is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body of man or other animals."[13] FDA has therefore determined that human hyaluronidase has pharmacological activity. There is no requirement in FDA's regulations that an active ingredient's pharmacological effect must be directly active against the disease state itself. If human hyaluronidase were not biologically and therapeutically active, FDA would characterize it as product component other than an active ingredient, such as an excipient or degradant,[14] which it has not.

Further bolstering this conclusion, FDA has approved Halozyme's Hylenex,[15] a human hyaluronidase, as a single-entity biological product with a standalone BLA for use:

- in subcutaneous fluid administration for achieving hydration;
- to increase the dispersion and absorption of other injected drugs; and
- in subcutaneous urography for improving resorption of radiopaque agents.[16]

FDA also has recognized that hyaluronidase is an active ingredient in fixed combinations. Ingredients to enhance the safety or effectiveness of the principal active component are active ingredients per 21 C.F.R. § 300.50—the regulation that CMS relies upon in the IPAY 2026 and 2027 guidance documents and the IPAY 2028 Draft Guidance.[17]

B. Human hyaluronidase results in clinically meaningful differences.

Human hyaluronidase provides clinically meaningful differences as part of a fixed combination. Patients receiving antibody treatment routinely fight to survive and to maintain basic functions and independence. Receiving treatment subcutaneously of a fixed combination of an antibody and human hyaluronidase, compared to intravenous administration of an antibody only, has been comprehensively demonstrated to have a clinically meaningful positive impact on how a patient feels, functions, and/or whether the patient survives.[18]

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[13] 21 C.F.R. § 210.3(b)(7).

[14] *See, e.g.*, FDA Final Guidance, Using the Inactive Ingredient Database at 1 n. 2 (July 2019) (link) (defining "excipients" to mean any *inactive ingredients* that are added intentionally to therapeutic and diagnostic products, *but that are not intended to exert therapeutic effects at the intended dosage*.").

[15] FDA originally approved Hylenex in 2005 in an application under section 505(b)(2) of the FDCA. On March 23, 2020, the former NDA was deemed a BLA under section 7002(e)(4) of the Biologics Price Competition and Innovation Act.

[16] *See* Hylenex Prescribing Information §§ 1.1-1.3 (link).

[17] *See infra* note 62 and accompanying text.

[18] These metrics of clinical benefit are consistent with FDA's articulation of clinical benefit in its patient reported outcomes guidance. *See, e.g.*, Final Guidance, Principles for Selecting, Developing, Modifying and Adapting Patient-Reported Outcome Instruments for Use in Medical Device Evaluation at 1 (Jan. 26,

- **Subcutaneous delivery of a fixed combination with human hyaluronidase has resulted in a meaningfully lower incidence of infusion-related reactions compared to the antibody given intravenously as a single component product.** Patients receiving antibodies intravenously can experience "infusion-related reactions," which are characterized by nausea, headache, tachycardia, low blood pressure, rash, and shortness of breath. Not only do these reactions have a profound impact on how the patient feels, but also they can have life-threatening consequences: an infusion reaction can be a true medical emergency, that can result in deployment of nursing and medical staff and a "crash-cart," containing cardiac and respiratory emergency medications and equipment in case the patient requires resuscitation.[19]

    - Subcutaneous delivery of a fixed combination of an antibody with human hyaluronidase has been demonstrated with two important cancer treatments to reduce the rate of infusion-related reactions by a factor of 3- fold and 5- fold respectively, compared to the antibody delivered intravenously.[20] Specifically, patients receiving one of these two antibodies were found to have an approximately 3.5-in-10 and 6.5-in-10 chance of experiencing an infusion reaction, respectively, but this risk decreases significantly with subcutaneous delivery of a fixed combination to an approximately 1-in-10 chance of a reaction. The reduced rate of infusion-related reactions provides a clinically important improvement in the benefit-to-risk profile for both the physician and patient.

- **Subcutaneous delivery of a fixed combination with Halozyme's human hyaluronidase has resulted in a meaningfully lower incidence of serious adverse events (SAEs) compared to the antibody given intravenously as a single component product.** FDA defines SAEs as those that result in a birth defect, congenital anomaly, disability or permanent damage, hospitalization, death, or are life-threatening.[21] Most SAEs are based on the need for hospitalization. SAEs affect how a patient functions, feels, and survives. For example, with an antibody used in the treatment of lung cancer, the rate was 30% lower with subcutaneous delivery of a fixed combination compared to intravenous antibody delivery (i.e., a rate of 19% versus 27%).[22] In addition, subcutaneous delivery of fixed combination of an antibody and human hyaluronidase used in the treatment of lung cancer resulted in a lower rate of a serious and potentially fatal adverse

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2022) (link) ("Patient-reported outcome (PRO) instruments facilitate the systematic collection of how patients feel, function, and survive as valid scientific evidence to support the regulatory and healthcare decision-making process.").

[19] *See* A. Barroso et al, Management of Infusion-Related Reactions in Cancer Therapy: Strategies and Challenges, ESMO (2024) (link).

[20] *See* Mateos M-V et al, Subcutaneous versus Intravenous Daratumumab in Patients with Relapsed or Refractory Multiple Myeloma (COLUMBA): A Multicentre, Open-Label, Non-Inferiority, Randomised, Phase 3 Trial, Lancet Haematology, 7(5):e370-e380 (May 2020) (link); *see also* Leighl N et al, Subcutaneous Versus Intravenous Amivantamab, Both in Combination With Lazertinib, in Refractory Epidermal Growth Factor Receptor–Mutated Non–Small Cell Lung Cancer: Primary Results From the Phase III PALOMA-3 Study, J of Clin Oncol, 42(30):3593-3605 (June 10, 2024) (link) (NSCLC Study).

[21] *See* FDA, What is a Serious Adverse Event? (May 18, 2023) (link). *See also* FDCA § 505-1(b)(4).

[22] Burotto M, et al, Brief Report: Updated data from IMscin001 Part 2: A Randomised Phase III, Open-Label, Multicentre Study Examining the Pharmacokinetics, Efficacy, Immunogenicity, and Safety of Atezolizumab Subcutaneous versus Intravenous Administration in Previously Treated Locally Advanced or Metastatic Non-Small-Cell Lung Cancer , J Thor Onc,19: 1460-1466 (2024) (link).

event of thromboembolism (9% versus 14%) compared to the treatment with the same antibody delivered intravenously.[23]

- **Subcutaneous delivery of a fixed combination with Halozyme's human hyaluronidase results in meaningfully improved overall survival compared to the antibody given intravenously as a single component product**. Patients with a specific type of lung cancer—EGFR mutated non-small cell lung cancer—had a dismal chance of survival until the advent of new targeted therapeutic agents given intravenously. One new treatment, an antibody, was approved for intravenous administration in 2021; it was later approved for administration with a second drug in 2024.[24] A large study evaluated, as an exploratory endpoint, the impact on patient survival of subcutaneous delivery of a fixed combination of human hyaluronidase at a dose of the antibody designed to match the intravenously delivered drug exposure. This study was completed and the results published in 2024.[25] The risk of death for patients receiving the subcutaneously delivered drug was 38% lower compared with intravenous administration. At 12 months, 65% of the patients receiving the subcutaneous product were alive compared with 51% who received treatment intravenously.

- **Subcutaneous delivery of a fixed combination with Halozyme's human hyaluronidase results in improved patient comfort and decreased emotional distress compared to the antibody given intravenously as a single component product**. Multiple studies have assessed patient-reported outcomes that evaluate patient preferences for receiving an antibody treatment subcutaneously with human hyaluronidase compared to intravenous delivery of the antibody alone.[26] Patients overwhelmingly reported a strong preference for subcutaneous delivery of a fixed combination. The most commonly cited reasons for this preference included: less time spend at a clinic, more comfort during administration, feeling the treatment was less emotionally distressing, and lower levels of injection site pain.[27] Further, as compared with the intravenous delivery of an antibody, a higher proportion of patients with multiple myeloma that were treated with subcutaneous delivery of the same antibody with human hyaluronidase reported at *every* timepoint in which they were asked that:

    - They "*never*" thought about discontinuing treatment;

    - Treatment was "*much easier*" than they expected; and

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[23] *See* NSCLC Study (link).

[24] *See* Approval Letter, BLA 761210 (May 21, 2021) (link); Approval Letter, BLA 761210/S-003 (Mar. 1, 2024) (link).

[25] *See* NSCLC Study (link).

[26] *See* Aguiar-Ibáñez r, et al, Differences Between Intravenous and Subcutaneous Modes of Administration in Oncology from the Patient, Healthcare Provider, and Healthcare System Perspectives: A Systematic Review, Adv Ther, 41:4396–4417 (2024) (link) (Perspectives Study); *see also* Usmani SZ, et al, Greater Treatment Satisfaction in Patients Receiving Daratumumab Subcutaneous vs. Intravenous for Relapsed or Refractory Multiple Myeloma: COLUMBA Clinical Trial Results, J Canc Res Clin Onc, 147:619-631 (2021) (link) (Treatment Satisfaction Study).

[27] *See* Treatment Satisfaction Study (link).

- Side-effects were *much better* than they expected.[28]

- As an additional example, patients treated with subcutaneous delivery of an antibody in fixed combination with human hyaluronidase for the treatment of multiple cancers, including lung cancer, reported preferring the fixed dose combination (71% vs. 21%) compared to intravenous delivery of the antibody, with the reason cited being "requires less time in the clinic," "feels more comfortable during administration," "feels less emotionally distressing," and "lower level of injection-site pain."[29]

A=Patient Preference
B=for those preferring SC, reasons for preference, with patients selecting up to 2 reasons

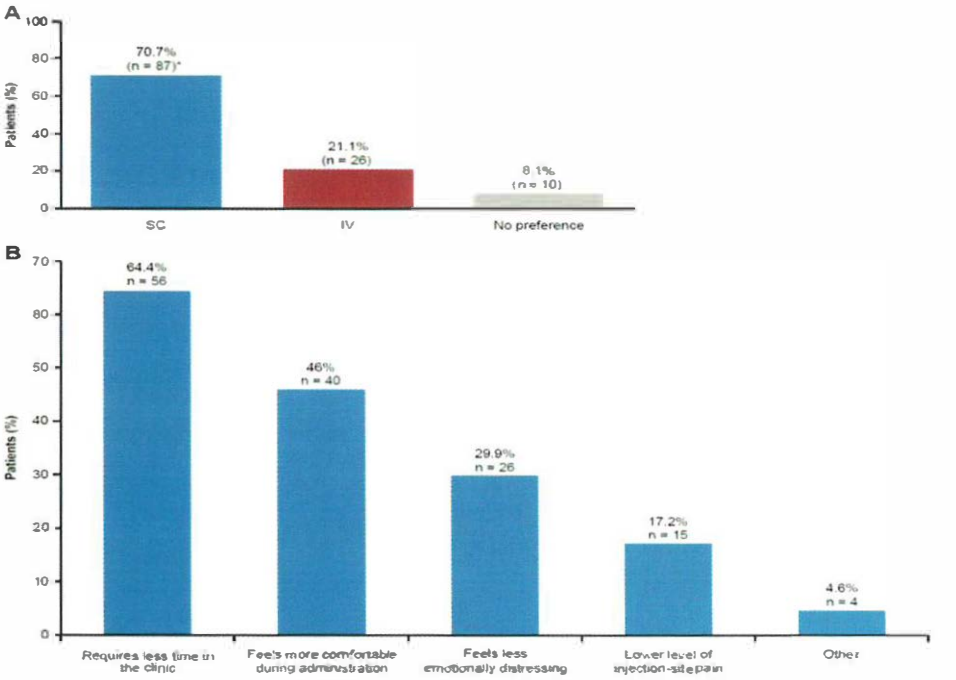

Figure 2. Patients' (A) preferred administration method and (B) reasons for preferring atezolizumab SC over IV. *95 confidence interval: 61.8 to 78.6. The patient preference questionnaire completion rate was 98 (n 123 of 126); 126 patient completed cycle 5 of treatment and were alive on cycle 6 on day 1. (A) Question 1 of the patient preference questionnaire: "All things considered, which route of administration did you prefer?" (B) Question 2 of the patient preference questionnaire had responses from 87 patients: "If you have a preference for one of the administration routes, what are the two main reasons for your preference?" IV, intravenous; SC, subcutaneous.

See footnote for image source.[30]

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[28] *See* Treatment Satisfaction Study (link).

[29] Capuzzo F, et al, Primary Results from IMscin002: A study to Evaluate Patient Preferences and Perceptions of Health Care Professionals for Atezolizumab Subcutaneous versus Intravenous for the Treatment of NSCLC, JTO Clin Res Rep 6:1-11 (2025) (link) (Patient Preferences Study).

[30] *See* Patient Preferences Study (link).

- These findings indicate that patients receiving subcutaneous delivery of cancer treatment with human hyaluronidase are less likely to discontinue or interrupt treatment, potentially increasing the likelihood of survival.

- **Subcutaneous delivery of a fixed combination with Halozyme's human hyaluronidase reduces patient treatment time and can reduce patient costs related to site of care.** When combined with an antibody, Halozyme's human hyaluronidase allows the other active ingredient to be injected subcutaneously in just minutes. Without this option, many treatments for serious illnesses (such as cancer, neurological diseases, and autoimmune diseases) can only be administered by lengthy intravenous infusions due to their large volume. Very frequently, the patient will need to receive this intravenous treatment in an infusion suite at a hospital or infusion center in a process that can take half a day or more: a pharmacist must prepare the drug for administration; the patient must wait for it to be prepared by the pharmacist in addition to the actual treatment administration time, which can be several hours; and the patient must wait during the required observation time after treatment for monitoring for emergence of infusion-related reactions.[31] FDA has acknowledged that switching from intravenous administration to a less burdensome route of administration provides a major contribution to patient care.[32]

    - Multiple studies with subcutaneous delivery of one or more biological products in combination with human hyaluronidase have demonstrated a significantly shorter treatment time—minutes instead of hours—and a shorter required observation time due to the lower occurrence of infusion related reactions.[33]

    - As another benefit, subcutaneous delivery also can occur in a doctor's office or at home, reducing the travel burden for patients and reducing their out-of-pocket costs as a result of avoiding more costly hospitals and infusion suite settings.[34] Indeed, a patient testimonial highlights the benefits of subcutaneous administration:

        > *With the IV antibody, a typical day was we would wake up and get in the car before sunrise so we get to the cancer center typically around 7:30 am and go in for labs, and they get the labs back an hour later and be upstairs to see my doctor maybe around 8:30 or 9 am. That visit would typically be about 20 minutes to 30 minutes. I would then go to the infusion center by about 10:30 am and do the intake stuff that takes a little bit of time . . . they need to order the premeds and the IV antibody to be sent to the infusion center. And really it's about this time that the trauma starts to kick in because I have these veins . . . stab*

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[31] *See* Patient Preferences Study (link).

[32] *See* FDA, Clinical Superiority Findings for Radicava ORS (edaraone) Oral Suspension (last visited June 5, 2025) (link) ("Radicava's oral suspension route of administration advances the ease and comfort of administration without the complications and risks associated with IV administration," which is particularly important "in the context of a chronic . . . disease that requires long-term treatment.").

[33] *See* Perspectives Study (link).

[34] McCloskey C, et al, A Systematic Review of Time and Resource Use Costs of Subcutaneous versus Intravenous Administration of Oncology Biologic in a Hospital Setting, PharmacoEconomics, 7:3-36 (2023) (link).

one . . . go for another vein . . . I then do the premeds, that would generally take one hour to get through IV Benadryl, IV steroids, and then the IV antibody would arrive typically around at 12:30 pm or 1 pm. That first dose is a superlong infusion. For the majority of my time it was a 3-hour infusion. We would get done then with that at 4:00-4:30 pm and then we would drive home, in the traffic . . . so this experience was sunrise to sunset.

With subcutaneous antibody now I typically show up and see my doctor at 9:00 am, see her for about 20 minutes . . . I get upstairs . . . the nurse checks everything out and calls pharmacy and they send the Subcutaneous antibody over in a few minutes and [it takes about] five minutes for the injection of subcutaneous antibody. From time I walk in those doors at around 8:00 am, I will be out the door by 9:30.

I've had 61 doses of subcutaneous antibody since January of 2021. If you took those 61 doses and those were still IV, at a 90-minute infusion that would have been 91 hours versus a 5-minute subcutaneous, which is a total 5 hours. ***That really is treatment scheduled around life. That is a reinvented patient experience. Why is that so important? Because when you have cancer time is everything.***

- **Subcutaneous delivery of a fixed combination with Halozyme's human hyaluronidase can reduce infection risk for patients by eliminating the need for an intravenous device (e.g., a port).** To avoid the need for multiple needle pricks and to ease administration burdens for healthcare providers, patients receiving intravenous treatments commonly undergo a surgical procedure to implant a port-a-cath into a vein. This port-a-cath serves as a catheter that that can be reused for each intravenous infusion without the need for additional vein punctures.

  - Although port-a-caths are convenient and can reduce patient discomfort, they are a source of infection, which can result in septic shock and even death. This risk is of particular importance in patients receiving chemotherapy, whose ability to fight infection can be seriously compromised. A recent JAMA article reports the rate of infection of 4.8 per 1000 catheter days.[35]

  - Subcutaneous delivery of a fixed combination with human hyaluronidase does not require a port-a-cath, as it is delivered as a simple injection under the skin, often in the abdominal area. The availability of several cancer treatments with human hyaluronidase that are administered subcutaneously has resulted in some cancer patients being able to move away from having any of their treatments intravenously, if their particular regimen of cancer treatments is administered entirely as pills or subcutaneous injections, mitigating the discomfort of having a port-a-cath and the attendant infection risks. As an example of this, for patients with the blood cancer multiple myeloma, the availability of an antibody treatment given subcutaneously with human hyaluronidase enabled patients receiving a commonly used four-drug treatment regimen to avoid the need for

[35] *See* Munsch et al, Complication Rates of Central Venous Catheters, A Systematic Review and Meta-Analysis, JAMA Internal Medicine, Volume 184, No. 5, 474-482 (March 2024) (link) (CVC Study).

intravenous treatment, where the three other treatments were already given orally or subcutaneously.

- In a similar context with "a central venous access device (CVAD), which is associated with an increased risk of thromboembolic events and access-associated infections," FDA determined, that the same drug administered subcutaneously provided greater safety for patients.[36]

- **Subcutaneous delivery of a fixed combination with Halozyme's human hyaluronidase can reduce cancer patients' exposure to infection by reducing the length of time spent in infusion facilities**. Despite advances in oncology care, infections remain a major cause of morbidity and mortality among cancer patients. Increased risks for infection are attributed, in part, to immunosuppression caused by the underlying malignancy and by the cancer treatment itself. Patients with cancer frequently are in healthcare settings and can be exposed in these settings to other patients that might have transmissible infections.

  - The CDC has highlighted that outpatient oncology facilities where infusion facilities are often located vary greatly in their attention to and oversight of infection control and prevention.[37] For example, there were a number of outbreaks of viral hepatitis and bacterial bloodstream infections in outpatient facilities that resulted from breaches in basic infection prevention practices (e.g., syringe reuse, mishandling of intravenous administration sets). A specific CDC guide is in effect to provide direction on basic infection control to better protect vulnerable patients.[38] The availability of subcutaneous delivery with human hyaluronidase allows for some patients to be treated at home or in a doctor's office. For patients who are still treated in infusion facilities, subcutaneous delivery with human hyaluronidase allows them to spend significantly less time in the infusion facility and thus have fewer hours of potential exposure to infectious pathogens.

  - FDA leadership has lauded these benefits. In June 2020, when FDA approved Phesgo two antibodies, pertuzumab and trastuzumab, in a fixed combination with human hyaluronidase for subcutaneous injection to treat adult patients with HER2-positive breast cancer, the Director of the FDA's Oncology Center of Excellence stated in the public press release, "[c]urrently, most patients with HER2-positive breast cancer receive trastuzumab and pertuzumab at infusion centers. With a new administration route, Phesgo offers an out-patient option for patients to receive trastuzumab and pertuzumab," which was particularly important during the coronavirus pandemic during which it was critical "to keep a strong focus on patients with cancer who constitute a vulnerable population at risk of contracting the disease."[39]

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[36] *See* FDA, Clinical Superiority Findings for Hizentra (link) ("Data demonstrated that patients treated with Hizentra subcutaneously had fewer of these [thromboembolic events and access-associated infections] than patients treated with IGIV via CVADs. Therefore, Hizentra provides greater safety than the previously approved IGIV formulation of immune globulin for CIDP as maintenance therapy . . . .").

[37] CDC, Basic Infection Control and Prevention Plan for Outpatient Oncology Settings (April 15, 2024) (link).

[38] CDC, Basic Infection Control and Prevention Plan for Outpatient Oncology Settings (Dec. 2011) (link).

[39] FDA Press Release, FDA Approves Breast Cancer Treatment That Can Be Administered At Home By Health Care Professional (June 29, 2020) (link).

- **Subcutaneous delivery of a fixed combination of an antibody with Halozyme's human hyaluronidase reduces HCP resources and time required for treatment preparation and administration compared to the antibody given intravenously as a single component product**. Multiple studies have consistently found both in and outside the United States that pharmacy, nurse, and doctor time and related costs associated with administering antibodies subcutaneously with human hyaluronidase for cancer are meaningfully lower when compared to the antibody administered intravenously. When infusion suite capacity is full and staff shortages can occur, use of the more efficient subcutaneous delivery also can enable more patients to receive treatment each day.[40]

    - Some have argued that, while combining biological products with hyaluronidase offers greater convenience and fewer infusion reactions, it may also increase overall healthcare spending.[41] These critics appear to take this position based largely on conjecture and despite recognizing "that newer hyaluronidase versions had similar or lower costs than the intravenous version[.]"[42] They also acknowledge that their analysis "did not account for potential savings associated with reduced time and cost" from the fixed combinations and that the transition to "could lead to direct healthcare savings due to lower administration fees and indirect savings from less patient and caregiver time spent receiving infusions."[43] Indeed, we have found a reduction, not an increase, in total healthcare spending as a result of hyaluronidase reformulations. A recent systematic literature review assessed the economic costs of antibodies delivered subcutaneously in fixed combination with hyaluronidase compared to intravenous administration of the antibody alone:

        > Economic costs associated with treatment, reported by 14 studies, were consistently higher for IV compared with SC therapy administration despite considerabl[e] heterogeneity in how costs were measured and reported across studies. Differences in direct costs were driven primarily by HCP time, day unit/hospitalization time, consumables, and drug wastage, whereas drug costs were similar between groups. Indirect cost savings were also observed for SC over IV administration in a subset of studies that reported these data and were driven primarily by the differential impact on patient and/or caregiver work productivity.[44]

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[40] State of Cancer Report 2023, LeanTaaS Institute (link).

[41] Kim J, Medicare Spending and Use of Subcutaneous Biologic Formulations with Hyaluronidase, the Oncologist (2025) (link) (Spending Study).

[42] *See* Spending Study at 2 (link). This article also speculates about the potential impact of fixed combinations of human hyaluronidase and antibodies on competition from biosimilars of the intravenous antibodies. But the vast majority of the intravenous antibody drugs mentioned in the article's Table 1 were approved fewer than twelve years ago. Accordingly, reference product exclusivity for the antibody drug, not competitive dynamics, is the likely reason for the lack of biosimilar competition. *See* PHSA § 351(k)(7).

[43] Spending Study at 3 (link).

[44] *See* Perspectives Study (link).

- Subcutaneous delivery of a fixed combination with human hyaluronidase also offers the following patient benefits:[45]

    - Reduces patient travel, and caregiver support costs, and other indirect patient out-of-pocket expenditures compared to that for intravenous delivery;

    - Allows for administration to occur at alternative sites of care that can be closer to a patient's home, reducing both patient and caregiver travel time burden;

    - Typically decreases the time spent at any site of care when compared to intravenous administration, as explained in the patient testimonial; and

    - Allows for certain therapies to be self-administered at home, eliminating the need for patients to travel to a medical facility, which decreases a patient's and caregiver's time absent from work.[46]

In sum, human hyaluronidase is biologically and therapeutically active and results in clinically meaningful differences. Subcutaneous fixed combination products containing human hyaluronidase and specific antibodies provide meaningful therapeutic advantages for patients and the public health. As explained above, these products can reduce side effects, improve efficacy, reduce patient burden, and reduce healthcare practitioner burden. These products also reduce overall cost to the healthcare system and patients. For these reasons, even if CMS adopts the Proposal, it should find that antibody plus human hyaluronidase fixed combinations are distinct QSSDs from the antibodies formulated alone.

IV. The Proposal is flawed as a matter of law.

A. The Proposal would create two meanings of "biological product" and does not reflect the single, best reading of the SSA—contrary to *Loper Bright*.

The Proposal conflicts with recent U.S. Supreme Court case law and executive action.

In *Loper Bright Enterprises v. Raimondo*, the Court held that agencies and reviewing courts must adopt the "single, best meaning" of statutory provisions.[47] The President also issued a memorandum directing the repeal of unlawful regulations that contravene *Loper Bright*.[48] CMS's Proposal under is flawed under *Loper Bright* for several reasons.

First, CMS now proposes to give the statutory phrase "biological product" two different meanings. To date, as explained above, CMS has interpreted "biological product" in the QSSD

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[45] *See* Perspectives Study (link); *see also* CVC Study (link).

[46] This benefit to patients is meaningful, especially to the considerable number of patients living in rural, tribal, or other remote regions across the U.S. who may not otherwise be able access life-changing therapies. Levitt LA, et al, Closing the Rural Cancer Care Gap: Three Institutional Approaches, JCO Onc Prac, 16:422-431 (2020) (link). *See also* Vyvgart Hytrulo, Prescribing Information, § 2 Dosage and Administration (link) ("VYVGART HYTRULO prefilled syringe may be administered by patients and/or caregivers after proper instruction in subcutaneous injection technique").

[47] *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 400 (2024) ("Courts instead understand that such statutes, no matter how impenetrable, do—in fact, must—have a single, best meaning.").

[48] The White House, Directing the Repeal of Unlawful Regulations (April 9, 2025) (link).

definition to mean "active ingredient" or combination of "active ingredients" and has used the RxNorm database to identify active ingredients. Now, changing course, CMS proposes to adopt—for certain fixed combination products only—a second, unique interpretation of "biological product" that requires consideration of biological activity, therapeutic activity, and/or clinically meaningful differences and disregards a component's active ingredient status, as recognized by FDA. This dualistic approach cannot be squared with the U.S. Supreme Court's decision in *Loper Bright*. An agency may not interpret the exact same statutory term, "biological product," one way for certain products and another way for other products. This phrase must have one single, best meaning. CMS's Proposal does not adhere to this requirement.

Second, CMS's Proposal also does not represent the best reading of the SSA in violation of the Supreme Court's holding. CMS's original approach—that "biological product" means active ingredient or combination of active ingredients for all biological products, including all fixed combinations—comported with *Loper*. It best fit the statutory text, which makes no mention of "therapeutically active," "biologically active," or "clinically meaningful" criteria for identifying QSSDs. Instead, the statutory QSSD definition applies to "[a] biological product . . . that is licensed under section 351(a) of the Public Health Service Act [PHSA]."[49] Under section 351(a), FDA has licensed antibody-human hyaluronidase combinations—separately from individual antibodies—as fixed combinations with two active ingredients.[50] It has also, as noted, licensed a biological product with human hyaluronidase as the sole active ingredient.[51] Thus, an antibody-human hyaluronidase combination qualifies as a separate "biological product" licensed under 351(a) of the PHSA. CMS's original interpretation therefore aligned with the statute.[52]

In contrast, the Proposal conflicts with the statute. There is no statutory qualifier in either the SSA or PHSA that permits CMS to treat certain fixed combination products differently than others. In particular, given the SSA's express reliance on licensing decisions under section 351(a) of the PHSA and the separate licensure of fixed combination products from individual antibodies, there is no statutory basis for applying the QSSD definition differently for only some fixed combination products. CMS's Proposal thus conflicts with the statutory focus on the product that is licensed under section 351(a) by FDA and the text of the QSSD definition more generally.

Finally, the addition of Part B drugs to the Program does not justify the Proposal. The statute has not changed, and the relevant parts of the QSSD definition—i.e., the text providing

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[49] SSA § 1192(e).

[50] *See, e.g.*, Darzalex Faspro (daratumumab and hyaluronidase-fihj), Herceptin Hylecta (trastuzumab and hyaluronidase-oysk), Hyqvia (Immune Globulin Infusion (Human), 10% with Recombinant Human Hyaluronidase), Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq), Opdivo Qvantig (nivolumab and hyaluronidase-nvhy), Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf), Rituxan Hycela (rituximab and hyaluronidase human), Tecentriq Hybreza (atezolizumab and hyaluronidase-tqjs), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc).

[51] *See* Hylenex recombinant (hyaluronidase human). *See also* Amphadase (hyaluronidase), Hydase (hyaluronidase), Vitrase (hyaluronidase).

[52] Given that FDA has licensed *biological products* containing human hyaluronidase as an active ingredient, including as the sole active ingredient, it is necessarily the case that human hyaluronidase is "applicable to the prevention, treatment, or cure of a disease or condition of human beings." *See* PHSA § 351(i)(1).

when a "[a] biological product" is a QSSD—apply equally to Part B and D drugs. Specifically, the QSSD definition states:

> "(1) IN GENERAL.—For purposes of this part, the term 'qualifying single source drug' means, with respect to an initial price applicability year, subject to paragraphs (2) and (3), ***a covered part D drug (as defined in section 1860D–2(e)) that is described in any of the following or a drug or biological product for which payment may be made under part B of title XVIII*** that is described in any of the following:
>
> . . .
>
> "(B) BIOLOGICAL PRODUCTS.—A biological product—
>
> "(i) that is licensed under section 351(a) of the Public Health Service Act and is marketed under section 351 of such Act;
>
> "(ii) for which, as of the selected drug publication date with respect to such initial price applicability year, at least 11 years will have elapsed since the date of such licensure; and
>
> "(iii) that is not the reference product for any biological product that is licensed and marketed under section 351(k) of such Act.[53]

As discussed above, CMS interprets subparagraph (B) and the term "biological product" in particular (as well as the similar provisions for drugs) for purposes of its aggregation methodology. This text is exactly the same for Part B and Part D drugs. Thus, the inclusion of Part B drugs provides no basis for novel aggregation methodology in IPAY 2028.

In sum, the statutory interpretation reflected in the Proposal does not represent the single, best meaning and thus cannot stand. CMS should abandon the Proposal to avoid violating the Administrative Procedure Act (APA) with an inconsistent and invalid statutory interpretation.

B. <u>CMS's Proposal second-guesses FDA's expert determinations.</u>

The Proposal conflicts with FDA's regulation that CMS invokes and FDA's conclusions about components' status as active ingredients.

As noted, the IPAY 2026 and 2027 Guidances and the IPAY 2028 Draft Guidance cross-reference FDA's definition of fixed combination drug at 21 C.F.R. § 300.50 for purposes of the aggregation principle. This regulation applies to:

> Two or more drugs . . . combined in a single dosage form when each component makes a contribution to the claimed effects and the dosage of each component (amount, frequency, duration) is such that the combination is safe and effective for a significant

[53] SSA § 1192(e)(1) (emphasis added).

> patient population requiring such concurrent therapy as defined in the labeling for the drug.[54]

The regulation recognizes "[s]pecial cases of this general rule are where a component is added:" "(1) To enhance the safety or effectiveness of the principal active component; and (2) To minimize the potential for abuse of the principal active component."[55] FDA interprets "component" as active ingredient.[56]

FDA has provided examples of fixed combinations that fall into these categories. For combinations in which one active ingredient is intended to "[p]rovide a direct effect that either potentiates or makes another active ingredient more tolerable," the agency gives the example of "using carbidopa to provide a lower dose of levodopa to minimize side effects."[57] For combinations in which one active ingredient is intended to "minimize an adverse reaction associated with another active ingredient," the agency has given as an example "using pyridoxine to minimize the toxicity of isoniazid;" and for combinations in which one active ingredient is intended to "reduce the abuse potential associated with another active ingredient" the agency has given the example of "using an opioid antagonist to reduce the abuse potential of an oral opioid product following manipulation for purposes of abuse."[58]

The regulation and FDA's examples highlight that an active ingredient in a fixed combination must have a clinically meaningful effect to be present in a fixed combination at all. Thus, CMS's continued reliance on this regulation underscores that active ingredients that serve either of these latter functions described as "special cases" of the general rule should be considered active ingredients for aggregation purposes. The Proposal to revisit clinical meaningfulness a second time thus is in tension with the very regulation that CMS cites.

The regulatory history of 21 C.F.R. § 300.50 supports this conclusion. The regulation was originally proposed over 50 years ago in 1971 in a proposed rule, which explained:[59]

> It is the consensus of these informed experts that a fixed dose combination drug must have an advantage to the patient over and above that obtained when one of the individual ingredients is used in the usual safe and effective dose. No drug should be present in a fixed combination unless its inclusion clearly enhances safety or efficacy and the fixed ratio of doses is safe and effective for all indications and for patient.[60]

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[54] 21 C.F.R. § 300.50.

[55] *Id.*

[56] 80 Fed. Reg. 79,776, 79,786 (Dec. 23, 2015) (link) (2015 Proposed Fixed Combination and Co-Packaged Drugs Rule) ("we have interpreted 'component' in § 300.50 to mean active ingredient.").

[57] *Id.* at 79,786.

[58] *Id.*

[59] Proposed Rule, "Proposed Statement Amplifying Policy on Drugs in Fixed Combinations," 36 Fed. Reg. 3126 (Feb. 18, 1971). *See also* Final Rule, "Fixed-Combination Prescription Drugs for Humans," 36 Fed. Reg. 20,037 (Oct. 15, 1971).

[60] *Id.*

This longstanding regulation makes clear that for FDA to approve a fixed combination product, "each ingredient designated as active" must contribute to the total effect of the drug. As noted, FDA defines "active ingredient" as "any component that is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body of man or other animals."[61]

FDA has regarded antibody-human hyaluronidase combinations as fixed combination products under 21 C.F.R. § 300.50. For example, FDA cited the fixed combination regulation, 21 C.F.R. § 300.50, in its review materials for one such product.[62] As explained above, FDA has also recognized that human hyaluronidase is an active ingredient. If FDA considers antibody-human hyaluronidase combinations to be fixed combination products under 21 C.F.R. § 300.50, then, like any other active ingredient in a fixed combination product, human hyaluronidase necessarily contributes to the total effect of the drug, enhances safety and/or efficacy, and furnishes pharmacological activity.

Indeed, in these fixed combinations, human hyaluronidase is similar to the example FDA has provided (e.g., carbidopa) for a component of a fixed combination product that "[p]rovide[s] a direct effect that either potentiates or makes another active ingredient more tolerable."[63] Carbidopa is used to allow use of a lower dose of levodopa to minimize side effects—in other words, CMS might conclude that it "affects the bioavailability of [levodopa] but is not therapeutically active against [Parkinson's disease]." Nevertheless, FDA recognizes as carbidopa as an active ingredient that affects how levodopa is dosed in a manner that affects safety or effectiveness. Similarly, as explained in section III, without human hyaluronidase, rapid subcutaneous delivery of an antibody is limited to just ~2 milliliters, significantly restricting the use of subcutaneous delivery as many drugs require higher doses to be effective. Human hyaluronidase thus affects the amount of drug that can be delivered subcutaneously at a given time, in a way that can affect safety or effectiveness (e.g., by lowering the rate of infusion-related reactions and other potential adverse events as compared to the single component antibody administered intravenously).

In sum, CMS's Proposal to differentiate among certain fixed combinations as described in 21 C.F.R. § 300.50 does not align with the longstanding regulation or FDA's approach to implementing that rule. Moreover, the fact that FDA regards antibody-human hyaluronidase combinations as fixed combination products under 21 C.F.R. § 300.50 provides further evidence that human hyaluronidase necessarily results in a clinically meaningful difference in the fixed combination product and is therapeutically active. As recognized in the text of the SSA, FDA is the agency charged with licensing biological products, including fixed combinations, and CMS should not second-guess FDA's determinations that human hyaluronidase is an active ingredient that plays a clinically meaningful role in antibody-human hyaluronidase combinations.

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[61] 21 C.F.R. § 210.3(b)(7).

[62] Cross-Discipline Team Lead Review, BLA 761064 at 21 fn. 4 (June 7, 2017) (link) ("The applicable regulations would be 21 CFR 300.5● Fixed-combination prescription drugs for humans. For labeling purposes, the term 'combination' is recommended.").

[63] 80 Fed. Reg. at 79,786.

C. The Proposal is inconsistent with the orphan-drug exclusion.

CMS's Proposal conflicts with the orphan-drug exclusion in the IRA. Under section 1192(e)(3) of the SSA, QSSD "does not include" "[a] drug that is designated as a drug for only one rare disease or condition under section 526 of the Federal Food, Drug, and Cosmetic Act [FDCA] and for which the only approved indication (or indications) is for such disease or condition."[64]

FDA has long interpreted "drug" in section 526 of the FDCA to mean "principal molecular structural features" of biological products.[65] For purposes of section 526 of the FDCA, FDA considers fixed combination and single-entity active ingredient products to be different "drugs" that require separate orphan-drug designations.[66] Given the SSA's express reference to the "drug" designated "under section 526" of the FDCA, Congress intended to adopt FDA's interpretation of "drug" for purposes of the orphan-drug exclusion.

For purposes of section 526 of the FDCA, FDA considers a fixed combination of an antibody with human hyaluronidase to be a different drug from the antibody. For example, based on FDA's website, FDA does not consider Vyvgart (efgartigimod alfa) and Vyvgart Hytrulo (efgartigimod alfa in combination with human hyaluronidase) to be the "same drug."[67] Nor does FDA consider Rituxan (rituximab) or Rituxan Hycela (rituximab in combination with human hyaluronidase) to be the "same drug."[68]

Therefore, the Proposal would conflict with this FDA interpretation and the statute's reference to FDA's designation decisions. Under CMS's Proposal, some fixed combinations would be considered to be the same "biological product" as an individual active ingredient within the fixed combination—even though FDA would say these are two different "drugs" under section 526. In this respect, the Proposal would result in absurd consequences. For example, a fixed combination of active ingredients X and Y could be aggregated with a biological product containing only active ingredient Y. But FDA would have granted separate orphan-drug designations to X and X+Y because they are different "drugs" under section 526 of the FDCA. It is unclear whether CMS would say that this type of QSSD can *never* qualify for the orphan-drug

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[64] SSA § 1192(e)(3)(A).

[65] 80 Fed. Reg. 79,776, 79,786 (Dec. 23, 2015).

[66] FDA, Office Director's Decisional Memorandum, NDA 21-844, at 1 (Dec. 12, 2005) (link) (stating that "fixed-combination drug products are not considered 'the same drug' as single ingredient products under the Orphan Drug Act and implementing regulations" and finding that IPLEX, a fixed-combination of rhIGF-1 and rhIGFBP-3, was not blocked from approval by exclusivity granted to INCRELEX, which contains rhIGF-1).

[67] Vyvgart Hytrulo is listed in the orphan-drug database (link) as having orphan-drug exclusivity for treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive, but there is no evidence that FDA has made a finding that Vyvgart Hytrulo is clinically superior to Vyvgart. *See* FDCA § 527(c); *See also* 21 C.F.R. § 316.34(c); FDA Clinical Superiority Website (link).

[68] Rituxan SC is listed in the orphan-drug database (link) as having orphan-drug exclusivity for treatment of adult patients with previously untreated and previously treated chronic lymphocytic leukemia in combination with fludarabine and cyclophosphamide, but there is no evidence that FDA has made a finding that Rituxan SC is clinically superior to Rituxan. *See* FDCA § 527(c); *See also* 21 C.F.R. § 316.34(c); FDA Clinical Superiority Website (link).

exclusion. This "potential QSSD" would need to have two orphan-drug designations under section 526, but a product with two designations is not eligible for the orphan-drug exclusion.

This absurdity shows that the Proposal is out of step with the longstanding meaning of "drug" in section 526 of the FDCA and FDA's designation of fixed combination products containing human hyaluronidase. These considerations underscore that the Proposal does not represent the single, best reading of the statute.

D. The Proposal departs from precedent without adequate explanation or fair notice.

CMS's Proposal is a clear departure from its IPAY 2026 and IPAY 2027 guidance. CMS has not provided adequate explanation for the proposed change. CMS also has failed to consider industry's reliance interests on the existing policy or provide industry with adequate notice of how CMS would determine that a component—that FDA has determined to be an active ingredient in a fixed-combination product—is not therapeutically or biologically active and does not produce a "clinically meaningful difference."

In *FCC v. Fox Television Stations*, the Supreme Court held that when an agency's "prior policy has engendered serious reliance interests that must be taken into account," "[i]t would be arbitrary and capricious to ignore such matters. . . . [A] reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy."[69] As recently as October 2024, CMS reaffirmed the approach to aggregation of all fixed combination products per the IPAY 2026 and 2027 guidance documents and rejected comments suggesting a test similar to the Proposal. The agency has provided no reasoned explanation for the abrupt change in approach from IPAY 2026 and IPAY 2027. As noted, nothing about the inclusion of Part B products in IPAY 2028 justifies the change, as the relevant parts of the QSSD definition are the same for Part B and D drugs. CMS also has not considered the reliance interests at stake if the Proposal is adopted.

Moreover, as the D.C. Circuit has explained, "[r]ule of law principles require that parties have fair notice and an opportunity to conform their behavior to legal rules."[70] CMS has proposed a vague, thinly described, and potentially inconsistent test in its Proposal. The fixed combination products that CMS intends to fall under this Proposal are "not biologically active against the disease state(s) the drug is indicated for and thus do[] not result in a clinically meaningful difference," and CMS also provides an example of a component in a fixed combination product that "affects the bioavailability of active moiety / active ingredient Y but is not therapeutically active against the disease state."[71] We have identified no statutory or regulatory definition of "biologically active," "therapeutically active," or "clinically meaningful differences" in the context of fixed combination products.[72]

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[69] *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515–16 (2009). *See also Dep't of Homeland Security v. Regents of the Univ. of California*, 591 U.S. 1, 30 (2020) ("When an agency changes course, . . . it must be cognizant that longstanding policies may have engendered serious reliance interests that must be taken into account.").

[70] *See Circus Circus Casinos, Inc. v. NLRB*, 961 F.3d 469, 476 (D.C. Cir. 2020). *See also id.* at fn 2.

[71] IPAY 2028 Draft Guidance at 13.

[72] The term "clinically meaningful difference" appears within the definition of a "biosimilar" in the PHSA, but it has a very circumscribed meaning that is not related to QSSD aggregation issues. PHSA § 351(i)(2) (noting that, among other things, biosimilarity requires "no clinically meaningful differences between the

It is difficult to divine what is the actual test here that CMS is proposing and what its key teams mean. The description raises many questions, including:

- Is the test whether the component is biologically active against the disease state and will CMS's conclusion on biological activity determine if there are no clinically meaningful differences? Or is the test two parts, where the component must not be active against the disease state and must not provide a clinically meaningful difference to be subject to the new policy?

- Is there a reason CMS uses "biologically active" in one passage but "therapeutically active" in another?

- Does this test apply not only to fixed combination products but also co-packaged products?

Furthermore, it is not clear what approach CMS will take to aggregate fixed combination products that fall within the scope of the Proposal, if adopted. Under one approach, to identify certain fixed combination products as QSSDs that fall under the Proposal, CMS might aggregate for any single BLA holder all dosage forms and strengths of products (a) containing the same combination of active ingredients as a given fixed combination product and (b) containing a single ingredient within that fixed combination product. Then CMS might apply the 11-year requirement in the definition of QSSD by looking to the earliest date of licensure of either of the individual components for certain fixed combination products but not others.

Alternatively, CMS might identify certain fixed combination products as QSSDs that fall under the Proposal by aggregating for any single BLA holder all dosage forms and strengths of products (a) containing the same combination of active ingredients as a given fixed combination product and (b) containing what it considers to be the single "biologically" or "therapeutically" active component within the fixed combination product. Unlike the prior approach, this approach would exclude products CMS has deemed to contain the "biologically" or "therapeutically" "inactive" component from the scope of aggregated products. Then, CMS might apply the 11-year requirement in the definition of QSSD to that narrower group of products but in a similar manner as the prior approach. CMS has failed to give any indication of what approach it might be taking here.

In sum, CMS has not appropriately explained the basis for its proposed change in statutory interpretation, and regulated industry does not have fair notice of the most basic aspects of how the Proposal would be implemented.

E. <u>The Proposal is arbitrary and capricious in contravention of the APA.</u>

The APA requires a court to set aside agency actions, findings, and conclusions found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."[73] As noted above, not only does the Proposal create two definitions of biological product, but also it conflicts with FDA's regulation of fixed combination products. This discrepant treatment of these functionally indistinguishable fixed combination products by CMS itself and also between CMS and FDA is the essence of the meaning of arbitrary and capricious government action.

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biological product and the reference product in terms of the safety, purity, and potency of the product."). If anything, this provision indicates that Congress knows how to specify when differences must be clinically meaningful—or not—and chose to exclude any such requirement from the QSSD definition.

[73] 5 U.S.C. § 706(2)(A).

Courts have repeatedly held that "an agency must treat similar cases in a similar manner unless it can provide a legitimate reason for failing to do so."[74] CMS has provided no legitimate reason.

Moreover, as discussed above, CMS's Proposal, if adopted, may result in the disparate treatment of fixed combination products that are orphan drugs when assessing whether they qualify for the orphan-drug exclusion from the definition of a QSSD and when assessing whether they otherwise meet the definition of a QSSD. Again, this discrepant treatment constitutes arbitrary and capricious agency action that must be set aside.

Finally, CMS's Proposal comes as an abrupt about-face less than a year after having a different, uniform policy for fixed combination products. As discussed above, there is not an adequate explanation for this change or the Proposal itself. The timing of the change and the thinness of the explanation put into high relief how arbitrary the policy is.

V. The Proposal is flawed as a matter of policy.

A. The Proposal discourages fixed combination products that help patients and reduce burden on healthcare resources.

As explained in section IV.D, it is not clear what approach CMS would take with respect to aggregation and application of the 11-year selection timeline for the fixed combination products identified in the Proposal, if adopted. However, any approach under the Proposal will have the effect of discouraging the development of fixed combination products and conflicts with FDA's policies encouraging their development. FDA has explained the importance of fixed combination products:

> Fixed-combinations are becoming increasingly important from patient and public health perspectives. Combination therapy is emerging as the standard of care in certain disease settings, such as cancer, cardiovascular disease, and infectious disease (for example, in human immunodeficiency virus (HIV) infections/acquired immunodeficiency syndrome (AIDS)). In recognition of the importance of such combination therapies, FDA has encouraged the development of these therapies through various policies and initiatives. For example, FDA recently finalized its guidance for industry titled *Codevelopment of Two or More New Investigational Drugs for Use in Combination* (Codevelopment Guidance). In the Codevelopment Guidance, FDA explained the potential therapeutic benefits of combination therapies, including improvement in treatment response, lower risk of developing resistance, and lower rates of adverse events.[75]

Although FDA clearly recognizes the importance of fixed combination products and has various policies to encourage their development, CMS's Proposal does exactly the opposite and discourages their development. Given concerns over CMS determining that one of the

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[74] *See Bracco v. Shalala*, 963 F. Supp. 20, 27-28 (D.D.C. 1997).

[75] Final Guidance, New Chemical Entity Exclusivity Determinations for Certain Fixed-Combination Drugs (Oct. 2014) (link). *See also* Final Guidance, Guidance for Industry Codevelopment of Two or More New Investigational Drugs for Use in Combination at 2 (June 2013) (link) ("FDA believes guidance is needed to assist sponsors in the codevelopment of two or more new investigational drugs.").

components in a fixed combination product does not result in a clinically meaningful difference, companies might avoid developing such products when, as explained in section III and confirmed by FDA, they provide significant therapeutic advantages.

B. The Proposal runs counter to government efficiency and creates administrative burden for CMS.

The April 9, 2025 Presidential Memorandum explicitly calls on agencies to review and repeal onerous regulations.[76] The Proposal would increase agency burden and therefore should be abandoned.

The Proposal would appear to require CMS to make case-by-case decisions about whether to aggregate a fixed combination with an individual active ingredient. CMS would need to make those decisions based on an ambiguous and fact-specific test, rather than deferring to the decision FDA already made on the issue. Implementation of the Proposal thus would be administratively taxing.

For example, it would require CMS staff to have or obtain the medical knowledge necessary to make assessments of clinical differences of every fixed combination that might be selected for the Program. Alternatively, implementation might involve an intensive interagency consult process with FDA. Resolution of the complex orphan-drug exclusion issues raised above also would require substantial administrative resources. Building an appropriate administrative record for such decisions would be time consuming as well.

This process therefore would undermine the Administration's goals to reduce red tape and enhance government efficiency.[77] It would be much less onerous to defer to FDA's expert decision that fixed combinations of biologics have at least one different active ingredient from a single-entity biological product, as reflected in FDA's licensure decisions under section 351(a) of the PHSA.

For the sake of conserving the government's scarce resources and maximizing governmental efficiency and productivity, the Proposal should be abandoned.

C. The Proposal creates uncertainty because it would be difficult to predict which fixed combination products will be aggregated and which will not.

Given how many unanswered questions there are about the Proposal, it would be challenging for industry and the public to predict which fixed combination products will and will not be aggregated. As explained in section IV.D, the Proposal lacks details regarding CMS's proposed test to identify the subset of fixed combination products affected by the Proposal, and the terms CMS employs in describing the Proposal are unclear and vague. Moreover, even if the Proposal were clear, it would require case-by-case CMS determinations regarding aggregation that will be difficult to predict.

This inability to forecast how CMS will implement this Proposal will inevitably disrupt research and development planning and strategic business partnerships that have brought to market fixed combination products that offer significant therapeutic advantages. In other words, this lack of clarity will stifle investment in fixed combinations—despite their therapeutic

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[76] The White House, Directing the Repeal of Unlawful Regulations (April 9, 2025) (link).

[77] *See, e.g.*, Executive Order 14219, § 1 (February 19, 2025).

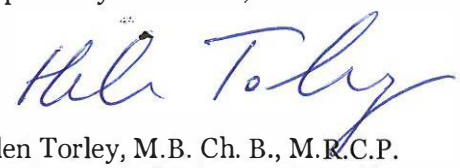
importance, as recognized by FDA and discussed above. Industry and investors will have no clarity as to whether they will have an 11-year period to recoup investment in a novel fixed combination or potentially no period at all. Furthermore, other stakeholders will also lose the predictability afforded by CMS's interpretation from IPAYs 2026 and 2027. Payors and investors will find it more difficult to predict which fixed combinations will be subject to the Program. These issues will be punted to an opaque CMS process that is divorced from FDA's science-based determinations.

To avoid these negative policy outcomes, CMS should revert to its approach to fixed combination aggregation as described in the IPAY 2026 and 2027 Guidances.

VI. Conclusion

For the reasons described above, Halozyme urges CMS to adhere to the definition of QSSD adopted in the IPAY 2026 and 2027 guidance documents for fixed combination products. If CMS decides to deviate from its IPAY 2026 and 2027 approach in identifying QSSDs, CMS should find that Halozyme's human hyaluronidase is an active ingredient with biological and therapeutic activity that provides clinically meaningful effects in fixed combination products, and therefore that fixed combinations of human hyaluronidase and antibodies should be considered distinct QSSDs from the individual active ingredients.

Respectfully submitted,



Helen Torley, M.B. Ch. B., M.R.C.P.
President and Chief Executive Officer
Halozyme Inc.

June 26, 2025

VIA ELECTRONIC DELIVERY: irarebateandnegotiation@cms.hhs.gov

Mehmet Oz, MD, MBA, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Drug Price Negotiation Program (MDPNP) - Draft Guidance for IPAY 2028

Dear Administrator Oz,

Haystack Project has, over the past years, actively engaged with the Centers for Medicare & Medicaid Services (CMS) on its implementation of the Medicare Drug Pricing Negotiation Program (MDPNP) through comments, participation in stakeholder engagement events, and meetings with CMS' MDPNP staff. Our comments to the initial set of guidance for IPAY 2026 and reiterated in response to the guidance for IPAY 2027 emphasized the MDPNP's high potential for unintended, but catastrophic, consequences for individuals with rare conditions.

In the short time since the Inflation Reduction Act of 2022 (IRA) was enacted, we have already seen decreased manufacturer and investor interest in rare and ultra-rare disease research. Our patient communities increasingly fear that unless this trajectory is disrupted, treatments within our scientific and technological reach will remain on the "shelf." We submit our comments to further this Administration's understanding of our communities' unique challenges, and to urge CMS to proactively steer its MDPNP implementation policies in a "do no harm" direction for rare disease access and innovation.

Haystack Project (Haystack) is a 501(c)(3) non-profit organization enabling our growing membership of rare and ultra-rare disease and rare cancer patient advocacy organizations to coordinate and focus efforts to resolve systemic obstacles impeding research and development of new treatment options and patient access to existing therapies. Our core mission is to evolve health care 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 disease states where unmet need is high and treatment delays and inadequacies can be catastrophic.

Since IRA enactment, Haystack Project participation has nearly doubled and now includes over 140 rare and ultra-rare disease patient advocacy organizations. We acknowledge the new out-of-pocket

cap, and the Medicare Prescription Payment Plan offer significant financial relief, and that this is due in part to the financial savings generated through the MDPNP. Haystack Project strongly believes Medicare savings must not threaten the fragile balance that has historically enabled researchers, manufacturers, and investors to capture an adequate return on investment for targeted treatments in small population diseases.

Our comments to the Draft Guidance briefly summarize the inherent challenges rare disease patients face, and our concerns the MDPNP will have disproportionate unintended consequence of limiting available treatment options for rare disease patients. We identify specific aspects of MDPNP implementation efforts to date as likely to have unintended consequences in rare diseases, and outline changes in industry/investor perceptions and behaviors that confirm the validity of Haystack Project's concerns. Finally, we recommend the following actions CMS can take to protect access and innovation, including:

- Reconsider the previous Administration's definition of Qualifying Single Source Drug (QSSD)
- Eliminate the "pill penalty."
- Work with Congress to amend the MDPNP's renegotiation processes to better align with public policy goals of deterring monopolistic ***behaviors*** and preserving innovation incentives.
- Require that Part D plans retain formulary inclusion for products with an MFP and enforce formulary inclusion requirements for treatments within the six "protected classes."
- Engage with a broad set of provider stakeholders to ensure that Part B effectuation does not constrict Medicare beneficiary access to Part B drugs.
- Engage in meaningful dialogue with Haystack Project and other patient organizations to identify alternative pathways (including through the Center for Medicare and Medicaid Innovation), that reduce prescription drug costs, deter monopolistic behaviors, and encourage innovation to address high unmet patient needs.

Haystack Project remains concerned that drug-pricing reforms will all but close the narrow commercial viability window for new rare and ultra-rare disease treatments and new rare indications for existing therapies. We are eager to meet with CMS and work together to identify pragmatic MDPNP refinements (and/or alternative pathways) that not only deliver meaningful savings for Medicare and its beneficiaries, but protect access and innovation for all patients, regardless of the rarity of their condition(s).

Rare and ultra-rare disease patients have high unmet needs and few available treatment options. The MDPNP injects new economic considerations into the risk/benefit calculations for rare disease research and development programs.

Countless lives have been improved or saved by new therapies enabled by incentives for orphan drugs. Unfortunately, much remains to be done:

- Of the approximately 10,000 rare diseases identified to date, 95% have no FDA-approved treatment option.
- 80% of rare diseases are of genetic origin, and are present throughout a person's life, even if symptoms are not immediately apparent.
- Diagnosing a patient with a rare disorder is usually a multi-year process involving a series of primary care clinicians, specialists, and diagnostic testing regimens. Patients often progress to more serious and more costly disease states by the time they receive a diagnosis.

Patients suffering from rare diseases that are currently untreatable continue to hope that the incentives toward innovation, coupled with increased scientific understanding of disease mechanisms, will stimulate progress toward treatment and, eventually, a cure. The innovation ecosystem in the U.S. has enabled our nation to emerge as the leader in global developing of rare disease treatments; nearly three quarters of orphan drugs were first developed, approved, and marketed in the U.S. NIH funding and research conducted through U.S. academic institutions have played a significant role in basic research related to drug targets and discovery of new therapeutic candidates, contributing to 99.4%[1] and 25% of approvals between 2009 and 2019, respectively. These contributions are crucial; however, they represent just 10% of the resources required to take a treatment candidate through the FDA approval process. Without interest from industry and investment stakeholders, rare disease patients have little hope that scientific advances will ever yield tangible improvements in available treatment options.

An estimated 1,400 promising rare disease treatment candidates, including many programs funded by NIH, have been "shelved" or abandoned due to inherent complexities and uncertainties in designing clinical trials and failure to make a "business case" based on economic calculations of R&D costs, projected risk, and population-based revenue estimates.[2] The MDPNP has further narrowed the viability window for rare disease R&D; we are now seeing rare and ultra-rare disease projects that had previously garnered investment interest join the stockpile of abandoned therapies. The fears and concerns our communities expressed when CMS started its MDPNP implementation are no longer projections of likely consequences. The trajectory is clear and tangible. It is not, however, unavoidable. We urge CMS to act with the urgency our communities deserve.

The IRA's premise that government negotiation is needed when innovators hinder generic competition does not reflect the economic realities for most orphan drugs.

The MDPNP was crafted to counteract and deter monopolistic behavior impeding generic competition. It was, therefore, structured to penalize "monopolists" with steeper mandatory discounts the longer the treatment remains on the market without generic competition. Unfortunately, any alignment

[1] Galkina Cleary E, Jackson MJ, Zhou EW, Ledley FD. Comparison of Research Spending on New Drug Approvals by the National Institutes of Health vs the Pharmaceutical Industry, 2010-2019. JAMA Health Forum. 2023 Apr 7;4(4):e230511. doi: 10.1001/jamahealthforum.2023.0511. PMID: 37115539; PMCID: PMC10148199.

[2] Developing Drugs for Rare Diseases: A New Approach to Generating Clinical Evidence

between the MDPNP and the public policy goal of reducing barriers to generic market competition assumes that manufacturer behaviors are responsible for prolonging single source status. This assumption does not apply to rare and especially ultra-rare diseases where interest from generic and biosimilar companies is limited by patient population.

According to IQVIA data through 2018, 101 orphan-designated drugs had lost all exclusivity but remained without generic competition. Some of these products had been off patent for a decade or more. This de facto monopoly is not an indicator of the monopolistic behavior MDPNP seeks to deter. It simply reflects the market reality of an addressable population too small to support a viable business case. Under the MDPNP, these orphan drugs would be deemed extended- or long-monopoly drugs subject to a ceiling price based on as little as 40% of the non-federal average manufacturer price.

Timely biosimilar competition in rare diseases is even more unlikely. Developing a biosimilar is more scientifically and financially demanding than generic drug development. This is reflected in the fact that only 14 of the 62 off-patent biologics in the U.S. had any biosimilar on the market as of December 2024. According to IQVIA, only one biologic without a non-orphan indication – the antibody eculizumab (Soliris, for ultra-rare blood disorders) – has attracted any biosimilar development interest. Overall, among biologics with patent expirations through 2034, 64% have orphan indications, 88% of which remain without any biosimilars in the pipeline. Biosimilar competition has, for the most part, been limited to biologics indicated for common diseases such as diabetes, cancer, and immune system disorders.

When generic or biosimilar competition *does* exist for orphan drugs, it typically happens much later in a product's lifecycle than in the non-orphan context. Most new non-orphan drugs have roughly 12–14 years from approval to first generic launch. High-revenue drugs can face generic entry soon after exclusivity ends. This is not the case for orphan drugs. Many orphan drugs launched in the 1990s or early 2000s remain without generic competition. According to an IQVIA study, off-patent orphan drugs lacking generic competition in the late 2010s had been off protection for a median of 8.4 years with no generic on the market. A typical orphan drug can easily go a decade past its patent/exclusivity expiration before a generic or biosimilar appears. In other words, assuming remaining patent protection after approval is 7-9 years, it is unlikely that an orphan drug would have generic or biosimilar competition until it nears long-monopoly status under the MDPNP.

As CMS continues to select and negotiate prices for drugs without generic competition, the set of negotiation-eligible drugs will include an increasing number of multiple-indication orphan drugs. We remain concerned that manufacturers will increasingly respond to the MDPNP's new financial realities by strategically avoiding R&D toward repurposing existing therapies and developing new treatments that, despite the potential to treat multiple rare conditions, are not expected to garner interest from generic manufacturers.

Haystack Project urges CMS to recognize and respond with urgency to the MDNPN's unintended disincentives that are already driving industry portfolio strategies away from rare and ultra-rare disease treatments.

Haystack Project and other rare disease patient advocacy organizations have repeatedly expressed concerns with the exceedingly narrow orphan drug exemption. While intended to "continue to incentivize drug development for rare diseases" the exemption's limited applicability (i.e., single-indication orphan drugs) disincentivizes R&D efforts in follow-on indications that have historically been the fastest way to bring the benefit of a new treatment to patients with few, if any, therapeutic options. Industry stakeholders now face a choice between limiting indications for an orphan drug to one disease, pursuing a subsequent use and rendering the drug eligible for selection based on the approval date for the first indication, or simply declining to invest in developing the product. Haystack Project, the National Organization for Rare Disorders (NORD) and other advocates have warned that "companies developing orphan drugs are now at increased risk of market failure – the opposite of what the Orphan Drug Act sought to achieve"[3] and that, given the inherent challenges to rare drug development, the MDPNP "begins to make the market for orphan products very unfavorable."[4]

Since the enactment of the IRA, a considerable number of rare disease R&D programs have been halted worldwide. In many cases, these were failures in the business case supporting continuing investment, not failures in safety or efficacy. The MDPNP is not the only force impacting the balance between risk and benefits for rare disease R&D programs. It has, however, incrementally shifted the reimbursement landscape in favor of programs with a more certain long and short-term payoff.

- After a change in leadership, BioMarin performed a strategic R&D asset review that resulted in in abandonment of four ultra-rare disease treatment candidates and prioritization of the three "most productive" assets.[5]
- Sanofi announced in mid-2024 that it was clearing its pipeline of several rare disease programs including its efforts on an anti-FGFR3 antibody in Phase 2 for achondroplasia (a form of dwarfism), as well as two Phase 1 assets - *SAR439459* (a TGFβ1 antibody for osteogenesis imperfecta) and *SAR444836* (an AAV gene therapy for phenylketonuria).[6]
- **Industry surveys indicate that companies are quietly reevaluating or discontinuing planned rare disease indications early in development due to the IRA. These decisions are not always announced publicly.** The MDPNP's chilling effect is particularly strong for small-molecule drugs, which face the shortest window before negotiation eligibility.

The MDPNP has also changed the financial landscape for R&D efforts related to "repurposing" orphan as well as non-orphan treatments in new indications. Haystack Project is concerned that decisions to pursue a new use of an existing treatment will increasingly depend on whether a manufacturer can recover its R&D costs within the short time between approval and imposition of a negotiated Medicare

[3] Inflation Reduction Act is Impacting Rare Disease Patients
[4] Id.
[5] BioMarin axes 4 candidates, centers R&D around 3 assets
[6] Sanofi will drop dwarfism drug as part of rare disease clear-out

price. Since rare and ultra-rare indications lack the "volume" to counter the discounts resulting from a negotiated price, we remain concerned that the rarest diseases will be disproportionately impacted if innovation after approval is chilled. It is, for example, all but impossible for any manufacturer to recoup its investment in new rare disease indications within the 1–5-year timeframe applicable to Otezla's Behcet's disease and pediatric psoriasis indications or Calquence's 2025 mantle cell cancer approval.

Moreover, although the extent to which a manufacturer recoups its R&D costs is a factor in determining CMS' initial offer, CMS lacks the statutory authority to stray from the statutory ceiling price. Once CMS selects a drug for negotiation and includes all uses of the active ingredient or moiety in its pricing determination, CMS' ability to establish an initial offer that reflects value and fully considers R&D costs will depend on whether the treatment is a small molecule or biologic, the addressable population for each indication, and the amount of time between each approval and selection. As we noted in our June 10, 2025 letter and more fully detail below -- Haystack Projects believes the Administration ***can and should*** work with Congress to improve the MDPNP and, in the interim, CMS should use its discretionary authority to facilitate rather than penalize advancement of new treatments and new indications for existing treatments, particularly those addressing rare conditions.

Haystack Project urges CMS to reconsider the previous Administration's definition of Qualifying Single Source Drug (QSSD)

CMS' decision to broadly define qualifying single source drug (QSSD) based on active ingredient/moiety for negotiation eligibility purposes was unexpected. Haystack Project had anticipated that CMS would align its definition with the statutory language starting the "clock" on selection eligibility from the date of NDA/BLA approval. We have previously voiced our concern that CMS'approach to identifying products eligible for negotiation maximizes the extent to which the IRA's drug price negotiation program will not only shape research and development activities for a product's a first approval but hinder research and development toward expanded labels for existing treatments. Haystack Project's patient and caregiver communities fear that unless CMS refines its QSSD definition, there is little hope that manufacturers will be able to justify investing in NDA/BLA approvals for multiple indication orphan drugs or rare and ultra-rare follow-on indications for existing non-orphan or orphan treatments.

CMS' QSSD determination has created a landscape that further exacerbates the tension between the legal obligation manufacturers have to their shareholders and public perceptions that these entities value profits over human lives. For example, it would be difficult to make a financial case for investing in clinical studies toward approval of an ultra-rare indication outside a product's original orphan designation unless the financial consequences of losing eligibility for the orphan drug exception were outweighed by projected revenue from a new indication. There is no clear pathway to do the "right thing" for patients that also comports with the fiduciary duty corporations always owe their

shareholders -- the smaller the population, the less likely it is that any manufacturer could justify investing in the research needed for FDA approval. The same considerations apply to multiple-orphan and even non-orphan drugs and is particularly acute in previously selected treatments with potential to address additional unmet needs in rare and ultra-rare conditions. It is difficult to conjure a scenario justifying investment in a rare follow-on indication if the drug is moving along the timeline toward negotiation eligibility. It would be impossible to justify these investments if doing so triggered renegotiation.

CMS, patients, and manufacturers can and should be aligned on incentivizing (or at least not discouraging) research that maximizes access to innovations across indications through a demonstration of safety and efficacy sufficient to garner FDA approval. CMS' QSSD interpretation skews incentives away from the repurposing initiatives that maximize the value of each FDA-approved and can meaningfully reduce unmet needs for our communities. Patients with ultra-rare conditions and rare cancers have voiced concerns that:

- Manufacturers will face pressures to focus on an orphan indication with the largest patient population.
- Pressures to focus on larger-population orphan designations/indications could delay product approval and increase initial research and development costs.
- The IRA's chilling effect on research and development will fall disproportionately on patients with ultra rare diseases and rare cancers.
- Investors and shareholders will seek to ensure that initial price points for newly approved drugs are sufficient to recoup research and development costs and achieve a profit margin from successful innovations.

Real-world examples since the enactment of the IRA have validated our communities' fears:

- **Alnylam halted a Phase 3 trial of Amvuttra (vutrisiran) in *Stargardt disease*** (an ultra-rare genetic blindness disorder). Amvuttra was originally approved for hereditary ATTR amyloidosis (an orphan neurological disease). Alnylam's CEO explicitly attributed the pause to the IRA, noting that because Amvuttra already had one orphan designation, "an additional orphan label could…open it for potential pricing scrutiny" under Medicare negotiation.
- **Eli Lilly canceled a Phase I trial of a small-molecule cancer drug** that had potential orphan applications, specifically citing the IRA's adverse impact on incentives for small-molecule oncology research (i.e., the "pill penalty" the Trump Administration seeks to eliminate).
- **In 2023, the value of rare disease partnering deals plummeted by approximately 25%**, even as partnering activity for drug developers overall rose by approximately 9%. This clear contrast suggests a post-IRA shift toward manufacturer hesitance in licensing or investing in rare disease programs.

- **Genentech (Roche) leadership has signaled a strategic sequencing of indications.** In August 2023, Genentech revealed it might delay an ovarian cancer indication for its small-molecule cancer treatment until it was able to submit data to FDA on a larger prostate cancer indication. Roche explained that delaying the ovarian cancer launch would allow "nine years of Medicare sales for both ovarian and prostate cancer" at full price, versus losing a few years on the prostate indication if launched later.
- **Relay Therapeutics decided in late 2023 to delay development of a drug for an ultra-rare form of cholangiocarcinoma (bile duct cancer)** until it could seek approval in a broader tumor-agnostic population.
- **The percentage of orphan-designated drugs that later obtained a second rare disease indication dropped by approximately 48% after IRA's passage**, according to National Pharmaceutical Council (NPC) data. One analysis projected a 40% decline in future orphan drug approvals (2026–2035) due to the IRA's disincentives.

We believe the examples above are just the beginning. Industry stakeholders have publicly voiced their concerns that without refinement the MDPNP companies might redirect research or sequence indications differently. Dave Fredrickson, Executive Vice President of AstraZeneca's oncology portfolio noted that *"Rare disease and cancer patients depend upon high-risk, low-probability drug development that takes many years to develop and aims for cure. If today's version of the law stands, patients in the United States with rare conditions, who have benefited from the Orphan Drug Act, will get delayed access to scientific breakthroughs relative to other parts of the world."*[7]

In addition, the Tufts Center for the Study of Drug Development reported early evidence that the percentage of orphan drugs receiving a second orphan designation has already dropped post-IRA. The authors of a 2023 JAMA Network Open research letter reflected on post-IRA changes in research and development, echoing our concerns. "Our analysis suggests that the potential foregone follow-on indication approvals for serious illness and unmet needs could be nontrivial," The authors noted the implicit trade-off between Medicare savings and fewer treatment options, stating that society must weigh "such potential losses…against the gains to consumers and society that come with lower drug prices."

While a trade-off is inherent to the MDPNP, CMS' refinement of the QSSD definition would provide a measure of comfort that any foregone treatments or follow-indications lean toward the "trivial" and away from the serious rare and ultra-rare conditions with the highest unmet need.

CMS should implement the Trump Administration's determination to eliminate the "pill penalty" through CMS' statutory discretion in selecting drugs for negotiation, while continuing to work with Congress toward a legislative "fix."

[7] AstraZeneca urges re-examination of unintended consequences of Inflation Reduction Act on American cancer and rare disease patients

The MDPNP has created a differential reimbursement landscape -- small-molecule drugs can be subject to a negotiated price 9 years after FDA approval; biologics are exempt until 13 years post-approval. The additional four years afforded biologics is significant given that approximately 50% of a drug's cumulative sales through its first 13 years are accumulated in years 10-13. Haystack Project appreciates this Administration's understanding that Medicare can secure savings on prescription drugs without perpetuating differential sets of incentives. The April 14, 2025, Executive Order entitled "LOWERING DRUG PRICES BY ONCE AGAIN PUTTING AMERICANS FIRST"[8] outlined a set of improvements to the Inflation Reduction Act, including prioritizing efforts to abolish the "pill penalty." Section 3(c) of the Executive Order directs that:

> The Secretary shall work with the Congress to modify the Medicare Drug Price Negotiation Program to align the treatment of small molecule prescription drugs with that of biological products, ending the distortion that undermines relative investment in small molecule prescription drugs, coupled with other reforms to prevent any increase in overall costs to Medicare and its beneficiaries.

We agree that the "pill penalty," if left in place, would significantly drive investment away from small molecule drugs, especially in diseases with large Medicare populations where negotiated prices would have the largest impact on overall revenue. cuts would hit hardest. In fact, early post-IRA signals (2023-2024) reveal a shift toward biologics and therapies for younger populations.

- In late 2023 Pfizer announced it would pivot away from small-molecule drugs in its oncology pipeline in favor of biologics.
- Biologic programs attracted 50% more venture capital funding in 2023 than research and development efforts in small molecules.
- The "hardest hit" is likely to be in oncology, particularly in rare cancers. Many cancer therapies are small molecules launched with a narrow indication and expanding to additional tumor types over time (usually more than 7-9 years post-approval).
    - These timelines suggest that the post-approval cancer research that has long yielded expanded treatment options may become economically infeasible.
    - Eli Lilly explicitly cited the IRA when terminating a small-molecule blood cancer drug program, saying the "IRA changes many dynamics for small molecules in oncology" such that the investment "no longer met our threshold."
    - Genentech has similarly indicated that it may delay launching certain small-molecule oncology drugs until a larger patient population indication is ready.
- In 2023, Vir Biotechnology discontinued an entire small-molecule program (including a promising hepatitis B cure)

[8] Lowering Drug Prices by Once Again Putting Americans First – The White House

- An analysis of trial activity found a "large reduction in industry-funded, post-approval clinical trials" initiated after the IRA's passage, particularly for small molecules.

Haystack Project fully supports the Administration in its efforts to level the playing field by abolishing the "pill penalty." In the interim, however, the Agency can and should act swiftly to mitigate the changes in manufacturer and investor perceptions likely to drive the set of available treatments in the future. The IRA granted CMS the statutory authority to select "up to" 15 treatments for negotiation during the IPAY 2027 cycle. This "permissive" language enables significant discretion for IPAY 2027 and subsequent negotiation cycles. For example, there is no requirement that CMS select and negotiate Medicare prices for 15 drugs for IPAY 2027, and no clear statutory limitation on the Agency's discretion to reconsider a selected drug list compiled by a previous Administration.

The "distortion that undermines relative investment in small molecule prescription drugs" will continue to impede investment in new treatments and disproportionately reduce interest in rare and ultra-rare conditions. We urge CMS to act now to remove the "pill penalty" and reverse the post-IRA trajectory disincentivizing investment in small molecule research and development programs.

Haystack Project urges CMS to work with Congress to amend the MDPNP's renegotiation processes to align with public policy goals of deterring monopolistic behaviors more precisely and protecting incentives for innovation.

Last year, Haystack Project met with CMS MDPNP staff to discuss potential improvements to CMS' stakeholder engagement efforts and express our communities' concerns that the Agency's decisions implementing the negotiation program would have unintended consequences for the rare and ultra-rare disease patients who remain without an FDA-approved treatment. Within that discussion, we noted that the apparent renegotiation "penalty" for new indications was a clear and direct disincentive that would deter investment in repurposing both orphan and non-orphan drugs for new rare and ultra-rare indications. We were relieved that CMS staff indicated a renegotiation would not always result in a lower negotiated price. Unfortunately, our measured optimism was short-lived. The Draft Guidance clearly anticipates discretionary selection based on a new indication with an implied goal of achieving at least a 15% reduction in the MFP.

The discussions above highlight the high potential that Medicare savings accrued through the MDPNP would come at a cost. Manufacturers and investors have started to reprioritize their portfolios in ways that signal a clear threat to future innovation in rare and ultra-rare diseases and rare cancers. The renegotiation mechanism exacerbates the MDPNP's disincentives by (1) imposing further price reductions based on time since approval for selected drugs that retain single source status. CMS has no discretion to determine whether "monopolist" behaviors impede generic market entry; and (2) triggering the potential for renegotiation (and a reduced price) based on manufacturer investment in successfully securing a follow-on indication. The latter not only reduces the MDPNP's transparency by

creating a discretionary renegotiation selection mechanism, but it also stands in direct opposition to the Administration's goal of preserving innovation. Moreover, it opens the potential that a drug would be subject to renegotiation multiple times over a short period – due to both new indications and changes in monopoly status to an extended- and then a long-monopoly drug. Although competition from a generic or biosimilar would end this cycle, manufacturers cannot facilitate generic market entry without the risk that its actions would deem the generic an authorized generic with no impact on renegotiation eligibility.

Haystack Project fully supports frameworks that impose penalties on manufacturers for behaviors that unfairly deter or impede generic competition and maintain the high prices associated with exclusivity. The MDPNP price ceiling structure and renegotiation mechanisms, however, impose penalties based on time without inquiry into monopolistic behaviors. We urge CMS to:

- Refine its definition of QSSD (as more fully detailed above).
- Work with Congress to:
    - Remove the renegotiation trigger related to new indications. There is no public policy rationale for imposing renegotiations toward lower prices based on new investments to give patients more treatment options.
    - Realign the ceiling price, negotiation, and renegotiation frameworks to
        - Give CMS pricing discretion to ensure that manufacturers can recoup their investment.
        - Enable CMS to utilize discretion in selecting drugs for negotiation and renegotiation based on behaviors, e.g., continuing price increases versus discounting to reflect the product lifecycle, anti-competitive behaviors deterring generic or biosimilar market entry, etc.
        - Remove the mandate to renegotiate drugs based on time since approval (change in monopoly status).

In the interim, CMS should select drugs for renegotiation in a manner that does not impose a financial penalty for manufacturer investments in repurposing drugs to new indications.

CMS should adhere to the IRA's statutory requirement that Part D plans retain formulary inclusion for products with an MFP and enforce formulary inclusion requirements for treatments within the six "protected classes."

For members of our patient communities relying on Medicare Part D to access treatment, the Inflation Reduction Act's (IRA's) provisions creating the Part D annual ($2,100 for 2025) out-of-pocket (OOP) cap and the beneficiary option to "smooth" out-of-pocket (OOP) prescription drug costs over the plan year will help address financial barriers to access that have historically left patients with the financial reality of having to choose between maintaining a sufficient housing and food budget and continuing their prescribed treatment regimen.

As negotiated drug prices are implemented, plans will face downstream impacts to their bottom line. The traditional rebates (reflected after the point of sale) will be replaced by the negotiated price (reflecting discounted cost at the point of sale). Manufacturers of drugs subject to a negotiated price may be unwilling to offer rebates to plans and their Pharmacy Benefit Managers (PBMs). The dynamics are uncertain and will vary based on whether there are other available drugs within the same category and class as the selected drug, as well as the PBM's and/or plan's ability to contract with manufacturers for favorable rebates on non-selected drugs. Rare, and ultra-rare disease patients often rely on off-label use of existing drugs to manage symptoms or slow disease progression, and the treatment protocols often require specific drugs or biologicals within a category or class. Switching to a "preferred" drug or switching from one that is no longer on formulary is, for many rare and ultra-rare patients, not an option.

The validity of our concerns on potential Part D sponsor/plan responses to Part D redesign has been reinforced by results of a 2023 survey of Part D stakeholders within Cencora's Managed Care Network. This double-blind, web-based survey[9] provides insight into how pharmacy directors, medical directors, and contracting managers/directors perceive and might respond to the shift in financial liability for Part D drugs. Most respondents anticipate narrower formularies in comparison to pre-IRA formulary designs and greater use of utilization management tools. Just 10% of respondents suggested that there would be no change in formulary design or utilization management strategies.

We urge CMS to:

- Enforce the MDPNP requirement that Part D plans include drugs subject to an MFP on their formularies, including those for which generic market entry overlaps with any remaining period of MFP applicability.
- Increase its oversight to ensure that plan formularies include all necessary medications and are no more restrictive than those implemented prior to IRA enactment.
- Ensure that plans implement meaningful expedited formulary exception processes to enable access when patients need treatments not included on formulary.
- Proactively monitor the impact of the Manufacturer Discount Program, the Medicare Drug Price Negotiation Program, and Part D redesign on formulary decisions.
- Identify and mitigate any access constrictions, both on the plan and sponsor levels, as well as program wide.
- Establish a formal mechanism for patients and patient advocacy organizations to communicate directly with CMS on their experiences, including any barriers to getting their prescribed medications when they need them.
    - This might include both a dedicated communication channel and a set of proactive forums for patients and clinicians to relay their real-world experiences.

[9] 2024 April JMCP Poster Abstract Supplement - FINAL.pdf

In addition, Haystack Project has remained concerned that the longstanding CMS policy extending beneficiary access protections Part D drugs within the six "protected" classes, i.e., immune-suppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics, has eroded from one year to the next. Individuals with extremely rare conditions, including those with rare forms of epilepsy, often require approaches to treatment that differ from treatment of more common forms of the condition. This could mean that a specific anticonvulsant drug is required, that two or more treatments are needed, or even that drug combinations that include products outside the anticonvulsant class are used along with an anticonvulsant drug to control seizures. Rare, genetic conditions impacting the immune system similarly require distinct, disease-specific treatment regimens to reduce disease burden or extend life. Medicare policy requiring that plans include all or substantially all drugs within the class was designed to ensure that formulary designs do not disadvantage and discriminate against the vulnerable patients requiring access to specific drugs or combinations of drugs.

Haystack Project urges CMS to engage with a broad set of provider stakeholders to ensure that Part B effectuation does not constrict Medicare beneficiary access to Part B drugs.

Haystack Project appreciates CMS' cautionary approach to establishing MFP effectuation mechanisms for Part B drugs. Incorporating MFP discounts into reimbursement mechanisms for Part B drugs introduces new administrative burdens and logistic complexities. Since these burdens will be accompanied by reimbursement cuts, we believe some constriction in access is inevitable. As selected drugs are subject to renegotiation cycles with increasingly deeper price cuts, the cumulative impact on provider willingness to administer Part B drugs could not only be catastrophic for beneficiaries but extend beyond the Medicare population.

Rare and ultra-rare disease patients relying on clinician-administered drugs struggle with serious, and potentially life-threatening conditions. Since any delays in treatment can have dire consequences, we strongly urge CMS to carefully monitor Part B drug administration patterns and track any reduction in Medicare participation among providers. Individuals in rural areas are at particular risk of having to either travel to distant academic medical centers or switch treatment regimens. Similarly, 340B covered entities relying on 340B discounts to maintain their infusion capabilities may find that the incremental burden of MFP effectuation combined with reductions in reimbursement for selected drugs tips the scales against offering infusion services to Medicare patients..

We urge CMS to reach out to provider stakeholders, including physician offices, infusion centers, hospital outpatient departments, rural providers, providers in underserved areas, and 340B covered entities to ensure that MFP effectuation mechanisms are crafted to maintain a sufficient set of willing providers across care settings and geographic areas.

CMS should refine its stakeholder engagement processes to facilitate a meaningful dialogue between patients, clinicians, researchers, and CMS MDPNP staff.

As noted above, Haystack Project met with CMS last year to express our member organizations' concerns with the stakeholder engagement processes for IPAY 2026. We were disappointed that the last Administration's changes, while providing more opportunities for public participation, failed to deliver more meaningful discussions. Neither the patient-focused events nor those convened for clinician/researcher input enabled any dialogue between speakers/attendees and the CMS staff charged with obtaining and utilizing stakeholder feedback throughout the negotiation processes. It was clear that CMS staff were present, but they were inexplicably relegated to an observer role.

Haystack Project appreciates that CMS contracted a facilitator to drive the discussions and has, from time to time, similarly relied on an external third party to guide a complex discussion. When we do so, however, we do not rely on a facilitator to drive the substance of the discussion. CMS' facilitators appeared responsible for the content and direction of the discussions but did not appear to have sufficient scientific or clinical understanding of the treatments and disease states to use responses obtained to one question to inform subsequent questions or target follow-up. Discussions may have been driven by a predetermined set of questions that may have been drafted generically for all roundtable discussions. The result was that the meetings were as static as the year before.

We once again urge CMS to

- Leverage or develop relationships with patient advocacy organizations, including Haystack, by enabling more meaningful CMS participation. Haystack is eager to engage in the type of candid dialogue that would provide a more robust foundation informing CMS' work.
- Allow Haystack and other groups, including researchers and clinicians, to pose questions to other participants and CMS.
- Create an environment that invites a dialogue between and among patients, providers, researchers, and CMS. Use of a facilitator can be helpful in ensuring that participants do not speak over each other and that each participant can contribute. This year's structure, however, relied on the facilitator to guide discussions and provided no opportunity to adjust questions dynamically or enable CMS staff to answer or ask questions in real time.

Conclusion

Despite incentives for developing orphan drugs, significant unmet need predominates in extremely rare conditions and rare cancers. We have previously engaged CMS to express our increasing concerns that health reform efforts initiated to decrease health care costs would fail to consider our patient communities. We remain concerned that the decisions the previous Administration made in implementing the MDPNP have already re-shaped how manufacturers and investors view R&D efforts

toward new treatments and new uses of existing therapies to address unmet needs in our rare and ultra-rare disease communities.

We strongly believe that the decisions this Administration makes within the next several months will influence the set of new treatment options in rare and ultra rare conditions and rare cancers for the foreseeable future. Haystack Project would appreciate the opportunity to meet with MDPNP implementation staff and leadership to further discuss the concerns within our communities and explore creative solutions, including potential initiatives outside the purview of CMS' Draft Guidance.

Once again, we thank you for considering our comments and look forward to a substantive discussion to ensure that all Medicare beneficiaries have access to the treatments they need. In the interim, if you have any questions or would like to discuss the issues raised in our comments, please contact our policy consultant, M Kay Scanlan, JD at mkayscanlan@consilstrat.com or at (410) 504-2324.

Very truly yours,

Kara Berasi, PharmD
CEO, Haystack Project

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HealthHIV

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Subject: Comments on CMS's Draft Guidance for the Medicare Drug Price Negotiation Program (ipay2028)

Thank you all for the opportunity to provide comments on *CMS's Draft Guidance for the Medicare Drug Price Negotiation Program (ipay2028).*

As background, HealthHIV is a national nonprofit working with healthcare organizations, communities, and providers to advance effective HIV, Hepatitis C (HCV), and sexually transmitted infection (STI) care through education and training, technical assistance and capacity building, advocacy, communications, and health services research and evaluation. HealthHIV submits this response grounded in decades of experience supporting education for providers and public programs that depend on uninterrupted, effective antiretroviral therapy (ART) for HIV care.

We would first like to recognize several aspects of the guidance that reflect thoughtful policy design. CMS's plan to publish explanatory summaries outlining the rationale and data sources behind each Maximum Fair Price (MFP) is a welcome step toward transparency, especially for communities historically excluded from drug pricing decisions. We also support the built-in mechanism for correcting manufacturer data errors, which—although limited in scope—can help prevent pricing distortions that might otherwise affect treatment access. And we appreciate CMS's intent to incorporate updated real-world utilization data into its MFP application process. This utilization flexibility is especially critical when looking at HIV, where dosing and formulation often shift as clinical needs evolve over a lifetime and across multiple morbidities.

Unlike many other drug classes, there are relatively few gold-standard, Grade A HHS treatment guidelines for HIV care—and the pipeline for new oral STRs has slowed significantly, particularly following the FDA pause of key clinical trials. This makes it even more important for CMS to preserve access to the few high-efficacy options available, rather than risk restricting them through rigid grouping or pricing policies.

And it's through the lens of antiretroviral therapy (ART)—where individualized dosing plays a critical role in adherence and health outcomes—that we see several areas of the guidance that warrant deeper consideration and contextualization, particularly around how CMS proposes to group and value HIV medications.

With that, we respectfully highlight five concerns:

1. Grouping Rules for STRs Could Risk Undermining HIV Treatment Stability

Recognizing that single-tablet regimens (STRs) are the foundation of long-term oral- formulation HIV care, the proposed framework overlooks some core clinical realities, personal and public health outcomes, and the everyday adherence challenges that People with HIV (PWH) face. And that effect has an impact on health *and* costs.

As outlined, CMS suggests that all drugs can be grouped for negotiation if they share a single active moiety, even if they are part of different fixed-dose combination products.

But in HIV care, these combinations are not clinically (or therapeutically) interchangeable. In fact, very recently, three Prescription Drug Affordability Boards (PDAB) came to that same conclusion (in Colorado, Maryland, and Oregon) in removing HIV medications from their affordability reviews.

STRs, we've learned, simplify a person's treatment regimen and support more routine uptake and adherence—all of which help prevent viral resistance, reduce transmission, and keep people healthier.

That's especially true for individuals with complex medical or psychosocial needs. This is the long-standing medical practice of U=U or "undetectable equals untransmissible." Sustained viral suppression, underpinned by STRs, plays a vital role in the President's *Ending the HIV Epidemic* initiative, particularly its goal to treat HIV rapidly and to effectively reduce onward transmission.

In HIV care, even small disruptions to access can have serious consequences. As proposed, the guidance risks overlooking how treatments function in daily, lifelong care. Even when regimens share some of the same ingredients, their effects, side effects, and how they interact with other medications can differ in crucial ways. Overall, for people with high-acuity needs—including those aging with HIV, experiencing cognitive decline, managing comorbidities, or facing housing instability—single-tablet regimens (STRs) offer a simplified and effective approach that reduces pill burden and supports better adherence, which potential access disruptions would threaten.

Here's one example of how things play out in one state—and the influence STRs have on adherence, health, and costs. A December 2024 report from Washington State's Apple Health (Medicaid) program[1] found that STRs were used by over 58% of PWH, up from 49.5% in 2022. The report also found that the use of STRs was associated with an 86% viral suppression rate, compared to 81% among those on multiple-tablet regimens (MTRs)

These findings highlight the clinical and public health value of STRs—and underscore why CMS must evaluate grouping and pricing policies through the lens of real-world patient outcomes, not just shared ingredients. While a 5% difference may appear modest, the lifetime cost of treating one new HIV infection exceeds $420,285[2]—making even small improvements in adherence and viral suppression clinically and economically significant. State-level reports also show how access disruptions tied to formulary changes and rebate dynamics can erode these gains across public health and safety-net systems.

Treating STRs as interchangeable—just because they share a single ingredient— overlooks how full regimens work together in the body, and in the context of a person's life. Even when two STRs contain one overlapping component, the other agents in the regimen affect absorption, side effects, drug-drug interactions, and how well someone tolerates the treatment long-term. For individuals with advanced HIV, co-occurring conditions, or aging with HIV—especially those with frailty, cognitive changes, or other access and affordability challenges—these differences really do matter. STRs are not plug-and-play. Switching requires more than a prescription change; it involves coordination between clinicians, case managers, insurers, and pharmacies. This includes verifying clinical appropriateness, obtaining payer approval, determining eligibility, updating AIDS Drug Assistance Program (ADAP) or 340B records, and ensuring the new medication is stocked and covered. Without that support, people face real risks: missed doses, treatment gaps, or cascading disruptions to housing, care retention, and support services tied to consistent ART adherence.

Without that coordination, providers, too, feel the administrative burden and strain— having to step in with more clinical oversight, more follow-up, and more effort to keep someone on track. Substitutions under CMS's current approach don't reflect these realities and may open the door to cost-based decisions that put provider judgment and patient treatment stability and long-term health at risk.

2. Prevention and Adherence Outcomes Must Be Part of the Equation

CMS's proposed value framework does not account for viral suppression, adherence outcomes, or the

[1] https://www.hca.wa.gov/about-hca/who-we-are/legislative-reports

[2] Bingham A, Shrestha RK, Khurana N, Jacobson EU, Farnham PG. Estimated Lifetime HIV-Related Medical Costs in the United States. Sex Transm Dis. 2021 Apr 1;48(4):299-304. doi: 10.1097/OLQ.0000000000001366. PMID: 33492100

demonstrable public health benefit of averted HIV transmissions.

As noted, the estimated lifetime cost of treating one HIV infection exceeds $420,285. ART regimens—particularly STRs and more recently and effectively long-acting injectables—prevent new infections and maintain suppression across vulnerable populations. For many, these medication formulations are not optional; they are the difference between viral control and rebound, and potential onward transmission.

If CMS chooses to negotiate prices without factoring in these long-term public health impacts, it will fail to reflect the true value of HIV treatment and prevention. That approach may be penny-wise but pound-foolish.

3. Public HIV Innovation Should Be Protected, Not Penalized

Much of the HIV treatment pipeline has been advanced through public sector investment. NIH (National Institutes of Health), NIAID (National Institute of Allergy and Infectious Diseases), and BARDA (Biomedical Advanced Research and Development Authority) have all played critical roles in supporting the development of new ART formulations. These contributions should be viewed as evidence of a national commitment to HIV innovation, rather than as a reason to suppress prices or undermine market viability.

Using federal support as a downward pricing factor may discourage future innovation in a field that already faces steep development costs and scientific hurdles. And with the recent pause by the FDA of the Wonders 1 and 2 Trials, the pipeline for new small- molecule HIV therapies is already shrinking. CMS should be careful not to accelerate that decline. Oral formulations are still the backbone of HIV treatment.

4. Transparency and Stakeholder Engagement Are Lacking

The current guidance provides no meaningful opportunity for external stakeholders— including HIV providers, advocates, and affected communities—to review the data and rationale used to group drugs or assign maximum fair prices (MFPs). These choices— made entirely within the agency—will directly shape access to medications that PWH depend on for viral suppression and survival.

In the context of HIV care, even minor disruptions to regimen access can lead to viral rebound, resistance, or loss of adherence—driving up both acute and long-term costs across systems, from emergency care to housing instability and other supportive service needs. When CMS leaves out the voices of those who prescribe, rely on, and study these therapies every day, it risks making decisions that are out of step with both clinical practice and real-life care. *ART isn't abstract—it's a lifetime commitment*. A commitment that comes with real personal and public health consequences if access is ever compromised.

5. Downstream Disruptions Could Erode Continuity of Care

While the guidance prevents direct substitution of given negotiated drugs with lower- cost alternatives, it *does not* prevent plans from steering patients toward lower-cost options within a given grouped drug class. This disconnect leaves room for potentially harmful and counterproductive utilization management tools like step therapy, prior authorization, or narrow networks to drive forced switching.

For people living with HIV, especially those with histories of treatment failure, switching regimens can lead to resistance or loss of viral suppression. CMS must do more to monitor and mitigate these downstream effects, including requiring plan-level data collection on patient ART stability and treatment continuity.

We urge CMS to:

1. Refrain from grouping STRs or other fixed-dose combinations based on shared moieties alone.
2. Integrate adherence, viral suppression, and transmission prevention data into drug valuation.
3. Recognize and protect publicly supported HIV innovations.
4. Build in transparent stakeholder input and publicly reviewable rationale for grouping and pricing.
5. Establish safeguards and monitoring mechanisms for post-negotiation switching and treatment disruption.

Thank you for your leadership *and* the opportunity to provide input. CMS has an opportunity to shape this program in a way that reflects not just economic logic, but medical reality and the lived experiences of the over 1 million people aging with and managing HIV across their lifetimes. We urge you to keep the needs of People with HIV at the center of CMS' implementation.

Sincerely,

Scott D. Bertani, MNM, PgMP

Director of Advocacy, HealthHIV

scottb@healthhiv.org

HDA
Healthcare Distribution Alliance
HEALTH DELIVERED

Filed by electronic submission to IRARebateandNegotiation@cms.hhs.gov.

June 26, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Draft Guidance for IPAY 2028 and Manufacturer Effectuation of Maximum Fair Price (MFP) for the Medicare Drug Price Negotiation Program (MDPNP)

Dear Administrator Oz,

On behalf of the Healthcare Distribution Alliance (HDA), thank you for the opportunity to submit comments to the Medicare Drug Price Negotiation Program Draft Guidance published on May 12, 2025. HDA represents primary pharmaceutical distributors — the vital link between the nation's pharmaceutical manufacturers and pharmacies, hospitals, long-term care facilities, clinics, and others nationwide. HDA members safely and securely distribute 95 percent of medicines sold in the United States to approximately 330,000 sites of care daily.

Our comments below are specific to the effectuation of the Maximum Fair Price (MFP) for selected drugs.

I. CMS Should Reconsider Its Assumptions on the Cash Flow Impact to Participating Pharmacies

Section 40.4.2.2 of the draft guidance titled, "Dispensing Entity Enrollment in the MTF" contains the following provision:

> Commenters particularly noted that small pharmacies that rely primarily on prescription revenue to maintain business operations would face material cashflow pressures due to the shift from payment by the Part D plan sponsor to a combination of Part D plan sponsor payment plus a potentially lagged MFP refund. Based on comments received, CMS is concerned that this challenge will be most acute in the transition period when MFPs for selected drugs first become effective in January 2026 and at the start of each subsequent initial price applicability year when MFPs for new selected drugs first become effective (i.e., at the start of a price applicability period with respect to a selected drug). **CMS does not anticipate this challenge to continue with respect to a selected drug once MFP refunds for that selected drug are flowing and dispensing entities become accustomed to the 14-day prompt MFP payment window *(emphasis added)*.**

This statement downplays the impact on all pharmacies, but especially small, rural, and independent pharmacies. While CMS anticipates that "cash flow issues will only arise once per MFP-eligible NDC," this framing ignores the cumulative burden on dispensing pharmacies. In practice, each newly

designated MFP drug introduces a separate acquisition–reimbursement gap. Informal estimates suggest that by the end of the first five years, at least half of all drugs dispensed to Medicare

beneficiaries under Part D could be subject to MFP. Over time, these disruptions accumulate per pharmacy and per product, resulting in a recurring and escalating strain on pharmacy cash flow.

Moreover, if future MFP prices reflect even deeper discounts, such as those that could result from implementation of the President's Most Favored Nation pricing policy, the gap between the up-front acquisition cost based on WAC and the subsequent MFP refund would widen even further. That could amplify the cash flow impact, especially for pharmacies serving high Medicare populations.

It's also conceivable that for individual patients receiving high-cost therapies, a single prescription could create a short-term cash crunch for the pharmacy, depending on acquisition timing and the delay between claims adjudication and MFP refund reimbursements. In such cases, this could lead to delayed dispensing or other forms of patient disruption.

Given CMS's well-established sensitivity to beneficiary access and continuity of care, we urge the agency to reconsider its assumptions and engage with stakeholders on strategies to mitigate pharmacy-level financial risks throughout the MFP rollout. Community pharmacies are a vital resource for Medicare beneficiaries, who often rely on them for accessible, local care and medication counseling. In turn, Medicare beneficiaries represent the largest share of business for many community pharmacies, making their financial stability essential to maintaining beneficiary access. The retrospective refund approach to MFP effectuation places an undue burden on pharmacies, which are effectively funding the discount program by fronting the cost of MFP drugs. This dynamic significantly increases the working capital requirements for all pharmacies, and does so most acutely for small, rural, and independent pharmacies. We encourage CMS to avoid minimizing these effects and to continue exploring operational improvements, such as prospective discount models, that would reduce financial strain while preserving access for beneficiaries.

II. HDA Supports CMS's Rejected Claims Flow-Through Policy

HDA supports CMS's pragmatic approach to allow rejected claims to flow through the Drug Data Processing System (DDPS) to the Medicare Transaction Facilitator (MTF), as outlined in Section 40.4.3.2. This policy gives the MTF visibility into the full range of claims activity, even if certain claims fall outside traditional pricing or billing expectations.

This decision helps confirm product eligibility despite downstream variability. It also helps prevent delays in pharmacies receiving their MFP refunds and will streamline reconciliation for all parties involved. HDA views this as an important step in ensuring program accuracy and efficiency and appreciates CMS's commitment to practical implementation choices in this area.

III. CMS Should Consider Part B Gaps and Engagement Opportunities in MFP Effectuation for Part B Drugs

HDA understands that CMS is not issuing specific guidance at this time for the effectuation of MFP prices for Part B drugs. However, HDA urges CMS to consider that this work will soon be necessary. Any future policy and effectuation plans must account for the financial, logistical, and clinical implications of applying MFP discounts to Part B drugs, especially for physician practices operating on narrow margins and dependent on timely reimbursement.

For example, it is unclear whether Wholesale Acquisition Cost (WAC) can play the same role in

calculating a standardized default refund amount for Part B as it does in Part D. WAC plays a much smaller role in Part B acquisition and reimbursement, and without such benchmarks, it is unclear how

CMS might implement a Standard Default Refund Amount (SDRA) across providers and products. This is just one challenge in addressing the differences between Part D and Part B in the marketplace.

Moreover, while the National Council for Prescription Drug Programs (NCPDP) has been an effective venue for working through MFP effectuation for Part D, there may be a lack of Part B expertise among the NCPDP membership. Unfortunately, we are not aware of a comparable forum for engaging industry stakeholders on Part B implementation and so as CMS prepares future guidance for MFP implementation under Part B, we urge the agency to begin laying the groundwork now. To that end, CMS should consider convening a technical advisory group to evaluate the feasibility of potential effectuation models and to help define the operational infrastructure required to support them. HDA and its members will continue to participate in industry forums to support CMS's implementation efforts.

IV. Mitigating Provider Disruption and Financial Strain

HDA appreciates CMS's encouraging interested parties to work together as necessary to develop mechanisms to assure timely effectuation of MFP refund payments. Specifically, the draft guidance references three potential pathways. 1.) Manufacturers making prospective access of selected drugs available at MFP and utilizing wholesaler chargeback programs, (2) Establishing pre-funded MFP refund payment accounts directly with dispensing entities; and/or (3) Leveraging established relationships between dispensing entities and Pharmacy Services Administrative Organizations (PSAOs) to establish accounts that are pre-funded by the manufacturer to expedites disbursement of MFP refund payments to dispensing entities

We feel each of these pathways has merit for the initial Part D drugs selected for negotiation in 2026 and 2027. However, when Part B drugs are added to the list of drugs being made available to Medicare beneficiaries, additional pathways will have to be considered to accommodate physician buy and bill practices.

For Part D drugs, much of today's infrastructure between wholesalers and manufacturers could support the above referenced pathways. Making products available at the MFP prospectively would require certain new capabilities that do not currently exist. One key challenge is how to limit the quantity of MFP products a pharmacy could purchase at the MFP price. For example, if 40 percent of a pharmacy's business is Medicare, is there a scalable way to allow that pharmacy to purchase 40% of its product at the MFP price and the remainder at WAC? The model would also need safeguards to prevent misuse and give manufacturers confidence in its integrity.

In addition to alleviating the cash flow burden and pharmacists' workload, a prospective model would reduce the administrative complexity of managing accounts receivable. For smaller, independent pharmacies, this could help prevent staff from being diverted away from patient care activities. Separately, future resolution of legal uncertainties, such as ongoing litigation around 340B retrospective discounting, could create conditions for broader stakeholder alignment.

When Part B drugs begin to enter the MDPNP, additional processes will be required in order to limit disruption and financial strain on physician practices. HDA recommends that CMS consider the current Inflationary Rebate mechanism from the IRA as a model for Part B drug

reimbursement. This approach will minimize provider disruption, simplify administration and ensure beneficiaries receive MFP-based cost sharing at the point of care.

Under this model, providers would continue acquiring and billing drugs as they do today, with reimbursement through existing systems (e.g., ASP + 6%). CMS would reconcile the difference between provider reimbursement and the MFP by collecting rebates from manufacturers—without involving providers in the adjustment process. This preserves the buy-and-bill model and avoids cash flow or workflow disruptions. CMS is well-positioned to implement this model using its existing claims and utilization infrastructure. Our member companies would welcome the opportunity to collaborate with CMS on this concept.

* * *

We appreciate the opportunity to provide comments to this draft guidance. We look forward to working with CMS to implement this important program and to help ensure that our downstream trading partners can continue to serve Medicare beneficiaries as they access the savings being generated by the Medicare Drug Price Negotiation Program. If you have any questions or need additional information, please contact Patrick Kelly (pkelly@hda.org).

Sincerely,

Patrick Kelly
Chief Advocacy Officer

HINJ
HealthCare Institute of New Jersey
ADVANCING GLOBAL HEALTH • LEADING NEW JERSEY'S ECONOMY

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June 26, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz:

The HealthCare Institute of New Jersey (HINJ – www.hinj.org) is the leading trade association representing New Jersey's life sciences community, including our biopharmaceutical and medical technology companies that are saving lives around the world by finding new treatments and cures, earning our state the moniker of "Medicine Chest of the World." We are deeply concerned about the potential impacts CMS's draft guidance for the Medicare Drug Price Negotiation Program could have on America's innovation ecosystem, our nation's patient community, and our ability to research and discover the next generation of treatments and cures.

Broadly, we remain deeply concerned with the disparity between market exclusivity periods for small molecule (9 years) and biologic medicines (13 years), creating a "pill penalty" which discourages investment and research into small molecule treatments and cures, stifles medical innovation, and ultimately impacts patients with as yet unmet medical needs. We will continue working with all stakeholders to address this unintended consequence of the Medicare Part D price negotiation program.

Additionally, CMS's proposed interpretation of a Qualifying Single Source Drug (QSSD) – a definition that would treat products with the same active ingredient or moiety as the same drug for negotiation purposes – risks discouraging further research into and development of improved combination therapies and products, routes of drug delivery and administration, and new indications that can be applied to additional health conditions – all of which are essential for improving patient outcomes. These innovations are particularly important for patients with various health conditions where treatment adherence, convenience, and personalization are critical to achieving better health outcomes and reducing overall healthcare costs throughout the public health system.

We urge CMS to follow the statute by applying the same definition for QSSDs that has been consistently used by the FDA for New Drug Applications (NDA) or Biologics License Applications (BLA). This approach would ensure a consistent federal regulatory framework that recognizes meaningful innovations that improve patient outcomes and expand patient access.

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Thank you for your consideration of these comments. Our companies look forward to continuing our partnership with CMS and all agencies to ensure that public policy recognizes the value of medical innovation our companies work so hard to provide to America's patient community.

Sincerely,

Christine Buteas

Chrissy Buteas
President and Chief Executive Officer
HealthCare Institute of New Jersey (HINJ)
buteas@hinj.org

FINAL: June 25, 2025

HealthyWomen Public Comment on CMS Draft Guidance for the Medicare Drug Price Negotiation Program Regarding QSSD Definition

As the nation's leading independent, nonprofit health information source for women, **HealthyWomen** is closely following implementation of the IRA's Medicare Drug Price Negotiation Program, and we appreciate the opportunity to comment on the May 12 draft guidance from the Centers for Medicare & Medicaid Services (CMS).

We have deep concerns about CMS' broad definition of qualifying single source drugs (QSSD), specifically that medicines with the same active ingredient (or active moiety for biologics) will be considered the same drug for purposes of price negotiation, including all dosage forms and strengths.

We support the goal of improving affordability but worry about the unintended consequences this policy may have on patient-centered innovation, a particular concern for historically underserved populations including women, rural patients and those living with chronic or rare diseases.

Impact on Innovation That Matters to Patients

By categorizing medicines with the same active ingredient or moiety as equivalent, CMS's proposed guidance disincentivizes the "post-approval" research and development that goes beyond the initial indication and often addresses specific unmet needs for treatment and care.

Innovations such as new indications, alternate delivery mechanisms and combination therapies are **not interchangeable**. They represent **meaningful progress** for patients in real-world scenarios—providing new treatment options, reducing treatment burden, improving adherence and enhancing quality of life.

For example, simplifying drug administration routes can eliminate the need for frequent hospital visits or invasive procedures, which can be a particular challenge for **women caregivers, working mothers and patients in rural areas and healthcare deserts.** These types of innovations go beyond pharmacology; they address **barriers to care** that are central to achieving equitable health outcomes.

Request for Policy Reconsideration

We respectfully urge CMS to **reverse its current interpretation** and align with the **statutory intent** of the IRA, which identifies QSSDs based on **distinct new drug applications (NDAs) or biologics license applications (BLAs)**. Failing to do so risks stifling progress in therapeutic areas where additional indications or delivery options and other innovations can substantially expand access for patients, particularly vulnerable populations.

At HealthyWomen, we believe that true healthcare progress is measured not just by scientific breakthroughs but by **how well those innovations reach and serve real patients**—especially those whose voices are too often left out of the policy conversation.

We stand with our fellow advocates in urging CMS to preserve and promote patient-centric innovation—for today's patients and tomorrow's.

Sincerely,
Beth Battaglino, RN
President and CEO, HealthyWomen

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Humana

June 26, 2025

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Comments on Medicare Drug Price Negotiation Program Draft Guidance

Dear Mr. Klomp,

Humana appreciates the opportunity to offer feedback and recommendations to CMS on the Medicare Drug Price Negotiation Program established by the Inflation Reduction Act (IRA). We provide these comments in response to the CMS draft guidance dated May 12, 2025, titled "*Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028*". Humana currently services approximately 5.8 million beneficiaries enrolled in our Medicare Advantage (MA) plans and 2.4 million beneficiaries enrolled in our Medicare Part D Prescription Drug Plans (PDPs). As a long-time sponsor of Part D plans, we hope you find our feedback and recommendations constructive in improving and bringing greater transparency to the Negotiation Program.

Humana supports CMS efforts to ensure the Medicare Drug Price Negotiation Program is implemented in a way that provides value for beneficiaries and taxpayers while promoting innovation in Medicare's payments for prescription drugs. We also appreciate the work the Trump Administration is doing to improve the program and eclipse the 22 percent in savings achieved in the program's first year. As CMS works to finalize this guidance, the agency should:

- **Minimize potential incentives for manufacturers to evade negotiation by adopting an expansive definition of single source drug and accounting for drug utilization across Parts B and D in drug ranking prior to selection.** Humana supports the proposal to group together all formulations of a single source drug with any fixed combination versions of the same drug where the additional active ingredient contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference. We also suggest that CMS develop a step in the drug selection process where utilization for the same product across Parts B and D is added together before the calculation of total expenditures and the ranking of drugs across Parts B and D.
- **Revisit the use of gross total expenditures for Part D drug selection for IPAY 2028.** In developing the ranked list of Part D drugs by total expenditures based on gross expenditures, CMS misconstrues the true cost of drugs to the Part D program. This is particularly problematic when Medicare Part B drugs will be ranked based on total expenditures using average sales

price (ASP), which represents costs net of manufacturer rebates and discounts. If CMS selected drugs for negotiation based on their net costs, it would be more likely that negotiated savings would not be replacing manufacturer discounts and rebates already working to lower costs in the Part D program.

- **Clarify that spending on Part B drugs paid for by MA plans will be reflected in the process for calculating Part B Total Expenditures for drug selection.** In the proposed calculation of total expenditures for Medicare Part B drugs, the draft guidance does not mention MA even though more than half of all eligible Medicare beneficiaries are enrolled in MA plans. Failing to account for Part B drugs paid for by MA plans would skew the ranking of high-cost drugs in the Medicare program. As acknowledged by CMS in other contexts, the statutory language referring to drugs or claims under "Part B" or "this part" incorporates units covered through Medicare Advantage.
- **Preserve and expand upon MA and Part D plan formulary flexibilities that bring down Medicare costs.** Humana supports the modifications CMS made in this year's draft guidance indicating it will allow plans more flexibility to prefer a biosimilar or generic over a selected drug with respect to tier placement and utilization management. However, we are concerned with the CMS proposal to not allow plans to continue similar formulary treatment from year-to-year after a selected drug has been removed via immediate substitution flexibility due to generic or interchangeable biosimilar competition. We do not believe this is aligned with Congressional intent for the Negotiation Program, which is directed towards drugs without generic or biosimilar competition. Lastly, Humana supports continued flexibility for MA plans to develop clinically appropriate step therapy practices for Part B drugs, including selected drugs.

We value this opportunity to provide recommendations related to the Medicare Drug Price Negotiation Program and are pleased to answer any questions you may have with respect to the comments below. As always, our feedback is aimed at ensuring that together we continue to advance our shared goals of improving the delivery of coverage and services in a sustainable, affordable manner to Medicare beneficiaries, and improving their total health care experience. We hope you find this feedback helpful.

Sincerely,

Michael Hoak
Vice President, Public Policy

CC:
Dr. Mehmet Oz, CMS Administrator
John Brooks, Deputy Administrator, Chief Policy and Regulatory Officer

Section 30. Identification of Selected Drugs for Initial Price Applicability Year 2028

CMS outlines the process that will be used to identify and select qualifying drug products and negotiation-eligible drugs for IPAY 2028, consistent with section 1192 of the Inflation Reduction Act (IRA).

Section 30.1 Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028

CMS specifies the criteria that will be used to identify qualifying single source drugs for IPAY 2028, consistent with IRA requirements. CMS provides additional detail on identification of combination products, stating that a distinct fixed combination drug with two or more active moieties / active ingredients will be considered as one active moiety / active ingredient for the purpose of identifying potential qualifying single source drugs. CMS also acknowledges that there may exist fixed combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference. CMS is soliciting comments on how CMS might consider grouping such fixed combination drug products with products containing at least one but not all of the active moiety(ies) / active ingredient(s) into the same potential qualifying single source drug for both drugs payable under Part B and/or covered under Part D, including input on terminology that could facilitate the effectuation of such a policy.

> **Humana Comment:** Humana believes that CMS should not institute policies as part of the Medicare Drug Price Negotiation Program that might incentivize manufacturers to develop products or formulations with limited clinical value in order to evade the Negotiation Program, potentially driving up drug prices and overall health system costs. For this reason, we support CMS taking an expansive approach to defining a qualifying single source drug for MFP purposes. This includes aggregating all formulations of fixed combination drugs as a single source drug except to the extent there are combinations of active moieties/ingredients that have clinically meaningful differences. In particular, fixed combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference would be grouped with other formulations of the single source drug.
>
> We believe this interpretation is appropriate, as the statute mandates that CMS aggregate a drug across dosage forms and strengths, including new formulations, for maximum fair price (MFP) purposes. Nothing in the statute specifies that CMS must aggregate by active moiety/ingredients. Just as CMS is not bound by the Food and Drug Administration's (FDA's) NDA and BLA enumeration system to define a drug, CMS is also not bound by the FDA's method of listing active moieties when determining how to aggregate a drug across formulations.
>
> Moreover, should CMS aggregate extended release and other dosing formulations common in orally administered Part D drugs but not aggregate the addition of hyaluronidase to Part B physician-administered drugs, CMS could inadvertently encourage a development shift toward administered drugs to avoid participation in the MFP process. We strongly encourage CMS to recognize the expansiveness of the formulation definition within statute and ensure that it is equally applied to oral drugs as well as administered drugs.

Section 30.2 Identification of Negotiation-Eligible Drugs for Initial Price Applicability Year 2028

CMS discusses methodology for identifying the drugs selected for negotiation in IPAY 2028. For Part D drugs, CMS will continue to use Prescription Drug Event (PDE) data to calculate total gross expenditures for each qualifying single source drug for dates of service during the 12-month period beginning November 1, 2024 and ending October 31, 2025. For Part B drugs, CMS intends to use Part B claims data for dates of service during the same 12-month period to calculate total gross expenditures for each qualifying single source drug.

Humana Comment: Humana appreciates the work the Trump Administration is doing to improve the Negotiation Program. In particular, we are encouraged by President Trump's April 15 Executive Order "Lowering Drug Prices By Once Again Putting Americans First," which included provisions on improving the Negotiation Program by seeking to make the program more transparent, prioritizing selection of high cost drugs, and minimizing negative impacts on pharmaceutical innovation.[1] We also support the Trump Administration's goal of eclipsing the 22 percent in savings achieved in the program's first year.[2] However, Humana believes CMS missed an opportunity to fulfill the promise of this EO by choosing not to revisit the use of gross expenditures for the calculation of Part D total expenditures as part of the drug selection process.

For the selection of Part D drugs for negotiation for IPAY 2026 and 2027, and as proposed in the draft guidance for IPAY 2028, CMS ranks Part D drugs by total expenditures based on the amount Part D plans pay pharmacies, or gross expenditures. These amounts do not reflect the significant discounts and rebates provided by manufacturers, negotiated on behalf of Part D plan sponsors, and reported to CMS as direct and indirect remuneration, which varies by drug and therapeutic class in part due to Medicare requirements. For example, research indicates that drugs in the six protected classes have the lowest levels of rebates relative to drugs outside of the protected classes.[3] According to the Medicare Trustees, over the past several years "direct and indirect remuneration (DIR) has dramatically increased as a percentage of gross drug spending, a factor that has significantly slowed Part D spending growth."[4]

In developing the ranked list of Part D drugs by total expenditures based on gross expenditures, CMS misconstrues the true cost of drugs to the Part D program. For example, researchers estimate that drugs selected for IPAY 2026 had levels of estimated Part D rebates ranging from 11% to 76% of the list price, with the majority of drugs incurring estimated rebates above 50%. Despite savings touted by the Biden Administration, in many cases the MFP negotiated by CMS closely approximated the drug's estimated price net of rebates.[5] After taking into account the fact that selected drugs are not subject to the 10% and 20% required discounts under the Medicare Discount Program, in some cases the government's negotiated price may only achieve modest savings for the Medicare program and federal government. If CMS selected drugs for negotiation based on their net costs, it would be more likely that negotiated savings would not be replacing manufacturer discounts and rebates already working to lower costs in the Part D program.

[1] Lowering Drug Prices by Once Again Putting Americans First – The White House
[2] Fact Sheet: President Donald J. Trump Announces Actions to Lower Prescription Drug Prices – The White House
[3] Medicare Part D Protected-Class Policy Is Associated With Lower Drug Rebates | Health Affairs
[4] 2025 Medicare Trustees Report
[5] Interpreting The First Round Of Maximum Fair Prices Negotiated By Medicare For Drugs | Health Affairs

The continued use of gross total expenditures for Part D drug selection for IPAY 2028 is particularly problematic when Medicare Part B drugs will be ranked based on total expenditures using average sales price (ASP), which represents costs net of manufacturer rebates and discounts. This creates an inconsistency in the selection of drugs for negotiation that could disadvantage standalone Part D plan sponsors. Moreover, the use of Part D net prices is consistent with traditional cannons of statutory interpretation, since at the time of IRA's enactment Congress was aware that CMS's regulations defined "gross covered prescription drug costs" as a price net of rebates. We strongly encourage CMS to address this issue moving forward by ranking and selecting Part D drugs for the Negotiation Program based on net costs.

Additionally, in the proposed calculation of total expenditures for Medicare Part B drugs, the draft guidance does not mention Medicare Advantage (MA) even though MA covers more than half of all eligible Medicare beneficiaries. Failing to account for the costs of Part B drugs paid for by MA plans would skew the ranking of high-cost drugs in the Medicare program. As acknowledged by CMS, the statutory language referring to drugs or claims under "Part B" or "this part" incorporates units covered through Medicare Advantage.[6] At the same time, if CMS does intend to account for MA utilization in determining Part B spending, it is critical that it be done in a way that avoids any new, burdensome data or reporting requirements for MA plans, consistent with the President's directives to reduce regulatory burdens. Accordingly, Humana encourages CMS to clarify that spending on Part B drugs paid for by MA plans will be reflected in the process for calculating Part B Total Expenditures. If additional data on Part B drug costs for MA enrollees are needed in order for these costs to be taken into account, we request that CMS provide MA plans with an opportunity to comment on any process that CMS intends to use if that process would impose new data or reporting requirements on MA plans.

Lastly, CMS describes how it will identify Part B and Part D high spend drugs separately, and "if a negotiation-eligible drug appears on both high-spend lists, it will receive only one ranking for purposes of selection, according to its combined Total Expenditures under both Part D and Part B." However, Humana is concerned about incentives for manufacturers to develop products with split utilization across Medicare Parts B and D to evade selection for the Negotiation Program. Under the proposed approach, a manufacturer with total expenditures under Medicare Parts B or D below the threshold for making it to the high-spend list could avoid selection, even if the drug's combined total expenditures were large enough to place it high on the combined Parts B and D list. Humana recommends that CMS develop a step in the drug selection process where utilization for the same product across Parts B and D is added together before the calculation of total expenditures and the ranking of drugs across Parts B and D.

[6] See U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2024). Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (89 FR 98252). CMS declined to include MA units in the calculation of Part B rebates at this time due to only operational considerations.

Section 30.4 Publication of the Selected Drug List

Consistent with IRA requirements, CMS will publish the selected drug list for initial price applicability year 2028 no later than February 1, 2026. CMS will also publish a list of the up to 50 top negotiation-eligible drugs (including the up to 15 selected drugs) ranked by combined total expenditures under Part B and Part D. Additionally, CMS will publish the list of drugs selected for renegotiation, if any, no later than February 1, 2026.

> **Humana Comment:** Humana supports CMS' intention to publish a list of the "up to 50 top negotiation-eligible drugs (including the up to 15 selected drugs) ranked by combined Total Expenditures under Part B and Part D" as part of the IPAY 2028 negotiation process, which is a change from prior years where such a list was not made publicly available. This change will bring needed transparency to the drug selection process, aligned with President Trump's April 15 Executive Order "Lowering Drug Prices by Once Again Putting Americans First."[7] Publication of this list will also help stakeholders understand the drugs that could be included in the Negotiation program in future years of the program based on total expenditures calculated as part of the IPAY 2028 process.

Section 40. Requirements for Manufacturers of Selected Drugs

Under the IRA, CMS must enter into agreements with manufacturers of selected drugs that set forth requirements of the primary manufacturer with respect to participation in the negotiation program.

Section 40.4 Providing Access to the MFP in 2026, 2027, and 2028

Consistent with previous guidance, CMS indicates that a primary manufacturer must provide access to the MFP in one of two ways: (1) prospectively ensuring that the price paid by the dispensing entity or Part B provider when acquiring the drug is no greater than the MFP; or (2) retrospectively providing reimbursement for the difference between the dispensing entity or Part B provider's acquisition cost and the MFP. CMS provides additional clarifications on how the effectuation of the MFP by manufacturers must occur.

> **Humana Comment:** We recognize CMS' interest in using Prescription Drug Event (PDE) for purposes of the Medicare Transaction Facilitator (MTF) data functionality that will assist manufacturers in providing access to the MFP. However, as expressed in our prior comments, we have concerns with the use of PDE to validate claims, including the shortened PDE window for selected drugs finalized as part of the CY 2026 Policy and Technical Changes final rule. Specifically, we are concerned that the shorted PDE submission window for selected drugs will require pharmacies to spend more time and resources tracking claim reversals and adjustments, contrary to CMS's goals in using PDE as an accurate source for tracking MFP-eligible claims. We encourage CMS to pursue alternatives to the use of PDE data, while limiting delays in MFP refunds and any undue burdens placed on pharmacies. This could include private market solutions that offer an alternative to the MTF or other proposals suggested by CMS, like prospective sales of selected drugs to dispensing entities at the MFP or pre-funded MFP refund payment accounts.

[7] Lowering Drug Prices by Once Again Putting Americans First – The White House

Section 40.4.1 Retrospective Refund Amount to Effectuate the MFP and the Standardized Default Refund Amount

CMS reiterates that the obligation to calculate and pay an appropriate amount to ensure the dispensing entity has access to the MFP rests with the Primary Manufacturer. A Primary Manufacturer can choose to refund an amount different than the Standardized Default Refund Amount (SDRA) if the Primary Manufacturer determines some other amount is appropriate and sufficient to make the MFP available. A dispensing entity can work with Primary Manufacturers to establish an MFP refund amount using the dispensing entity's actual acquisition cost or an adjusted standardized pricing metric that ensures the MFP has been made available, and the Primary Manufacturer would indicate such agreed amount when reporting the claim-level payment elements provided by the Primary Manufacturer to the MTF DM.

> **Humana Comment:** Humana appreciates the development of a SDRA to facilitate the MFP refund process from manufacturers to dispensing entities. However, for purposes of transparency, we believe that Primary **M**anufacturers' MFP effectuation plans indicating whether they will use the SDRA or an alternative should be made available to dispensing entities shortly after they are submitted to CMS and prior to the start of the IPAY. Under current guidance, it is our understanding that a manufacturer could try to obtain a dispensing entity's acquisition cost from a third party, unbeknownst to the dispensing entity itself. Ideally, CMS would require a dispensing entity to consent to providing its acquisition cost to a manufacturer for purposes of MFP refunds; at a minimum, by making MFP effectuation plans available, dispensing entities can better prepare their systems and processes for whether to expect a refund amount based on the SDRA or some other amount.

Section 60. Negotiation Process

The IRA requires CMS to develop and use a consistent methodology and process for negotiation with the aim of achieving agreement on "the lowest maximum fair price for each selected drug." CMS here describes the negotiation process, including engagement with Primary Manufacturers and interested parties, the development of the written initial offer, the process for making such offer and providing a concise justification to the Primary Manufacturer of a selected drug, the process and requirements for accepting an offer or providing a statutory written counteroffer, optional negotiation meetings between CMS and the Primary Manufacturer, additional price exchange opportunities, the conclusion of negotiation, the publication of the MFP, and explanation of the MFP.

Section 60.2.2.3 Determination of Payment Amount for Selected Drugs Payable Under Part B and Covered Under Part D

CMS interprets the language in section 1194(c)(1)(B) of the Act to mean it should calculate a single amount across the payment amount under section 1847A(b)(4) of the Act and the sum of the plan-specific enrollment weighted amounts for all dosage forms and strengths of a selected drug that is payable under Part B and covered under Part D. Section 1194(c)(1)(B) of the Act provides for the calculation of "an amount," in the singular, for each selected drug, even if such drug is payable under Part B and covered under Part D.

> **Humana Comment:** Humana supports the calculation of one MFP that would apply to all dosage forms (once enrollment weight adjusted appropriately), payable under Medicare Part B and Part D, for each selected drug. Providing for one MFP minimizes potential incentives for manufacturers to shift their drug development or commercialization strategy to toward or away from physician-administered drugs.

Section 80. MFP-Eligible Individuals in 2026, 2027, and 2028

CMS outlines criteria that determine whether a beneficiary is an "MFP-eligible individual" and defines the settings in which the MFP must be honored. For 2026 and 2027, individuals furnished medications by pharmacies and other dispensing entities will generally qualify for the MFP. For 2028, MFP effectuation will be extended to include hospitals, physician offices, and other provider facilities to coincide with the selection of Part B drugs. CMS anticipates that Medicare Advantage plan requirements under 42 C.F.R. Part 422 will apply to selected drugs. CMS is soliciting comments on how best to monitor MA plans' use of Part B step therapy practices to ensure compliance with program rules and any data or policy clarifications that may be needed for implementation.

> **Humana Comment:** Humana supports continued flexibility for MA plans to develop step therapy practices for Part B drugs, including selected drugs. Step therapy and other utilization management tools are evidence-based tools that help ensure patients receive timely, clinically appropriate, and evidence-based care. These tools are used situationally by Humana to ensure appropriate use of drug therapies and to prevent fraud, waste, and abuse. In order to minimize disruption for members, Humana uses technology and analytics to improve the patient experience and speed access to medications, while ensuring utilization is appropriate for the right member, at the right time to drive the right outcomes. Our proactive approach also helps reduce administrative burdens and inefficiencies for the provider.
>
> We believe existing MA program rules and reporting requirements should be applied to selected drugs. We are not aware at this time of any requirements or clarifications that are needed. CMS can monitor potential issues relating to an MA plan's use of Part B step therapy practices through the Part C reporting requirements that cover organization determinations and reconsiderations. Moreover, CMS has the authority to conduct audits relating to step therapy.
>
> Consistent with the President's directive to reduce regulatory burdens, CMS should rely on existing processes and avoid establishing any new requirements or reporting burdens unless/until there is an indication that process changes may be needed. Although outside the scope of the current comment solicitation, in relation to the President's directive to reduce regulatory burden, Humana recommends that CMS revisit existing limitations on Part B step therapy to bring these requirements into greater alignment with step therapy practices allowed under Medicare Part D, including applying consideration of these practices not just to members who are new to a product but to existing utilizers. This approach gives plans the greatest flexibility to design cost-effective treatment regiments, which yield net savings to the Medicare program, while ensuring that each member is using the most clinically appropriate drug for their condition.

Section 80.1 Direct Member Reimbursements and Access to the MFP for Selected Drugs in 2026, 2027, and 2028

CMS proposes to make Medicare plan sponsors responsible for facilitation of the MFP in instances where an MFP-eligible individual submits a covered direct member reimbursement (DMR) request. For DMRs involving in-network claims, the plan sponsor is responsible for reimbursing the individual at least the difference between the cash price paid by the enrollee to the dispensing entity and the negotiated price. For DMRs involving out-of-network claims, the plan sponsor is responsible for reimbursing the individual at least the difference between the cash price paid by the enrollee to the dispensing entity

and the MFP plus any dispensing fees, since there is not a negotiated price for the out-of-network dispensing entity.

> **Humana Comment:** Humana appreciates the clarification from CMS on treatment of direct member reimbursement requests (DMRs) for selected drugs. However, we encourage CMS to provide additional detail on DMRs for selected drugs in the final guidance. Specifically, it is not clear how a Part D plan sponsor should go about processing the DMR request if the plan does not have information on a dispensing fee charged by a pharmacy. Humana recommends that CMS include examples of the calculations described in the draft guidance in the final guidance to assist plan sponsors in implementing this policy. These examples should cover varying situations involving in-network and out-of-network claims; member position in the benefit (deductible, etc.); and other factors that may impact the dispensation of the DMR request.
>
> Additionally, in the draft guidance CMS indicates that "Primary Manufacturers and Part D plan sponsors may establish a reimbursement process related to DMR requests for MFP-eligible claims as necessary to ensure MFP effectuation for these MFP-eligible individuals." It is ultimately the Primary Manufacturer's responsibility to ensure that MFP-eligible individuals do not pay more than the MFP plus a dispensing fee. Humana encourages CMS to contemplate a process whereby impacts of covered DMRs for selected drugs are mitigated for Part D plan sponsors and any necessary refunds are appropriately charged to manufacturers with minimal Part D plan administrative burden.

Section 110. Part D Formulary Inclusion of Selected Drugs

CMS specifies conditions under which selected drugs must be included on a Part D plan formulary, and conditions in which selected drugs may be removed from a formulary. CMS will use its formulary review process to assess instances where plans may use tiering decisions, cost-sharing, and/or utilization management to limit access to selected drugs.

> **Humana Comment:** Humana supports CMS not creating new, uniform tier placement or utilization management restrictions for selected drugs. For example, many selected drugs may be older due to the criteria for negotiation eligibility, and newer drugs may be the preferred standard of care or the best option for new patient initiation based on the scientific and clinical evidence for a Medicare population. It is critically important that P&T committees be able to assess individual drugs for patient safety and pharmacoeconomic purposes. Inappropriate tier placement or other requirements could also unduly impact formulary, rebate and other negotiations pertaining to non-selected Part D drugs. And as more drugs become subject to negotiation over time, multiple drugs within a therapeutic class may have negotiated prices; the manufacturers of these drugs may be willing to offer additional price concessions for preferred relative formulary placement, reducing overall Part D drug spending.
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> Additionally, Humana believes increasing generic and biosimilar use is an important tool in bringing down total drug costs and increasing competition in the prescription drug market. We support the modification CMS made in this year's draft guidance indicating it will use its formulary review process to assess:
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> - any instances where a selected drug is placed on a higher tier than non-selected **brand** drugs in the same class (Note: emphasis added);

- any instances where Part D sponsors impose more restrictive utilization management (i.e., step therapy and/or prior authorization) for a selected drug compared to a non-selected **brand** drug in the same class (Note: emphasis added).

Prior versions of CMS guidance did not include the specification that this extra level of review would apply to brand drugs only. We believe this change is a step in the right direction to ensure Part D plan sponsors have appropriate flexibility to encourage use of generic and biosimilar products where appropriate.

Section 110.1 Formulary Inclusion Exception Successor Regulation for 2027 and 2028

CMS notes that Part D plan sponsors may, as an immediate substitution, remove a selected drug from the formulary and replace it with a new generic or interchangeable biological product of the selected drug if such sponsor meets the regulatory notice and timing requirements. CMS is clarifying here that removals under the formulary inclusion exception cannot be carried over to subsequent years within the price applicability period simply because a selected drug was removed in a preceding year during the price applicability period. Instead, any removal must independently meet the immediate substitution requirements for each plan year because, consistent with CMS' longstanding policy, CMS considers each plan year's formulary to be separate and distinct from the prior year.

Humana Comment: We previously supported the CMS proposal to allow Part D sponsors to replace selected drugs on formulary through the immediate substitution process when an equivalent drug comes to market. We believe this proposal provides appropriate flexibility for plan sponsors to develop formularies that drive the lowest net costs to the plan, the Medicare program, and Medicare beneficiaries.

However, we are concerned with the CMS proposal to not allow plans to continue similar formulary treatment from year-to-year after a selected drug has been removed via immediate substitution flexibility due to generic or interchangeable biosimilar competition. We do not believe this is aligned with Congressional intent for the Medicare Drug Price Negotiation Program, which is directed towards drugs without generic or biosimilar competition. Instead, Humana strongly encourages CMS to revisit alternatives considered in the CY 2026 Part D Draft Program Instructions that would allow a Part D sponsor to remove a selected drug that is either a brand name drug or a reference product as a maintenance change within 90 days of adding, respectively, a corresponding generic drug, interchangeable biological product or non-interchangeable biological product to the same or a lower cost-sharing tier and with the same or less restrictive utilization management requirements.

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June 26, 2025

SUBMITTED ELECTRONICALLY VIA ***IRARebateandNegotiation@cms.hhs.gov***

Chris Klomp
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 21244-1859

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 - 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Mr. Klomp:

Incyte appreciates the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services' (CMS's) *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 - 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028* (the Draft Guidance).[1]

At Incyte, we exist to positively affect the lives of patients through heavy investment in biopharmaceutical research and development (R&D). Headquartered in Wilmington, Delaware, we employ more than 1,900 people in the U.S. of which 729 work in R&D. Incyte's world-class scientists are committed to finding solutions for some of the most critical unmet medical needs. In 2024 alone, Incyte invested $1.9 billion[2] in R&D, representing nearly 45% of the company's total net revenues during that time. Revenue from sales of our approved products, chiefly Jakafi® (ruxolitinib), fuel Incyte's clinical development program of 20 investigational medicines intended to transform the treatment of cancer and inflammatory and autoimmune conditions.[3]

Incyte supports the comments submitted by our trade associations, the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Innovation Organization (BIO), on the Draft Guidance. Incyte writes separately to provide additional comments on Sections 30.1 "Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028" and Section 60.2.1.1 "Determination of a 30-Day Equivalent Supply for a Selected Drug."

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[1] Available at https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf
[2] Excludes the value of Incyte's acquisition of Escient, announced on April 23, 2024. If the Escient transaction was included in total R&D investment, Incyte's R&D spend would total approximately $2.6 billion, representing 61% of total revenue.
[3] Incyte Corporation Pharmaceutical Portfolio, https://www.incyte.com/what-we-do/pharmaceutical-portfolio (last visited June 25, 2025).

As Incyte has previously conveyed to CMS, we are concerned that CMS's expansive interpretation of a qualifying single source drug (QSSD) is unlawful and risks treating two distinct FDA-approved products—intended for entirely different therapeutic areas—as the same drug. Applying CMS's interpretation to Incyte's drugs Opzelura® (ruxolitinib) topically applied cream and Jakafi® (ruxolitinib) oral tablets illustrates the serious flaws with the agency's approach. Opzelura is a topical cream approved to treat two diseases found in the skin, atopic dermatitis and nonsegmental vitiligo,[4] while Jakafi is an oral tablet approved to treat rare hematologic cancers and immunologic conditions.[5] As two distinct products with non-overlapping indications in separate therapeutic areas, Opzelura and Jakafi were approved based on the results of different clinical trials. They each were approved under separate new drug applications (NDAs). These two drugs are treated by payers as two distinct medicines, are listed in separate therapeutic categories, and share no competing therapeutic agents.

Yet under CMS's expansive QSSD interpretation, CMS appears like it would treat Opzelura and Jakafi as the same QSSD and subject both products to the same maximum fair price (MFP). As discussed further below, treating Opzelura and Jakafi as the same QSSD does not comport with the best interpretation of the statute, would present significant operational challenges, and would not reflect the reality that Opzelura and Jakafi serve different patient populations with unrelated medical needs and vastly different disease prevalence. Given these meaningful legal, clinical, and market distinctions, CMS must treat Opzelura and Jakafi as separate potential QSSDs under the statute.

Additionally, as stated in our prior comments, we urge CMS to consider the practical limitations of standardizing pricing around a 30-day equivalent supply, particularly for topically applied drugs like Opzelura. The quantity used can vary significantly from patient-to-patient, and prescribers do not typically determine usage based on a fixed monthly amount, making the 30-day pricing model ill-suited for this route of administration and dosage regimen. Incyte requests that CMS issue guidance clarifying how it intends to calculate a 30-day supply for topical medications and ensure that any methodology accounts for variable dosing patterns and real-world clinical use.

Incyte's comments on the Guidance include the following:

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I. CMS Should Not Aggregate QSSDs with Clinically Meaningful Differences

CMS's claim that it can group clinically-distinct drugs under the same QSSD simply because they share an active moiety and the same manufacturer cannot be squared with the IRA.[6] The text, structure, and purpose of the

[4] See Opzelura Prescribing Information at https://www.opzelura.com/opzelura-prescribing-information

[5] See Jakafi Prescribing Information at https://www.jakafi.com/jakafi-prescribing-information

[6] Draft Guidance § 30.1. Because Opzelura and Jakafi both were approved under NDAs, for simplicity, our comments discuss the QSSD criteria for NDA-approved drugs – i.e., a QSSD includes "all dosage forms and strengths of the drug with the same active moiety and the same holder of a New Drug Application (NDA), inclusive of products that are marketed pursuant to

statute reflect a drug-specific framework—one that requires the identification, selection, and establishment of prices for individual products, not molecular categories. Congress permitted limited aggregation for calculating expenditures across dosage forms and strengths of the *same* drug, but nowhere authorized collapsing clinically distinct products into a single QSSD. The statutory scheme depends on treating each QSSD as a discrete therapeutic entity, reflecting the reality that drugs with different indications, patient populations, and routes of administration, often warrant different prices. Aggregating them would distort the ranking and selection process, misalign incentives, and subvert any semblance of a "fair" negotiation process. The profound differences between real-world drugs like Opzelura and Jakafi underscore why such aggregation is not only legally unsound but also leads to absurd results that Congress could not have intended.

A. QSSD Aggregation Is Not Consistent With the Best Interpretation of the Statute

The statute does not authorize CMS to aggregate distinct QSSDs with clinically meaningful differences. Under the Supreme Court's recent decision in *Loper Bright Enterprises v. Raimondo*, agencies must adopt the *best* interpretation of a statute—not merely a "permissible" one.[7] As the Court made clear, "[i]n the business of statutory interpretation, if it is not the best, it is not permissible."[8] CMS's interpretation fails that test. Aggregating QSSDs with clinically meaningful differences departs from the IRA's text, structure, and purpose, and thus does not reflect the best interpretation of the statute.

i. The Text and Purpose of the Use of Data Provision Demonstrates that Clinically Different Drugs Must Not be Aggregated

Start with the text.[9] The statute provides that, in determining whether a QSSD qualifies as a negotiation-eligible drug, the Secretary "shall use data . . . aggregated across dosage forms and strengths of the drug, including new formulations of the drug, such as an extended release formulation, and not based on the specific formulation or package size or package type of the drug."[10] CMS contends that this provision authorizes the agency to treat two different products that share an active moiety and NDA holder as a single QSSD.[11] Not so.

The text of the Use of Data provision makes clear that aggregation is permitted only *within* a single drug—specifically, across its dosage forms and strengths, including certain new formulations—and only *after* a QSSD has been identified. The phrase "including new formulations of the drug, such as an extended release formulation" limits the scope of permissible aggregation to clinically similar variants of the same underlying drug. The term "including" signals that "new formulations" are a subset of "dosage forms and strengths," not a broader or independent category.[12] Thus, a "new formulation" must remain a formulation of *the same drug*—not a distinct QSSD with meaningful clinical differences.

That reading is confirmed by Congress's illustrative example: "an extended release formulation." Extended release versions are designed to release the same active moiety over a longer period, allowing for less frequent dosing. Extended release versions are often clinically similar to the original drug—they treat the same condition and an overlapping patient population. By contrast, CMS's approach permits aggregation across drugs with separate and

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different NDAs." *Id.* However, our position that CMS should not aggregate QSSDs with clinically meaningful differences applies equally to products licensed under a biologics license application.

[7] 603 U.S. 369 (2024).

[8] *Id.* at 400.

[9] *See Permanent Mission of India to the United Nations v. City of New York*, 551 U.S. 193, 197 (2007) ("We begin, as always, with the text of the statute.").

[10] Social Security Act (SSA) § 1192(d)(3)(B).

[11] *See* IPAY 2028 Draft Guidance § 30.1 at 10-12.

[12] *See Montello Salt Co. v. Utah*, 221 U.S. 452, 465 (1911) ("including" can denote an illustration, not an expansion); *Federal Land Bank of St. Paul v. Bismarck Lumber Co.*, 314 U.S. 95, 100 (1941) ("'Including' connotes an illustrat[ion]").

distinct target populations and divergent indications in different therapeutic areas—an interpretation flatly inconsistent with the statute's context and example of extended release formulation.

Congress further clarified the narrow scope of permitted aggregation by directing that CMS *not* calculate and rank expenditure data based on "the specific formulation or package size or package type of the drug."[13] The words "specific formulation," "package size," and "package type" denote specific subsets of a distinct FDA-approved product, further demonstrating the type of data aggregation that is permitted under the statute—i.e., across the dosage forms and strengths of a single clinically coherent drug, not across fundamentally distinct products. CMS's approach, which would permit aggregation of any two products that share a manufacturer and an active moiety, ignores the product-specific meaning of the words "specific formulation," "package size," and "package type" and thus impermissibly expands the scope of data aggregation.

The overall structure of the IRA confirms what the text of the provision requires. The IRA's framework consistently treats each QSSD as a distinct unit of analysis—one that must be separately identified, ranked, selected, and priced.[14] That structure presupposes product-level precision, not ingredient-level generalization. To be sure, the statute authorizes aggregation when ranking the top 50 QSSDs by total Medicare expenditures to select the highest-spend drugs for the program.[15] But the Use of Data provision explicitly states that it applies only *after* the relevant QSSD has been identified, and each QSSD is defined by reference to a distinct FDA-approved product.[16]

ii. The Compute and Apply IRA Provision Further Reinforces that Clinically Different Drugs Must Not be Aggregated

Moreover, after CMS sets the MFP for a selected drug, the agency must "compute and apply the maximum fair price across different strengths and dosage forms of a selected drug and not based on the specific formulation or package size or package type of the drug."[17] This Compute and Apply provision parallels the Use of Data provision. Under both provisions, CMS is directed to operate "across dosage forms and strengths of the drug . . . and not based on the specific formulation or package size or package type of the drug." The fact that the Compute and Apply provision noticeably omits "including new formulations of the drug, such as an extended release formulation" reinforces that that phrase "new formulations" is intended to provide an example of "dosage forms and strengths" that must be aggregated, but does not permit CMS to aggregate new formulations that are not dosage forms and strengths of the same drug.

The statute clearly contemplates that these two provisions will have precisely the same scope: Congress would not direct the agency to take into account forms of a QSSD for purposes of ranking the top 50 QSSDs by total Medicare expenditures, but then exempt those forms from the Compute and Apply Provision—and thus not impose the MFP on that form. That would be nonsensical. Imagine a selected drug where a "new formulation" accounts for virtually all of its Medicare expenditures. Exempting that "new formulation" from the compute and apply provision—effectively depriving the agency of the ability to set the price of the version of the drug responsible for the bulk of its Medicare expenditures—would defeat the entire purpose of the Negotiation Program statute. Such an interpretation of the statute is to be avoided where an equally compelling interpretation is available.[18] Statutes must be read as a whole, and this one compels product-specific pricing. Aggregating across clinically distinct drugs collapses the entire statutory scheme.

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[13] SSA § 1192(d)(3)(B).
[14] *See* SSA §§ 1192 to 1196.
[15] SSA § 1192(b)(1)(A)-(B).
[16] A separate reason why CMS cannot aggregate Opzelura and Jakafi under the same QSSD is because the products were approved under separate NDAs. For additional detail, please reference PhRMA's comments on this issue.
[17] SSA § 1196(a)(2).
[18] *See* Quarles v. United States, 587 U.S. 645, 654 (2019) ("We should not lightly conclude that Congress enacted a self-defeating statute").

iii. Common Sense Commands that Clinically Different Drugs Must Not be Aggregated

Reading the statute to treat clinically different drugs differently also makes practical sense. Distinct drugs that treat different conditions and therefore serve different patient populations—such as one used for rare blood cancers and another for inflammatory/autoimmune conditions in the skin—can have dramatically different pricing based on their clinical profiles, market conditions, and therapeutic alternatives. Congress would not have designed a program that arbitrarily groups such drugs together, forcing a single price on heterogeneous treatments that may differ significantly in benefit-risk profiles, indicated disease states, dosing regimens (e.g., chronic versus intermittent use), and anticipated treatment durations. All of these affect real-world use, tolerability, and pricing dynamics. Doing so would defeat the program's stated aim of negotiating "fair" prices. Fairness cannot be achieved if clinically different drugs are treated as if they were the same.

B. Applying QSSD Aggregation to Opzelura and Jakafi Demonstrates the Serious Flaws in CMS's Expansive Approach to Aggregation

The single best real-world example of why grouping clinically distinct drugs makes no sense under the statute are Incyte's drugs Opzelura and Jakafi. Both drugs manufactured by Incyte contain the active ingredient ruxolitinib (and thus the same active moiety), but they are fundamentally different medicines in every other way. As described further below, the two drugs differ in therapeutic areas, FDA-approved indications, patients that they treat, benefit-risk profiles, and routes of administration. One treats autoimmune pigmentation and inflammation in dermatology. The other treats cancers and immune responses following bone marrow transplantation in oncology. Opzelura is applied to the skin; Jakafi is taken orally. These fundamental differences demonstrate that Opzelura is not a "new formulation" of Jakafi.

i. Opzelura and Jakafi Are Distinct Products That Treat Different Conditions in Different Therapeutic Areas

Below, we highlight some of the legal, clinical, and market differences between Opzelura and Jakafi.

Different Indications in Different Therapeutic Areas. Jakafi was first approved in 2011. It is approved to treat malignant and non-malignant conditions arising from the body's bone marrow. Specifically, Jakafi is approved to treat: (1) intermediate or high-risk myelofibrosis; (2) polycythemia vera in patients who have had an inadequate response to or are intolerant of hydroxyurea; (3) steroid-refractory acute graft-versus-host disease (GVHD), and (4) chronic GVHD after failure of one or two lines of systemic therapy. Myelofibrosis and polycythemia vera are both rare, progressive blood cancers. Myelofibrosis is a life-threatening condition in which scar tissue develops in the bone marrow; in polycythemia vera, the bone marrow overproduces red blood cells, which can cause life-threatening cardiovascular complications. GVHD, in turn, is a systemic disorder that can occur in recipients of an allogeneic bone marrow transplant. In patients with GVHD, immune cells from transplanted tissue attack healthy cells in the patient, causing gastrointestinal ailments, liver problems, and skin irritation.

A decade after Jakafi's approval, through Incyte's long-running R&D efforts, Opzelura was approved by the FDA. In contrast to Jakafi, Opzelura is approved to treat two diseases found in the skin, atopic dermatitis and nonsegmental vitiligo. Atopic dermatitis, also known as eczema, is a pruritic inflammatory condition that affects millions of Americans. It causes itchy and inflamed skin that can lead to serious complications like infections and can impair quality of life through sleep disturbances, anxiety, and depression. Vitiligo is a long-term skin condition in which patches of skin lose their pigment as the immune system attacks and destroys melanocytes. Nonsegmental vitiligo is the most common type of vitiligo, in which depigmented patches appear on both sides of the body. Opzelura is the first and only medication approved by FDA to treat nonsegmental vitiligo.

Opzelura and Jakafi are not interchangeable, as their different routes of administration are essential to their respective safety and efficacy profiles. Notably, the bioavailability of topical ruxolitinib is approximately 6–7%, compared to about 95% for the oral formulation, resulting in vastly different systemic exposures and clinical effects. It would not be medically appropriate to use Opzelura to treat myelofibrosis, polycythemia vera, or GVHD because Opzelura would not have the intended effect on the site of treatment, the bone marrow. Conversely, the systemic hematologic effects observed with oral ruxolitinib, such as drops in hemoglobin and platelets, would not be acceptable in the treatment of atopic dermatitis or vitiligo. Similarly, it would not be medically appropriate to use Jakafi, an oral tablet that causes systemic effects, to treat atopic dermatitis or nonsegmental vitiligo, which are localized skin conditions.

Different Therapeutic Classes, Therapeutic Alternatives, and Market Dynamics. Because Opzelura and Jakafi are fundamentally different products approved to treat different conditions in different therapeutic areas, they are treated as separate and distinct products by payers, including federal and state health care programs. For example, the Department of Veterans Affairs (VA), Department of Defense (DOD), and the Federal Employee Health Program (FEP) classify these two drugs as separate therapeutic agents and separately negotiate the prices of these two drugs.[19] These federal health programs do not aggregate these two distinct drugs.

State Medicaid plans treat them separately as well. Opzelura and Jakafi are included in separate therapeutic classes in Preferred Drug Lists across state Medicaid plans; for example, in Pennsylvania, Jakafi is included in the "Oncology Agents, Oral" therapeutic class, while Opzelura is included in the "Immunomodulators, Dermatologics" therapeutic class.[20]

As these drug classifications demonstrate, Jakafi and Opzelura compete in separate therapeutic categories with dissimilar market dynamics. Because Jakafi and Opzelura have non-overlapping approved indications, they also have non-overlapping therapeutic alternatives. The pricing for the two products reflects their unique marketplace characteristics, competitors, and therapeutic value: Jakafi is approved to treat rare diseases with much smaller patient populations and fewer therapeutic alternatives, while Opzelura is approved to treat non-life-threatening dermatologic conditions with a wider array of treatment options for patients with atopic dermatitis.

Other than a shared active moiety/active ingredient and manufacturer, Jakafi and Opzelura are different in virtually every other conceivable dimension, as summarized below in Table 1. As the VA, DOD, FEP, and State Medicaid programs demonstrate, no reasonable observer would consider Opzelura to be a "new formulation" of Jakafi as Congress intended that term to be used in price negotiation.

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[19] In the Veterans Affairs' system, Opzelura is in the Drug Class: "Dermatological, Topical Other" and the Therapeutic Category: "Dermatological Agents." Jakafi is in the Drug Class: "Immunological Agents, Other" and the Therapeutic Category: "Immunological Agents." In the Defense Department TRICARE system, Opzelura is in the Uniform Formulary Class; "ATOPY," and Jakafi is in the Uniform Formulary Class: "Oncological Agents." In the Federal Employee Health Benefit Program, Opzelura is listed as "Eczema Agent" and Jakafi is listed as "Antineoplastic Enzyme Agents."

[20] *See* Pennsylvania Statewide Preferred Drug List (Jan. 6, 2025), https://www.papdl.com/content/dam/ffs-medicare/pa/pdl/penn-statewide-pdl-2025-v5.pdf. *See also, e.g.*, Arizona Medicaid Preferred Drug List (Apr. 1, 2025), https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/az/pharmacy/AZ-Preferred-Drug-List-Medicaid.pdf (listing Jakafi as an antineoplastic and Opzelura as a dermatological agent); TennCare Preferred Drug List (June 1, 2025), https://contenthub-aem.optumrx.com/content/dam/contenthub/onboarding/assets/Tenncare/Tenncare-PDL.pdf (listing Jakafi as an oncological agent that treats myelofibrosis and Opzelura as a dermatologic that treats atopic dermatitis); MassHealth Drug List (May 12, 2025), https://mhdl.pharmacy.services.conduent.com/MHDL/pubdownloadpdfcurrent.do?id=45 (listing Jakafi under the "Oncology Agents – Kinase Inhibitors" category and Opzelura under the "Dermatological Immune Suppressants" category); Iowa Medicaid Program Preferred Drug List (May 20, 2025), https://www.iowamedicaidpdl.com/content/dam/ffs-medicare/ia/iowa-webpdl-july-2025.pdf (listing Jakafi under the "Antineoplastics – Protein-Tyrosine Kinase Inhibitors" category and Opzelura under the "Atopic Dermatitis" category).

Table 1: Key Differences in Opzelura and Jakafi

	Opzelura	Jakafi
Product Form	Topical Cream (1.5%, 60g tube)	Tablet (60-count bottle)
Route of Administration	Topical	Oral
Dosing Regimen	Apply thin layer of cream twice daily directly to affected area of skin; up to 20% (atopic dermatitis) or 10% (non-segmental vitiligo) of body surface area	Take 1 tablet twice a day
Pivotal Studies	TRuE AD1 TRuE AD2 TRuE-V1 TRuE-V2	COMFORT-1 COMFORT-2 RESPONSE REACH-1 REACH3
Uses Addressed by Approved Indications	**Dermatological Approvals** -Mild to Moderate Atopic Dermatitis (2021) -Non-Segmental Vitiligo[1] (2022)	**Antineoplastics Approvals** -Myelofibrosis[1,2] (2011) -Polycythemia Vera[1,2] (2014) **Immunological Approvals** -Acute Graft Versus Host Disease[1,2] (2019) -Chronic Graft Versus Host Disease[1,2] (2021)
Orphan Drug Designations (Approved)	no orphan drug designations	Treatment of myelofibrosis Treatment of polycythemia vera Treatment of graft versus host disease
Wholesale Acquisition Cost	WAC per package (15mg/g (60g tube)) in 2025 ~$2,094	WAC per package (5-25mg/1 (60 tablets)) in 2025 ~$17,600
Standalone Approvals	FDA approved each drug under a separate, complete NDA reviewed by different, distinct review divisions within the FDA	

1. *Approval represents area of unmet need – first approved therapy for indication*
2. *Rare Disease*

Different Route of Administration. Opzelura is a topical cream that is designed to deliver the drug into the skin – not through it. It delivers the active ingredient into the skin, concentrating the drug's action at the site of application and achieving higher local levels without generating high plasma concentrations—thereby reducing the risk of systemic side effects. In developing Opzelura, Incyte invested considerable resources to develop a stable composition in which ruxolitinib could be dissolved at a high concentration and delivered locally to the skin, without significant transdermal or systemic effects or skin irritation. These advances required substantial financial investment and years of work by a dedicated team of scientists at Incyte, leading to the creation of an innovative oil-in-water emulsion with adequate solubility, permeability, and hydrophilic-lipophilic balance to effectively deliver higher levels of ruxolitinib to the area of application. In addition, topicals are inherently complex products, as excipients can significantly impact drug delivery, absorption, and tolerability. Topical formulations also face entirely different stability challenges and must remain effective under a range of environmental and usage conditions. Incyte undertook these efforts to address unmet needs and advance treatment options for certain dermatological conditions.

By contrast, Jakafi is an oral tablet that travels into the gastrointestinal tract, where the active ingredient dissolves and passes into the bloodstream. The vascular system then carries the active ingredient to all parts of the body, including the site of treatment, the bone marrow.

Different FDA Approvals. In light of the vast therapeutic and chemical differences in the two drugs, to secure approval for Opzelura, FDA required Incyte to provide a body of evidence supporting its safety and efficacy that

would ordinarily be required for a drug with a novel active ingredient. Incyte conducted many new studies of Opzelura, including juvenile animal toxicology studies, a two-year carcinogenicity study (not required for oncology products), five skin irritation studies (specific to topical formulations), pharmacokinetic studies, a maximum use study, as well as pivotal clinical safety and efficacy studies. Not surprisingly, in light of these profound differences, different divisions within FDA reviewed each new drug application for Opzelura and Jakafi. Opzelura was reviewed by the Division of Dermatology and Dentistry. Jakafi was reviewed by the Division of Hematologic Malignancies 1 and the Division of Non-Malignant Hematology. Further underscoring their differences in therapeutic uses and therefore regulatory treatment, none of Opzelura's indications have orphan drug designation, while each approved indication of Jakafi does.

Despite these innumerable differences, CMS's approach would treat Opzelura as a "new formulation" of Jakafi under the IRA and thus would subject both products to the same MFP. This is not the best interpretation of the statute. As demonstrated by the products' numerous differences—including therapeutic classes, FDA-approved indications, and routes of administration—Opzelura and Jakafi are fundamentally distinct drugs that must be recognized as separate potential QSSDs under the IRA.

ii. Treating Opzelura and Jakafi as the Same QSSD Would be Unworkable Under the IRA

In addition to violating the statute, treating Opzelura and Jakafi as the same QSSD would present CMS with significant operational complexities during the "negotiation" process. Jakafi and Opzelura have almost no overlap across any of the factors that CMS must use as "the basis" for determining offers and counteroffers.[21] As discussed above, the FDA approved each drug based on distinct pivotal trials. The two drugs have distinct therapeutic alternatives and unique pricing that reflects their positioning within their respective markets. They are subject to distinct unit costs of production and distribution and are supported by different patents, FDA approvals, and regulatory exclusivities. The products' stark differences on every factor that CMS is required to consider when establishing MFPs further supports that Congress did not intend for CMS to apply the same MFP to both products. If CMS maintains this flawed approach, the agency may be faced with difficult situations where the same factor may counsel for an upward adjustment for one product but a downward adjustment for the other. These operational complexities underscore the fundamental flaws with attempting to treat these two distinct drugs as one QSSD.

C. CMS Should Adopt a Consistent Approach to Promote Innovation

i. Considering Innovation for Some QSSD Determinations But Not Others Would be Arbitrary and Capricious

In the Draft Guidance, CMS is soliciting comments on whether the agency should consider if an active ingredient in a fixed combination drug has a "clinically meaningful difference" against a disease state when determining which other products to aggregate under a QSSD with that fixed combination drug.[22] If CMS considers whether there is a "clinically meaningful difference" when identifying QSSDs for fixed combination drugs, it would be arbitrary and capricious for CMS not to also consider clinically meaningful differences between products with a single active moiety.

Historically, CMS's position was that "[i]f a drug is a fixed combination drug with two or more active moieties / active ingredients, the distinct combination of active moieties / active ingredients will be considered as one active moiety / active ingredient for the purpose of identifying potential [QSSDs]."[23] While CMS appears to believe that approach is "generally appropriate," CMS is now considering an exception for fixed combination drugs for which

[21] SSA § 1194(e).
[22] IPAY 2028 Draft Guidance § 30.1 (p. 13).
[23] IPAY 2026 Revised Guidance § 30.1; IPAY 2027 Final Guidance § 30.1.

"one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference."[24] In such a case, CMS is soliciting comments on "grouping such fixed combination drug products with products containing at least one but not all of the active moiety(ies) / active ingredient(s) into the same potential [QSSD]."[25]

CMS's existing fixed combination drug policy appears to rest on the clinical meaningfulness of its constituent active moieties. The idea behind treating fixed combination drugs as distinct QSSDs is that using multiple active moieties together may produce a different or better clinical effect than using either active moiety alone. For example, in its final guidance for IPAYs 2026 and 2027, and its Draft Guidance for IPAY 2028, CMS states that "a corticosteroid inhaler would not be aggregated with a fixed combination inhaler from the same NDA / BLA holder that contains the same corticosteroid combined with a long-acting beta agonist."[26] In this example, the fixed combination drug produces a clinically meaningfully effect (i.e., long-acting) that corticosteroid on its own would not. CMS is now soliciting comment on whether it should consider whether the addition of an active moiety "result[s] in a clinically meaningful difference" when identifying QSSDs for fixed combination drugs, such that CMS could presumably group a fixed combination drug product with other products containing the active moiety that is "therapeutically active" against the disease state. But if CMS is going to apply that principle in the context of fixed combination drugs—and look at whether two products involve a "clinically meaningful difference"—then consistency requires it to apply the same test when comparing drugs with just one active moiety to one another.

For instance, while Opzelura and Jakafi share the active moiety in ruxolitinib, they differ in every conceivable fashion, including their clinically meaningful differences, detailed above. Consistent with its fixed-combination proposal, CMS should account for these clinically meaningful differences when assigning QSSDs to single-ingredient products. To do otherwise would be arbitrary and capricious. Inconsistent reasoning is a textbook example of arbitrary and capricious agency action. It is well established that "[u]nexplained inconsistency" in agency decision-making is a paradigmatic violation of the APA.[27] As the D.C. Circuit has consistently emphasized, "[a] long line of precedent has established that an agency action is arbitrary when the agency offers insufficient reasons for treating similar situations differently."[28] "[U]nexplained inconsistencies in [a] final rule" are arbitrary and capricious.[29]

The inconsistent treatment between fixed combination drugs and single-active moiety drugs would be blatant. CMS cannot reasonably assert that clinical differences matter in one context but ignore them in another, particularly where the statutory purpose—ensuring fair and accurate identification of negotiation-eligible drugs—applies equally to both. If the presence or absence of a clinically meaningful difference justifies grouping decisions for fixed combination drugs, the same logic must apply to products with a single active moiety. Anything less would reflect a results-driven approach, not reasoned decision-making, and would fall short of the APA's baseline requirement of consistency.

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[24] IPAY 2028 Draft Guidance § 30.1 (p. 13) (emphasis added).
[25] IPAY 2028 Draft Guidance § 30.1 (p. 13).
[26] IPAY 2026 Revised Guidance § 30.1; IPAY 2027 Final Guidance § 30.1; IPAY 2028 Draft Guidance § 30.1.
[27] *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 222 (2016).
[28] *Cnty. of Los Angeles v. Shalala*, 192 F.3d 1005, 1022 (D.C. Cir. 1999) (quoting *Transactive Corp. v. United States*, 91 F.3d 232, 237 (D.C. Cir. 1996)) (cleaned up); *see Burlington N. & Santa Fe Ry. Co. v. Surface Transp. Bd.*, 403 F.3d 771, 777 (D.C. Cir. 2005); *see also Grayscale Invs., LLC v. Sec. & Exch. Comm'n*, 82 F.4th 1239, 1245 (D.C. Cir. 2023) ("Failing to distinguish prior orders in similar cases . . . fails to satisfy the APA's reasoned decision-making requirement.") (cleaned up).
[29] *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 59 (D.C. Cir. 2015); *see Engine Mfrs. Ass'n v. EPA*, 20 F.3d 1177, 1182 (D.C. Cir. 1994) (finding "unexplained inconsistency" in rule was "not reasonable"); *General Chem. Corp. v. United States*, 817 F.2d 844, 846 (D.C. Cir. 1987) (holding agency action was arbitrary and capricious because its analysis was "internally inconsistent and inadequately explained"); *ANR Storage Co. v. FERC*, 904 F.3d 1020, 1026-28 (D.C. Cir. 2018) (FERC market-power analysis was internally inconsistent and thus unlawful where FERC applied one set of assumptions and then "turned on a dime" and applied conflicting assumptions).

ii. CMS Should Adopt a Policy That Promotes and Rewards U.S. Innovation

Consistent with broader Administration initiatives to incentivize U.S.-driven R&D and manufacturing, CMS should adopt a policy that promotes and rewards the type of innovation exemplified by Opzelura. The Agency's current approach discourages companies from maintaining ownership and continuing to invest in the full lifecycle of their innovations. This approach risks undermining American scientific leadership and economic growth.

As noted above, Incyte reinvested 45% of its revenue in R&D in 2024[30] to develop the next generation of treatments for oncology and immunology patients. By penalizing companies that retain and continue investing in their innovations, CMS's policy threatens to erode the domestic pharmaceutical ecosystem that drives American scientific leadership and economic growth.

The development of Opzelura is a clear success story in American pharmaceutical innovation. It was invented by a team of U.S. scientists working at Incyte in our Delaware laboratory. Bringing Opzelura to market required Incyte to invest substantial financial resources to develop a stable topical formula that could transport high levels of ruxolitinib to the skin, as well as to complete the many studies required for FDA approval. [redacted] The scale of this investment underscores Opzelura's distinctiveness and the magnitude of clinical and scientific effort required to bring innovative dermatology treatments to patients. Much of that R&D effort occurred in the U.S. This investment and years of R&D efforts delivered a new treatment option for patients in the U.S. with atopic dermatitis and nonsegmental vitiligo. For patients with nonsegmental vitiligo, Opzelura is currently the only FDA-approved medicine for repigmentation.

CMS's approach of treating entirely different medicines with the same active moiety and manufacturer as a single QSSD harms American innovation by disincentivizing continued R&D in existing molecules to find new treatment advances. The United States is a global leader in pharmaceutical innovation, with American companies like Incyte at the forefront of the development of new therapies for various diseases. Incyte scientists continue to investigate new potential dermatological uses for Opzelura, such as hidradenitis suppurativa and prurigo nodularis, contributing to sustained American job growth and research capacity. And, Opzelura was approved in the United States before any other country, meaning American patients were the first to benefit from its development. Today, Opzelura continues to generate American jobs and drive pharmaceutical innovation in the United States. The majority of Opzelura tubes sold in the United States are manufactured in the U.S. and the entire commercial supply in the U.S. is packaged here.

Under CMS's current approach, innovative new treatments like Opzelura could prematurely face price-setting solely because they share the same active moiety and manufacturer as a clinically different drug. CMS's interpretation:

- Discourages continued R&D into existing molecules, even where clinical advances may represent significant breakthroughs for patients.
- Could lead to product divestiture. If Incyte were to divest Opzelura, the possibility of CMS aggregating Opzelura with Jakafi for purposes of QSSD designation would be removed despite no change in the medicine itself, solely because of a change in the NDA-holder/manufacturer.
    - CMS's policy therefore incentivizes companies that divest rather than retain products, potentially pushing U.S. pharmaceutical innovations into ex-U.S. ownership.

[30] Incyte's investment in R&D (as a percentage of revenues) exceeds industry averages. The Congressional Budget Office states that on average, pharmaceutical companies spend about one-quarter of their revenue on R&D. https://www.cbo.gov/publication/57126

- Violates the text of the statute by failing to recognize that distinct FDA-approved products with meaningful clinical differences should constitute separate QSSDs under the IRA.

To support American innovation and promote patient access to meaningful new treatments, CMS should revise its interpretation of "new formulation" as part of its QSSD framework. A policy that recognizes and rewards the full lifecycle of U.S.-driven innovation—like that represented by Opzelura—is essential to maintaining the United States' leadership in pharmaceutical development and ensuring continued investment in high-risk, high-reward therapeutic advances.

II. CMS Should Clarify How It Intends to Calculate a 30-Day Supply for Topical Medications

Incyte appreciates that CMS recognizes the challenges of applying a 30-day equivalent supply framework to Part B drugs, which often do not conform to standard dosing patterns. However, as Incyte has previously raised, there are also significant challenges in applying this framework to topical medications, such as creams, foams, and ointments.

It remains unclear how CMS intends to define a 30-day supply for a product like Opzelura, where the amount used varies based on the size of the affected area and the specific indication. For example, for atopic dermatitis, the Prescribing Information directs patients to "[a]pply a thin layer twice daily to affected areas of up to 20% body surface area."[31] For nonsegmental vitiligo, the instruction is to "[a]pply a thin layer twice daily to affected areas of up to 10% body surface area."[32] Thus, the amount of product actually used by patients on a 30-day-basis can vary significantly, both from patient-to-patient as well as for a given patient depending on their symptoms (e.g., disease severity or flareups). Applying a uniform 30-day supply metric to such products risks producing inaccurate utilization estimates, which could in turn distort pricing benchmarks and complicate CMS's single-MFP approach.

Incyte respectfully requests that CMS issue guidance clarifying how it intends to calculate a 30-day supply for topical medications and ensure that any methodology accounts for variable dosing patterns and real-world clinical use.

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Incyte appreciates the opportunity to comment on this Draft Guidance. We hope that CMS will provide clarity on the issues outlined above and respond to our comments. We would welcome the opportunity to meet with you or answer any questions CMS may have about our comments. Thank you.

Sincerely,

Signed by:
Sheila Denton
52FADDB41B1A4CD...

Sheila Denton
Executive Vice President and General Counsel
Incyte Corporation

[31] Opzelura Prescribing Information, https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/215309s004lbl.pdf.
[32] *Id.*

I am writing to submit a public comment regarding the implementation of the Medicare Drug Price Negotiation Program and its scheduled rollout in 2026.

While the goal of lowering prescription drug costs for Medicare Part D beneficiaries is commendable and necessary, I must raise a serious concern about the unintended financial harm this program may impose on pharmacies — particularly independent pharmacies like mine that serve rural and underserved communities.

Under the current framework, pharmacies will be reimbursed at the CMS-determined Maximum Fair Price (MFP) — for example, $100 — but may be required to purchase the drug at or near wholesale acquisition cost (WAC), such as $500. While the manufacturer is expected to refund the difference, the refund may arrive up to 30 days later. This effectively forces pharmacies to front thousands of dollars in costs, causing severe and unsustainable cash flow strain.

This is not a hypothetical concern. In our business, high-cost medications often arrive with razor-thin reimbursement windows. If pharmacies are required to float these losses for even one billing cycle, the cumulative burden will jeopardize our solvency, even if reimbursement eventually arrives.

Moreover, the basis for the manufacturer refund calculation remains unclear. Is the refund calculated on the difference between WAC and MFP? If not, what price benchmark will be used? Without clarity, pharmacies cannot forecast cash flow or ensure they will be made whole.

This structure could lead to:

- Delays in patient access to negotiated drugs
- Reluctance or refusal by pharmacies to stock MFP-designated drugs
- Closures of independent pharmacies already operating on slim margins

I respectfully urge CMS to:

1. Define the precise pricing benchmark used to calculate manufacturer reimbursement to pharmacies.
2. Require that any manufacturer refund to the pharmacy occurs within a shortened time frame (e.g., no more than 14 business days).
3. Explore direct reimbursement mechanisms to ensure pharmacies are not forced to finance Medicare’s cost savings at the expense of their own financial health.

Pharmacies are essential partners in patient access and medication adherence. If we are not protected from unworkable cash flow requirements, the very access this policy is designed to expand may be irreparably harmed.

Thank you for your time and for considering this critical aspect of implementation.

Sincerely,

To Whom It May Concern,

The MFP MTF for Dispensing Entities will impose a heavy burden on pharmacies, specifically independent pharmacies.

[redacted] We manage 52 independent pharmacies in Georgia, Alabama, South Carolina, North Carolina, and Florida. Most of our stores are located in rural communities.

While I do think it is imperative to lower brand drug prices, we must create a solution that does not shift the financial burden to the pharmacies.

We had the opportunity to work with [redacted], a CMS computer program design employee, who has been tasked with developing the platform that will be used for the MTF process.

It is not effective or logical to have the pharmacies (with the smallest amount of cash flow) pay the higher (old) price for the drug, then go to the MTF platform and apply for reimbursement in the form of a "rebate" from the manufacturer to meet the lower (new) price.

Why doesn't the manufacturer lower the price initially?

If there is "leftover" stock with the wholesaler at the higher (old) price, then why doesn't the wholesaler (with more cash flow than the small pharmacy) work out getting a rebate with the manufacturer?

Or, the PBM can pay for the (old) higher price until that inventory runs out.

It just makes no sense to place the financial burden on the entity with the smallest bank account (the pharmacy) when the wholesalers, pharmaceutical manufacturers, and PBMs who ALL are Fortune 50 companies could work this out amongst themselves.

If you do not change this process before it starts, you will see MORE independent pharmacies go out of business because they do not have the cash flow available for this.

Thank you for your consideration,

[redacted]

Please accept this comment to the draft guidance:

Respectfully, there is a far more productive means to reduce drug costs in the US vs price controls. The current/Biden-era approach to drug price negotiations is based upon Price Controls. This approach inserts risk/uncertainty into new drug development. As has been widely noted and seen in practice, price controls reduce manufacturer incentives to invest in R&D / new drugs.

A far better approach would align manufacturer and U.S. interests while rewarding the U.S. for providing THE market that justifies pharma R&D. The opportunity is based upon the simple fact that the US is THE market for new drugs while Europe, Asia and other markets free-load off of the US. The US should adopt an ***"Anchor Team/Tenant"*** approach to drug development and the US market. As is often done in real estate (where our current President is well-versed) Anchor Teams/Tenants share in financial upside brought on by their participation. Applied to new drug development, marketing and sales, the suggested approach entails the Federal Government providing U.S. market access for new drugs in exchange for a 10% or similar revenue share for all fees earned on the new drug outside the U.S. The Feds might provide this as an alternative to price controls or as a standalone. Fees from these fees paid by manufacturers would then be distributed to the payers who purchase the drugs on a pro rata bases starting with CMS.

Respectfully submitted,

[redacted]

June 20, 2025

Chris Klomp
Deputy Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program Draft Guidance; Comment Request (FR Doc. 2025-08607)

Dear Deputy Administrator Klomp:

I appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services' draft guidance for the third cycle of the Medicare Drug Price Negotiation Program. I have two concerns with the draft guidance and the impact it could have on patients' access to physician-administered treatments.

I am a Clinical Pathologist and Medical Microbiologist [redacted]. As such, I am keenly aware of how important it is to ensure patients have reliable access to complex therapies, including those administered in clinical settings and covered by Medicare Part B. I worry that CMS' new guidance could make many clinics, doctor's offices, and small hospitals financially unviable.

First, I urge CMS to use caution in implementing a Standard Default Refund Amount (SDRA) to facilitate manufacturer refunds for price-set Part B drugs. While CMS has figured out a simplified refund approach for Part D, it is far more complicated in Part B due to the greater variety in acquisition costs of Part B drugs.

The standardized refunds that CMS has established for Part D drugs seem appropriate because they are based on wholesale acquisition costs, which generally reflect what pharmacies pay for those drugs. Unfortunately, no such uniform baseline exists for Part B drugs, whose acquisition costs can vary dramatically among medicines and providers. Moreover, ASP is by definition an average, meaning that a significant number of providers purchase drugs at prices higher than ASP. A flat SDRA based on ASP alone, therefore, risks systematically under-refunding providers that work with more expensive therapies.

Before proceeding with a one-size-fits-all default refund, I urge CMS to engage directly with a broad cross-section of providers to gather necessary feedback -- from those who will actually be affected.

My second concern is that the CMS-negotiated *maximum fair prices* on drugs will be factored into the calculation of *average sales prices* (which are market-based, volume-weighted averages of the prices paid by both Medicare and commercial insurers).

Consider a simplified hypothetical. Currently, a clinic purchases a cancer drug up-front for $10,000, administers it to a patient, and then bills Medicare for $10,600 -- the average sales price plus the add-on payment of 6%, or $600.

Under the IRA, if CMS sets that drug's maximum fair price at $5,000 after negotiations, the clinic would only be able to bill Medicare for $5,300 -- the maximum fair price plus the 6% add-on payment, which has now declined to $300.

In other words, after netting out the cost of the drug itself, the clinic's add-on reimbursement would decline from $600 to $300 -- a 50% drop.

This reduction in Medicare add-on payments alone could bankrupt many providers. Of course, I recognize that CMS doesn't have the power to unilaterally avert these reimbursement cuts, since the IRA plainly specifies that clinics may only bill Medicare for the maximum fair price plus 6% -- rather than the ASP plus 6% that they have historically billed.

However, CMS risks further compounding the damage -- if it requires the statutorily lower *maximum fair prices* on Medicare drugs to be factored into the calculation of *average sales prices*.

Consider another simplified hypothetical, again using our formerly $10,000 drug that has a newly negotiated maximum fair price of $5,000. Assume that Medicare accounts for half of the drug's market share, while commercial insurance accounts for the other half. The average sales price -- the volume-weighted average price paid by both Medicare and commercial insurers -- would drop from $10,000 previously to $7,500.

Providers could lose thousands of dollars per drug administered.

That's because in the effectuation of MFPs for Part B drugs, manufacturers will likely give after-the-fact rebates to providers to refund them down to the maximum fair price. However, during the two-quarter lag time between when manufacturers report ASP data to CMS and when the ASP pricing files are updated on CMS' website, ASPs may drop sharply. As a result, providers may purchase the drugs up-front at a much higher price than the reimbursement they eventually receive -- even after factoring manufacturer rebates.

If CMS were to define the Standard Default Refund Amount (SDRA) as equal to ASP minus MFP, the clinic that purchased the drug up-front for $10,000 might only receive Medicare reimbursement of $5,300, plus a manufacturer rebate of just $2,500 (the new average sales price of $7,500 minus the maximum fair price of $5,000).

That would leave the clinic with a loss of $2,200 on each unit of the drug -- a proposition that's wholly unsustainable. Providers will have no choice but to cease offering certain medicines subject to negotiated prices.

Compounding the damage even further, many commercial insurers base their own reimbursements to providers on average sales prices. A recent survey found that over 63% of

payers in the commercial market and Medicare Advantage base their reimbursement on average sales prices. So if ASPs decline due to the inclusion of maximum fair prices, commercial insurers' add-on payments to providers will likewise decline. According to recent research, providers could collectively lose up to $37 billion in add-on payments for Part B drugs selected for negotiation across Medicare, Medicare Advantage, and the commercial market.

Simply put, the current guidance poses an existential financial threat to many providers, particularly those in rural areas. Nationwide, nearly half of rural hospitals already operate on negative margins. One recent study found that 432 of America's rural hospitals are vulnerable to closure. Unsustainably low reimbursements from Medicare and other payers would accelerate the decline of small and rural providers. It would jeopardize countless patients' access to lifesaving care.

To avoid this outcome, I urge CMS to explicitly exclude maximum fair prices from ASP calculations. By doing so, CMS can do its part to prevent drug price negotiations from inadvertently bankrupting providers and decreasing patients' access to lifesaving medicines.

Proponents of the Inflation Reduction Act wanted to give seniors lower drug prices. It's up to CMS to ensure that lower prices don't inadvertently put hospitals, clinics, and doctor's offices out-of-business and deprive patients of lifesaving drugs at any price.

Sincerely,

[redacted]

I would like to make a public statement about this program. I do understand that Medicare spending is ridiculously high and out of control. I also agree something has to be done, but I think this is the wrong way to go. I. The past 2 years Manufacturers have lowered the AWP on many brand names. Why can't they just do this as well? Making this "rebate" program is going to hurt Local pharmacies and it will definitely decrease patient access.

Let's take Eliquis for example. It is a very highly prescribed medication. The AWP is over $700/ cost for a pharmacy is maybe about $600 and CMS is putting in a max price of less than $300? This is putting the stress of floating $300 on small independent pharmacies! I understand the manufacturer is supposed to send an unknown rebate about, but when? How much? There seems to be no guarantee that these small pharmacies will ever get reimbursed for their cost or even enough to operate. How long will the pharmacy have to shoulder this loss? How will they stay open and operate?

This program seems to incentivize pharmacies to NOT participate in Medicare at all! If their choice is to close or not participate, then either way it is a lose lose situation for Medicare Recipients. I practice in a rural state. I could definitely see many patients being forced to larger chains, making them drive an hour just to get medicine!

There does have to be something done with pharmacy spending, but you are taking the wrong track this time. You should focus on the games the Medicare Part D PBMs play, not make up a new game that will definite put pharmacies out of business and Patients lose access to life saving meds!

June 24, 2025

Chris Klomp
Director, Center for Medicare
7500 Security Boulevard
Baltimore, MD 21244-1850

Medicare Drug Price Negotiation Program Draft Guidance -- FR Doc. 2025-08607

Dear Deputy Administrator Klomp,

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) draft guidance on implementation of the Medicare Drug Price Negotiation Program, including manufacturer effectuation of the Maximum Fair Price (MFP) for selected Medicare Part B drugs beginning in 2028.

As a physician whose clinical specialty is family medicine with a subspecialty in geriatric medicine and former federal regulator, I support efforts to reduce out-of-pocket drug costs and ensure sustainable access to care. But the guidance as written leaves open two critical policy decisions that, if mishandled, could destabilize providers and limit access to essential treatments. I urge CMS to use its full administrative authority to address these risks.

1. Protect the Integrity of ASP by Excluding MFP

CMS has not yet clarified whether MFPs will be incorporated into future ASP calculations. If they are, it would distort a widely used market-based benchmark, artificially driving ASP down over time. This would have ripple effects throughout the broader healthcare system.

Many commercial and private Medicare Advantage payers tie reimbursement for provider-administered therapies directly to ASP. According to Avalere, 63% of non-Medicare fee-for-service plans use ASP-based formulas to reimburse physicians. Including MFP in ASP calculations would drag these reimbursement rates down as well, compounding financial pressures for providers across all markets.

Avalere estimates that this erosion could contribute to up to $37 billion in lost provider add-on payments across Medicare and commercial payers from 2028 to 2032. While the decline in Medicare fee-for-service reimbursement is largely driven by the IRA's mandated shift from ASP + 6% to MFP + 6%, the reductions in commercial and Medicare Advantage reimbursement -- up to 18% overall, and 23% for certain specialties -- are directly tied to the inclusion of MFP in ASP.

To avoid these outcomes, CMS should make a clear commitment in its final guidance:

- MFP will not be included in future ASP reporting or calculation.

This step is fully within CMS's authority and is essential to preserving a functional, market-based reimbursement benchmark across both public and private coverage.

2. Avoid a One-Size-Fits-All Standard Default Refund Amount (SDRA)

CMS has also requested feedback on whether to implement a Standard Default Refund Amount (SDRA) to facilitate manufacturer refunds for selected Part B drugs. While administrative simplicity is a reasonable goal, choosing the wrong metric to calculate the SDRA risks under-reimbursing providers whose acquisition costs exceed the assumed baseline.

In general, Part B lacks a reliable, uniform pricing benchmark like the wholesale acquisition cost, which has been chosen by CMS to calculate the SDRA in the effectuation of MFPs for Part D drugs. Part B providers' actual acquisition costs vary widely depending on contracts, volume, and class of trade. If CMS decides on a SDRA pegged to the ASP or another average, it could shortchange a substantial share of providers -- forcing many to essentially take a loss on reimbursement for critical physician-administered therapies.

CMS should proceed thoughtfully and engage directly with providers before finalizing any default methodology. A flexible, data-informed approach is essential to avoid widespread financial disruption in the delivery of care.

Conclusion

CMS has the authority and the responsibility to ensure that implementation of the IRA does not jeopardize access to care. Two steps are especially important: first, ensuring that MFP is not incorporated into ASP calculations; and second, avoiding establishing a SDRA that fails to reflect the realities of provider acquisition costs.

These are essential safeguards to preserve the financial stability of the providers millions of patients depend on. All fall squarely within CMS's existing authority. By taking these steps, CMS can help prevent the most harmful consequences of the IRA, protect providers, and maintain a reimbursement system that supports access across both public and private insurance.

Thank you for considering these comments. Please do not hesitate to contact me with any questions.

Sincerely,

PUBLIC SUBMISSION

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Medicare Program; Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program Draft Guidance; Comment Request (CMS-4210-N)

Comment On: CMS-2025-0054-0001
Guidance: Medicare Program; Inflation Reduction Act Medicare Drug Price Negotiation Program

Document: CMS-2025-0054-DRAFT-0001
Comment on CMS-2025-0054-0001

Submitter Information

Name: [redacted]
Address:
[redacted]
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General Comment

To Whom It May Concern,
I am writing in strong support of the Centers for Medicare & Medicaid Services' (CMS) ongoing implementation of the Medicare Drug Price Negotiation Program under the Inflation Reduction Act (IRA). The proposed draft guidance for 2026 through 2028 is a vital step in addressing one of the most urgent healthcare issues facing our country: the unsustainable cost of prescription drugs. This initiative has the potential to significantly improve access to life-saving medications, reduce the overall burden of advanced diseases, and help the United States align its pharmaceutical pricing with that of other developed nations.
Prescription drug prices in the United States are among the highest in the world. According to recent data from the RAND Corporation, drug prices in the U.S. are nearly three times higher than those in 32 other nations. These excessive costs are not only a financial burden on individuals and families but also a significant driver of national healthcare spending. The proposed Medicare Drug Price Negotiation Program takes a critical step toward correcting this imbalance by allowing CMS to negotiate maximum fair prices (MFPs) for high-

expenditure, single-source drugs. This negotiation is long overdue and represents a pivotal move to rein in prices while maintaining access to innovation and essential treatments.

High drug costs are a major barrier to care for millions of Americans, particularly seniors and individuals with chronic or rare diseases. The consequences of unaffordable medications are both personal and systemic. Patients forced to ration their prescriptions or skip doses altogether often experience worsening health, more frequent hospitalizations, and higher long-term costs to the healthcare system. By securing lower drug prices through negotiation, CMS can dramatically improve medication adherence and ensure that cost is no longer a deciding factor between health and hardship for Medicare beneficiaries. This not only saves lives but also enhances the quality of life for those most in need of care.

When patients cannot afford essential medications, manageable conditions often progress into advanced diseases, resulting in higher mortality, greater suffering, and dramatically higher treatment costs. Preventable complications from conditions like diabetes, hypertension, and heart disease place an enormous financial burden on both patients and the healthcare system. Negotiating fair drug prices is a proactive, cost-effective solution. By increasing affordability, we can prevent the escalation of disease, reduce emergency department visits and hospital admissions, and promote a healthier aging population. The downstream savings will far outweigh the initial investment in the negotiation process.

The United States currently spends significantly more on prescription drugs than other developed countries, where governments often negotiate prices directly with manufacturers. This disparity not only inflates costs for Americans but also places U.S. companies and consumers at a competitive disadvantage. Through the IRA, we now have the opportunity to bring Medicare's purchasing power in line with global best practices, leveraging our market size to achieve more equitable pricing. This helps not just Medicare beneficiaries but sets a precedent that could eventually benefit all Americans.

The draft guidance also outlines the requirements for manufacturer effectuation of the negotiated MFPs. It is essential that these guidelines are implemented rigorously to ensure transparency, accountability, and compliance from drug manufacturers. Without robust enforcement mechanisms, negotiated prices may not translate into real savings for patients. We urge CMS to ensure that all stakeholders are held to the standards outlined and that any efforts to subvert or delay price reductions are addressed promptly.

The Medicare Drug Price Negotiation Program is a transformative policy that reflects the government's commitment to addressing one of the most pressing healthcare affordability crises. It offers a tangible solution to soaring prescription drug prices, improves access and adherence, reduces long-term costs by preventing the progression of diseases, and brings U.S. drug pricing practices in line with the rest of the world. I commend CMS for its leadership on this issue and strongly support the continued and expanded implementation of this program through the 2026–2028 cycle.

Thank you for the opportunity to provide input on this essential policy initiative.

Sincerely,

[redacted]

June 24, 2025

Via Electronic Submission

IRARebateandNegotiation@cms.hhs.gov
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1859

Subject: Medicare Drug Price Negotiation Program Draft Guidance; Infusion Providers Alliance Comments on Draft Guidance for Initial Price Applicability Year 2028

The Infusion Providers Alliance, which represents nearly 1,000 infusion centers across 43 states, is pleased to comment on Draft Guidance for Initial Price Applicability Year (IPAY) 2028, which is the first year Part B drugs will be subject to the Maximum Fair Price (MFP) payment methodology from the Inflation Reduction Act. The IPA is committed to protecting the integrity of the provider-patient relationship, and we advocate for policies that ensure timely and adequate patient access to high-quality care in IPA members' convenient, community-based, non-hospital settings. IPA members are key access points for patients seeking infusible drug treatments for complex diseases such as multiple sclerosis, arthritis, Crohn's Disease, ulcerative colitis, and many rare diseases.

We have grave concerns about the potential impact to our providers and their ability to continue to serve patients who need access to Part B drugs subject to Secretarial "negotiation" under the Inflation Reduction Act. Because the key part of our reimbursement for drug administration is tied to the price of the drug through the "add-on" payment to the average sale price (ASP) plus 6 percent payment methodology, policies that substantially reduce that add-on payment will have enormous negative ramifications to our providers and the patients we serve.

The IPA's top legislative priority is enacting *The Protecting Patient Access to Cancer and Complex Therapies Act*, which removes providers from the drug pricing negotiations between the manufacturer and Medicare, and preserves the ASP+6% reimbursement structure, while securing the same savings (to Medicare and beneficiaries) demanded by the IRA via a rebate paid by the manufacturer to CMS. That policy has been endorsed by 58 patient and provider organizations including Infusion Providers Alliance (IPA), International Foundation for Autoimmune & Autoinflammatory Arthritis, American Academy of Allergy, Asthma, & Immunology (AAAAI), Association of Women in Rheumatology (AWIR), Cancer Support Network, Community Oncology Alliance (COA), Digestive Health Physicians Association (DHPA), and Large Urology Group Practice Association (LUGPA), among others.[1]

Similarly, as detailed below, we urge CMS to retain the ASP pricing methodology for Medicare Advantage and commercially insured patients by clarifying through regulation that the MFP will not impact the ASP reimbursement methodology. Failure of CMS to clarify this issue will put commercially insured patients who require these products at the same access risk or, alternatively, higher cost care in the hospital setting, which will afflict Medicare beneficiaries because of the IRA.

Background on the High Quality and Efficient Care IPA Members Provide in their Infusion Clinics and Physician Offices

The IPA membership is comprised of organizations that either operate the infusion portion of a specialist physician's practice or companies that administer biologic medications in freestanding facilities in the community where many Medicare beneficiaries reside. These care sites are an important and convenient access point for care, saving Medicare $0.65 on the dollar for drug administration compared to infusions provided at hospital outpatient departments.

Physicians, nurses and highly trained medical personnel are better able to monitor a patient and ensure adherence if the infusions are done in an in-office setting. Office-based infusion services have been shown to produce improved patient adherence, a key metric for the treatment of chronic and complex diseases that require infusions. A recent study by Stanford University found that patients receiving infusions in an office-based setting had a 79 percent adherence rate, compared to 74 percent at the hospital and 64 percent at

[1] Part B Access Coalition Letter on Protecting Patient Access to Cancer and Complex Therapies Act of 2023

home.[2] In addition, patients enjoy the more relaxed atmosphere of the non-hospital setting, which prevents them from being unnecessarily exposed to severely ill and often contagious patients who require hospital care. A recent, first of its kind study published in the *Journal of Clinical Pathways* found that shifting injected and infused specialty medications from high-cost hospital outpatient settings to more affordable, clinically appropriate alternative settings is associated with favorable clinical outcomes and quality in the non-hospital outpatient settings compared with hospital outpatient settings.[3] Authors conclude widespread adoption of site-of-care management strategies that offer alternatives to the hospital outpatient setting might reduce the burden of rising health care costs, increase affordability, enhance patient convenience, and improve patient choice.

Physician practices and infusion facilities that directly administer drugs to patients in outpatient facilities typically engage in a practice known as "buy and bill." They pre-purchase drugs and bill the payer for reimbursement once the medication is administered to the patient. To maintain the viability of administering drugs in this setting, reimbursement must account for not only the drug acquisition cost, but also overhead costs such as intake and storage, equipment and preparation, nursing staff, facilities, and spoilage insurance.

Providers of Part B drugs have two sources of reimbursement from Medicare and other payers: their professional fee, which covers a small fraction of their costs,[4] and the "add-on" payment, related to the cost of the drug. The professional fee for a complex drug is less than $120 and has been declining over the years in both real and nominal terms (as noted in the chart below). More troubling, physician practices and infusion clinics have seen these reimbursement cuts while hospital outpatient departments are simultaneously experiencing substantial payment *increases*. Indeed, relative payments compared to hospitals have steadily declined from 47.9% of HOPD payments in 2015 to 35.9% in 2025.

These disturbing reimbursement trends favoring hospitals are exacerbated by the dramatic expansion of the 340B drug discount program, which has made Part B drug administration

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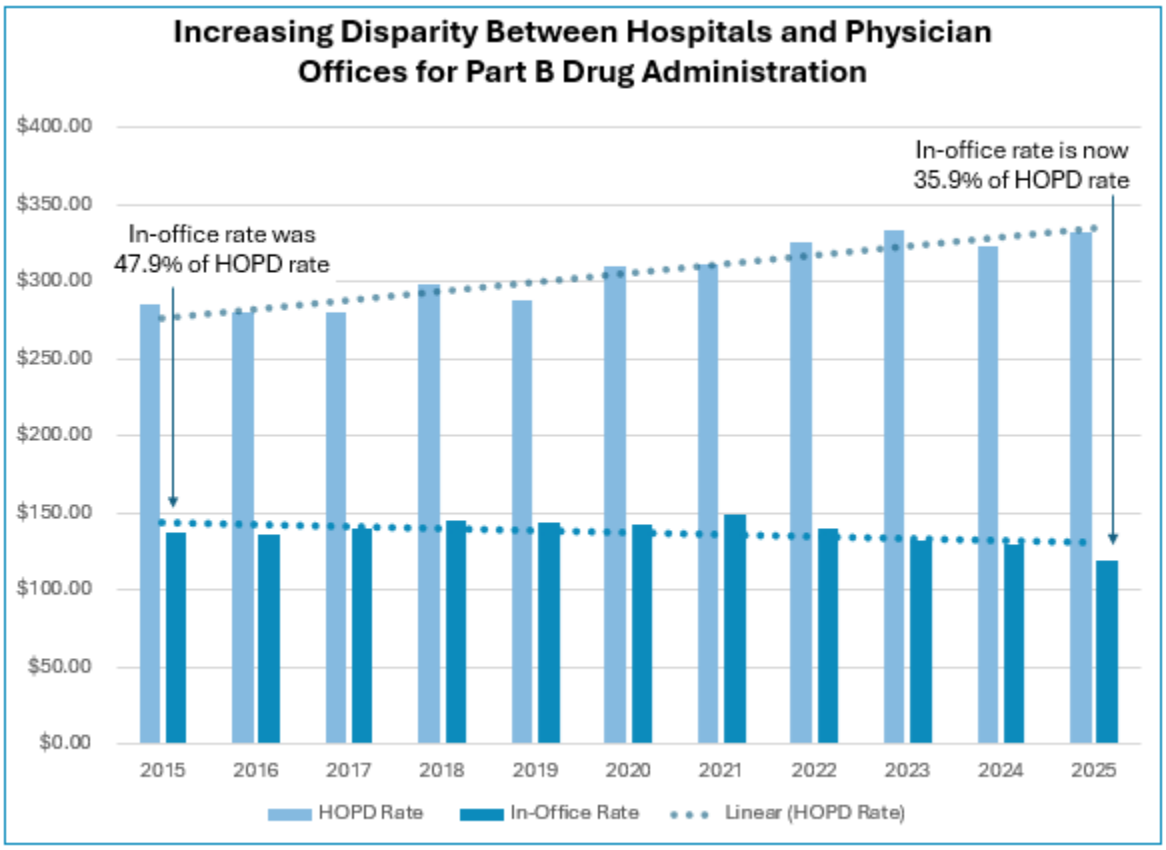
[2]Giese-Kim, May Wu, et al. "Home Infliximab Infusions are Associated with Suboptimal Outcomes Without Cost Savings in Inflammatory Bowel Disease." The American Journal of Gastroenterology. July 22, 2020. https://journals.lww.com/ajg/Abstract/9000/Home_Infliximab_Infusions_Are_Associated_With.99217.aspx

[3] Raj L, Stinson G, Langsam JW, DeMacio J. Comparison of specialty injection and infusion adverse events among hospital outpatient settings vs non-hospital outpatient settings. J Clin Pathways. 2025;11(1):34-38. doi:10.25270/jcp.2025.11.01

[4] "Medical Benefit Drug Economics: The Price of Furnishing Part B Drugs." National Infusion Center Association

extremely profitable for 340B hospitals (where margins are 60 percent or more per drug) but has threatened independent practices and infusion facilities with further provider consolidation, which only drives up costs to Medicare, all payers, and most importantly, patients.



Data based on Code 96413: Chemotherapy administration intravenous infusion, up to one hour
Sources: HOPD Rate = Hospital Outpatient PPS: Addendum B / In-Office Rate = PFS Search

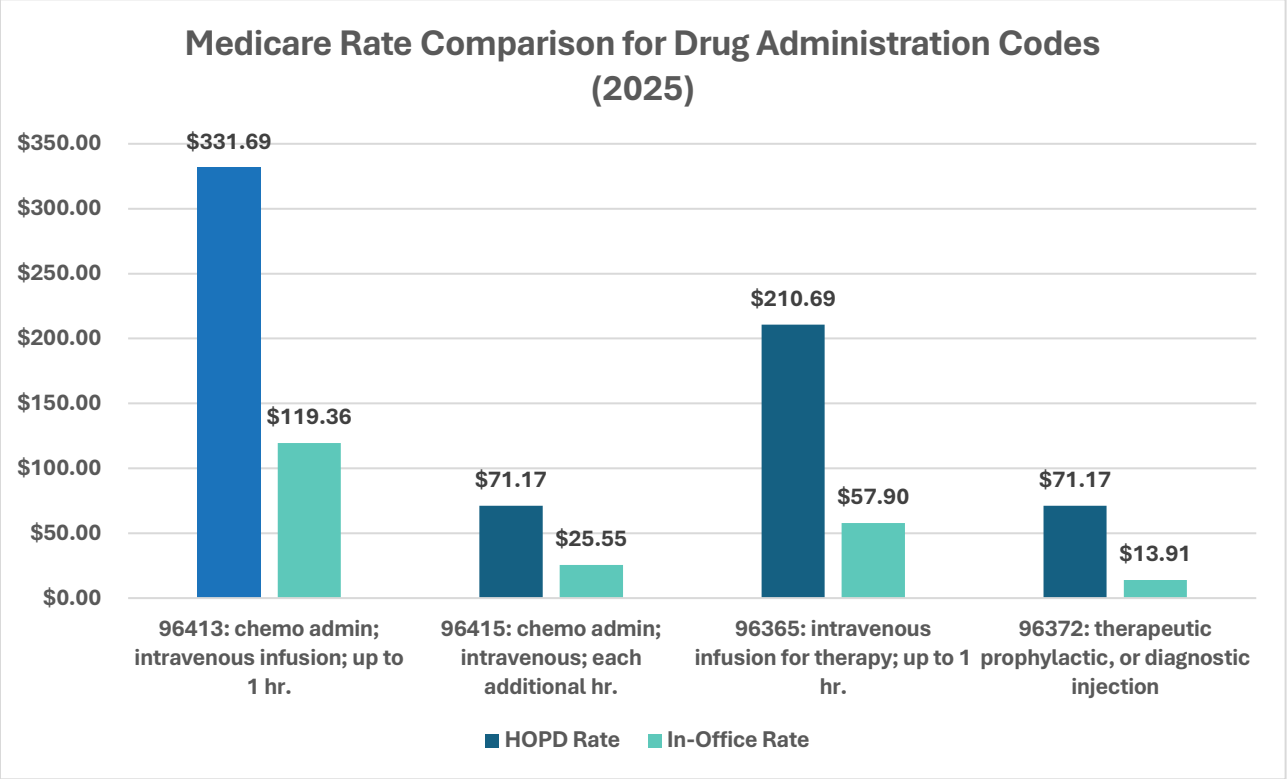


Figure 1: Citations: HOPD Rate = Hospital Outpatient PPS: Addendum B / In-Office Rate = PFS Search

Untoward Implementation of the Inflation Reduction Act Could Threaten Patient Access to Part B Drugs

Under the IRA, reimbursement for Part B drugs subject to Secretary negotiation will be slashed from Average Sales Price plus six percent to the Maximum Fair Price (MFP) plus 6 percent.[5] According to the Congressional Budget Office, reimbursement for Part B drugs (and the associated add-on payment) will be cut by 50 percent or more for those drugs that are subject to negotiation.[6] For example, the add-on payment would be reduced from $430 to $215 for a Part B drug whose reimbursement was cut from $10,000 to $5,000 (after sequestration). Cuts of this magnitude could threaten patient access to these drugs.

[5] MFP-designated products of manufacturers that refuse to agree to the "negotiated" price would be subject to a 1,900% excise tax or other products of the manufacturer could be excluded from coverage by Medicare and Medicaid.

[6] Congressional Budget Office: How CBO Estimated the Budgetary Impact of Key Prescription Drug Provisions in the 2022 Reconciliation Act. https://www.cbo.gov/publication/58850

Once these Part B reimbursement cuts commence in 2028, many more essential drugs to these practices and infusion centers will receive similar cuts, with as many as 20 added annually. The paltry professional fee simply cannot sustain these practices and infusion clinics. Over the long-term this policy could jeopardize the viability of medical practices and infusion centers, especially those in rural or underserved areas. If infusion centers and physician practices can no longer afford to administer these drugs, patients will be forced to obtain their medications in the more expensive hospital setting, assuming those facilities have the capacity to handle the extra patients.

The economic impact of these cuts would be substantially magnified if these statutory payment cuts to Medicare flow through to commercially insured enrollees. Depending on the drug, the payment cuts to our infusion centers and physician practices would be magnified two to three-fold, as commercially insured patients often have a much larger market share than Medicare-covered beneficiaries. That is an economically untenable prospect and will certainly threaten the long-term viability of these providers who are at the front lines of caring for some of the most vulnerable and sick Medicare beneficiaries. Congress would not have silently permitted CMS to decide whether to trigger such a massive, across-the-board and long-lasting deterioration of the marketplace that is crucial to patients' health.

Legal Analysis of Excluding MFP from ASP Payment Methodology

The IRA requires the manufacturer to provide Part B drug providers with the maximum fair price (MFP) but is silent on whether those prices would be used to calculate the ASP. Specifically, for Medicare fee-for-service, the payment rate is MFP+6%, not ASP+6%. However, the law does not speak to whether payments by Medicare Advantage and commercial plans, which are typically based on ASP, would be impacted, by the new MFP requirement. While the IRA does specify that Medicare Advantage beneficiaries are entitled to coinsurance based on the lower MFP+6% rate, it is silent on how providers would be reimbursed.

Historically, many private payors and Medicare Advantage plans have used ASP as the basis of the payment formula for physician-administered drugs.[7] They could continue to follow this long-standing practice after the MFP is available by ignoring that artificially deflated price, assuming CMS keeps publishing ASPs. We strongly urge CMS to continue

[7] Milena Sullivan, et al., *Commercial Spillover Impact of Part B Negotiations on Physicians*, Avalere (Sept. 16, 2024), https://avalere.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians.

publishing market-based ASPs, which would exclude MFPs from this payment methodology.

In addition, the legislative history of IRA enactment shows that the Senate considered and subsequently rejected regulating commercial drug prices due to the Byrd Rule. The IRA was considered under budget reconciliation rules, which require provisions to be primarily budgetary in nature. Provisions that have only an "incidental" impact on the budget are considered non-germane and subject to a point of order. Pricing policies that impact Medicare reimbursement of prescription drugs are clearly germane; however, policies that affect commercial prices (e.g., price caps on commercial drug prices) are not germane, even if they have an incidental fiscal impact. This is the primary reason the IRA lacks any legislative language requiring MFPs to be used to calculate ASPs, which commercial payers utilize. It would be entirely inappropriate for CMS to use this legislative exclusion as the basis for now subjecting commercial prices to the MFP price controls specified in the IRA for Medicare only.

Finally, under the "major questions doctrine", federal agencies are not authorized to make decisions with "vast economic and political significance" absent explicit statutory language that provides clear congressional authorization to do so.[8] The IRA is silent, and as such, does not permit inclusion of MFPs in the calculation of ASP. Certainly, the Part B drug spend meets the significance criteria, and it would be a disallowed, improper use of executive authority to seize this power from the Congress who writes the statutes and deliberately did not authorize the MFPs to be included in the ASP methodology.

Conclusion

A key Trump Administration priority in health care policy has been encouraging Part B drugs to be provided in the physician/clinic setting,[9] which is paid about one-third of the amount as hospitals for administering the identical drugs. These practices and infusion facilities cannot absorb a 50 percent cut to the primary form of reimbursement – the add-on payment – and still provide these drugs to patients. Yet hospitals have many other streams

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[8] *West Virginia v. Env't Prot. Agency*, 597 U.S. 697, 732, 734 (2022); *Util. Air Regul. Group v. EPA*, 573 U.S. 302, 324 (2014).

[9] Indeed, in an April 15, 2025 Executive Order, President Trump called on the Secretary to propose regulations "to ensure payment within the Medicare program is not encouraging a shift in drug administration and volume away from less costly physician offices to more expensive hospital outpatient departments." Exec. Order No. 14,273, Lowering Drug Prices by Once Again Putting Americans First, Section 11, available at https://www.whitehouse.gov/presidential-actions/2025/04/lowering-drug-prices-by-once-again-putting-americans-first/

of revenue to cost shift (including inpatient procedures, diagnostics, surgery, endowments, and many other lines of business). The Trump Administration has the opportunity to protect this vital access channel to patients by simply adopting a straightforward reading of the statute and limiting these payment cuts to Medicare patients and ensuring that other patients can continue to access these low-cost and convenient providers. It should do so without equivocation, recognizing that these providers not only provide excellent care but also provide needed competition to huge hospital systems, which are attempting to consolidate the provider market further.

Thank you for the opportunity to provide our comments.

Sincerely,

Doug Ghertner
President
Infusion Providers Alliance

Elliott Warren
Executive Director
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June 26, 2026

Chris Klomp
Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1859

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the "Maximum Fair Price" in 2026, 2027, and 2028

Dear Deputy Administrator Klomp:

On behalf of Johnson & Johnson (J&J), we submit the following comments in response to the Centers for Medicare & Medicaid Services' (CMS, the Agency) *Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the "Maximum Fair Price" in 2026, 2027, and 2028* (Draft Guidance).

At 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 tomorrow's breakthroughs to our current and future patients, including Medicare, Medicaid, and Marketplace beneficiaries.

Despite our serious concern with the Inflation Reduction Act (IRA) and the Medicare Drug Price Negotiation program (the Program), J&J seeks to continue our engagements with CMS to address our concern about the implementation of this program and the far-reaching impacts of the IRA on biopharmaceutical innovation and access to life-saving treatment. We respectfully offer the following comments and strongly encourage their implementation as CMS finalizes IPAY 2028 Guidance. We look forward to continuing our active partnership with CMS to achieve our mutual goals of improving quality and outcomes for the patients we serve.

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J&J is a member of Pharmaceutical Researchers and Manufacturers of America (PhRMA) and Biotechnology Innovation Organization (BIO) and echoes their comments in response to this Draft Guidance. Our recommendations are as follows:

Recommendations on CMS Drug Selection Policies

I. Recognize Clinical Value of Fixed Combo Drugs and Urge CMS not to Finalize any Changes to the Definition of a Fixed Combination Drug
II. Conform the Qualified Single Source Drug (QSSD) Definition to Well-Established Statutory Definitions
III. Remove the Extra-Statutory "Bona Fide" Marketing Standard
IV. Strictly Adopt the Statutory Language Related to the Plasma-Derived Product Exclusion from QSSD
V. Rescind CMS Successor Regulation on Interchangeable Biologic Products
VI. Promote Predictability and More Fully Assess the Likelihood of a Biosimilar's Licensing and Marketing in Implementation of "Biosimilar Pause"
VII. Revise Orphan Drug Exclusion (ODE) Policies to Protect Pharmaceutical Innovation for Rare Diseases
VIII. Rescind Policies that Hold Primary Manufacturers Accountable for Secondary Manufacturers

Recommendations on Drug "Negotiation" Process

I. Remove Proposal to Collect Forward Looking "Market Data"
II. Adopt Recommended Changes to Factors and Appendix A
III. Improve the Timeline Required of Manufacturers to Submit Manufacturer Data
IV. Improve the Registration Process for Patient Listening Sessions and Provide Greater Transparency on How the Agency Uses Stakeholder Input to Inform the "Negotiation" Process and Determination of "MFP"
V. Enhance Transparency for "MFP" Ceiling Price Calculations, and Calculate "MFP" Ceiling Price at the Lowest Unit of Measure (LUM)
VI. Further Clarify the Information and Process Needed on Renegotiation Criteria and Timelines

Requirements to Operationalize "MFP" Effectuation in IPAY 2026 and 2027

I. Ensure Long Term MTF Support for Operational Feasibility, as No Private Solution Exists
II. Provide Manufacturers with Immediate Clarification on MTF Technical Requirements and Functionality, and a Clear and Accelerated Testing Schedule

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III. Provide Clarity on Credit / Debit Ledger and Dispute Process, and Ensure Claims Data Transparency for Reversals
IV. Implement Solutions to Provide Accessibility and Usability of 340B Claims Data to Manufacturers Seeking to Comply with Statutory Obligations to Effectuate the "MFP"
V. Establish a CMS Pre-funded "MFP" Discount Pool to Address Pharmacy Cashflow Concerns
VI. Ensure Manufacturers Acting in Good Faith Receive Protection from Civil Monetary Penalties for Circumstances Outside of their Control, Including Delayed Release of Technical Requirements or MTF Operational Failures
VII. Finalize Proposal Related to Claims with Drug Data Processing System (DDPS) Edits
VIII. Continue Formulary Inclusion Exceptions for All Future IPAY Periods

J&J Recommendations for "MFP" Effectuation under Part B

I. Consider Key Differences for "MFP" Effectuation for Part B from the Process Established for Part D
II. Provide Visibility to Manufacturer Required Claims Data for Part B "MFP" Effectuation
III. Adopt a Standard Default Refund Amount (SDRA) Under Part B Based on Average Sales Price
IV. Exclude "MFP" from the Calculation of ASP to Minimize Access Risks for Patients under "MFP" Effectuation and for Accurate Calculation on Inflation Rebates

Recommendations on CMS Drug Selection Policies

I. Recognize Clinical Value of Fixed Combo Drugs and Urge CMS not to Finalize any Changes to the Definition of a Fixed Combination Drug

CMS should reject any deviation from the existing approach to fixed combination drugs due to the evident absence of legal authority and the lack of scientific expertise noted above. CMS does not have the legal authority under the IRA to treat "fixed combination drugs" with multiple, distinct, active ingredients as the same QSSD as single active ingredient products. There is no statutory basis for this approach that impermissibly expands the QSSD definition beyond the clear statutory language of the IRA and Congressional intent. The IRA does not impose or permit the addition of a requirement that all active ingredients or moieties of a fixed combination drugs be "biologically active" against the treated disease or make a "clinically meaningful difference." In fact, these terms are not referenced at all in the IRA.

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Further, the Agency does not possess the requisite scientific expertise to make subjective determinations as to whether any active ingredient is "biologically active" against the disease states the drug is indicated for and whether it results in a "clinically meaningful difference." CMS' guidance is also inconsistent with the Food and Drug Administration's (FDA) definition of a fixed combination drug, and CMS has provided no legal or scientific basis for treating certain fixed combination drugs differently from others particularly when CMS does not have the requisite scientific expertise. FDA has affirmatively determined fixed combination products to be a separate drug from any single active included in the fixed combination based on the different molecular structural features of the fixed combination. Active ingredients, whether biologically active against the disease state or not, serve clinical purposes and provide benefits that have been acknowledged by the FDA.

CMS' request for input on a new approach to fixed combination drugs reflects a fundamental misunderstanding of the value of fixed combination medications. The example that CMS uses—addition of a second active ingredient that "affects the bioavailability" of the first active ingredient—assumes that such a combination would not result in a "clinically meaningful difference." This assumption is wrong. Fixed combination drugs, in which one active ingredient improves the bioavailability of the second active ingredient, are created by drug developers and approved by the FDA specifically because they provide clinically meaningful improvements for patients. Active ingredients that affect bioavailability can determine whether the product works at all or whether it works considerably better. These new products generate specific benefits, which include improving patient outcomes, reducing adverse events, increasing the tolerability of the drug, improving patient adherence, reducing dose administration time by hours for each administration, and by providing an alternative route of administration for patients with poor venous access. These advances, which would only be possible via such fixed combination drugs, generate an improved patient experience, which is evident in the overwhelming patient preference for fixed combination drugs. In addition, these products produce significant economic benefits due to reduced administration costs, fewer hospital visits, and enhanced overall efficiency within healthcare settings.

Such a policy change would directly disincentivize development of these important products that deliver clear benefits for patients and reduce healthcare costs by creating undue uncertainty. CMS' potential new approach would make it economically infeasible to develop these important therapies, which require costly research and clinical trials. We urge CMS not to finalize any changes to the definition of a fixed combination drug.

II. Conform the Qualified Single Source Drug (QSSD) Definition to Well-Established Statutory Definitions

CMS' QSSD definition is inconsistent with the plain language of the IRA, and CMS erroneously relies on language that applies only to the determination of eligibility for the small biotech exemption to aggregate products approved under separate New Drug

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Applications (NDAs) or Biologics License Applications (BLAs) into a single QSSD. In addition, CMS' decision to aggregate products in this way creates a significant disincentive to continued product development, which will have a negative impact on important innovation for patients. CMS should conform the QSSD definition to the statutory requirements such that to be included in a QSSD, each individual drug product or biological product must be approved or licensed under the same NDA or BLA, either as part of the original application or under a supplement to such application, and at least seven years or 11 years after the date of FDA approval or licensure (as applicable) before the selected drug publication date.

III. Remove the Extra-Statutory "Bona Fide" Marketing Standard

We object to CMS' "bona fide" marketing standard. § 1192(e) states that the presence of an "approved and marketed" generic drug under Federal Food, Drug and Cosmetic Act § 505(j) or biosimilar under PHS § 351(k) results in the exclusion of the reference product from the definition of a QSSD. This is a critically important protection provided to manufacturers that face generic competition and, therefore, already are subject to substantial pricing pressure. In articulating this protection, the plain language of the statute refers to a generic drug or biosimilar that is "marketed."

However, CMS creates a new standard to determine whether a reference drug or biological is excluded from the definition of a QSSD and, therefore, protected from price setting. That new standard – not found in the statute – requires "bona fide marketing" of the generic drug or biosimilar.

This change in substantive legal standard is troubling for several reasons. First CMS has effectively added the phrase "bona fide" to the statute. Second, the standard is undefined and based on the Agency's subjective determination of this standard. Regulated parties are provided no notice as to what CMS believes is "bona fide" marketing and what is not. The criteria to be applied are not disclosed, creating substantial uncertainty for manufacturers and others seeking to understand which products are eligible for selection. Further, this approach deviates significantly from CMS' established and objective approach in determining if a product has been marketed under the Part D Program or the Medicaid Drug Rebate Program (MDRP).

An extra-statutory "bona fide" marketing standard, applied to generic drugs and biosimilars, undermines the statutory purpose as clearly articulated by Congress in the text to protect otherwise qualifying single source drugs from the compulsory discounting mechanism. There is significant risk that the protection intended by Congress will be

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rendered null if CMS applies this subjective and unauthorized standard. We therefore urge CMS to remove the "bona fide" marketing requirement and apply the statute as written.

IV. Strictly Adopt the Statutory Language Related to the Plasma-Derived Product Exclusion from QSSD

We strongly recommend CMS adhere to the statutory language describing the plasma-derived product exclusion outlined in section 1192(e)(3)(C) of the Act and ensure that CMS references multiple sources to make this determination. In section 30.1.3, CMS notes that the Agency considers "plasma-derived product is a licensed biological product that is derived from human whole blood or plasma, as indicated on the approved product labeling."[1] Aligned with the Agency's current and prior guidance, CMS should continue to reference multiple sources, such as the drug's approved label and other FDA resources like the Approved Blood Products List. We also encourage CMS to reference the totality of relevant therapies and refer to the FDA's Cellular and Gene Therapy Products website to clarify that other plasma-derived products are appropriately captured in this exclusion.

V. Rescind CMS Successor Regulation on Interchangeable Biologic Products

In section 110.1 of the Draft Guidance, CMS discusses the successor regulation provision related to the immediate substitution of new interchangeable biologic products for selected drugs as finalized in the Final CY 2026 Part D Redesign Program Instructions. J&J continues to oppose CMS' decision on the successor regulation issue and to allow such substitution. We believe that allowing immediate or maintenance substitution of biosimilars undercuts the IRA's explicit requirement that Part D sponsors include the *selected drugs* on their formularies. Furthermore, we believe that allowing biosimilar substitution exceeds CMS' authority because the plain language of the statute applies only to generic drugs.

VI. Promote Predictability and More Fully Assess the Likelihood of a Biosimilar's Licensing and Marketing in Implementation of "Biosimilar Pause"

The statute allows specific biosimilar manufacturers to request a "pause" before selecting the reference product for "Maximum Fair Price" ("MFP") price-setting. This pause is intended to give time for the biosimilar product to obtain approval and commence marketing, provided CMS determines there is a "high likelihood" that the biosimilar will be "licensed and marketed." However, we are concerned that CMS' interpretation of the "high likelihood" standard unnecessarily restricts access to this pause. J&J specifically encourages CMS to consider additional evidence, including related to patent disputes, and

[1] Section 30.1.3 of the Draft Guidance, Page 18

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forward-looking statements on operational readiness investments, when assessing the "high likelihood" of a biosimilar's licensing and marketing. Lastly, we continue to have concerns with the bona fide marketing standard's applicability here as was articulated above.

VII. Revise Orphan Drug Exclusion (ODE) Policies to Protect Pharmaceutical Innovation for Rare Diseases

Current guidelines disqualify a drug from the ODE immediately upon receiving a second orphan designation or a new indication outside of its initial designation, regardless of whether it involves a different rare disease or another type of disease. In the Draft Guidance, CMS outlines that it will apply the seven or 11 year selection eligibility timeline retroactively from the date of initial approval or licensure. J&J disagrees with this approach, and we urge CMS to instead use the date a drug's ODE status ceases as the basis for determining the seven or 11 years of drug selection eligibility.

CMS should start the eligibility clock from the point of ODE status loss, rather than reverting to the original approval date. This approach will create a more consistent framework for determining eligibility for price setting and support continued innovation for these rare diseases under the program, ensuring fair access to treatments for patients.

VIII. Rescind Policies that Hold Primary Manufacturers Accountable for Secondary Manufacturers

The IRA provides a statutory definition for "manufacturer" which states "… any entity which is engaged in production…OR the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products." Despite this clear statutory definition, CMS has used guidance to establish a conflicting interpretation of what entities qualify as a "manufacturer," and define new terminology for "Primary Manufacturer" and "Secondary Manufacturer." CMS has assigned responsibility and liability to Primary Manufacturers for the information and actions of corporate entities that the Agency deems "Secondary Manufacturers." The concept and terms "Primary Manufacturer" and "Secondary manufacturer" are not referenced in the IRA, and CMS' use of these terms improperly ignores and overrides the statutorily adopted manufacturer definition in a manner that exceeds CMS authority.

Primary Manufacturers do not have the legal or operational authority to compel a Secondary manufacturer's compliance with required information sharing or pricing actions. Primary Manufacturers do not have access to the required data elements for Secondary manufacturers required for submission to CMS, and do not have the authority needed to ensure their compliance with providing access to the "MFP". Organizations

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deemed by CMS as Primary Manufacturers and Secondary manufacturers are in many instances distinct and unaffiliated entities. Primary and Secondary manufacturers can be direct competitors in a market and have no incentive to exchange or provide commercial practices. There is nothing in the guidance that obligates Secondary manufacturers to cooperate or comply with Primary Manufacturers. In fact, use of the Primary / Secondary manufacturer construct heightens exposure to federal and state antitrust laws due to the required sharing of proprietary information. This concern was noted by CMS in its February 2016 Medicaid Program Final Rule in which the Agency agreed not to finalize its proposal on sharing of pricing data between competing manufacturers and recognized the challenges of obtaining pricing information from non- related manufacturers.

Further, even if a Primary Manufacturer were willing to try to compel a Secondary Manufacturer to share required information for submission to CMS or providing access to the "MFP" on eligible claims, it would be overly burdensome, as it would require restructuring of contracts and business terms, as well as the establishment of a process to obtain the information. We strongly oppose any policy that would apply Civil Monetary Penalties (CMPs) to Primary Manufacturers for the actions or inactions of Secondary manufacturers in making the "MFP" available.

CMS should rescind policies that hold Primary Manufacturers accountable for Secondary Manufacturers. We recommend that CMS use the unique product labeler ID assigned to each entity by the FDA to better identify Primary Manufacturer instead of reviewing only the holder of an NDA or BLA. To ensure compliance with the IRA's statutory requirements to provide access to the "MFP" on eligible claims, CMS should establish a process in which each manufacturer is responsible for effectuating the "MFP" on their own National Drug Code (NDC). CMS can enable this by requiring Secondary manufacturers to enter into separate agreements with CMS and the MTF for "MFP" effectuation.

Recommendations on Drug "Negotiation" Process

I. Remove Proposal to Collect Forward Looking "Market Data"

In Section 50.1 of the Draft Guidance, CMS outlines its approach to manufacturer-specific data and solicits comment on the inclusion of "forward-looking" market data, which could include, but not be limited to, a range of information from forecasted net revenue and volume by indication, net pricing, and annual gross-to-net ratio trends across market channels. J&J opposes the collection of this information and requests CMS to remove this data element from the final guidance and future ICR.

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This type of information is not fact, inconsistent, and beyond the scope of the definition of data. The use of projections is highly problematic as they are, at best, estimates, based on assumptions and external factors that are subject to change and should not be used as the basis for CMS decision-making. We further oppose inclusion of "forward-looking" market data as we believe this request is beyond what is required by section 1194(e)(1)(E) and is inconsistent with the definition of data as forecast information is an estimation, not objective, empirical fact. The submission of these projections would challenge a manufacturer's ability to certify that the data submitted to CMS is complete and accurate. Lastly, we remain highly concerned that the potential utilization of this type of information and the potential for such information to become available would jeopardize manufacturers' ability to comply with regulations in place by the Securities and Exchange Commission. Projections and analyses of how a drug may perform in the market and different channels are kept strictly confidential to ensure that this type of data does not inappropriately influence investors or external entities, ensuring consistency with manufacturer's obligations under Securities and Exchange Commission requirements.

We again strongly encourage CMS to remove the inclusion of "forward-looking" market data from its final guidance and ICR as collection of this information is inconsistent and highly dynamic, reaches beyond what is required in statute, and defies the definition of data.

II. Adopt Recommended Changes to Factors and Appendix A

As discussed in the Sections 50.1, 50.2, and 60.3.1 of the Draft Guidance and within Appendix A of the Draft Guidance, CMS outlines definitions that will be used in collected data for the "negotiation" program. In this Draft Guidance, CMS seeks comments from the public about the inclusion of considering healthcare services as potential therapeutic alternatives, ways to streamline definitions of the factors considered during "negotiation" and seeks input regarding the Primary Manufacturer's research and development (R&D) costs. Aligned to comments J&J has submitted in the past, we continue to recommend a number of changes to the following definitions outlined in Appendix A:

- *Research and Development (R&D) Costs*

  J&J continues to recommend that CMS simplify the process for reporting R&D costs. In the Draft Guidance, CMS reduces the amount of information manufacturers are required to submit to simplify the reporting of R&D costs. While we appreciate this change and support its inclusion in the final guidance, we continue to believe that the cost reporting structure can be significantly further simplified. As noted in our previous comments, J&J recommends that CMS simplify the R&D reporting requirements to

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allow the Primary Manufacturer to offer an attestation in instances where the manufacturer believes to have fully recouped the R&D costs. While collection of R&D data for the purposes of determining Primary Manufacturer cost recoupment is required by statute, we continue to have concern that the approach currently outlined by CMS is unnecessarily burdensome. The calculation of R&D spending may not be compatible with existing financial accounting practices and neglects the multi-faceted and interlinked elements that comprise the research ecosystem, which may result in an incomplete and inaccurate calculation of R&D investment and ignore indirect costs. CMS' approach on R&D costs does not accurately reflect the true costs of innovation or the associated risk. We urge CMS to simplify R&D cost reporting as one reported number that meets the requirements of the statute.

- *Consideration of Health Care Services as Therapeutic Alternatives*

  In Section 60.3.1, CMS solicits comments on the potential to consider health care services as potential therapeutic alternatives to the selected drug. J&J is concerned by this proposal as it lacks detail and does not provide a consistent measure by which to consider therapeutical alternatives to the selected drug and therefore does not support this proposal. Fundamentally, the comparison of costs of a drug to health care services is challenging as they are priced and reimbursed using very different methodologies. For instance, CMS' own approach in calculating reimbursement for healthcare services administered in the inpatient setting relies on the Medicare Severity Diagnosis Related Groups (MS-DRGs) reimbursement methodology. The calculation of this reimbursement depends on a number of inputs and is the average of costs submitted by a hospital for several procedures and services assigned to the MS-DRG. Clearly, this methodology differs substantially from the pricing and reimbursement methodology used for drugs. As currently proposed, CMS has provided very little detail on how a health care service would be selected or identified, how the comparison of costs would be calculated, and the way in which this information would inform the "MFP". For the reasons outlined above, we do not support CMS' proposal to consider healthcare services as a potential therapeutic alternative to the selected drug.

- *Prior Federal Financial Support*

  J&J recommends CMS remove data related to prior federal financial support from manufacturer submission requirements. We continue to have concerns, as described in our comments from previous years, that CMS uses an overly broad definition for novel therapeutic discovery and development of a selected drug to set the "MFP" and the potential unintended consequence that it will be a factor to reduce the "MFP".

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Further we oppose CMS' inclusion of tax credits for orphan disease drugs as a form of Federal financial support. These tax credits were established as an incentive for drug development for the treatment of individuals, and Medicare beneficiaries, with rare diseases. The inclusion of these tax credits as a form of prior Federal financial support to adjust, or reduce, the "MFP", would be entirely antithetical and works against the necessary supports to the development of orphan disease drugs.

Operationally, the reporting of this data is challenging as many of these data elements are not known to manufacturers, or the level of granularity requested is not captured. Therefore, we recommend CMS remove these data from manufacturer submission requirements or limit this information solely to funding that resulted in a patent application containing a Government Interest Statement and/or research where a patent assignee was a US government agency.

- *Patents, Exclusivities, and Approvals*

  As part of the "negotiation" process, CMS requires the Primary and/or Secondary Manufacturer to submit data on patents and regulatory exclusivities. J&J has submitted extensive comments in previous years on the importance of patents and exclusivities in the incentive to develop novel and innovative therapies and the need for CMS to revise its guidance on the way in which it collects this information. As noted previously, a patent is a constitutionally protected property right granted by the US Patent and Trademark Office that protects new and innovative invention and are an essential incentive that allow innovative pharmaceutical companies to take on the considerable risk, and make the substantial investments, required to develop new medicines that benefit patients. Upon expiration of this exclusivity period, generic companies are permitted to reference innovator clinical data which facilitates generic entry. Together, patent and regulatory exclusivities provide the predictable incentive framework necessary for the development of innovative medicines, which in turn yield significant benefits for patients.

  We again encourage the Agency to revise its guidance so that: (A) expired and non-public patents and (B) expired regulatory exclusivities are not required for submission. Instead, this information should be disclosed at the discretion of the Primary and/or Secondary Manufacturer.

  Section 50.1 and Appendix A of the Draft Guidance requires a Primary Manufacturer to submit to CMS "relevant patents," both *expired* and unexpired, that are related to the

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selected drug.[2] We urge the Agency not to require the submission of expired patents. This requirement creates an undue burden for Primary and/or Secondary Manufacturer(s) given the expansive definition of QSSD and the overly broad request for patent information. We are also concerned that CMS has not clearly delineated how this information will be used in the "negotiation" process and determination of "MFP".

Additionally, we urge the Agency not to require the submission of non-public patent applications as this forced disclosure of confidential information may hinder industry collaboration. This forced disclosure will disincentivize companies from collaborating, which will hinder the discovery and development of new innovations and ultimately reduce patient choice. As such, we strongly encourage CMS to update its guidance to clarify that the submission of any non-public patent information by a Primary or Secondary Manufacturer should be discretionary.

CMS is also seeking to collect information regarding the selected drug's regulatory exclusivities. We encourage the Agency to clarify that expired regulatory exclusivities are not required for submission. Instead, this information should be disclosed at the discretion of the Primary and/or Secondary Manufacturer. In view of CMS' expansive definition of QSSD, requiring the submission of expired regulatory exclusivities is labor-intensive and burdensome and provides very limited value to CMS in determining the "MFP" as they do not delay or prohibit competition. This onerous requirement is particularly complicated by the fact that expired regulatory exclusivities are not maintained in the course of regular business activities.

Lastly, requiring a Primary and/or Secondary Manufacturer to submit expired regulatory exclusivities disproportionally and negatively impacts small molecule drugs. Unlike biologics, small molecule drugs may be rewarded one or more New Clinical Investigation ("NCI") Exclusivities for developing different innovations relating to new indications to help patients. However, these NCI Exclusivities often run concurrently with a later expiring exclusivity, such as a drug's New Chemical Entity ("NCE") Exclusivity. As a result, many expired NCI exclusivities may never have been material to a product's market share as they expire before, or shortly after, the expiry of the NCE exclusivity. In sum, for all of the above reasons, we strongly encourage CMS to update its guidance to clarify that the submission of any expired regulatory exclusivities by a Primary or Secondary Manufacturer should be discretionary.

- *Market Data and Revenue and Sales Volume Data*

[2] Appendix A, Page 210

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As outlined in our previous comments, J&J is concerned with the requirements for Primary Manufacturers to submit to CMS market data and revenue and sales volume data for the selected drug to inform the "negotiation" process. These definitions are very broad and often required to be confidential, proprietary information. We ask CMS to remove these data from submission requirements.

J&J continues to oppose the inclusion of Manufacturer Net Medicare Part D Price in the market data and revenue and sales volume data, which was introduced in manufacturer requirements for IPAY 2027. We are concerned that manufacturer submission of this price could create flawed comparisons with therapeutic alternatives because manufacturers are unable to validate or understand how this information is being used, especially because rebates for therapeutic alternatives are proprietary. We also ask CMS to share with manufacturers of selected drugs the net Medicare Part D price for therapeutic alternatives.

- *Evidence About Alternative Treatments*

  The submission and consideration of evidence about alternative treatments are considered optional in the “negotiation” process. We remain concerned that as currently conceived, there is an inappropriate overemphasis on the non-clinical, manufacturer specific data that bear little to no influence on beneficiary health. J&J continues to believe that the factors which examine the impact to beneficiaries’ health and outcomes are the most critical in assessing a drug and should be weighed more heavily than the other factors listed in Appendix A.

  Therapeutic Advance – For this optional evidence, CMS describes its intention to “examine improvements in outcomes to determine the extent to which a selected drug represents a therapeutic advance as compared to its therapeutic alternative(s)”. It further notes that for the purposes of “negotiation”, the Agency will “consider the extent to which the drug represents a therapeutic advance at the time of consideration based on all available information” available. This definition still lacks the necessary amount of detail and transparency into how the Agency intends to assess a drug’s therapeutic advance. Aligned to our previous comments, the definition still does not clarify if this assessment encompasses both safety and efficacy of a drug. We also encourage CMS to consider the characteristics of a drug that impact the therapeutic advancement a drug offers such as the patient experience, mode of administration, adherence to medication regimens, and impact on quality of life.

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Outcomes – CMS defines this optional evidence to include clinical outcomes or outcomes related to the functioning, symptoms, quality of life, or other aspects of a patient's life. J&J asks CMS to further clarify if it also includes cost of care outcomes.

Unmet Medical Need – J&J recommends that CMS broaden the definition of unmet need beyond the availability of therapies to also include the drug's therapeutic profile correlated to the needs of the disease type and patients and subpopulations, especially those with historically disparate access or outcomes. CMS should take an approach that harmonizes the definition in Appendix A with FDA's definition for unmet medical need, and orphan and pediatric regulatory exclusivities codified in other federal statutes.[3]

Off-Label Use – CMS defines off-label use as use of drug that is not approved by the FDA but is included in "evidence-based clinical practice guidelines and the off-label use is a medically-accepted use covered under Part D or Part B".[4] However, we ask CMS to clarify how manufacturers can provide evidence related to off label use that may not be included in evidence-based guidelines.

III. Improve the Timeline Required of Manufacturers to Submit Manufacturer Data

In Section 40.2, CMS states its intent to require manufacturers to submit required information for the IPAY 2028 by March 1, 2026, noting that manufacturers will not be able to finalize Q4 2025 data until end of January 2026. As outlined in statute, CMS was not required to establish such a short timeline, and we are concerned by the Agency's approach since failure to meet this difficult timeline is under the penalty of excise tax liability. The Agency's proposed approach therefore exceeds authority under the IRA and poses significant and unnecessary administrative and regulatory burden.

IV. Improve the Registration Process for Patient Listening Sessions and Provide Greater Transparency on How the Agency Uses Stakeholder Input to Inform the "Negotiation" Process and Determination of "MFP"

J&J continues to encourage CMS to conduct public engagement events to seek input from patients, caregivers, advocacy organizations and other interested parties in order to gain real perspectives and experiences related to the selected drugs, conditions or diseases treated by the selected drugs, and therapeutic alternatives to the selected drugs. For the patient-focused events and Town Hall, it is critical that CMS continue to make the process to provide patient or caregiver feedback simple and we recommend that CMS minimize any questions requesting personal health information (PHI), which could deter patients and

[3] https://www.fda.gov/media/86377/download
[4] Appendix A, page 215

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caregivers from providing feedback. Additionally, we recommend that CMS provide greater transparency for how they will use the patient/caregiver focused input. We encourage CMS to provide to manufacturers a summary of findings of the patient/caregiver input and the patient/caregiver listening sessions, including how this information was used in the Agency's assessment of the selected drug prior to the initial offer.

V. Enhance Transparency for "MFP" Ceiling Price Calculations, and Calculate "MFP" Ceiling Price at the Lowest Unit of Measure (LUM)

Manufacturers require more transparency around CMS' calculation of the "MFP" ceiling price. We remain concerned that the current calculation is overly complex and lacks the transparency manufacturers need to verify the "MFP" ceiling price. Transparency is essential to enabling manufacturers to validate the accuracy of the "MFP" ceiling calculation and make informed counter-offers during the "negotiation" process.

In Section 60.1 of the Draft Guidance, CMS states that for the purposes of determining a single price included in an initial offer, CMS intends to base the single price on the cost of the selected drug per 30-day equivalent supply. CMS is soliciting comment on whether it should take an alternative approach to negotiating the single price for the selected drug—for example, on a per-unit basis rather than a 30-day equivalent supply basis, or on the basis of days' supply less than 30 days—for drugs for which a 30-days' supply is not representative of the typical use of such drug (for example, drugs that have only one formulation and are indicated for administration once in a course of treatment, or drugs that are typically administered daily for a short period such as two weeks).

Instead of 30-day equivalent supply, J&J strongly advocates for the "MFP" ceiling price to be established based on the lowest unit of measure that is the same (common) across all prices, volumes, dosage forms and strengths for the selected drug. We encourage CMS to adopt this common lowest unit of measure-based approach for drugs selected under both Part B and D. It's important to note that drugs covered under Part B are typically not dispensed in 30-day packages; instead, they are administered—such as through infusion or injection—within a physician's office at varying frequencies that do not align neatly with a 30-day period.

Determining a single "MFP" ceiling price based on a lowest unit of measure offers a more straightforward and transparent method, aligning better with existing claims billing practices throughout the pharmaceutical supply chain and Medicaid. This approach reduces burden and facilitates easy conversion to package size or billing unit type (e.g., MG for Part B or ML for Part D). Once a common billing unit conversion is established (e.g. ML), the prices can be appropriately weighted to derive at a combined single "MFP" ceiling price

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for both Part B and Part D (e.g. Both Prices converted to a price per/ML). Upon "negotiation" and for “MFP” application purposes, CMS can reconvert the single “MFP” back to the lowest unit of measure according to each program's billing type (e.g., Price per MG for Part B vs. Price per ML for Part D).

The illustrative example below demonstrates how CMS could implement a lowest unit of measure-based approach for calculating the “MFP” ceiling and the application of “MFP” across dosage forms and strengths for a drug with Part D and Part B utilization.

Example: Part B & D “MFP” Ceiling Calculation at the Lowest Unit of Measure

Step 1: Convert Part B Billing Price Type to a Common Billing Type (e.g. per ML)

In this example, the Part D Billing Price is **$1000 per ML**. For this product, each ML represents 90 MG dosage strength of Part B Billing Units at the lowest unit of measure (1ML=90MG), and each Part B unit price is $8 per MG. To convert the Part B Billing Price to an equivalent price per ML, the price of $8 per MG is multiplied by the number of MG units within 1ML or calculated as $8 X 90 MG, which is equal to **$720 p/ML**.

Original Billing Price before conversion:
Part B = $8 per MG
Part D = $1000 per ML

After the conversion to a common Billing Price per ML:
Part B= $720 per ML (equivalent to $8 per MG X 90 MG that is in each ML)
Part D= $1000 per ML

Step 2: Convert Part B Billing Units to a Common Billing Type (e.g. per ML)

In this example, the total Part D Billing Units equals 200 ML units, and the total Part B Billing Units equaled 31.5K MG units. Since each Part D Billing Unit of 1ML is equal to 90 MG Billing Units, to convert the Part B Billing Units to a common ML Billing Type, divide the total Part B Billing Units of 31.5K MG by 90 MG.

Original Billing Units Before Conversion:
Part B = 31,500 MG Billing Units
Part D = 200 ML Billing Units

After the Conversion to a Common Billing Unit (e.g. ML):
Part B= 350 ML Units (equivalent to 31,500 MG / 90 MG)
Part D=200 ML Units

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Total 550ML Combined Part B and Part D Equivalent Billing Units

Step 3: Calculate % Weight of Total Billing Units @ Common LUM by Program

Part B = 64% (350/550ML) Part B common units per ML divided by the total
Part D = 36% (200/550ML) Part D common units per ML divided by the total

Step 4: Calculate a Single "MFP" @ the Common LUM Billing Unit Type (e.g. ML)

The sum product of Step 1 and Step 3: Part B Billing Price converted at $720 p/ML X the 64% weight + Part D Billing Price $1000 p/ML X 36% weight = $820 Single "MFP" ceiling per/ML LUM.

								Step 1		Step 2	Step 3	Step 4
Medicare Program	NDC 9	Product Description	Billing Type	Billing Unit Type	Billing Units LUM	Pricing Type	**NDC 9** Price Type p/LUM*	**NDC 9** Converted Common price p/LUM	**NDC9** Total Billing Units @ LUM	**NDC9** Total Billing Units @ common LUM	**NDC 9** Common LUM % Weight	**Single "MFP" Ceiling / ML**
Part D	12345-0234	1 ML X 90MG Vial	NCPDP	ML	1	EWA**	$1,000/ML	$1,000/ML	200 ML	200 ML	**36%**	**$821/ML**
Part B	12345-0234	1 ML X 90 MG Vial	HCPCS	MG	90	ASP**	$8/MG	$720/ML	31,500 MG	350 ML	**64%**	

*For NDC-9 with multiple NDC-11s, CMS can calculate a weighted average within the NDC-9 to arrive at a single price per LUM

** EWA = Enrollment Weighted Average; ASP = Manufacturer Calculated Average Sales Price

Example: Application of the "MFP" Across Dosage Forms and Strengths based on Lowest Unit of Measure by program (Part B or D)

If the "MFP" Ceiling of $820 per ML is negotiated to $500 per ML, CMS will need to convert the negotiated price back to the respective programs' billing price type, such as price per MG for Part B or price per ML for Part D.

Step 1: Convert Negotiated Single "MFP" Price per ML to Part B Price per MG LUM

In this example, the $500 per ML is divided by 90 MG units to arrive at $5.56 per MG Part B Billing Price (Note: 90MG = 1ML for this product)

							Step 1
Medicare Program	NDC 9	Product Description	Billing Type	Billing Unit Type	Billing Units LUM	**Negotiated Single "MFP"**	**NDC-9** Conversion to program Price Type p/LUM
Part D	12345-0234	1 ML X 90MG Vial	NCPDP	ML	1	**$ 500/ML**	$500/ ML
Part B	12345-0234	1 ML X 90 MG Vial	HCPCS	MG	90		$5.56 / MG

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VI. Further Clarify the Information and Process Needed on Renegotiation Criteria and Timelines

Within Section 130.1 through 130.4 of the Draft Guidance, CMS outlines the methodology it intends to utilize to identify and select "renegotiation-eligible drugs", the data that will be considered, and the process for "renegotiation". As outlined in the Draft Guidance, CMS intends on identifying drugs that have met certain criteria, such as a new FDA-approved indication, experiencing a change in monopoly status, or undergoing a "material change" to one of the 1194(e) factors.[5] The Agency also notes a drug would be selected if renegotiation is likely to result in a 15 percent or greater change in the "MFP" and the change in "MFP" would have a significant impact on the Medicare program.

- *Further define material change in factors of the selected drug*

We encourage CMS to further clarify the process by which material changes to the factors under consideration will be assessed, particularly those that are beyond the changes to indication or monopoly status. We recommend that CMS increase the threshold for expected change in the "MFP" to at least 35 percent, aligning with similar percentage change in the non-FAMP applicable percentages between short-monopoly (75 percent) and long-monopoly (40 percent) drugs. This adjustment would support CMS' objective of achieving consistency in defining a "significant change" in the "MFP" when a drug undergoes renegotiation due to new indications or material changes in section 1194(e) factors.

- *Simplify process for data submission and allow manufacturers to update prior ICR*

CMS also provides information on the process by which "renegotiation-eligible drugs" would be considered and the submission of both voluntary and mandatory data submissions. J&J encourages that CMS further clarify and simplify the process for data submission, timelines, and deadlines for manufacturers to ensure compliance. As currently defined, the process outlined carries the risk of further exacerbating the complexities and burdensome nature of data submission required during an initial "negotiation". Section 130.3.2 of the Draft Guidance on Data Collection from Primary Manufacturers and Other Interested Parties for Renegotiation states "once a renegotiation-eligible drug is selected for renegotiation, CMS will collect new information for all section 1194(e)(1) data elements from all Primary Manufacturers with a drug selected for renegotiation". We are concerned that this would be overly burdensome. Instead, we encourage CMS to allow manufacturers to submit updates to original data elements and

[5] Section 130.1.4. Page 193 of the Draft Guidance.

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attest that the ICR responses have not significantly changed since submission of the original data elements.

- *Clarify deadlines for data submission for selected drugs*

Lastly, we are concerned that the timelines for data submissions remain vague in the Draft Guidance and encourage the Agency to clarify the timelines by which selection will begin and the deadlines to submit data. At present, the guidance simply state that the process would begin approximately 15 months after the end of the "negotiation" period for the drug's IPAY. The guidance lacks information on how long manufacturers will have to review CMS' assessment for renegotiation, submit updated data, or the timelines by which CMS will update the given drugs "MFP". As such, we strongly urge CMS to clarify these timelines in the final guidance.

Requirements to Operationalize "MFP" Effectuation in IPAY 2026 and 2027

I. Ensure Long Term MTF Support for Operational Feasibility, as No Private Solution Exists

J&J supports an MTF as an end-to-end solution for "MFP" Effectuation. A comprehensive MTF enables CMS to holistically manage the program and provide full visibility, critical for program integrity, and supports program scalability as envisioned by the IRA. A centralized MTF as the end-to-end data and payments facilitator supports a standardized "MFP" effectuation process, limiting pharmacy process variability, providing a central hub to manage manufacturer / pharmacy transactions. An end-to-end "MFP" increases CMS' ability to manage and promote accountability for the program and deduplicating 340B claims, in alignment with statutory requirements. While we recognize the need for flexibility and adaptability as the program evolves, we advise against a decentralized approach that may introduce excessive variability in "MFP" effectuation process, create significant and unsustainable costs for manufacturers, and diminish CMS' ability to maintain oversight. We emphasize that we are aware of *no current private market solutions today* that offer the comprehensive end-to-end functionality envisaged for the MTF.

- *Revise MTF Agreements to reflect CMS' liability for the MTF, remove 180-day termination clause, and offer safe harbors to manufacturers acting in good faith*

We are concerned about CMS' recently finalized MTF Agreements which grant the Agency the right to terminate MTF functionality with only 180 days' notice to manufacturers. Manufacturers are developing systems that are reliant upon the MTF and require long-term support for its functionality. Any significant changes or removal of MTF capabilities would

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make implementation of "MFP" effectuation impossible. Alternative solutions do not currently exist, and manufacturers would not be able to implement alternative solutions in that timeframe. Such a change would very likely affect patients' access to selected drugs.

Moreover, we stress that we remain concerned that the MTF Agreements require manufacturers to accept the MTF "as is" while broad liability disclaimers shift risk of implementation of the MTF to manufacturers resulting in manufacturers being responsible for MTF operational failures and security and confidentiality risks outside of manufacturers' control. We urge CMS to work with manufacturers to substantially revise these agreements and offer safe harbors for manufacturers acting in good faith.

We underscore that to enable an operational "MFP" effectuation model, CMS must finalize the MTF build and implementation for IPAY 2026 and beyond. We encourage CMS to refrain from making changes that could compromise program integrity, impede manufacturers' ability to meet statutory obligations, and increase burdens on pharmacies and providers.

II. Provide Manufacturers with Immediate Clarification on MTF Technical Requirements and Functionality, and a Clear and Accelerated Testing Schedule

Manufacturers' ability to build and implement systems to support "MFP" effectuation and integration with the MTF relies upon having a clear understanding of CMS / MTF technical requirements. In past comments, J&J has recommended that CMS expedite the MTF build and enhance collaboration with manufacturers by implementing a co-development process and sharing comprehensive end-to-end technical requirements with impacted manufacturers by March 1, 2025, to enable manufacturers to meet critical design and build timelines. J&J has continued to advocate for greater transparency regarding the technical requirements and specified our limited capacity to implement any new technical requirements communicated to manufacturers after April 15, 2025, by the go-live deadline of January 1, 2026.

While we appreciate the monthly manufacturer calls and user centered design calls with the MTF DM, we are concerned that manufacturers continue to lack visibility to end-to-end technical requirements for both the MTF DM and PM, and have had no opportunity for engagement with the MTF PM. We are further concerned that the testing schedule is unclear and has been delayed without explanation. We continue to ask for the establishment of a recurring bi-weekly meeting cadence to enable effective solution development and implementation. Direct engagement from CMS and both the MTF DM and PM is crucial to clarify the business requirements and ensure the mutual ability to implement and integrate systems by January 1 for IPAY 2026.

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- *Provide clarity and protection from CMPs for scenarios in which manufacturers and Part D plan sponsors require time beyond January 1 to develop and establish a Direct Member Reimbursement (DMR) process*

Additionally, we are concerned that Section 80.1 of the Draft Guidance states that for IPAY 2026 – 2028, access to the "MFP" for an "MFP"-eligible individual that submits a covered DMR request for a selected drug will be facilitated through a reimbursement process established by Primary Manufacturers and Part D plan sponsors. The Draft Guidance does not provide details on this process, including CMS or the MTFs' role in facilitating this process, and the applicability of payment timelines and other requirements outlined in CMS Guidance. J&J is concerned that this process has not yet been established, and development and implementation by January 1, 2026 may not be feasible. Therefore, we ask CMS to provide further clarity and protection from CMPs for scenarios in which manufacturers and Part D plan sponsors require time beyond January 1 to develop and establish such a process.

III. Provide Clarity on Credit / Debit Ledger and Dispute Process, and Ensure Claims Data Transparency for Reversals

J&J requests that CMS provide immediate clarity to manufacturers around the credit / debit ledger. The ledger has significant impact on manufacturer payments and financial flows, and we ask CMS to provide manufacturers with visibility to the credit/debit ledger maintenance protocols, such as reversing and offsetting claims, accounting for negative balances, and credit and debit details.

We note that Section 40.4.3.2 of the Draft Guidance introduces new uncertainty related to the credit/debit ledger by providing contradictory processes for sharing claim reversals with manufacturers. The second paragraph of this section states that "the MTF DM will transmit updated claim-level data elements to the Primary Manufacturer, including the "MTF XRef ICN" (see Table 2) that links an adjustment to the previous MTF ICN." J&J agrees with this approach; however, the fourth paragraph of this section outlines a different process, stating that for claims designated as a full reversal after the "MFP" refund has been transmitted, "the MTF DM will instruct the MTF PM to issue a credit equal to the previously paid "MFP" refund payment. Primary Manufacturers will not need to submit claim-level payment elements back to the MTF DM for full reversals." J&J urges CMS to clarify that the MTF will share with manufacturers any reversal, including full reversals, as an updated claim. It is critical that these claim reversals are always shared with manufacturers once an original claim is shared, regardless of payment status, so that manufacturers can update the accounting and ensure accurate refund funds are available.

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In addition, J&J urges CMS to clarify the dispute management process, including compliant management methodology (initiation, escalation, and resolution), the timeframe manufacturers expect to respond and resolve disputes, and how CMS will account for manufacturers' ability to verify discrepancies such as 340B duplicates. We ask CMS to confirm that pharmacy complaint submissions without evidence will not be accepted, that manufacturers have an unspecified amount of time to resolve, submit evidence, and adjust payments where required, and that manufacturers may conduct dispute audits as deemed necessary (including beyond 120 days) when any underlying issue or 340B duplicate is identified. Additionally, we ask for clarification on how manufacturer disputes with MTF related to data accuracy, completeness and transmission impact the 14 day payment period. Specifically, to enable program integrity and help ensure accurate "MFP" payments, we ask CMS to clarify that it will "pause" the 14-day payment period without risk of CMPs while the MTF reviews and addresses these data disputes.

Moreover, we underscore the importance of ensuring accuracy for the date stamp included on the manufacturer refund advice (MRA). It is essential for CMS to implement a process that ensures this date is stamped accurately and promptly, as delays can lead to unnecessary complaints and disputes related to the prompt payment window and threatens program integrity.

IV. Implement Solutions to Provide Accessibility and Usability of 340B Claims Data to Manufacturers Seeking to Comply with Statutory Obligations to Effectuate the "MFP"

We urge CMS to implement policies to facilitate accessibility and usability of 340B claims data to manufacturers seeking to comply with statutory obligations to effectuate the "MFP" in IPAY 2026 and future years. In the Draft Guidance, CMS states it is "… considering ways to incorporate asynchronous 340B data into MTF processes in the future." We strongly urge CMS to take immediate action to ensure 340B integrity, especially given the 340B Program's intersection with the IRA and "MFP" Effectuation.

Specifically, J&J recommend CMS require mandatory use of 340B modifiers on all pharmacy and provider claims across all channels, paired with a 340B claims data repository to help ensure all 340B claims are accurately captured and identified for accurate "MFP" effectuation. Use of back-end 340B rebates aligns with this approach and also enables achievement of these goals. This comprehensive 340B solution enables the level of transparency essential to address existing challenges, reduce duplicate claims, and ensure compliance under the IRA.

- *Require 340B modifiers on all pharmacy and provider claims*

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In our experience, a very limited number of covered entities (CEs) voluntarily provide the 340B identifier on claims. Mandatory use of 340B claim indicators or modifiers is critical in enabling manufacturers and CMS to accurately identify 340B claims to avoid duplicate discounts, as required by statute. CMS should make clear that CE's obligation to maintain adequate records includes the timely use of modifiers on all pharmacy claims to identify the claim as 340B or non-340B, and that these modifiers must be applied consistently across all channels to help identify and verify 340B prescriptions.

- *Enforce CE compliance with mandatory modifiers*

To enforce CEs' compliance, we recommend that CMS (1) reject Part D claims submitted without required modifiers and (2) conduct periodic audits on their appropriate use. CMS should require CEs to include the appropriate 340B / non-340B modifier on the Part D Prescription Drug Event (PDE) record within 72 hours of the prescription being filled at the pharmacy, and prior to the exchange of the PDE data with the MTF DM for "MFP" effectuation. This timeline is feasible, as CMS has acknowledged that TPAs can identify most 340B claims within the 72-hour period following dispense. Because the success of this solution requires CE compliance and accountability for data accuracy, to enforce CEs' compliance with required modifiers, CMS would reject Part D claims submitted without required modifiers, and CMS would conduct periodic audits on their appropriate use.

- *Pair mandatory modifiers with a 340B claims data repository*

Mandatory modifiers, paired with a 340B claims data repository, will help to ensure all 340B claims are accurately captured and identified. Similar to the claims data repository CMS is exploring implementing under the Inflation Rebate Program, the claims data repository would provide a centralized database that contains critical claims level data on 340B units under Part D and B to ensure accurate identification of 340B claims and verification of claims.[6] In establishing the repository, CMS should make clear that CEs must participate as part of their audit obligations. Paired with the use of 340B modifiers on all pharmacy and provider claims that are applied consistently across all channels to help verify 340B claims, the repository will enhance data transparency, program integrity, and compliance with the statutory prohibition on duplicate discounts. As noted, it also enables CMS' compliance with the statutory requirement to remove 340B units from IRA Inflation Rebate Calculations for Part D.

- *Consider manufacturer rebate models as a complementary solution for 340B validation*

[6] 89 FR 97710

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We also encourage CMS to consider manufacturers' 340B rebate models as a complementary solution to provide real-time data validation to prevent duplicate discounts that are contrary to law. Such models could solve the issue of de-duplication between the IRA "MFP" and the 340B price for "negotiation" eligible drugs in a manner that does not impact the finances of 340B hospitals or impose undue administrative burdens. Such models allow private-sector innovation to solve, at no cost to the government, some of the 340B / "MFP" duplication challenges.

V. Establish a CMS Pre-funded "MFP" Discount Pool to Address Pharmacy Cashflow Concerns

CMS has outlined a requirement for Primary Manufacturers to describe their process for mitigating material cashflow concerns for dispensing entities in manufacturer "MFP" Effectuation Plans. J&J acknowledges the financial challenges faced by pharmacies; however, it is important to emphasize that manufacturers have limited capacity and no statutory obligation to address these cash flow concerns. Financial reporting obligations under the Sarbanes-Oxley Act require manufacturers to ensure that payments provided to customers or third parties are substantiated and directly linked to specific purchases.[7] Compliance with these legal requirements limits a manufacturer's ability to resolve pharmacy cash flow issues.

J&J continues to urge CMS to leverage its statutory authority to establish a CMS pre-funded "MFP" discount pool to effectively mitigate any pharmacy cashflow concerns and reduce financial and operational burden for pharmacies and all stakeholders. The cashflow magnitude, compliance with fiduciary requirements under Sarbanes Oxley and antikickback statute preclude manufacturers from supporting an "MFP" pre-fund pool. CMS is best positioned to pre-fund an "MFP" discount pool to mitigate untenable financial risk to pharmacies and other stakeholders.

VI. Ensure Manufacturers Acting in Good Faith Receive Protection from Civil Monetary Penalties for Circumstances Outside of their Control, Including Delayed Release of Technical Requirements or MTF Operational Failures

J&J appreciates the ongoing engagement with CMS, including the monthly manufacturer calls and the assignment of dedicated personnel to facilitate quicker responses to manufacturer inquiries. However, given that CMS is leveraging an agile process, the lack of visibility to end-to-end technical specifications, including critical components such as transaction codes and detailed information on the credit ledger process has resulted in a

[7] Sarbanes-Oxley Act of 2002; Public Law 107-204

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significant ambiguity on the elements needed to accurately develop systems to comply with the program's requirements. J&J has communicated the clarity needed to CMS and has not received the clarity needed, which has forced us to make our own assumptions in finalizing the development of our system build strategy. J&J is documenting these assumptions and will communicate them to CMS including in the submission of our "MFP" effectuation plan on September 1, 2025.

J&J strongly urges CMS to provide adequate protection – such as a hold harmless or safe harbor provision – from civil monetary penalties (CMPs) for manufacturers acting in good faith and who have been engaged in deep partnership with the Agency to develop a workable system, particularly in circumstances beyond their legal and operational control. Such circumstances include delays in CMS' release of technical MTF specifications that extend beyond the communicated, requisite manufacturer build timelines, as well as issues related to MTF operations, or if CMS elects to terminate the MTF DM and / or PM.

Manufacturer participation in the CMS MTF-PM clearly indicates a manufacturer's good faith efforts to comply with its statutory obligations to provide access to the "MFP" without duplication with 340B discounts. We ask CMS to leverage its broad statutory authority and significant discretion in implementing the IRA to determine that such good faith efforts are deemed "access" under the law and that manufacturers working in good faith to participate in the MTF-PM, therefore, be deemed as having provided access to the "MFP" and granted a safe harbor from CMPs. This safe harbor would protect manufacturers from CMPs in cases where CMS does not communicate critical requirements for the MTF system, or the MTF has technical issues outside of the manufacturer's control, which may delay payment. J&J urges CMS to establish this safe harbor, especially in the program's first years, to recognize manufacturers' good faith efforts to participate in the MTF-PM option to comply with their statutory obligations.

The Draft Guidance states that CMS will send the Primary Manufacturer a Notification of Potential Noncompliance upon discovery and confirmation of a failure to make the "MFP" available. CMS outlines a process in which Primary Manufacturers will have 10 business days to respond to the Notification to provide additional context, evidence refuting the violation, proof of mitigation of noncompliance, and/or other factors for CMS' consideration. J&J is concerned that 10 business days does not provide enough time for manufacturers to investigate, gather required information and provide it to the MTF, particularly in light of the broad scale of the program, and high volume of claims, including for Secondary Manufacturers. We urge CMS to extend the 10 days to 60 days to allow manufacturers sufficient time to adequately respond to such Notifications.

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VII. Finalize Proposal Related to Claims with Drug Data Processing System (DDPS) Edits

In the Draft Guidance, CMS provides a list of DDPS edits that directly relate to the determination and verification of "MFP" eligibility. CMS states the MTF will not transmit "MFP" claims to manufacturers when those claims have open DDPS edits included on this list. J&J underscores that manufacturers must receive clean claims from the MTF DM in order to initiate the 14-day payment period. Therefore, we are aligned to and support the process outlined in Draft Guidance to ensure that claims with open DDPS edits impacting the determination and verification of "MFP" eligibility should not be transmitted to manufacturers until such edits are cleared and resolved.

VIII. Continue Formulary Inclusion Exceptions for All Future IPAY Periods

For IPAY 2026-2028, CMS has maintained its exception for formulary inclusion for Part D selected drugs. In Section 110.1, the Agency specifically notes that this policy has been in place due to concern on a selected drugs formulary placement and potential risk for patient access. We share in this concern and therefore urge CMS to ensure selected drugs maintain their formulary placement in all future years and should extend beyond 2028 as a critical means to ensure consistency in the program and stability in patient access. Further, maintaining a consistent approach for all future years reduces regulatory burden, simplifies the Program's administration on an annual basis, and provides the necessary predictability for patients, providers, and manufacturers.

J&J Recommendations for "MFP" Effectuation under Part B

J&J appreciates the opportunity to provide input on CMS' development of an "MFP" effectuation model for Part B drugs for IPAY 2028. A workable "MFP" effectuation approach under Part B requires CMS to adopt and facilitate a data-driven retrospective discount model facilitated by an MTF. Similar to Part D, J&J supports a centralized MTF approach for data exchange and payment facilitation for "MFP" effectuation under Part B to enable operational feasibility and minimize the risk of unwieldy variability while better enabling CMS to maintain appropriate levels of oversight for the Program. A standardized approach enhances operational efficiency, improves transparency and promotes program integrity by ensuring CMS is able to manage the program end-to-end.

Aligned to our mutual goal of program integrity, we support claims level transparency, and a retrospective refund and claims data transparency to enable claims validation prior to payment. A retrospective model reduces program integrity risk and increases program compliance. Additionally, we urge CMS to ensure that "MFP" effectuation does not impose

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substantial financial risks on Part B providers that could hinder beneficiaries' access to Part B drugs subject to "negotiation".

I. Consider Key Differences for "MFP" Effectuation for Part B from the Process Established for Part D

While we recognize that certain aspects of the Part D "MFP" Effectuation model may be applicable to Part B, there are distinct challenges for "MFP" effectuation under Part B. It is important to note the significant differences between these two programs, which introduce unique operational challenges that must be accounted for as CMS considers "MFP" effectuation policies for IPAY 2028. J&J seeks to partner with CMS and serve as a resource as the Agency considers and develops these policies.

In the Draft Guidance, CMS is seeking feedback on how "MFP" refund payments for drugs payable under Part B may differ from the process established for Part D. Some key differences are summarized below:

- **Diversity of Providers:** There is significantly larger number of providers under Part B compared to the number of dispensing entities in Part D. These Part B providers include hospital outpatient departments, physician offices, infusion clinics, etc., each with their own distinct operational considerations. The staggering provider volume and variety of provider setups will undoubtedly add layers of administrative and operational complexity related to claims, transactions, and disputes, which must be accounted in "MFP" effectuation policies for IPAY 2028 for to enable operational feasibility.
- **Extended Payment Period for Claims:** To align with the existing Medicare Part B claims processing timelines, the manufacturer payment period for eligible "MFP" claims in Part B should be a minimum of 30 days rather than the 14 days currently required by CMS for "MFP" effectuation under Part D. Part B claims involve additional complexities not present in Part D that require additional processing time, such as deriving the NDC-11 from the Healthcare Common Procedure Coding System (HCPCS) Code, and processing necessary billing unit of measure conversions. For instance, while Part B claims are typically submitted in units of measure (such as MG) described by the HCPCS code, they can also be submitted in the NCPDP standard, such as ML, necessitating conversions. Furthermore, Part B claims must be checked for duplication resulting from claims in which a specialty pharmacy sends a patient's medication directly to a healthcare facility for administration (aka "white bag" claims), as they often overlap with the service codes submitted alongside the drug HCPCS Code (J-Code). Given these concerns, we recommend extending the reimbursement timeline to 30 days to align with industry standards.

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- **Claims Processing Variability:** Unlike Part D, where all claims are processed through the Drug Data Processing System (DDPS) that shares data with the MTF DM for "MFP" effectuation, Part B claims are processed by multiple Medicare Administrative Contractors (MACs). This increases the number of sources exchanging data with the MTF, necessitating increased coordination and data validation to ensure manufacturers consistently receive standardized, accurate and complete data.
- **Role of Group Purchasing Organizations (GPOs):** GPOs typically negotiate discounts and purchase drugs under Part B, and this dynamic will impact provider acquisition costs for Part B drugs.
- **Avoiding Duplicate Discounts with Discarded Drug Refund Program:** It is imperative for CMS to account for the discounts that have already been provided under the Discarded Drug Program in Part B. This will ensure that manufacturers are not subjected to duplicate discounts on the portions that have either already been refunded or will be refunded through the program.
- **Enhancing Data Transparency:** CMS must establish policies to address the current lack of data transparency related to Medicare Advantage claims for "MFP" effectuation under Part B.
- **Identifying NDC-11s for Accurate Claims Processing:** For some Part B drugs, a single HCPCS code may correspond to multiple qualifying single-source drugs. To address this and ensure accurate identification of "MFP"-eligible claims and calculation of "MFP" discount amounts, CMS must establish a requirement for Part B providers to identify NDC-11s on Part B drug claims.
- **Comprehensive 340B Solution:** Similar to Part D, there is a need for a comprehensive 340B data transparency solution to help identify 340B claims and avoid duplicate discounts in accordance with the statute.

II. Provide Visibility to Manufacturer Required Claims Data for Part B "MFP" Effectuation

Aligned to a data-driven approach, manufacturers require critical claims data that enable verification of "MFP" eligible claims and refund amounts without duplication with 340B. Manufacturers must be provided with access to standardized, accurate and complete claims level data at time of invoice, scrubbed by the MTF for accuracy and completeness, to enable validation required for compliance with our fiduciary responsibilities arising under Sarbanes Oxley.

J&J supports the claims level data that CMS intends to provide to manufacturers for "MFP" effectuation under Part D outlined in Table 2 in the Draft Guidance. Manufacturers continue to require those fields for Part B "MFP" effectuation. In addition to the critical data

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elements outlined in Table 2, there are additional data required by manufacturers for "MFP" effectuation under Part B. These *additional or new* data elements for Part B are outlined in the table below:

Table: Additional Manufacturer Required Data for Part B Effectuation

Field Name	Field Description / Notes
Plan Name	Name of the health plan that provides insurance coverage for the patient (ex: field 11C on HCFA 1500 form). This is particularly important for Medicare Advantage Plans.
Plan ID Code	Identifier of the health plan that provides insurance coverage for the patient (with explicit crosswalk to Name). This is particularly important for Medicare Advantage Plans.
HCPCS Code (aka: "J-Code" / Q-Code)	The HCPCS code utilized by the billing provider to indicate the drug that was administered (ex: field 24D on HCFA 1500 form)
NDC-11	The 11-digit National Drug Code that indicates the drug that was administered
Service Provider NPI	National Provider Identifier (NPI) for physician that administered the drug to the patient (ex: field 24J on the HCFA 1500 form)
NPI of Billing Provider	National Provider Identifier (NPI) for entity that billed the drug being administered to the patient (ex: field 33A on HCFA 1500 form)
Billed HCPCS Quantity	The number of HCPCS units that were billed by the service provider (ex: field 24G on the HCFA 1500 form). This field helps with validation to identify duplicate claims, and aberrant quantities.
NDC Unit Quantity	The quantity of administered drug (in NDC units). This field is needed to support manufacturer conversions from HCPCS quantities into NDC quantities.
Service Location State	State abbreviation indicating the state in which the drug was administered
Place of Service Code	Place of Service Code as described in Schedule / Exhibit (ex: field 24B on HCFA 1500 form; e.g,: 11 = Office)

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Primary Diagnosis Code	Indicates patient's primary diagnosis code (standard ICD-10 Code format) (ex: field 24E on HCFA 1500 form)
Allowable Cost of Drug	The allowable charges for covered drug based on the negotiated fee the provider agrees to accept from the payer to provide this drug. This data element will assist manufacturers in preventing duplicate discounts between buy-and-bill and specialty dispense.
Encrypted Patient ID Code	A patient-level identifier that remains fixed when multiple claims are billed across different dates of service and across different invoices for the same patient. This field helps to identify duplicate claims and abnormal claim activity.
Claim Number (assigned by billing provider)	The claim number / identifier assigned by the billing provider
Claim Number (assigned by plan)	The claim number / identifier assigned by the plan
HCPCS Modifiers 1, 2, 3, 4	Modifier Codes 1, 2, 3, and 4 designated by billing provider (ex: field 24D on HCFA 1500 form, regardless of presence) (includes JW, JZ, JG, TB, UD, JA, JB)

Additional rationale is provided below to support manufacturer requirements for the additional critical claim level data for Part B outlined in the table above:

- **NPI of Billing Provider Required to Enable Payment Efficiencies Under Part B:** Given the large number of Part B providers, wide variety and frequent changes in provider set ups and provider / facility relationships, it is important that CMS facilitate payment of "MFP" refunds at the facility level and for credit / debit ledger management. To enable this, manufacturers must have access to the NPI of the billing provider.
- **HCPCS Codes, NDC-11s and Modifiers Are Required to Effectuate Part B "MFP" Claims:** As Part B drugs are billed using HCPCS codes, it is critical for Part B "MFP" Effectuation that manufacturers receive the HCPCS code used by the provider to bill for the drug on each "MFP" eligible claim. We note that the HCPCS codes might not accurately reflect specific drugs administered, especially when multiple drugs share a HCPCS code. To determine the accurate "MFP" refund amount, manufacturers must identify the drug's NDC, which is not required on Part B claims. *Therefore, we urge CMS to require the submission of NDC-11 codes for reimbursement under Part B FFS and on*

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MA claims. To enforce NDC-11 reporting, claims submitted without this information should be rejected. Manufacturers must also receive all J-Code modifiers used on "MFP" eligible claims, including modifiers used to identify units under the discarded drug refund program, route of administration, and 340B units.

- **Data Required to Support 340B Deduplication:** Under section 1193(d)(2) of the Act, manufacturers are required to provide access to the "MFP" on eligible claims in a nonduplicated amount to the 340B ceiling price. As noted in the Draft Guidance, as CMS is currently declining to assume responsibility for deduplicating claims, manufacturers must adopt processes to identify and deduplicate 340B claims. In order to do this, it is critical that manufacturers receive the critical data elements outlined in the table above, including 340B modifiers (JG, TB, UD), as well as Prescriber NPI, Service Provider NPI, and NPI of Billing Provider with Date of Service, and Claim Number (assigned by billing provider).

  We are concerned that 340B modifiers may be unreliable if they are not accurately used. Additionally, we note that the 340B modifiers are not required under Medicare Advantage. Therefore, manufacturers require additional data to validate and more accurately identify and deduplicate 340B claims. We strongly urge CMS to require MA plans to mandate 340B covered entities' use of mandatory 340B modifiers on claims to improve transparency and better identify 340B-eligible claims. In addition, we are aligned to PhRMA's comments urging CMS to adopt and require an additional modifier for "non-340B" claims, similar to the JZ modifier implemented under the Discarded Drug Refund Program. A non-340B modifier would improve transparency and support clearer and more accurate identification of 340B claims.

  J&J notes that a comprehensive solution to 340B transparency is required to support transparency and program integrity for both Part D and B. As outlined in our comments above, we support the mandatory use of 340B modifiers on all claims across all channels, paired with a 340B Claims Data Repository to help ensure all 340B claims are accurately captured and identified for accurate "MFP" effectuation. Use of back-end 340B rebates aligns with this approach and also enables achievement of these goals.

III. Adopt a Standard Default Refund Amount (SDRA) Under Part B Based on Average Sales Price

J&J supports the establishment of an SDRA for selected drugs under Part B to provide predictable provider reimbursement and reduce disruptions in patient access to selected drugs that may arise from uncertainty and financial risks faced by providers. J&J

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encourages CMS to adopt Average Sales Price (ASP) as the basis for the calculation of the SDRA for "MFP" eligible claims under Part B. The calculation should account for the provider add-on payment (for example, ASP + 6% - "MFP" + 6%). J&J does not support a WAC based calculation, as acquisition cost is often lower than WAC because of discounted pricing available to providers through GPO contracting. An ASP-based calculation minimizes risk of provider disruption, as providers are familiar with ASP as the basis for reimbursement under Medicare Part B, but also Medicare Advantage and some commercial plans. However, as described in more detail below, it is critical that in implementing this SDRA calculation, CMS ensure "MFP" is excluded from manufacturer calculation of ASP to prevent significant financial loss for providers administering selected drugs and access issues for patients.

IV. Exclude "MFP" from the Calculation of ASP to Minimize Access Risks for Patients under "MFP" Effectuation and for Accurate Calculation on Inflation Rebates

The IRA stipulates provider reimbursement for selected drugs under Part B be based on "MFP", rather than ASP. This statutory change is expected to significantly reduce provider reimbursement for selected drugs, with a significant impact to oncology providers.[8] J&J is concerned about the potential ramifications for provider practices and the consequent loss in patient access to selected drugs that may result from this reduced reimbursement. To avoid further financial strain on providers and help to safeguard patient access to selected drugs, *it is critical that CMS clarify that the "MFP" should be excluded from the calculation of ASP.*

Inclusion of "MFP" in the calculation of ASP would rapidly erode ASP, leading to even greater impact to provider reimbursement, as ASP is the basis of reimbursement for drugs under Medicare Part B, but also Medicare Advantage and some commercial plans. Importantly, the law does not require CMS to include "MFP" in the calculation of ASP, and therefore CMS has the authority under the law to make this clarification to avert significant financial consequences for providers and potential access challenges for Americans.

Furthermore, the law specifically excludes "MFP" from the calculation of Average Manufacturer Price (AMP). Under the Inflation Rebate Program, AMP is used to calculate inflation rebates that manufacturers owe for Part D drugs with price increases greater than the rate of inflation, while ASP is applied for Part B drugs. To achieve program integrity and consistency in how rebates are determined across the Inflation Rebate Programs, CMS

[8] https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians

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should adopt a uniform approach regarding the treatment of "MFP" in these two price points and maintain similar "MFP" exclusion for the determination of inflation rebates.

We further note that including "MFP" in ASP can artificially trigger inflation rebates when there are no pricing changes for a drug. For instance, if a drug ceases to be a selected drug, its ASP may rise once the "MFP" is no longer in effect and phases out of the ASP calculation. As a result, manufacturers would be liable for an inflation penalty despite taking no pricing actions. Therefore, to ensure the accuracy of inflation rebate penalties, it is critical that CMS confirm that "MFP" is excluded from the calculation of ASP.

***

J&J appreciates the opportunity to submit comments in response to the Draft Guidance. Given the short timeline, we strongly recommend CMS work with manufacturers of selected products and other stakeholders to urgently address operational concerns and ensure readiness for IPAY 2026. Aligned with the Agency's stated objectives, we also encourage CMS to carefully consider areas in which the Medicare Drug Price "Negotiation" Program could benefit from improved and streamlined approaches and definitions, in service of ensuring the highest value and health for Medicare beneficiaries. For questions, please contact jroche8@its.jnj.com.

Sincerely,

Jacqueline Roche, DrPH
Head, Payment and Delivery Policy & Global Policy Institute
US Policy, North America
Johnson & Johnson Innovative Medicine

KAISER PERMANENTE®

June 25, 2025

Chris Klomp
Deputy Administrator
Director, Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1859

Submitted electronically to IRARebateandNegotiation@cms.hhs.gov

Re: ***Medicare Drug Price Negotiation Program Draft Guidance***

Dear Deputy Administrator Klomp:

Kaiser Permanente appreciates the opportunity to comment on the *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028* (hereinafter "Draft Guidance").

Kaiser Permanente is the largest private integrated health care delivery system in the U.S., delivering health care to 12.6 million members in eight states and the District of Columbia.[1] Kaiser Foundation Health Plan, Inc. and our health plan subsidiaries are Medicare Advantage Organizations (MAOs) and provide more than 1.9 million Medicare beneficiaries with prescription drug coverage through Medicare Advantage Prescription Drug plans (MAPDs). Kaiser Permanente's mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Within our footprint, we maintain a primarily internalized pharmacy system, including 545 outpatient, hospital, infusion, specialty and mail order pharmacy sites staffed by nearly 16,000 pharmacy personnel. [redacted] Our Permanente Medical Group (PMG) physicians and other authorized practitioners prescribe, and our pharmacies dispense, over 100 million outpatient prescriptions and administer over 80 million inpatient and clinic medication doses.

General Comments

We appreciate CMS' continued efforts to provide timely implementation guidance for the Medicare Drug Price Negotiation Program (hereinafter the "Negotiation Program"). As the first set of negotiated prices will become effective in 2026, we continue to view this program as a

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., one of the nation's largest not-for-profit health plans, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 40 hospitals and over 600 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

critical mechanism toward addressing a dysfunctional prescription drug market and curbing unsustainably high drug prices for Medicare beneficiaries. The Negotiation Program and the negotiated maximum fair prices (MFPs) must continue to improve drug affordability without unintentionally establishing a price floor for selected drugs that would prevent health systems from negotiating deeper discounts for patients.

As an integrated delivery system, Kaiser Permanente is uniquely impacted by various aspects of the Negotiation Program since we are not only an MAPD, but also a prescription drug purchaser that negotiates directly with pharmaceutical manufacturers as well as a dispensing entity. Through this unique lens we offer the following recommendations for how CMS can support the successful implementation of the Negotiation Program:

- CMS should broadly group fixed combination drug products with products containing overlapping active moiety(ies) / active ingredient(s) into the same potential qualifying single source drug (QSSD) for both Part B and Part D drugs unless the different active components present a clinically meaningful difference;

- CMS should evaluate whether spending data from MA plans for Part B drugs materially differs from fee-for-service Part B expenditures when identifying qualifying single source Part B drugs; and

- For the duration of the Negotiation Program, CMS should continue its formulary inclusion policies to not implement explicit tier placement or utilization management requirements and refrain from applying any special formulary treatment toward selected drugs.

Section 30.1 – Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028

Within the Negotiation Program, CMS identifies a potential QSSD using data aggregated across dosage forms and strengths of the drug, including new formulations of the drug. In the case of a fixed combination drug containing two or more active moieties or active ingredients ("active components"), CMS considers this a distinct QSSD from a product containing only one of those active components. CMS acknowledges, however, that there may exist fixed combination drugs for which one of the active components is not biologically active against the disease state(s) the drug is indicated for—and thus does not result in a clinically meaningful difference. With this in mind, CMS is soliciting comments on how to consider grouping fixed combination drug products with products containing at least one but not all the active components into the same potential QSSD for both Part B and Part D drugs.

Kaiser Permanente supports an expansive approach to defining a QSSD and recommends that CMS aggregate all formulations of fixed combination drugs as a QSSD, except to the extent there are combinations of active components that have clinically meaningful differences. Such an approach ensures that drug manufacturers cannot circumvent price negotiation simply by modifying or combining therapies in ways that do not meaningfully change clinical value. There have been multiple reports of drug manufacturers reformulating products to sidestep or delay price

negotiation by adding new active components that may assist in creating new routes of administration (e.g., subcutaneous injection vs. infusion) but provide no clinically meaningful difference from the originator.[2]

Defining a QSSD in this manner also aligns with the intent of the Inflation Reduction Act, as the statutory text is clearly concerned with the potential for product hopping, requiring CMS to identify QSSDs by aggregating varying forms of administration of the same active moiety, including extended-release versions.[3] Including all formulations of fixed combination drugs, except to the extent combinations of active components have clinically meaningful differences, promotes fairness in the drug selection process and will help eliminate incentives for manufacturers to engage in product hopping.

Section 30.2 – Identification of Negotiation-Eligible Drugs for Initial Price Applicability Year 2028

Beginning in 2028, the Negotiation Program will, for the first time, include Part B drugs, specifying that a negotiation-eligible drug is a QSSD that is among the 50 QSSDs with the highest Total Expenditures under Part B. Within the Draft Guidance, CMS indicates it will identify Part B high-spend drugs by examining Part B claims data over a 12-month period for dates of service between November 1, 2024 through October 31, 2025. The Draft Guidance, however, does not indicate whether CMS will consider MA spending on Part B drugs when determining the "Total Expenditures under Part B."

Kaiser Permanente encourages CMS to evaluate whether Part B spending data for MA plans is materially different from spending in the fee-for-service program. Given that a majority of Medicare beneficiaries are enrolled in MA plans, failing to account for potential variations in utilization or pricing patterns could result in a skewed assessment of Part B drug spending and a skewed ranking of negotiation-eligible drugs. If CMS performs an initial analysis that includes MA spending data or intends to fully account for MA utilization in determining Part B spending, we recommend doing so through a collaborative process with MA plans and in a manner that avoids new, burdensome reporting requirements.

Section 110 – Part D Formulary Inclusion of Selected Drugs

CMS has indicated that it will preserve its current formulary inclusion framework and will not impose mandatory tiering or utilization-management rules for selected drugs. We strongly support this decision. It squarely aligns with the Inflation Reduction Act, which intentionally leaves formulary placement of selected drugs to Part D plans, and it safeguards our ability to design evidence-based formularies that optimize safety, clinical appropriateness and value for beneficiaries.

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[2] *See* Michael Erman, *Focus: Drugmakers go under the skin, skirting early US Medicare price negotiations*, Reuters, Jul. 28, 2023, available at https://www.reuters.com/business/healthcare-pharmaceuticals/drugmakers-go-under-skin-skirting-early-us-medicare-price-negotiations-2023-07-28/; Josh Nathan-Kazis, *Big Pharma Counted on This Loophole. It May Be Closing*., Barron's. May 13, 2025, available at https://www.barrons.com/articles/general-mills-stock-earnings-report-26cac46a.

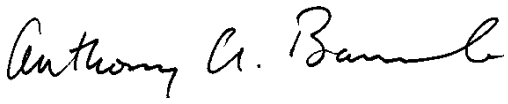
[3] *See* U.S.C. § 1320f-1(d)(3)(B)

We therefore urge CMS to keep this policy intact for future years and to avoid any special treatment—such as protected-class status or mandatory preferred-tier placement—for selected drugs. Kaiser Permanente, for instance, may negotiate deeper discounts on a clinically comparable alternative whose price falls below the maximum fair price of the selected drug. Requiring us to favor the higher-priced product in our formulary would raise costs for members and the Part D program, while weakening the competitive pressure that yields those savings. The Negotiation Program should expand—not restrict—market competition and must not designate winners within a therapeutic class.

* * *

We appreciate CMS' consideration of our comments, and we look forward to working together to ensure the successful continued implementation of the Negotiation Program. Please feel free to contact me at anthony.barrueta@kp.org or Simon Vismantas at simon.p.vismantas@kp.org with any questions or concerns.

Sincerely,



Anthony A. Barrueta
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kalderos

Submitted via email to IRARebateandNegotiation@cms.hhs.gov

June 26, 2025

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
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Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp:

Kalderos appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' ("CMS") Medicare Drug Price Negotiation Program ("Price Negotiation Program" or the "Program") Draft Guidance regarding the Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 (hereinafter, "Draft Guidance"). Kalderos supports the goals outlined by CMS in the Draft Guidance, particularly those goals related to transparency, program integrity, and compliance; however, we have some concerns about a lack of guidance regarding the effectuation of the MFP for Part B claims, use of the MTF PM, and an approach for preventing duplicate discounts, as well as the need for more transparency among stakeholders.

Kalderos is building unifying technologies that bring transparency, trust, and efficiency to drug discount and rebate programs, including the Medicaid Drug Rebate Program ("MDRP"), the 340B Drug Discount Program ("340B Program"), and the Inflation Reduction Act of 2022 ("IRA"), in compliance with applicable laws and regulations. Kalderos seeks to solve problems in drug discount and rebate programs by connecting stakeholders; enabling simple, streamlined communication; and applying machine learning to create smart data science tools. We are genuinely committed to being an honest broker administering a fair, balanced process assisting providers (including 340B covered entities), payors, and manufacturers to ensure the right drug price is applied to the right transaction, in compliance with laws and contract terms.

I. Non-Compliance and Kalderos' Solution.

Despite years of attempts to educate providers and payers about how to prevent noncompliant discounts and rebates from happening, Kalderos continues to identify hundreds of millions of dollars each year in noncompliance. These unintended duplicates are evidence that traditional chargeback-based or similar solutions are unsuccessful at preventing drug discount and rebate noncompliance.

Identifying when the right discount applies to the right sale, without triggering duplicate discount provisions is a challenging task and costs significant time, money, and resources. Over the years, stakeholders have implemented several different approaches to prevent duplicate discounts, including the HRSA's Medicaid Exclusion File and the use of modifiers, all of which have failed to be effective. Importantly, CMS has still not stated how they will ensure duplicate discounts with the MFP do not occur.

Given the scope of the problem, the expected growth of the problem with the IRA and Medicare inflation rebates, and the failure of current attempts, new approaches, including the use of rebates, data sharing, and greater cross-agency collaboration between HRSA and CMS, are necessary to reduce instances of noncompliance across drug discount and rebate programs. Kalderos has developed one such solution—a new platform, Truzo. Truzo is a technology-driven model for effectuating the MFP and the 340B price directly to covered entities and other dispensers as a rebate. Kalderos developed this solution to solve the duplicate discount concerns with the MFP and as a more transparent improvement to the traditional chargeback model, under which wholesalers purchase drugs from manufacturers, sell them to covered entities at a 340B contract price, and then charge the manufacturer for the difference between the purchase and 340B ceiling price. Through the Truzo platform, a covered entity pharmacy purchases the drug at the non-discounted price (e.g., wholesale acquisition cost), dispenses a drug to a patient from the pharmacy's own inventory, and collects both the patient's copayment and the reimbursement from the payer. If the dispense is determined to be MFP or 340B eligible, the dispenser or covered entity submits a request for an MFP or 340B rebate, as applicable, from the manufacturer for the units dispensed to the patient. This request is submitted to the manufacturer via Truzo. The manufacturer then pays the rebate to the dispenser or covered entity on eligible claims well within 14 days.

Truzo offers a number of significant benefits that impact all stakeholders. Using a rebate model, complete claims-level data is exchanged between all parties to effectuate a discount, preventing nearly 100% of noncompliant discounts. Additionally, all stakeholders will be able to access a central ledger of claim and rebate information, ensuring complete transparency to all parties. This transparent approach fosters trust and creates positive working relationships with all stakeholders, instead of adversarial ones, an approach taken by CMS in the MFP program through the acknowledgement that data must be exchanged. Further, with respect to 340B claims, since 340B rebate funds flow directly to covered entities, they experience greater control over program savings. In many cases, covered entities will access rebates faster without the need to wait for accumulation and replenishment of the discounted drug.

Indeed, CMS has recognized in the Draft Guidance that a rebate model is important for the effectuation of the MFP at the point of sale while complying with the duplicate discount prohibitions built into the statute. We believe it is crucial that a technology-based rebate system enter the market now to transition the system to rebates in advance of MFPs going live in 2026. Kalderos continues to welcome an opportunity to conduct a functional demonstration of Truzo to CMS.

Importantly, we are concerned that the Draft Guidance fails to provide a process for ensuring that compliance with the 340B:MFP duplicate discount provision is followed. It is of vital importance that the final guidance regarding the Price Negotiation Program adequately

addresses the manner by which noncompliant MFP transactions can be prevented from occurring, and in cases where noncompliance is unable to be prevented, provide a manner to identify and resolve disputes. Failure to do so would significantly weaken the purpose and intent of the Price Negotiation Program, as without effective safeguards against these issues, CMS will be unable to ensure that eligible individuals receive access to products at the MFP without triggering a duplicate discount, consistent with the statute. Such failure could also open the Price Negotiation Program to challenge based on an arbitrary and capricious implementation of the Program.

II. CMS Must Permit Manufacturers to Obtain Data to Prevent Duplicate Discounts.

We appreciate that the statutory language found in § 1193(d) of the IRA makes clear that the Primary Manufacturer of a selected drug is not required to provide access to the MFP for a selected drug to MFP-eligible individuals who are also eligible to receive the drug at the 340B discounted price if the 340B discounted price is lower than the MFP for such selected drug.

However, we are concerned that the Draft Guidance does not expressly prohibit covered entities or their contract pharmacies from "accumulating" a transaction where a 340B-eligible beneficiary receives a product at MFP, potentially leading to a covered entity or contract pharmacy receiving both a MFP rebate and a 340B chargeback on the same unit dispensed. Instead, the Draft Guidance places the burden on the manufacturer for preventing a MFP and 340B discount applying to the same dispense.

In the Draft Guidance, CMS states that it will not, at this time, "assume responsibility for deduplicating discounts between the 340B ceiling price and MFP."[1] Instead, CMS "intends to provide Primary Manufacturers with a process to identify applicable 340B-eligible claims through the reporting of claim-level payment elements to the MTF,"[2] and is "continuing to explore the feasibility of incorporating 340B-related transactional data from 340B covered entities or their TPAs identifying claims eligible under section 1193(d)(1) of the Act into MTF processes in the future."[3] However, in the Draft Guidance, CMS has only proposed including a "340B Claim Indicator (as *voluntarily reported* by [the] dispensing entity)",[4] and has not proposed to make the submission of 340B claim-level identification mandatory.

By declining to make any reasonable plan to address duplicates or to take ownership over preventing duplicate discounts, CMS has shifted this burden to manufacturers. In doing so, CMS must endorse an approach that permits manufacturers to obtain data to be able to effectively prevent these duplicates.

As stated above, identifying when the right discount applies to the right dispense, without triggering duplicate discount provisions, is a challenging task and costs significant time, money, and resources. Over the years, stakeholders have implemented several different approaches to

[1] CMS, "Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028" at 96.
[2] *Id.*
[3] *Id.*
[4] Draft Guidance at 65.

prevent duplicate discounts, all of which have failed to be effective. For example, our experience with the use of modifiers finds them to be inadequate to consistently identify duplicate claims. For example, in some states, 340B covered entities must submit a code when seeking reimbursement from a state to identify when the entity dispensed a 340B drug. If a code were used on a claim, the state would exclude that claim when seeking rebates from the manufacturer. Despite the apparent benefits of using claims-level code data rather than dispensing entity claim data, modifiers have been largely ineffective in preventing duplicate discounts. For example, even if a 340B covered entity correctly identifies a claim as a 340B claim as opposed to a MFP claim, which does not occur consistently, that modifier may be removed at some point given the many handoffs between a pharmacy, third-party administrator, or pharmacy benefit manager ("PBM"), among others. We understand that thirty-eight (38) states require claims modifiers from covered entities when submitting claims to Medicaid for reimbursement. For these states, Kalderos has identified approximately $150,000,000 in 340B duplicate discounts over the last six years.

Further, a CMS data repository would likely only be effective where the government is the payer. Commercial 340B claims would not be included in such data sharing, which would create disparate systems in the marketplace and add further confusion.

In light of these challenges, we urge CMS to not rely exclusively on modifiers or CMS data and to encourage the sharing of claims-level data to allow clear review of claims among stakeholders.

III. Additional Guidance from CMS is Needed Regarding the Effectuation of the MFP For Part B Claims.

In the Draft Guidance, CMS notes that it "is not at this time including detailed policy on providing access to the MFP for selected drugs payable under Part B" and notes that it "intends to align policies and operations for providing MFP access for Part B drugs with those for Part D."[5] However, this will be complicated, as drug purchasing, delivery, dispensing, reimbursement, and subsequent accounting and billing practices are very different between Part B and Part D.

Given these complexities, the MFP must be effectuated as a rebate model for all Part B drugs. Effectuation of the MFP through a rebate model is particularly necessary for Part B "buy and bill" products, as these products are often purchased before a particular patient is identified and may be dispensed to a patient before knowing whether the MFP applies. A rebate will allow compliance after data is exchanged to demonstrate whether the MFP applies to a particular claim.

Additionally, CMS should require identification of 340B administered units for all practice sites that administer and bill CMS for payment. This is currently required as part of the Hospital Outpatient Prospective Payment System ("OPPS") for hospital billing of Part B drugs (using the "TG" modifier), but it is unclear whether this is required for Federally Qualified Health Centers ("FQHCs") and other grantees who may not bill under the OPPS.

[5] Draft Guidance at 54.

At a minimum, CMS should require the following data elements as they will be paramount in preventing 340B:MFP duplicate discounts:

Data Element	Description
Unique Transaction ID	A distinct identifier for each claim to allow CEs traceability to a specific dispense
NDC-11	The 11-digit National Drug Code identifying the specific drug dispensed or administered
NDC-9	The first two segments of the National Drug Code identifying the specific drug dispensed or administered
Quantity Dispensed / Administered / Wasted	The amount of the drug dispensed, administered to a patient, or wasted
Unit of Measure	The metric used to quantify the drug (i.e. mL, EA)
Patient First Name	The first name of the patient receiving the drug
Patient Last Name	The last name of the patient receiving the drug
Date of Birth	The birth date of the patient receiving the drug
Patient Zip	The zip code of patient's home address
Patient Token (Can be used instead of patient identifiers)	A unique patient token generated out of the system of record to identify the patient receiving the drug without sharing any PHI
Ordering Physician NPI	The National Provider Identifier (NPI) of the physician who prescribed the NDC11.
Submitter 340B ID (If dispensing entity is a registered covered entity)	The 340B identifier for the Covered Entity submitting the claim
Submitter NPI	The NPI of the entity submitting the claims data
Dispense / Administration Location	A location identifier (ex. NPI) where the drug was dispensed or administered
Date of Service	The date the drug was administered or dispensed to the patient
Date Paid	The date when the plan originally paid the provider for the dispensation or administration of the drug
Healthcare Common Procedure Coding System (HCPCS) code	Current Procedural Terminology (CPT) codes are a system of medical codes used to describe and report medical services and procedures
ICD-10	The International Classification of Diseases, 10th Revision (ICD-10) code indicating the diagnosis or condition associated with the drug administration

Insured's Plan Name or Program Name	The name of the health insurance plan or government program (e.g., Medicaid, Medicare, commercial insurer) covering the patient's prescription or medical service
Insured's Policy, Group, or FECA Number	The unique identifier assigned to the insured's health insurance policy, group plan, or Federal Employees' Compensation Act (FECA) claim
Waste Modifier	A modifier appended to billing codes to indicate a portion of a drug that was unused and properly discarded

IV. Additional Guidance Needed Around Use of MTF PM

The Draft Guidance states that "the MTF DM will produce remittances for all MFP refund payments facilitated by the MTF PM or for claims for which the Primary Manufacturer indicates to the MTF DM that the MFP was provided prospectively."[6] However, CMS should clarify how remittances will be provided where the manufacturer is not using the MTF PM to facilitate such payments. Additionally, CMS should provide clarification on Primary Manufacturers' responsibilities when terminating participation in the MTF PM.

V. Kalderos' Truzo Platform is a Private Market Solution that Can Offer an Alternative to the MTF PM.

Kalderos agrees with CMS' proposal that Primary Manufacturers will have the option to delegate to a third-party vendor the function of issuing MFP refund payments via the MTF PM and reporting claim-level payment elements. We also appreciate CMS's recognition that private market solutions offer an alternative to the MTF and could eliminate the need for CMS to operate an MTF in the future.

Kalderos has already developed a solution that can share verified data and route refund payments from manufacturers to dispensing entities, offering an alternative to the MTF PM. As discussed above, Kalderos has developed a technology-driven rebate model, Truzo, that is configurable and can be used for compliance with multiple discount programs, including the effectuation of the MFP. In developing and testing this Platform, we built the proper architecture to protect data while being easily scalable and interoperable with other systems.

Further, Kalderos understands that CMS "hosts frequent MTF systems and technical calls to engage with manufacturers and dispensing entities on implementation details and operational topics such as system integration, secure data exchange protocols, system user experience, and other components to inform the design and functionality of the MTF DM and MTF PM and to share information and hear feedback on technical and operational aspects of the Negotiation Program."[7] These calls should be expanded to include additional entities, including third party vendors such as Kalderos that are capable of contributing private market solutions to technical and operational aspects of the Negotiation Program.

[6] Draft Guidance at 57.
[7] Draft Guidance at 56.

VI. Kalderos Supports CMS' Position that a Manufacturer Can Choose to Refund an Amount Different Than SDRA (WAC – MFP).

Kalderos supports CMS' position that a Primary Manufacturer can choose to refund an amount different than the SDRA if the Primary Manufacturer determines some other amount is appropriate and sufficient to make the MFP available.

In the Draft Guidance, CMS states that "using WAC to calculate an SDRA generally best approximates the acquisition costs of dispensing entities and offers a reliable refund amount for both manufacturers and dispensing entities that agree to use such a standardized pricing metric."[8] However, this will not be the case for many Part B drugs, which may be subject to rebates and discounts off of the drug's WAC.

CMS further notes that "a dispensing entity can work with Primary Manufacturers to establish an MFP refund amount using the dispensing entity's actual acquisition cost or an adjusted standardized pricing metric that ensures the MFP has been made available, and the Primary Manufacturer would indicate such agreed amount when reporting the claim-level payment elements." However, "agreement" on the different amount is only applicable when the manufacturer is using the MTF-PM. If a manufacturer effectuates MFP outside the MTF-PM, then a dispensing entity does not have to agree. Kalderos agrees with this proposal. Manufacturers may have additional capabilities to ensure the refund amount is appropriate. For example, the manufacturer may want to provide an amount greater than SDRA as part of its plan to address dispensing entities who identify as having cash flow issues. Kalderos' Truzo platform has the flexibility to make these appropriate calculations based on data provided by the manufacturers.

VII. CMS Should Require Dispensing Entities to Include a 340B Claim Indicator for all Part D Claims.

Table 2 ("MTF DM Claim-Level Data Elements") currently lists the 340B Claim Indicator as "voluntarily reported by the dispensing entity."[9] However, this data element is only effective if it is mandatory.

If this data element remains voluntary, dispensing entities will be unlikely to include the 340B claim indicator on Part D claims because Part D PBM plans would know the drug is a 340B drug and could reimburse the dispensing entity at a lower rate than it would otherwise reimburse if the drug was not indicated as being a 340B drug.

Further, the Draft Guidance states that "[b]eginning January 1, 2025, the 'Submission Clarification Code' value of '20' and the 'Submission Type Code' value of 'AA' was added to the PDE record to indicate a 340B claim. A dispensing entity may voluntarily apply these indicators to a Part D claim to indicate the claim is being billed for a 340B drug." CMS should report how many claims that pass through the MTF DM include the 340B Claim Indicator.

[8] Draft Guidance at 58.
[9] Draft Guidance at 65.

Finally, the Draft Guidance states that "Primary Manufacturers may not impose additional reporting requirements on dispensing entities to support MFP eligibility verification, regardless of whether the Primary Manufacturer utilizes the MTF PM."[10] Kalderos does not support limiting Primary Manufacturers' ability to impose additional reporting requirements on dispensing entities. While the provision of some patient information would not help the manufacturer verify patient-specific MFP-eligibility, certain patient information, like patient name, date of birth, and/or a patient token, may be necessary to ensure de-duplication of 340B:MFP discounts for Part B drugs.

VIII. CMS Must Permit Manufacturers to Audit the Data Submitted When Requesting an MFP Rebate.

Data inaccuracies related to the Medicare and Medicaid programs remain a significant challenge, with some estimating that such errors cost the Medicare and Medicaid programs up to $100 billion per year.[11] CMS must permit drug manufacturers to audit the data submitted by dispensing entities when requesting a MFP rebate to reduce the risk of the submission of inaccurate data.

We note that it is standard commercial practice to permit drug manufacturers to audit the data provided by parties who request a rebate or chargeback. For example, contracts between manufacturers and wholesalers typically permit the manufacturer to audit supporting evidence related to chargebacks. Similarly, rebate agreements between manufacturers and PBMs typically permit the manufacturer to audit supporting evidence related to commercial rebates. These audits reduce the risk of inaccurate data being submitted by allowing the manufacturer the ability to verify the accuracy and legitimacy of discount or rebate requests.

In addition to the commercially standard practice allowing manufacturers to audit wholesalers and PBMs, similar audit language is typically included in contracts between wholesalers and pharmacies, as well as audit language found in contracts between PBMs and pharmacies. Should a manufacturer choose to contract with wholesalers or PBMs to effectuate MFPs between the manufacturer and beneficiaries/dispensing entities, the manufacturer's standard audit language, combined with the audit language contained in wholesaler and PBM agreements with dispensing entities, will allow the manufacturer the ability to audit data submitted by dispensing entities.

Accordingly, while we support the Draft Guidance language noting that CMS may audit this data, we ask that CMS explicitly permit manufacturers and other stakeholders who are not wholesalers or PBMs, like Kalderos, to enter into agreements with dispensing entities to audit the data submitted by dispensing entities requesting a MFP rebate.

We note that, under a claims-based rebate model (such as Kalderos' Truzo platform), auditing is less critical, as all parties have access to a central ledger of claim and discount

[10] Draft Guidance at 69.

[11] *See* CloudMed, 340B Recovery, available at https://www.cloudmed.com/government-navigation-suite/340b-recovery/ for an example of 340B Recovery Services.

information, ensuring complete transparency to all parties. This approach fosters trust and creates positive working relationships between key stakeholders.

IX. Additional Guidance is Needed to Ensure that Complaints and Disputes Related to the MFP are Handled Appropriately.

Kalderos supports CMS' proposal to establish a centralized intake system for receiving reports related to access to the MFP. Section 90.2.2 of the Draft Guidance states that this system is "intended to address complaints and disputes related to MFP availability and MTF functionality and is not intended to receive general comments or feedback related to the implementation of the Negotiation Program as a whole."[12]

The Draft Guidance notes that "CMS intends to review complaints regarding access to the MFP on a case-by-case basis and monitor overall trends and emerging compliance issues reported via the complaints and disputes system, including issues related to determining acquisition costs."[13] However, the Draft Guidance does not establish a formal process or mechanism to enable the appropriate handling and referral of disputes and complaints that present evidence of potential non-compliance.

While we support CMS' intent to monitor the Price Negotiation Program, we are concerned that the Draft Guidance does not provide manufacturers with an adequate opportunity to participate in program integrity. Specifically, we are concerned that the lack of a formalized process for manufacturers to report duplicate discounts or other MFP dispensing issues to CMS will limit manufacturers' ability to implement effective safeguards against such risks. Effective program integrity requires the participation of all parties with obligations under the IRA. We urge CMS to issue guidance establishing a process for manufacturers and other stakeholders to formally engage in the program integrity process.

Further, in the spirit of program integrity, CMS should report on complaints received, as well as trends and emerging compliance issues identified, in order to promote transparency and ensure that other participating entities do not make the same mistakes.

* * *

Thank you for the opportunity to submit these comments to the Draft Guidance. If you have any questions about these comments, please do not hesitate to contact me at rusty.hensley@kalderos.com.

Sincerely,

DocuSigned by:
Rusty Hensley
648A3E39099443A...

Rusty Hensley
Chief Legal and Administrative Officer
Kalderos

[12] Draft Guidance at 173.
[13] Draft Guidance at 58.

LUGPA
Integrated Practices
Comprehensive Care

June 26, 2025

Via Electronic Submission

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1859
IRARebateandNegotiation@cms.hhs.gov

RE: Medicare Drug Price Negotiation Program Draft Guidance; Large Urology Group Practice Comments on Draft Guidance for Initial Price Applicability 2028

Dear CMS:

The Large Urology Group Practice Association (LUGPA), which has represented more than 150 independent urology group practices for more than 10 years, is pleased to comment on Draft Guidance for Initial Price Applicability Year (IPAY) 2028, the first year Part B drugs will be subject to the Maximum Fair Price (MFP) payment methodology from the Inflation Reduction Act. LUGPA practices provide a massive portion of urology care received in this country and, as such, are concerned about policies that could have adverse implications for our patients and our practices. As this policy change represents such a possibility, depending on particular nuances of applicability and implementation, we believe it is essential to highlight potentially unintended consequences which would undermine and even contravene the IRA's goals of improving access to and reducing the cost of life saving medications.

The LUGPA membership is comprised of independent urology practices in the communities across the country; in light of the incidence of GU pathology, in most of our membership, Medicare patients account for 40-50% of those for whom care is provided. LUGPA members are key access points for patients seeking injected or infused drug treatments for complex diseases such as urogenital cancers (bladder, kidneys, prostate, testicles, urethra), endometriosis, fibroids, and other urogenital conditions. Freestanding sites of care are an important and convenient access point, saving Medicare $0.65 on the dollar for drug administration compared to infusions or certain injections provided at hospital outpatient departments.

We have grave concerns about the potential impact to our members and their ability to continue to serve patients who need access to Part B drugs under the Inflation Reduction Act. Because the key part of our members' reimbursement for drug administration is tied to the average sales price (ASP) of the drug through the "add-on" 6 percent payment methodology, policies that substantially reduce that add-on payment – which is intended to account for all of the providers' costs and efforts of acquisition, storage, and some aspects of administration – will have enormous negative ramifications to our physician group practice members and the patients they serve.

We urge CMS to adopt a payment structure that retains the ASP+6% payment methodology for providers and patients wherever possible, including by excluding negotiated Maximum Fair Prices (MFPs) from manufacturers' ASP calculations. In addition, we urge CMS to retain the

ASP + 6% reimbursement methodology for non-Medicare FFS patients (Medicare Advantage and commercially insured patients) by clarifying through regulation that the MFP will not impact the ASP reimbursement methodology.

Failure of CMS to clarify this issue will put all patients, including commercially insured patients who require these products, at the same access risk or that will afflict Medicare beneficiaries because of the IRA's reduction in physician reimbursement.

Proposed Implementation of MFPs Could Threaten Patient Access to Injected and Infused Drugs

As CMS describes in the Draft Guidance, under the current implementation plan for the IRA, reimbursement for Part B drugs subject to Secretary negotiation will be slashed from ASP + 6% to the Maximum Fair Price (MFP) + 6 %.[1] According to the Congressional Budget Office, reimbursement for Part B drugs (and the associated add-on payment) will be cut by 50 percent or more for those drugs that are subject to negotiation.[2] For example, the add-on payment would be reduced from $430 to $215 for a Part B drug whose reimbursement was cut from $10,000 to $5,000 (after sequestration).

Once these Part B reimbursement cuts commence in 2028, many more essential drugs to these practices and infusion centers will receive similar cuts, with as many as 20 added annually. The significantly reduced professional fee simply cannot sustain the practices and clinics that administer these drugs. Over the long-term, this policy could jeopardize the viability of medical practices delivering critically important urological care from administering any drugs subject to negotiation, especially those in rural or underserved areas. If physician practices can no longer afford to administer these drugs, patients will be forced to obtain their medications in the more expensive hospital setting, assuming those facilities have the capacity to handle the extra patients.

The economic impact of these cuts would be substantially magnified if these statutory payment cuts to Medicare flow through to commercially insured enrollees. Depending on the drug, the payment cuts to physician practices could be magnified two to three-fold, depending on the ratio of commercially insured beneficiaries. That is an economically untenable prospect and will certainly threaten the long-term viability of providers. Congress would not have silently permitted CMS to decide whether to trigger such a massive, across-the-board and long-lasting deterioration of the providers that are crucial to patients' health.

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[1] MFP-designated products of manufacturers that refuse to agree to the "negotiated" price would be subject to a 1,900% excise tax or other products of the manufacturer could be excluded from coverage by Medicare and Medicaid.

[2] Congressional Budget Office: How CBO Estimated the Budgetary Impact of Key Prescription Drug Provisions in the 2022 Reconciliation Act. https://www.cbo.gov/publication/58850.

CMS has Discretion to Retain the ASP + 6% Payment Rate Because the IRA Does Not Require CMS to Lower Providers' Payments to the MFP + 6% Payment Rate

The IRA requires the manufacturer to provide Part B drug providers with the maximum fair price (MFP) but is silent on whether those prices would be used to calculate the ASP. Specifically, for Medicare fee-for-service, the Draft Guidance states that the payment rate for Part B drugs subject to negotiation would be MFP+6%, not ASP+6%. However, the IRA does not speak to whether payments by Medicare Advantage and commercial plans, which are typically based on ASP, would be impacted by the new MFP requirement. While the IRA does specify that Medicare Advantage beneficiaries are entitled to coinsurance based on the lower MFP+6% rate, it is silent on how providers would be reimbursed.

Historically, many private payors and Medicare Advantage plans have used ASP as the basis of the payment formula for physician-administered drugs.[3] They could continue to follow this long-standing practice after the MFP is available by ignoring that artificially deflated price, assuming CMS keeps publishing ASPs. We strongly urge CMS to continue publishing market-based ASPs, which would exclude MFPs from this payment methodology.

In addition, the legislative history of IRA enactment shows that the Senate considered and subsequently rejected regulating commercial drug prices due to the Byrd Rule. The IRA was considered under budget reconciliation rules, which require provisions to be primarily budgetary in nature. Provisions that have only an "incidental" impact on the budget are considered non-germane and subject to a point of order. Pricing policies that impact Medicare reimbursement of prescription drugs are clearly germane; however, policies that affect commercial prices (e.g., price caps on commercial drug prices) are not germane, even if they have an incidental fiscal impact. This is the primary reason the IRA lacks any legislative language requiring MFPs to be used to calculate ASPs, which commercial payers utilize. It would be entirely inappropriate for CMS to use this legislative exclusion as the basis for now subjecting commercial prices to the MFP price controls specified in the IRA for Medicare only.

Finally, under the "major questions doctrine", federal agencies are not authorized to make decisions with "vast economic and political significance" absent explicit statutory language that provides clear congressional authorization to do so.[4] The IRA is silent, and as such, does not permit inclusion of MFPs in the calculation of ASP. Certainly, the potential change in drug reimbursement would meet the economic significance criteria, and it would be a disallowed, improper use of executive authority to seize this power from the Congress, which deliberately did not authorize MFPs to be included in the ASP methodology.

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[3] Milena Sullivan, et al., *Commercial Spillover Impact of Part B Negotiations on Physicians*, Avalere (Sept. 16, 2024), https://avalere.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians.

[4] *West Virginia v. Env't Prot. Agency*, 597 U.S. 697, 732, 734 (2022); *Util. Air Regul. Group v. EPA*, 573 U.S. 302, 324 (2014).

LUGPA Members Provide High Quality and Efficient Care in Outpatient Clinics

Physicians, nurses and highly trained medical personnel are better able to monitor a patient and ensure adherence when medications are injected or infused in an in-office setting. Office-based services have been shown to improve patient adherence, a key metric for the treatment of chronic and complex diseases. A recent study by Stanford University found that patients receiving infusions in an office-based setting had a 79 percent adherence rate, compared to 74 percent at the hospital and 64 percent at home.[5] In addition, patients enjoy the more relaxed atmosphere of the non-hospital setting, which prevents them from being unnecessarily exposed to severely ill and often contagious patients who require hospital care. A recent, first of its kind study published in the *Journal of Clinical Pathways* found that shifting injected and infused specialty medications from high-cost hospital outpatient settings to more affordable, clinically appropriate alternative settings is associated with favorable clinical outcomes and quality in the non-hospital outpatient settings compared with hospital outpatient settings.[6] Authors conclude widespread adoption of site-of-care management strategies that offer alternatives to the hospital outpatient setting might reduce the burden of rising health care costs, increase affordability, enhance patient convenience, and improve patient choice. To maintain the viability of administering drugs in this setting, reimbursement must account for not only the drug acquisition cost, but also overhead costs such as intake and storage, equipment and preparation, nursing staff, facilities, and spoilage insurance.

Providers of Part B drugs have two sources of reimbursement from Medicare and other payers: their professional fee, which covers a small fraction of their costs,[7] and the "add-on" payment, related to the cost of the drug. The professional fee for a complex drug is less than $120 and has been declining over the years in both real and nominal terms (as noted in the chart below). More troubling, physician practices and infusion clinics have seen these reimbursement cuts while hospital outpatient departments (HOPDs) are simultaneously experiencing substantial payment *increases*. Relative payments compared to hospitals have steadily declined from 47.9% of HOPD payments in 2015 to 35.9% in 2025.

These disturbing reimbursement trends favoring hospitals are exacerbated by the dramatic expansion of the 340B drug discount program, which has made Part B drug administration extremely profitable for 340B hospitals, but has threatened with further consolidation, which only drives up costs to Medicare, all payers, and most importantly, patients.

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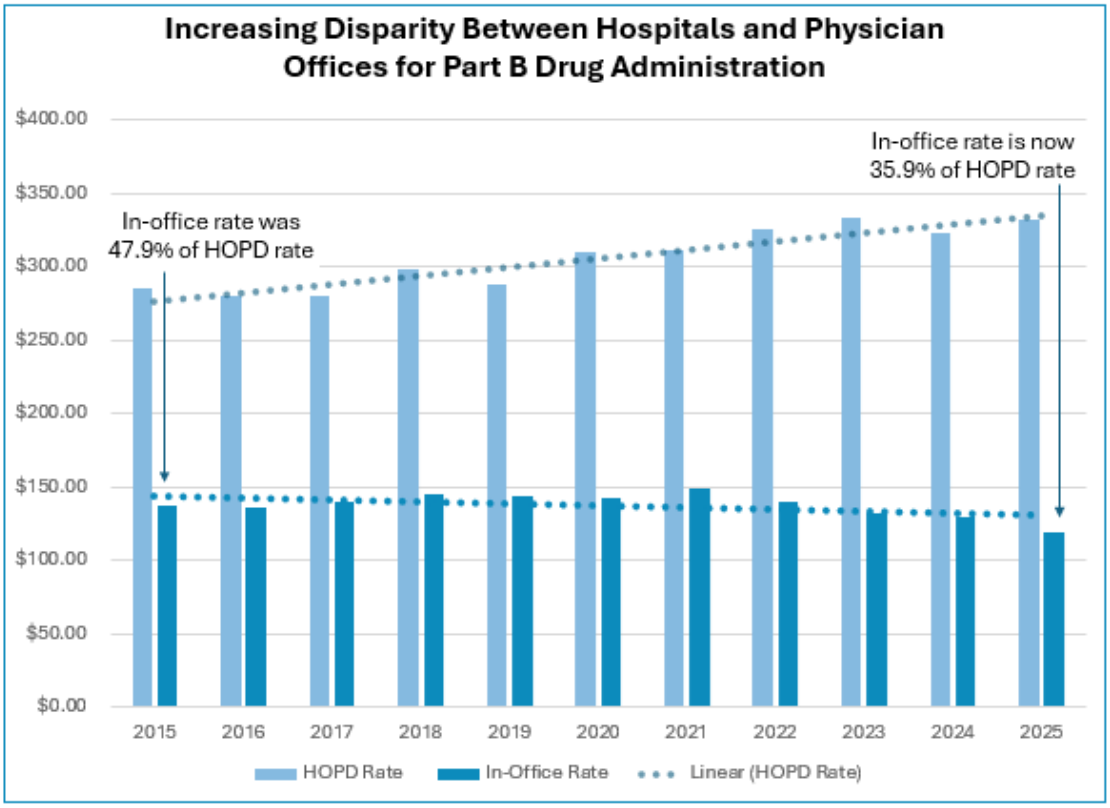
[5]Giese-Kim, May Wu, et al. "Home Infliximab Infusions are Associated with Suboptimal Outcomes Without Cost Savings in Inflammatory Bowel Disease." The American Journal of Gastroenterology. July 22, 2020. https://journals.lww.com/ajg/Abstract/9000/Home_Infliximab_Infusions_Are_Associated_With.99217.aspx

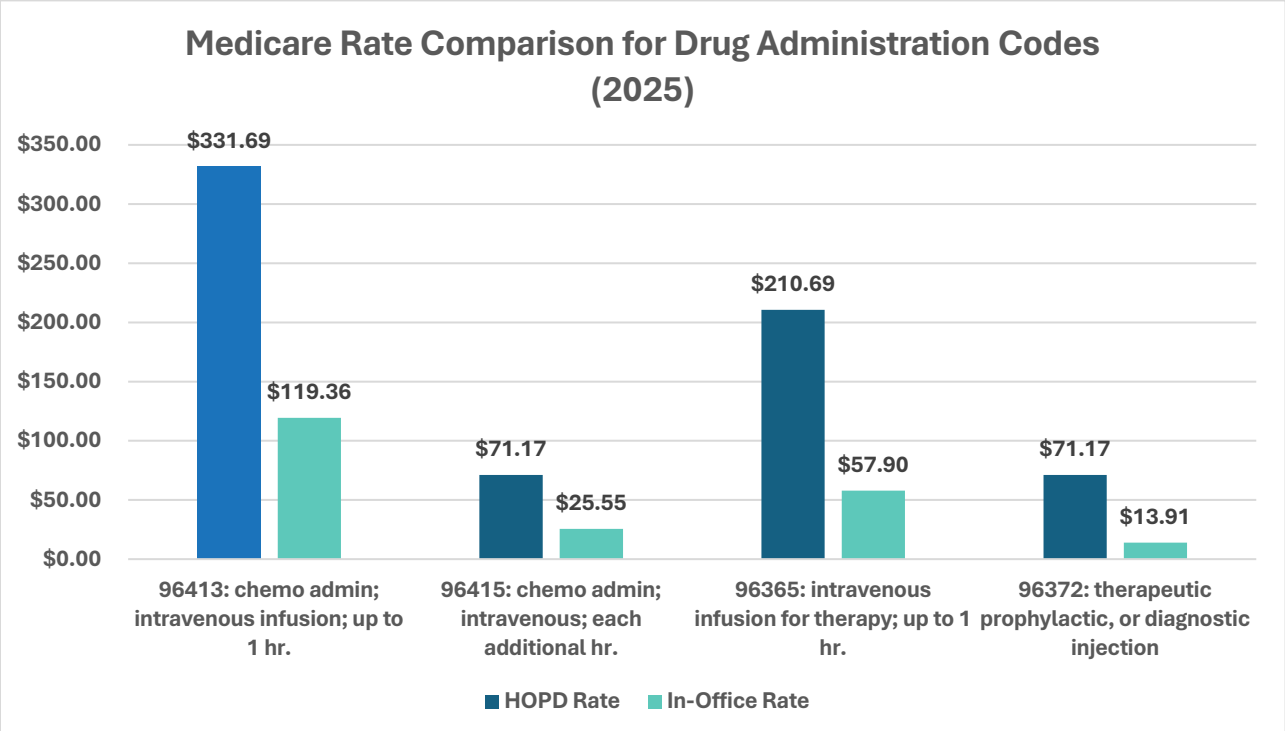
[6] Raj L, Stinson G, Langsam JW, DeMacio J. Comparison of specialty injection and infusion adverse events among hospital outpatient settings vs non-hospital outpatient settings. J Clin Pathways. 2025;11(1):34-38. doi:10.25270/jcp.2025.11.01

[7] "Medical Benefit Drug Economics: The Price of Furnishing Part B Drugs." National Infusion Center Association



Data based on Code 96413: Chemotherapy administration intravenous infusion, up to one hour
Sources: HOPD Rate = Hospital Outpatient PPS: Addendum B / In-Office Rate = PFS Search

Figure 1: Citations: HOPD Rate = Hospital Outpatient PPS: Addendum B / In-Office Rate = PFS Search



Conclusion

A key Trump Administration priority in health care policy has been encouraging Part B drugs to be provided in the physician/clinic setting,[8] which is paid about one-third of the amount as hospitals for administering the identical drugs. LUGPA members' practices cannot absorb a 50 percent cut to the primary form of reimbursement – the add-on payment – and still provide these drugs to patients.

One of LUGPA's legislative priorities is enacting *The Protecting Patient Access to Cancer and Complex Therapies Act*, which removes providers from the drug pricing negotiations between the manufacturer and Medicare, and preserves the ASP+6% reimbursement structure, while securing the same savings (to Medicare and beneficiaries) demanded by the IRA via a rebate paid by the manufacturer to CMS. That policy has been endorsed by 58 patient and provider organizations including Infusion Providers Alliance (IPA), International Foundation for Autoimmune & Autoinflammatory Arthritis, American Academy of Allergy, Asthma, & Immunology (AAAAI), Association of Women in Rheumatology (AWIR), Cancer Support Network, Community Oncology Alliance (COA), and Digestive Health Physicians Association (DHPA), among others.[9]

Consistent with the intent of that legislation, the Trump Administration has the opportunity to protect this vital access channel to patients by simply adopting a straightforward reading of the statute, limiting these payment cuts to Medicare patients, and ensuring that other patients can continue to access these low-cost and convenient providers. It should do so without equivocation, recognizing that these providers not only provide excellent care but also provide needed competition to huge hospital systems, which are attempting to consolidate the provider market further.

On behalf of LUGPA, we would like to thank CMS for providing us with this opportunity to comment on the Draft Guidance. Please feel free to contact Dr. Mara Holton at 410.504.4004 or mholton@aaurology.com if you have any questions or if LUGPA can provide additional information to assist CMS as it considers these issues.

Thank you,

Scott Sellinger, MD, FACS
President

Mara Holton, MD
Chair, Health Policy

[8] In an April 15, 2025, Executive Order, President Trump called on the Secretary to propose regulations "to ensure payment within the Medicare program is not encouraging a shift in drug administration and volume away from less costly physician offices to more expensive hospital outpatient departments." Exec. Order No. 14,273, Lowering Drug Prices by Once Again Putting Americans First, Section 11, available at https://www.whitehouse.gov/presidential-actions/2025/04/lowering-drug-prices-by-once-again-putting-americans-first/.

[9] Part B Access Coalition Letter on Protecting Patient Access to Cancer and Complex Therapies Act of 2023.

June 26, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Oz,

Life Sciences Pennsylvania appreciates the opportunity to provide comments on the proposed interpretation of a Qualifying Single Source Drug (QSSD) in the latest guidance for the IRA 2028 Initial Price Applicability Year (IPAY) that lays out the selection and negotiation processes for the upcoming Inflation Reduction Act cycle.

Life Sciences PA is the statewide trade association for the Commonwealth's life sciences community. Our membership is comprised of more than 950 organizations representing the entire life sciences ecosystem – early-stage biotech companies, medical device and diagnostics makers, large pharmaceutical manufacturers, academic research institutions, patient advocacy groups and myriad service industries supporting the research, development and manufacturing of medicines and technologies in Pennsylvania.

We are submitting this comment with deep concern that this draft guidance for the Medicare Drug Price Negotiation Program will stifle future medical breakthroughs and fail to address the diverse healthcare needs of patients. We're particularly concerned that CMS's interpretation disincentivizes post-approval R&D, especially efforts to develop new formulations or delivery methods that address unmet needs and reduce barriers to access. For example, in oncology, shifting from intravenous to subcutaneous administration can dramatically reduce treatment time, improve patient comfort, and ease burdens on caregivers and providers, especially in rural or underserved areas. These kinds of innovations aren't interchangeable, they're essential.

The proposed interpretation of a Qualifying Single Source Drug (QSSD) risks discouraging the development of new combination products, routes of administration, and indications that are essential for improving patient outcomes. These innovations are particularly important for patients in rural communities, where treatment adherence, convenience, and personalization are critical to achieving better health outcomes.

We urge CMS to follow the statute and identify QSSDs by reference to a distinct New Drug Application (NDA) or Biologics License Application (BLA), consistent with the FDA's regulatory framework. This approach would ensure that meaningful innovations are appropriately recognized and preserved for patient access.

Thank you for your consideration of our request.

Sincerely,

Christopher P. Molineaux
President & CEO
Life Sciences Pennsylvania

Lilly USA, LLC

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June 26, 2025

VIA E-MAIL (IRARebateandNegotiation@cms.hhs.gov)

Chris Klomp
CMS Deputy Administrator and Director of the Center of Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1859

RE: Medicare Drug Price Negotiation Program Draft Guidance

Dear Deputy Administrator Klomp,

Eli Lilly and Company (Lilly) appreciates the opportunity to respond to the Medicare Drug Price Negotiation Program Draft Guidance (Guidance). Lilly is one of the country's leading innovation-driven, research-based pharmaceutical and biotechnology corporations. Our company is devoted to seeking answers for some of the world's most urgent medical needs through discovery and development of breakthrough medicines and technologies and through the health information we offer. Ultimately, our goal is to develop products that save and improve patients' lives.

As a member of both the Pharmaceutical Researchers and Manufacturers Association of America (PhRMA) and the Biotechnology Industry Organization (BIO), Lilly largely joins those groups in their comments on the Draft Guidance and encourages CMS to carefully consider the input of those organizations. That said, Lilly would like to offer the following comments to highlight matters of concern and Lilly-specific positions.

Lilly urges CMS to consider these perspectives seriously to redress the significant risks to U.S. global biomedical leadership stemming from the implementation of this program. Lilly remains concerned about the impact of the Inflation Reduction Act's (IRA's) price controls on our industry's ability to continue leading the world in pharmaceutical research and discovery – especially for serious chronic, and rare diseases.

Doubling-down on the flawed implementation guidance of the program's first year would disincentivize investment in future therapies, fail to adequately account for appropriate measures of a drug's total value, and jeopardize long-term patient benefits from new discoveries. Innovation is not a switch that can be turned back on once it is lost. It depends on a clear valuation of therapeutic progress and a recognition that breakthrough treatments are made possible only through policies that foster the steady pace of scientific advancement that must occur over time.

The next generation of medicines – whether for Alzheimer's, obesity, cancer, or rare genetic disorders – will be shaped by the choices made today. We urge CMS to consider these perspectives seriously as it refines this program, ensuring the U.S. maintains its leadership position as the global engine of medical progress and hope for patients for decades to come.

This letter is structured as follows:

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I. CMS Should Reform Policies That Undermine Innovation and Threaten Tomorrow's Breakthroughs

The disparate treatment of small molecule drugs under the IRA's timeline already threatens to chill future innovation—particularly in therapeutic areas where oral formulations are essential for patient access, adherence, and affordability. CMS's current implementation approach adds insult to injury through its interpretation of the Qualifying Single Source Drug (QSSD) provisions, which compound this disadvantage. By aggregating across all dosage forms, indications, and routes of administration, CMS effectively erases meaningful distinctions in clinical value, lifecycle investment, and regulatory approval pathways. This not only contradicts the statutory text and undermines FDA's longstanding regulatory principles—it also runs counter to President Trump's executive order prioritizing innovation and differentiated value in drug pricing.

This framework sends the wrong signal: that science-based innovation will be undercut by arbitrary timelines and inconsistent regulatory policy. Nowhere is this more visible—or more damaging—than in the case of non-opioid pain medications. Despite a national overdose crisis claiming over 100,000 lives annually and a federal imperative to accelerate alternatives to opioids, the IRA's structure disproportionately discourages investment in small molecule therapies that could expand access to safer pain relief.[1]

Further, if CMS is going to pursue an expansive aggregation policy under QSSD, it cannot simultaneously maintain an arbitrary and overly restrictive definition of "bona fide marketing." This is the critical "silver lining" opportunity: a narrowly and predictably defined marketing standard could provide a safeguard against premature price setting and preserve incentives for future breakthroughs. Yet CMS's current approach—tying "bona fide marketing (BFM)"to vague and inconsistently applied data signals such as Prescription Drug Event (PDE) or Average Manufacturer Price (AMP)—grants the agency de facto discretion over when a product's exclusivity

[1] Smith, W. & Popovian, R. (2024). *The Left-Hand Doesn't Know What the Right-Hand is Doing: The Federal Government and Opioids*. https://pioneerinstitute.org/wp-content/uploads/PNR-554-Opiod-WP-v02.pdf

period begins. This is particularly problematic for small molecule medicines subject to the IRA's 9-year timeline, as it restricts competition-based exemptions and disrupts predictable investment planning. A tighter, statutorily grounded standard—such as the MDRP's established "market date"—would promote consistency, accelerate competition, and uphold the Trump administration's stated commitment to regulatory clarity and innovation-driven access.

A. End the "Pill Penalty" to Uphold Pro-Competition, Pro-Innovation Pricing Principles

The IRA's 9/13 negotiation timeline subjects small molecule drugs to government price-setting just nine years after FDA approval, while biologics receive 13 years before facing price controls. This asymmetry—commonly referred to as the "pill penalty"—has generated bipartisan concern among lawmakers and industry leaders for its chilling effect on small molecule R&D.

Estimates by the University of Chicago predict a $232 billion reduction in R&D for small molecule medicines over the next 20 years. R&D is already shifting away from small molecule medicines targeting cancer, despite their vitally beneficial patient impact.[2] By disproportionately accelerating government price controls on pills, the IRA has created a two-tiered investment landscape that skews incentives away from small molecule innovation, despite their outsized potential for improving patient access, affordability, and ease of use. In Alzheimer's disease alone, 60 small -molecule therapies are currently in the pipeline—many of which could be undermined by the shortened exclusivity window.[3]

This concern is especially acute for genetically targeted therapies (GTTs), which the FDA classifies as small molecules that are therefore subject to the nine-year negotiation timeline—even though they are among the most advanced and complex therapies in development. GTTs hold transformative promise for high-need areas like ALS, Alzheimer's Disease, Parkinson's and other neurodegenerative diseases, and could revolutionize care for conditions like high cholesterol and cardiovascular disease. Like other gene therapies that FDA regulates as biologics, GTTs require intensive R&D investment, complex manufacturing and long clinical development timelines. The current framework sends the wrong signal: that science-based innovation will be undercut by inconsistent policy. The IRA's innovation penalty also collides with national priorities to curb the opioid epidemic. The societal cost of opioid addiction—over $1.5 trillion annually—is vastly higher than the projected $129 billion in IRA savings over a decade. Meanwhile, the pharmaceutical pipeline for non-opioid pain treatments is shrinking just as the need expands. Today, fewer than 10% of the 50 million Americans living with chronic pain have access to FDA-approved non-opioid alternatives.[4],[5]

New evidence underscores the scale and timing of this impact. Since the IRA's introduction, there has been a 35% reduction in early-stage Phase I and II small molecule therapies under development

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[2] Mheinl. (2024). *Policy Brief: The Impact of Price Setting at 9 Years on Small Molecule Innovation Under the Inflation Reduction Act | The Initiative on Enabling Choice and Competition in Health Care*. Uchicago.edu. https://ecchc.economics.uchicago.edu/2023/10/09/policy-brief-the-potentially-larger-than-predicted-impact-of-the-ira-on-small-molecule-rd-and-patient-health-2/

[3] Cummings, J. L., Zhou, Y., Lee, G., Zhong, K., Fonseca, J., Leisgang-Osse, A. M., & Cheng, F. (2025). Alzheimer's disease drug development pipeline: 2025. *Alzheimer's & Dementia: Translational Research & Clinical Interventions*, *11*(2). https://doi.org/10.1002/trc2.70098

[4] Smith, W., & Popovian, R. (2024). *The Left-Hand Doesn't Know What the Right-Hand is Doing: The Federal Government and Opioids*. https://pioneerinstitute.org/wp-content/uploads/PNR-554-Opiod-WP-v02.pdf

[5] *An Innovation Agenda for Addiction | IFP*. (2024, December 10). Institute for Progress. https://ifp.org/an-innovation-agenda-for-addiction/

among small and midsize biotech companies (2021–2023). Given that Phase II and III development each typically last 40 months, this drop is expected to lead to a meaningful decline in FDA approvals over the next 5–6 years.[6] Private-sector funding for non-opioid pain medications has dropped over 30%, while 60% of life science investors now deprioritize these drugs, citing IRA-induced risks. For a class of therapies already facing a 99% attrition rate, this pricing structure is functionally an innovation deterrent.[7,8]

Venture capital (VC) has also shifted away from small molecule development targeting Medicare populations. A statistically significant 74% decline in median VC investment size has been observed for indications with high projected Medicare utilization—including Alzheimer's disease, non-small cell lung cancer, multiple myeloma, prostate cancer, and head and neck cancer—while no such decline is seen for indications with lower Medicare exposure. This creates a structural disadvantage for therapeutic areas with high unmet need in older populations.[9]

Modeling further shows that eliminating the pill penalty by aligning small molecule price-setting with biologics at year 13 would increase new drug approvals for the Medicare-aged population by approximately 20%. Extending the timeline to 15 years would cut projected drug losses for seniors by nearly 50%.[10]

Yet, CMS's current approach to transparency and negotiation—including its extra-statutory "bona fide marketing" standard, potential disregard for manufacturer-submitted data, and opaque methodologies for price setting—exacerbates rather than mitigates this imbalance.

If CMS's transparency policies are not accompanied by a consistent, lawful, and balanced framework, then small molecule developers face a double penalty: shortened market exclusivity *and* unpredictable negotiation rules. This disincentivizes investment, narrows future treatment options, and ultimately contradicts the Trump administration's pro-innovation, pro-competition approach to drug pricing policy.

B. Several QSSD Interpretive Issues Need to be Fixed

CMS's implementation choices around the QSSD designation compound the pill penalty and risk locking in systemic disadvantages for small molecule innovators. In effect, the combination of shortened exclusivity and overbroad QSSD aggregation policies creates a "double penalty" that undermines the very innovation, competition, and access the IRA is intended to support.

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[6] Petra. (2025, April 9). *Inflation Reduction Act – Two Years On Investor Behavior, R&D Impacts, & Proposed Solutions - Vital Transformation*. Vital Transformation. https://vitaltransformation.com/2025/04/inflation-reduction-act-two-years-on-investor-behavior-rd-impacts-proposed-solutions/

[7] Smith, W., & Popovian, R. (2024). *The Left-Hand Doesn't Know What the Right-Hand is Doing: The Federal Government and Opioids*. https://pioneerinstitute.org/wp-content/uploads/PNR-554-Opiod-WP-v02.pdf

[8] *An Innovation Agenda for Addiction | IFP*. (2024, December 10). Institute for Progress. https://ifp.org/an-innovation-agenda-for-addiction/

[9] Petra. (2025, April 9). *Inflation Reduction Act – Two Years On Investor Behavior, R&D Impacts, & Proposed Solutions - Vital Transformation*. Vital Transformation. https://vitaltransformation.com/2025/04/inflation-reduction-act-two-years-on-investor-behavior-rd-impacts-proposed-solutions/

[10] IBID

Lilly remains concerned that key aspects of the Agency's interpretation—specifically its definition and aggregation policies around QSSDs—directly contradict the statutory text, undermine longstanding FDA regulatory principles, and run counter to the current Administration's stated priorities, including those under President Trump's Executive Order on drug pricing and innovation.

1) CMS's Definition of QSSD Contradicts the Plain Language of the IRA and Undermines Regulatory Certainty

CMS's decision to define a QSSD based on active moiety or ingredient—regardless of whether products are approved under distinct NDAs or BLAs—ignores the clear language of the statute. For example, the IRA defines the term QSSD as "**a** covered part D drug," i.e., "**a** drug" that "**is** approved" or "**a** biological product" that "**is** licensed." [11] The IRA's repeated use of the singular, and the link between QSSDs and FDA "approval" or "licensure," underscores that defining a QSSD to include multiple drugs or biological products is contrary to law. After all, FDA approval for a drug or biological product applies to an individual product, not all products with the same active moiety or ingredient. The Trump administration repeatedly emphasized the importance of regulatory certainty and aligning CMS policy with FDA frameworks.[12] By aggregating across products with different regulatory histories and development timelines, CMS is creating an ambiguous and unpredictable pricing regime that chills investment in follow-on innovation—particularly in areas such as extended-release formulations, adherence technologies, or differentiated delivery systems.

According to PhRMA, 60% of drugs approved by the FDA between 2017 and 2021 were modified versions or new uses of existing therapies—exactly the type of innovations now threatened by CMS's QSSD approach.[13]

This directly contradicts President Trump's repeated public commitments to fostering next-generation drug development and avoiding blunt, one-size-fits-all government pricing schemes that disincentivize innovation. Recent Executive Orders warned of the risks of overregulation and protected future biopharmaceutical advances from arbitrary pricing mandates.[14]

2) CMS's Expenditure Aggregation Policy Conflicts with Both Statutory Text and Trump-Era Cost Transparency Reforms

CMS's choice to aggregate expenditures across distinct FDA applications likewise conflates separate products and again conflicts with the statute. This is inconsistent with the Trump administration's push for cost transparency tied to specific product lines—not arbitrary, consolidated definitions that blur meaningful distinctions between therapeutics.[15]

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[11] 42 U.S.C. § 1320f-1(e)(1) (emphasis added); U.S.C. § 1395w-102(e).
[12] Weinstock, M. (2017). Regulatory reform takes hold during Trump's first 100 Days. Retrieved from https://www.modernhealthcare.com/article/20170427/NEWS/170429869/regulatory-reform-takes-hold-during-trump-s-first-100-days
[13] PhRMA analysis of FDA New Drug Approval Sheets (2008 through 2021) and CMS Dashboard (2021), AdisInsight Database and/or PhRMA Medicines in Development Reports
[14] Wayne, C. (2025, February 3). Trump's 10-For-1 "Unleashing Prosperity Through Deregulation" Executive Order: What's Next?. *Forbes*. https://www.forbes.com/sites/waynecrews/2025/02/03/trumps-ten-for-one-unleashing-prosperity-through-deregulation-executive-order-whats-next/
[15] Landi, H. (2025, February 25). *Trump issues executive order to crack down on price transparency rules for hospitals, payers*. Fierce Healthcare. https://www.fiercehealthcare.com/providers/trump-issues-executive-order-crack-down-price-transparency-hospitals-payers

Additionally, the Trump-era reforms to the Medicare drug pricing system emphasized rewarding therapeutic differentiation and empowering consumers and clinicians with meaningful pricing data.[16],[17] CMS's current interpretation undermines that approach by folding unique products into a single expenditure metric, making it impossible to distinguish the value of discrete innovations.

3) CMS's Application of MFP Across Molecules Instead of Products Conflicts with FDA Standards and Could Force Market Exit

Just as CMS should only aggregate expenditures within a single NDA or BLA, it must likewise apply the MFP only across the dosage forms and strengths within the selected product's NDA/BLA. By applying a single MFP to all formulations with the same active ingredient, regardless of regulatory pathway, CMS is acting contrary to law and creating an untenable pricing environment.

This creates perverse incentives for manufacturers to withdraw differentiated formats from the Medicare market and threatens the commercial viability of specific patient-centered presentations—particularly those that cost more to manufacturer, distribute, or administer (e.g., digital injection systems vs. vials).That outcome would be particularly troubling for the Trump administration, which has publicly decried policies that reduce patient choice or lead to government-induced shortages.[18]

4) CMS Oversteps Statutory Authority by Requiring Manufacturers to Offer Every Package Size or Product Presentation

Section 60 of the Draft Guidance states that manufacturers must offer every package size or presentation of a dosage form and strength—a position with no support in the IRA's statutory language.[19]

The statute requires that the Maximum Fair Price (MFP) apply "across different strengths and dosage forms" of a selected drug—not across every formulation, package size, or configuration ever derived from the original active ingredient. CMS's decision to aggregate all current and future uses and treatments is overreach—precisely the type of action the Trump administration consistently opposes in both healthcare regulation and broader agency governance.[20] CMS cannot "rewrite clear statutory terms to suit its own sense of how the statute should operate."[21]

CMS's interpretation also has immediate and damaging real-world implications for the future of patient care and medical innovation. The idea that new indications or configurations of an already-approved active ingredient are minor or "non-innovative" tweaks ignores both the science and the

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[16] in. (2025). *Executive Order 14273 Summary: Pricing, Transparency, and Competition in the Pharmaceutical Industry*. Nera.com. https://www.nera.com/insights/publications/2025/_executive-order-14273-summary-.html?lang=en
[17] *CMS Takes Action to Lower Prescription Drug Prices and Increase Transparency | CMS*. (2019, May 16). Cms.gov. https://www.cms.gov/newsroom/press-releases/cms-takes-action-lower-prescription-drug-prices-and-increase-transparency
[18] *Trump Administration Puts Patients Over Paperwork by Reducing Healthcare Administrative Costs | CMS*. (n.d.). Www.cms.gov. https://www.cms.gov/newsroom/press-releases/trump-administration-puts-patients-over-paperwork-reducing-healthcare-administrative-costs
[19] Inflation Reduction Act of 2022, Pub. L. No. 117-169, 136 Stat. 1818.
[20] Tracking The Trump Administration's Early Deregulation Agenda. (2025). *Forefront Group*. https://doi.org/10.1377/forefront.20250331.581404
[21] *Util. Air Reg. Group v. EPA*, 573 U.S. 302, 328 (2014).

economics of post-approval research. In oncology, for example, it is well-established that many drugs are approved for narrow populations initially, with additional indications—such as earlier lines, combination regimens, or other tumor types associated with a biomarker-driven subtypes—approved later based on rigorous clinical trials. These are not marginal changes; they represent life-extending breakthroughs for patients who previously had few or no options.[22]

As an example, PhRMA data show that the average cost of post-approval research to bring a new oncology indication to market can range from $100 million to over $300 million per indication, depending on trial size, biomarker development, regulatory compliance, and safety surveillance.[23] In some cases, particularly in rare cancers or pediatric populations, this research continues well after initial FDA approval and requires sustained investment over 5–10 years.[24] If CMS's policy forces all future configurations, strengths, or new uses into a single MFP from the moment of selection, it effectively eliminates any business case for this downstream investment—because the revenue potential is already capped, while the clinical risk and research cost remain high.

The net effect is a chilling of lifecycle innovation. Manufacturers will be disincentivized from pursuing new uses for existing molecules, even when those uses serve unmet needs in new populations, improve medication adherence (e.g., with new formulations), or expand equity of patient access (e.g., with fixed-dose combinations or oral alternatives). In oncology alone, more than 60% of new indications approved between 2014 and 2022 were for existing drugs, often building on foundational R&D to extend survival or tailor treatment to newly identified genetic subtypes.[25] These advances are only possible because the regulatory and reimbursement system has historically supported reinvestment after initial launch.

CMS's MFP aggregation policy undermines that structure. By rolling everything into a single price—regardless of clinical differentiation or future indication—CMS severs the link between additional patient benefit and additional R&D incentive. This not only jeopardizes the availability of tomorrow's treatment options but also conflicts with the Trump administration's pro-innovation, value-recognition approach to drug pricing. Instead, CMS should adhere to the statutory text, respect FDA-defined distinctions in dosage forms and indications, and preserve incentives for meaningful therapeutic progress after initial approval.

5) <u>CMS's Position Undermines the Innovation Incentives the Trump Administration Worked to Protect</u>

CMS's approach undercuts the delicate balance struck by Congress—particularly the provision that newer drugs approved within the last 7 or 11 years would be excluded from price setting to preserve incentives for innovation. CMS's broad QSSD definition and expenditure aggregation strategy disregard that safeguard and effectively *backdoor* older drugs' pricing onto newer ones—potentially making even recent market entrants vulnerable to rapid price setting. This contradicts

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[22] Spreafico, A., Hansen, A. R., Abdul Razak, A. R., Bedard, P. L., & Siu, L. L. (2021). The Future of Clinical Trial Design in Oncology. *Cancer Discovery*, *11*(4), 822–837. https://doi.org/10.1158/2159-8290.cd-20-1301
[23] *Research and development continues long after a medicine is initially approved | PhRMA*. (2025). Phrma.org. https://phrma.org/blog/research-and-development-continues-long-after-a-medicine-is-initially-approved
[24] Vivelo, C., Reilly, K. M., Widemann, B. C., Wedekind, M. F., Painter, C., O'Neill, A. F., Mueller, S., Elemento, O., Gross, A. M., & Sandler, A. B. (2023). The Landscape of US and Global Rare Tumor Research Programs: A Systematic Review. *The Oncologist*, *29*(2), 106–116. https://doi.org/10.1093/oncolo/oyad285
[25] *New report shows high-impact R&D happens after cancer medicines are first approved*. (2025). Phrma.org. https://phrma.org/blog/new-report-shows-high-impact-rd-happens-after-cancer-medicines-are-first-approved

both the text and spirit of the IRA as well as President Trump's repeated statements that government should not punish American drug developers for improving upon their own products.[26]

C. Transparency in Negotiation Must Be Lawful, Predictable, and Free of Structural Bias Against Small Molecule Innovation

Lilly supports transparent, data-driven policymaking. However, transparency must be tied to statutory fidelity and due process—especially where CMS's implementation risks reinforcing structural biases in the IRA, such as the well-documented "pill penalty."

1) The "Bona Fide Marketing" Standard Creates Arbitrary Barriers to Competition and Access

If CMS insists on collapsing distinct dosage forms, indications, and delivery mechanisms under a single QSSD designation—thereby triggering earlier price controls and compressing commercial viability—then it must adopt a clear and legally grounded definition of when a product has truly entered the market. CMS's proposed interpretation of what constitutes "bona fide marketing (BFM)" instead compounds the harm created by its overbroad QSSD aggregation policy.

Rather than relying on established statutory definitions, CMS proposes to tie "bona fide marketing" to ambiguous utilization data, such as prescription drug event (PDE) claims or average manufacturer price (AMP) signals. These data sources are often delayed, incomplete, or not reflective of true commercial availability, especially for low-volume or specialty medicines. For example:

- **Alzheimer's Disease** - Approximately 60 small molecule therapies are in the Alzheimer's pipeline, many of which target early-stage or prodromal disease.[27] Based on historical and emerging launch patterns in Alzheimer's, these therapies are likely to enter the market through constrained pathways—including narrow initial indications, payer-imposed access controls, and phased commercialization strategies.[28],[29] In such cases, CMS's reliance on early utilization signals such as PDE claims or AMP data to define "bona fide marketing" is particularly problematic. These metrics may not reflect actual commercial availability for months after approval. If CMS fails to recognize the true market entry date—for example, by delaying BFM recognition of an oral tau inhibitor—developers may be penalized with premature selection and compressed exemption periods. This creates disincentives for post-approval evidence generation, indication expansion, and lifecycle innovation. More broadly, such regulatory ambiguity undermines policy goals of promoting earlier Alzheimer's detection and improving patient access to innovative therapies.

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[26] *Remarks by President Trump at S.204, "Right to Try" Bill Signing – The White House*. (2018). Archives.gov; The White House. https://trumpwhitehouse.archives.gov/briefings-statements/remarks-president-trump-s-204-right-try-bill-signing/

[27] Cummings, J. L., Zhou, Y., Lee, G., Zhong, K., Fonseca, J., Leisgang-Osse, A. M., & Cheng, F. (2025). Alzheimer's disease drug development pipeline: 2025. *Alzheimer's & Dementia: Translational Research & Clinical Interventions*, *11*(2). https://doi.org/10.1002/trc2.70098

[28] Hamilton, E. (2024, November 14). *Axios Event: Access to Alzheimer's treatments is limited under coverage policies, experts say*. Axios. https://www.axios.com/2024/11/14/axios-event-future-of-cognitive-care

[29] Liu, A. (2022, January 12). *For Biogen's Aduhelm, narrow coverage from CMS "could effectively spell the end": analyst*. Fierce Pharma. https://www.fiercepharma.com/marketing/biogen-alzheimer-s-drug-aduhelm-cms-restrictive-draft-reimbursement-ruling-could

- **Oncology** - Between 2010 and 2020, over 60% of FDA-approved oncology therapies were small molecules, many launched with narrow labels later expanded through post-market studies.[30] For example, a kinase inhibitor approved for a type of relapsed leukemia may only be used in hundreds of patients at launch. But under CMS's current BFM logic, low utilization could delay recognition of market entry, yet aggregation under QSSD could trigger selection for *all* future formulations and expanded uses. This deters manufacturers from pursuing label expansions, combination regimens, or new delivery methods, all of which are critical in oncology innovation. Moreover, price controls tied to limited early uptake can distort value assessments for highly personalized cancer treatments.

- **Cardiometabolic Disease** - In the treatment of diabetes and heart failure, oral fixed-dose and combination therapies are increasingly being developed to simplify regimens and improve adherence. These often involve multi-phase launch strategies to align with coverage negotiations or gradually onboard health systems. If CMS fails to recognize this as "bona fide marketing," but later aggregates *all* strengths and indications under one QSSD, it risks discouraging future investment in oral fixed-dose and combination therapies that could improve outcomes and reduce hospitalizations. This is directly at odds with the Administration's prioritization of cardiometabolic risk reduction and population health improvement.[31]

If CMS's opaque BFM standard stalls the start of the exemption period, developers will have to decide whether to delay launch entirely to preserve their protected timeline or absorb the risk of early selection before a therapy reaches the majority of intended patients. The result is a chilling effect on early access, particularly for complex or precision-targeted small molecule therapies that may take years to reach full clinical and commercial potential.

Moreover, CMS's interpretation conflicts with the Trump administration's executive orders focused on streamlining market entry, reducing regulatory barriers, and fostering therapeutic competition. Executive Order 13948, for instance, emphasized the importance of regulatory clarity in supporting generic and biosimilar entry, a principle reaffirmed by numerous FDA initiatives such as the Drug Competition Action Plan.[32]

The stakes for generic competition are equally high. A vague or discretionary BFM standard muddies the signal for when follow-on manufacturers can begin development. According to data from the Association for Accessible Medicines (AAM), delays in generic entry can impose significant costs on the healthcare system, with estimates suggesting that even modest postponements may result in billions of dollars in lost savings across affected products.[33] For biosimilars, where entry is already slower and more costly, a lack of clarity around reference product launch dates adds unnecessary complexity and cost.

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[30] Liu, G., Chen, T., Zhang, X., Ma, X., & Shi, H. (2022). Small molecule inhibitors targeting the cancers. *MedComm*, *3*(4). https://doi.org/10.1002/mco2.181

[31] The White House. (2025, February 13). *Fact Sheet: President Donald J. Trump Establishes the Make America Healthy Again Commission*. The White House. https://www.whitehouse.gov/fact-sheets/2025/02/fact-sheet-president-donald-j-trump-establishes-the-make-america-healthy-again-commission/

[32] *Lowering Drug Prices by Putting America First*. (2020, September 23). Federal Register. https://www.federalregister.gov/documents/2020/09/23/2020-21129/lowering-drug-prices-by-putting-america-first

[33] *The U.S. Generic & Biosimilar Medicines Savings Report September 2024*. (n.d.). https://accessiblemeds.org/wp-content/uploads/2025/01/AAM-2024-Generic-Biosimilar-Medicines-Savings-Report.pdf

By contrast, adopting the Medicaid Drug Rebate Program's (MDRP) "market date" standard—which is based on when a product is first offered for sale—would provide a clear, objective, and legally supported definition of "bona fide marketing." This would promote certainty across the supply chain, allow fair and timely application of the IRA's exemption periods, and ensure the negotiation process reflects real-world market dynamics. Crucially, it would also strengthen the case for earlier and more robust generic and biosimilar competition—a central priority for this administration and a key lever in achieving sustainable drug affordability.[34]

Ultimately, if CMS continues to combine overbroad QSSD aggregation with a vague and discretionary BFM standard, the result will be a systemic barrier to both innovation and competition. A narrow, objective definition is not only consistent with statutory principles and regulatory precedent—it is essential to achieving the IRA's goals without compromising the development of tomorrow's life-saving therapies.

II. Align the MFP-Methodology with Rigorous Scientific Standards and Broader Dimensions of Value

At its core, the IRA's current price-setting framework fundamentally undervalues the real-world therapeutic and economic contributions of existing medicines. Rather than reflecting the full scope of a drug's clinical value—such as survival gains, quality-of-life improvements, long-term cost offsets, and sustained investment in post-approval research—the process relies on a narrow and incomplete view of pharmaceutical innovation. By prioritizing blunt statutory timelines and rigid utilization-based criteria over therapeutic differentiation, the negotiation framework treats decades of scientific progress as a sunk cost rather than an asset to be rewarded.

This structural bias against already-approved therapies distorts incentives across the healthcare ecosystem. It penalizes manufacturers for investing in long-term research that leads to additional indications, improved formulations, and expanded patient populations. Drugs that have demonstrated consistent clinical benefit—often validated across multiple randomized trials and real-world studies—are devalued simply because they have been on the market longer. The assumption that a medicine's value declines with time ignores the evolving evidence base, deepening clinical utility, and increased access that emerge only after initial approval.

In doing so, the IRA framework treats innovation as a one-time event, not an ongoing process. This not only undermines the commercial sustainability of evidence-based lifecycle investment—it sends a chilling signal to the R&D community: bring a product to market, and the clock starts ticking toward government-mandated price controls, regardless of continued innovation or patient impact. Without structural changes, the IRA risks entrenching a model that rewards speed over durability, and novelty over impact—undermining the very innovation ecosystem it claims to balance.

Therefore, Lilly urges CMS to revise its approach to price setting under the IRA to ensure that the full clinical and societal value of a medicine is meaningfully reflected in the negotiation process. As stated, the framework fails to capture the real-world benefits of innovation—particularly for

[34] The White House. (2025, April 15). *Fact Sheet: President Donald J. Trump Announces Actions to Lower Prescription Drug Prices*. The White House. https://www.whitehouse.gov/fact-sheets/2025/04/fact-sheet-president-donald-j-trump-announces-actions-to-lower-prescription-drug-prices/

treatments that extend survival, improve quality of life, or deliver long-term cost offsets. Instead, the negotiation process relies on limited and often delayed data inputs, undervalues therapeutic differentiation, and risks reducing complex scientific achievements to static, one-dimensional price points.

A. Preserving the Integrity of Therapeutic Comparisons in the Drug Negotiation Process

CMS should uphold a rigorous, science-based approach when identifying therapeutic alternatives. Historically, therapeutic alternatives have been defined and assessed through the structured lens of pharmaceutical evidence—drawing on comparative effectiveness, clinical practice standards, and patient-centered outcomes. Diluting this framework would introduce undue complexity and create administrative burdens that could slow patient access to novel treatments. This expansion also contradicts key policy goals emphasized by the Trump administration, which has sought to promote innovation while ensuring that price regulation efforts do not stifle competition, limit therapeutic choice, or arbitrarily favor one mode of treatment over another.[35] Instead, President Trump's health care priorities have emphasized evidence-based comparisons within therapeutic classes—not speculative cross-modality evaluations that could distort price signals and reduce investment in targeted pharmaceutical innovation.[36]

CMS should restrict therapeutic comparisons in the drug negotiation process to pharmaceutical alternatives with similar indications, and regulatory status. Expanding comparisons to include non-drug services under Medicare Part A or B—such as procedures or diagnostics—would dilute the scientific basis of value assessment and introduce inappropriate proxies that do not reflect the unique risk, development cost, or patient impact of biopharmaceutical innovation. Medicines are not interchangeable with services, and conflating the two threatens to erode the integrity of the negotiation process and devalue future advancements.

1) Ensure Transparent, Scientifically Rigorous Evaluation of Therapeutic Alternatives

CMS's proposed changes to the evaluation of therapeutic alternatives under Section 1194(e)(2) raise significant concerns. The removal of structured question categories and the decision not to require disclosure of QALY-type metrics diminish the transparency and rigor that Congress intended.

We support CMS's effort to reduce burden on stakeholders, but it is essential that therapeutic comparisons reflect robust, patient-centered data. CMS should not discount the methodological variability and other concerns associated with cost-effectiveness metrics. While Lilly acknowledges the challenges with QALY-related terminology, CMS must still ensure that underlying data inputs—particularly those used by internal contractors or external evidence vendors—are methodologically sound, accessible, and subject to patient-centered scrutiny. Therefore, we recommend that CMS:

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[35] Olsen, M. W., Joldersma, L., Sullivan, M., Flint, A., Donaldson, E., Stengel, K., & Scott, M. (2025, April 21). *Trump EO Lays Out a Roadmap for Drug Pricing Action*. Avalere Health Advisory. https://advisory.avalerehealth.com/insights/trump-eo-lays-out-a-roadmap-for-drug-pricing-action

[36] *Fact Sheet: President Donald J. Trump Announces Actions to Put American Patients First by Lowering Drug Prices and Stopping Foreign Free-riding on American Pharmaceutical Innovation*. (2025, May 12). The White House. https://www.whitehouse.gov/fact-sheets/2025/05/fact-sheet-president-donald-j-trump-announces-actions-to-put-american-patients-first-by-lowering-drug-prices-and-stopping-foreign-free-riding-on-american-pharmaceutical-innovation/

- Restore structured therapeutic alternative categories (e.g., manufacturer, patient/caregiver, clinical perspectives);
- Clarify whether cost-effectiveness-type metrics are used even if not explicitly labeled as QALYs;
- Adopt evidence standards (e.g., GRACE, GRADE, ISPOR) for third-party sources and internal modeling efforts.

Transparency in how these inputs are used is critical to ensure that drugs addressing unmet need or serving marginalized populations are not undervalued in the MFP process.

B. Expand the Definition of Value to Reflect Patient-Centered Outcomes, Societal Benefit, and Next Generation Innovation

The current implementation of the IRA negotiation framework relies heavily on retrospective, static, and utilization-based metrics that fail to account for the cumulative nature of biomedical innovation. By prioritizing past expenditures and narrow benchmarks of clinical use, CMS's current Information Collection Request (ICR) framework risks reducing the value of complex therapies—particularly in oncology, neurology, and rare diseases—to simplistic, backward-facing pricing models.

This retrospective approach is fundamentally misaligned with how innovation occurs in the real world. Every major therapeutic advance builds upon prior research, regulatory learning, and scientific iteration. Pricing that ignores this continuum effectively disincentivizes the next breakthrough—especially in high-risk areas where commercial viability depends on a stable and predictable reward environment.

Moreover, the ICR framework does not sufficiently account for patient-reported outcomes (PROs), quality-of-life improvements, patient preferences, or caregiver burden reductions, all of which are particularly salient in diseases like cancer, Alzheimer's disease, cardiometabolic conditions and autoimmune conditions. For example, in metastatic breast cancer, therapies that delay disease progression by even a few months can significantly reduce pain, preserve mobility, and enable patients to maintain independence during critical life stages—impacts that are rarely captured in claims data alone.[37],[38] In Alzheimer's disease, early-stage treatments that delay cognitive decline may reduce the need for full-time caregiving, postpone institutionalization, and allow patients to remain safely at home longer—benefits that directly affect caregiver quality of life and overall health system costs.[39] Similarly, in autoimmune diseases such as rheumatoid arthritis or Crohn's disease, biologic therapies that achieve durable remission can prevent irreversible joint damage,

[37] Krohe, M., Hao, Y., Lamoureux, R. E., Galipeau, N., Globe, D., Foley, C., Mazar, I., Solomon, J., & Shields, A. L. (2016). Patient-Reported Outcomes in Metastatic Breast Cancer: A Review of Industry-Sponsored Clinical Trials. *Breast Cancer: Basic and Clinical Research*, *10*, BCBCR.S39385. https://doi.org/10.4137/bcbcr.s39385
[38] Clarijs, M. E., Thurell, J., Friedrich Kühn, Uyl-de, C. A., Hedayati, E., Karsten, M. M., Jager, A., & Koppert, L. B. (2021). Measuring Quality of Life Using Patient-Reported Outcomes in Real-World Metastatic Breast Cancer Patients: The Need for a Standardized Approach. *Cancers*, *13*(10), 2308–2308. https://doi.org/10.3390/cancers13102308
[39] Nandi, A., Counts, N., Bröker, J., Malik, S., Chen, S., Han, R., Klusty, J., Seligman, B., Tortorice, D., Vigo, D., & Bloom, D. E. (2024). Cost of care for Alzheimer's disease and related dementias in the United States: 2016 to 2060. *Npj Aging*, *10*(1), 1–8. https://doi.org/10.1038/s41514-024-00136-6

improve work productivity, and reduce reliance on corticosteroids or surgical interventions—real-world benefits not reflected in traditional utilization-based pricing models.[40]

By failing to incorporate these broader measures of value, the negotiation process disproportionately favors short-term cost containment over long-term health and economic benefit.

This risks undervaluing treatments that:

- Improve functional independence;
- Reduce hospitalizations, emergency visits, or need for long-term care;
- Preserve patient dignity and quality of life in progressive or incurable conditions.

Additionally, the current framework does not adequately recognize therapies that spur downstream innovation—whether through biomarker discovery, drug-device integration, or combination regimens.[41] These spillover effects are often invisible to CMS's current model but are well-documented in academic literature as essential to sustaining progress across therapeutic classes.[42,43]

To address these gaps, CMS should revise the ICR and MFP determination process to reflect a broader, more dynamic definition of value that captures:

- Patient-reported outcomes and quality-of-life improvements, especially in chronic and life-limiting conditions;
- Societal cost offsets and caregiver burden reductions, including reduced disability, increased workforce participation, and avoided institutionalization;
- Ongoing innovation incentives, including line extensions, follow-on indications, and platform technologies;
- Scientific spillover benefits, such as contributions to treatment paradigms, diagnostics, and clinical trial infrastructure.

A narrowly constructed view of value not only underrecognizes the impact of today's medicines—it erodes the financial and scientific infrastructure needed to develop tomorrow's cures. Without a more expansive, future-oriented approach, the IRA risks codifying a valuation system that punishes long-term investment, sidelines patient voice, and sacrifices sustainability for administrative simplicity.

C. CMS's MFP Framework Perpetuates Pricing Distortions, Renegotiation Uncertainty, and Innovation Risk

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[40] Mamasaidov, A., Sakibaev, K., Zhumabaeva, S., Isakov, U., Eshbaeva, C., Abdyllaev, J., Abdikhalilov, B., & Salieva, R. (2025). Impact of Biological Therapies on Quality of Life in Rheumatoid Arthritis: A Narrative Review. *Open Access Rheumatology: Research and Reviews*, *Volume 17*, 73–86. https://doi.org/10.2147/oarrr.s523778

[41] Goto, H., Souma, W., Jibu, M., & Ikeda, Y. (2020). *Multilayer Network Analysis of the Drug Pipeline in the Global Pharmaceutical Industry*. ArXiv.org. https://arxiv.org/abs/2003.04620

[42] Aldieri, L., Bruno, B., Senatore, L., & Vinci, C. P. (2020). The future of pharmaceuticals industry within the triad: The role of knowledge spillovers in innovation process. *Futures*, *122*, 102600. https://doi.org/10.1016/j.futures.2020.102600

[43] US), A. (2025). *THE IMPACT OF PUBLICLY FUNDED BIOMEDICAL AND HEALTH RESEARCH: A REVIEW*. Nih.gov; National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK83123/

1) Protect Transparent, Evidence-Based Negotiation from Distorted Pricing Signals

CMS cites the example of a manufacturer's WAC reduction as a factor that may inform MFP determination. Lilly strongly cautions against this approach. Strategic price reductions may occur for numerous reasons—such as bundling, competitive entry, or access goals. Using isolated WAC changes to reduce an MFP introduces a chilling effect on manufacturers' ability to reduce list prices and disincentivizes pre-IPAY price reductions that would otherwise benefit Medicare and patients.

We recommend that CMS:

- Avoid using isolated WAC reductions as a proxy for "reasonable pricing;"
- Include a detailed explanation of how each 1194(e) factor was weighed in setting the MFP.

The inclusion of the removal of structured therapeutic evidence review and the misapplication of pricing trends all pose risks to the integrity of the Medicare Drug Price Negotiation Program. These policy shifts, if not corrected, may have the unintended consequence of suppressing R&D in areas of unmet need, disincentivizing proactive price reductions; and reducing transparency in how patient benefit is evaluated. We urge CMS to affirm the principles of bilateral, transparent, and evidence-driven negotiation by refining the proposed data collection and review approach under Section 50.

D. Forward-Looking Data and Opaque Price Setting Undermine Investment and Innovation

We strongly recommend CMS not finalize the addition of "forward-looking market data" for the selected drug.[44] The reliance on forecasted data risks distorting the negotiation process by embedding assumptions about future uptake, policy shifts, evolving clinical guidelines or clinical guidelines that may not materialize. This is particularly problematic in dynamic therapeutic areas such as oncology, where real-world utilization patterns are unpredictable, and innovation cycles are fast-moving. Use of these speculative data points could suppress investment in high-risk therapeutic areas, discourage early market access, and ultimately reduce the diversity of treatment options available to Medicare beneficiaries.

This proposal to collect forward-looking "market data"—such as forecasted net revenue, volume by indication, gross-to-net ratios, and market share—is not supported by the text or structure of the statute. Section 1194(e)(1)(A)(i) references "market data and revenue and sales volume data for the drug in the United States," which, in context, refers to actual historical data. Prospective financial forecasts are not suitable for determining the MFP, which must be based on a good-faith assessment of present value and real-world use.[45]

Even if it were allowed under the statute, reliance on forecasted data risks distorting the negotiation process by embedding assumptions about future uptake, policy shifts, or clinical guidelines that may not materialize. This is particularly problematic in dynamic therapeutic areas such as oncology, where real-world utilization patterns are unpredictable and innovation cycles are fast-moving. Overweighting these forecasts data could suppress investment in high-risk therapeutic

[44] *See* Guidance at 104.
[45] As BIO and PhRMA noted in their 2024 comments, "[f]orecasts are speculative by nature… and do not provide reliable indicators of pricing power or innovation value." (BIO, 2024 CMS Comment Letter; PhRMA, 2024 Submission on IPAY Guidance).

areas, discourage early market access, and ultimately reduce the range of treatment options available to Medicare beneficiaries. Lilly recommends that CMS:

- Clarify that forward-looking data are not required and will not be dispositive in MFP determinations;
- Treat any voluntary forecasts as illustrative rather than determinative;
- Confirm that pricing trends will be evaluated only in the context of realized historical performance.

As BIO and PhRMA noted in their 2024 comments, "[f]orecasts are speculative by nature… and do not provide reliable indicators of pricing power or innovation value." (BIO, 2024 CMS Comment Letter; PhRMA, 2024 Submission on IPAY Guidance).[46]

E. Elevating "Certain" Evidentiary Factors Without a Transparent Framework Risks Regulatory Capture

CMS's proposal to give greater weight to "certain" data—without specifying which sources, standards, or criteria will be favored—undermines transparency and due process. For small molecule manufacturers operating within shorter IRA timeframes, the absence of a defined evidentiary hierarchy makes it difficult to understand regulatory requirements and ultimately invest, plan, or even defend the value of innovation.

The Trump administration repeatedly called for predictable, lawful policymaking—urging agencies to avoid vague standards and to adhere to congressional intent.[47] CMS should publish a transparent scoring framework or evidentiary weighting rubric before making price determinations that disproportionately impact a certain class of drugs.

Transparency and due process require more than disclosing CMS decisions after they are made. It requires clearly defined, statute-consistent, and fair processes that manufacturers can understand, anticipate, and plan around. Without this, CMS will entrench the IRA's structural disincentives for small molecule innovation, further penalize products subject to earlier price-setting, and undermine the Trump administration's long-standing commitment to market-based competition, reduced regulatory burdens, and accelerated generic entry.

We strongly urge CMS to revise its transparency policies by:

- Adopting the MDRP "market date" as the sole determinant for IRA exemption and selection;
- Clearly identifying and publishing all data sources and calculation methodologies used in MFP setting;
- Creating an evidentiary framework to govern clinical and manufacturer-submitted inputs;

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[46] Seshamani, M. (2024). *CENTER FOR MEDICARE*. https://www.cms.gov/files/document/medicare-drug-price-negotiation-final-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf

[47] The White House. (2025, February 18). *Fact Sheet: President Donald J. Trump Reins in Independent Agencies to Restore a Government that Answers to the American People*. The White House. https://www.whitehouse.gov/fact-sheets/2025/02/fact-sheet-president-donald-j-trump-reins-in-independent-agencies-to-restore-a-government-that-answers-to-the-american-people/

- Provide specific details citing which bodies of evidence (specific studies or guidelines) influenced the set MFP in its explanation;
- And considering statutory or regulatory remedies to correct the IRA's pill penalty, or at minimum, not exacerbate its effects through implementation.
- Such revisions are essential to restoring investor confidence in small molecule pipelines and ensuring equitable access to future therapies across therapeutic areas.

F. Renegotiation Criteria Must Be Predictable, Transparent, and Innovation-Supportive

As outlined in the draft guidance, Lilly is concerned that several elements of the renegotiation process—particularly the breadth of CMS's discretion, the proposed 15% threshold for MFP changes, and requirements for forward-looking data—introduce significant policy and operational uncertainty that could have downstream effects on innovation, market stability, and ultimately patient access.

1) Threshold for Significant MFP Change Should Be Increased

CMS proposes to trigger renegotiation based in part on a 15% change in the MFP. This threshold is unreasonably low given the natural variability of clinical and economic data over time and does not account for inflationary, manufacturing, or market dynamics. Such a narrow margin may inadvertently subject drugs to frequent renegotiation, undermining price predictability and investment planning.

We recommend that CMS define "significant change in MFP" as a minimum of 35%, which would more appropriately reflect material shifts in value without capturing minor fluctuations that may not meaningfully affect Medicare spending or clinical value.

2) CMS Should Clearly Define and Limit the Scope of "Material Change" and "New Indication"

CMS's use of e(1) and e(2) factors to define "material change" (including changes in clinical benefit, unmet need, or cost-effectiveness) is overly broad and risks capturing routine label expansions or lifecycle management efforts that are essential to meeting evolving patient needs—particularly in areas such as oncology and rare diseases, where indications are often developed sequentially over time.

Nearly 60% of oncology medicines receive follow-on approvals long after their initial approval, often seven or more years later.[48] Without clarity, manufacturers may be disincentivized from pursuing such label expansions that could benefit patients with high-burden conditions such as diabetes complications, obesity-related disease, or orphan cancers, for fear of triggering renegotiation prematurely.

3) Allow Streamlined Manufacturer Submissions for Reassessment

We strongly encourage CMS to allow manufacturers to submit updates to original Information Collection Requests (ICRs) rather than requiring entirely new submissions for each potential

[48] Based on interim results from PhRMA analysis of FDA data conducted by Partnership for Health Analytic Research, July 2022.

renegotiation trigger. Requiring duplicative reporting on unchanged factors adds unnecessary burden and is inconsistent with regulatory efficiency.

Moreover, CMS should permit manufacturers to submit attestations of no significant change in applicable pricing factors, rather than imposing default data submission obligations annually. This flexibility would reduce compliance burden and allow both industry and CMS to focus resources on truly meaningful changes.

4) Reinstatement of Acquisition Cost Reporting

We are also concerned by CMS's decision to remove acquisition cost reporting from the list of pricing factors relevant to R&D recoupment analysis. Acquisition cost plays a key role in understanding true manufacturer investment and the risk profile of a product—particularly for biologics with complex supply chains or specialty cold chain requirements, as seen in oncology and obesity treatment.

Given that oncology R&D costs average $4.46 billion and relies heavily on private investment, restoring this data element is essential. Private capital has become the dominant source of innovation funding, as federal R&D funding fell from 67% of U.S. R&D in the 1960s to just 21% by 2020, with venture funding increasing by 800% in some therapeutic areas—most notably oncology.[49],[50],[51] Lilly recommends reinstating acquisition cost as a required element of the ICR to maintain a complete and accurate picture of innovation risk and manufacturer return.

G. Healthcare Services Payable Under Medicare Part A or Part B Should not be Considered Therapeutic Alternatives

Data limitations present a formidable challenge. The absence of standardized, high-quality data on the efficacy and outcomes of non-drug therapies makes valid comparisons with pharmaceutical treatments inherently difficult. This limitation hampers the ability to accurately assess the relative value of different therapeutic options, potentially leading to suboptimal negotiation outcomes.

In addition, the complexity in evaluation must be acknowledged. Assessing non-pharmaceutical treatments involves different metrics and considerations. These treatments necessitate multifaceted assessments that extend beyond the straightforward efficacy and safety evaluations typically applied to drugs. Therapeutic classes themselves can be very broad, and expanding beyond pharmaceutical products may lead to reviews that are too broad in scope. This inherent complexity could impede the clarity and efficiency of price determination.

Healthcare services encompass a broad spectrum of treatments, from physical therapy to surgical interventions, which do not lend themselves to direct comparison with drug treatments in terms of

[49] Aylin Sertkaya, & Franz, C. (2022, December 16). *DEVELOPMENT AND APPROVAL COST ANALYSIS*. Nih.gov; Office of the Assistant Secretary for Planning and Evaluation (ASPE). https://www.ncbi.nlm.nih.gov/books/NBK603192/
[50] Gormley, B. (2021, October 14). *Healthcare Venture-Capital Fundraising Surges*. WSJ; The Wall Street Journal. https://www.wsj.com/articles/healthcare-venture-capital-fundraising-surges-11634171080?msockid=1f99d81d4dd86dc135e6cc554cca6cd8
[51] *Redesigning Federal Funding of Research and Development - Center for American Progress - Bing*. (2020). Bing. https://www.bing.com/search?q=Redesigning+Federal+Funding+of+Research+and+Development+-+Center+for+American+Progress&PC=U531&cvid=9486d6f65093414cbba1d5c7b4d27f7d&FORM=ANAB01

cost, outcomes, and applicability. Limiting therapeutic alternatives to pharmaceutical products ensures a focused, manageable scope for the program's process.

Further complicating matters is the challenge of defining the healthcare services or episodes of care associated with non-acute conditions. Unlike discrete pharmaceutical interventions, non-drug therapies—such as behavioral health interventions, physical therapy, or chronic disease management programs—often involve ongoing, variable, and multi-provider care over extended periods of time. This variability makes it difficult to delineate the boundaries of a single episode of care or identify the full set of services to be evaluated. Moreover, outcomes may depend as much on patient adherence, provider coordination, or social determinants as on the treatment modality itself. Without clear, consistent definitions of what constitutes the "treatment" or "intervention," any comparative evaluation risks becoming too diffuse or inconsistent to inform effective pricing or value assessments.

Moreover, the scope of Medicare coverage must be considered. Not all non-drug therapies are covered under Medicare Part B or Part D, limiting their relevance in the context of the program. Comparing interventions such as pharmacologic vs. non-pharmacologic approaches—across different benefit categories (e.g., Part A vs. Part B or D) – is not methodologically appropriate, as these categories are governed by distinct evidentiary standards and reimbursement frameworks. Focusing solely on pharmaceutical products ensures that the negotiation process remains within the bounds of Medicare coverage, enhancing its effectiveness.

Lilly strongly urges CMS to preserve the integrity of the framework by limiting therapeutic alternatives to pharmaceutical products. This stance ensures that negotiations remain grounded in reliable data and achievable assessments, ultimately safeguarding patient access to necessary medications and upholding the statutory intent of the Medicare program.

H. Prevent Program Overreach by Aligning Data, Refund, and Rebate Requirements with Statutory Intent and Economic Reality

1) CMS Should Adopt Certain Streamlined Definitions Related to R&D

As we have previously highlighted, CMS proposals require 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.[52] Because these proposals go beyond U.S. GAAP and SEC requirements, the burden they impose is specific to the Program and the time and resources needed to comply would be in addition to existing obligations. In addition, there are inconsistencies with the Paperwork Reduction Act (PRA),[53] 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.[54] This high data collection burden is

[52] 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.
[53] *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").
[54] 5 C.F.R. § 1320.5(d)(1)(i)-(iii).

not necessary to ensure the "proper performance of the agency's functions." CMS should limit the data requested to only those subjects and formats reasonably necessary to support the Program as provided for by the statute.

a. Acquisition Costs

CMS defines "acquisition costs" as "costs associated with the Primary Manufacturer's purchase from another entity of the rights to hold previously approved or future NDA(s) / BLA(s) of the selected drug." Such rights can be acquired via a number of different deal structures, and we assume this definition includes costs associated with licensing arrangements, co-development or clinical product supply agreements, and/or milestone payments. We recommend CMS acknowledge these diverse payment classifications in the final definition.

We also highlight that a manufacturer may acquire another company and that the acquisition cost may entitle the manufacturer to the rights to several potential drugs of the acquired company. In such circumstances, we recommend CMS acknowledge the manufacturers will need to make certain assumptions to apportion the costs associated with acquiring a company to the selected drug.

b. Pre-Clinical Research Costs

CMS defines 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." But the direct and indirect research costs associated with products that may be subject to the Program could have been incurred more than 20 years ago when this data was not required to be captured or retained. As a result, this data may not be available. Companies without access to historical data will be unable to fully reflect the R&D costs associated with a selected drug, whereas those with new products may be able to – ultimately jeopardizing the usefulness of the data to the Program.

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 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. If CMS is unwilling to adopt this approach then the agency should streamline these requirements to limit regulatory burden on stakeholders.

First, we assume that 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 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, CMS requires manufacturers to collect and provide data on "direct" and "indirect" research costs. As we previously highlighted, manufacturer financial systems are not configured to classify all expenses as direct v. indirect nor assign all direct expenses to a particular potential drug, as neither U.S. GAAP nor SEC regulations require delineation of R&D expenses in this way. The requirement to separate these costs creates regulatory burden with no clear benefit to CMS—particularly given that it is unclear how CMS uses this information. Thus, we recommend that CMS combine these questions allowing manufacturers to describe their methodologies comprehensively.

c. Post-Investigational New Drug (IND) Application Costs

The definitions in this R&D cost category are also limited to only those expenses "for each FDA-approved indication." In addition, CMS does not allow reporting of indirect expenses or any "ongoing" research. These limitations meaningfully limit the data that can be reported to CMS by excluding transactions that are otherwise included in manufacturers' financial statements. As a result, 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, as it represents a meaningful amount of expense and would facilitate a better understanding and interpretation by CMS of the research and development costs of a selected drug that will be subject to MFP for all future indications (unless the selected drug is renegotiated).

d. Abandoned and Failed Drug Costs

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 better depict the expenses incurred.

Also, as we described in our previous written comments, we appreciate CMS's acknowledgement that manufacturers incur R&D costs associated with failed or abandoned products. However, CMS continues to propose limiting the reporting of basic pre-clinical research costs for failed or abandoned products to those costs associated with products that have "the same active moiety / active ingredient or mechanism of action as the selected drug."

We disagree with this limitation and believe it is overly narrow, as a large portion of basic pre-clinical research expense would not be assignable to any marketed product. For example, Lilly has made significant investment in researching Alzheimer Tau Tangle targeting molecules, some of which has failed, but all of which has contributed to the overall advancement of Alzheimer's research.[55] As a result, we recommend that CMS allow manufacturers to allocate the basic pre-clinical research costs associated with abandoned or failed products to selected dugs in the same disease state or therapeutic class. This recommendation is consistent with CMS's proposal to include in "failed or abandoned drug costs" an allocation of direct post-IND costs for drugs in the same therapeutic class as the selected drug that did not achieve FDA approval.

2) <u>CMS Should Define that MFP Refunds Cannot Exceed the Standard Default Rebate Amount (SDRA)</u>

[55] *Lilly's tau drug for Alzheimer's flunks phase 2 test*. (2024, August 9). Pharmaphorum. https://pharmaphorum.com/news/lillys-tau-drug-alzheimers-flunks-phase-2-test

The SDRA relies on the notion that manufacturers must cover the mark-ups charged by others in the supply chain which creates serious concerns. First, this concept creates incentives for gaming by encouraging middlemen, dispensers and other entities within the pharmaceutical supply chain to raise prices because they know the manufacturer will come along and pay for these inflated costs. The argument might be that this would not occur because someone would have to "float" the inflated acquisition price, but as we have seen in other programs, there is no end to creativity intermediaries will deploy.

This problem is exacerbated by the fact that manufacturers lack influence over the prices dispensers pay to supply chain intermediaries, such as wholesalers. If CMS was the party at risk to such gamesmanship, we have no doubt the agency would take steps to prevent the misallocation of taxpayer dollars. But as the Department of Justice recently recognized in a similar situation, "it is arguably worse for the government to play fast and loose with others' (drugmakers') money on the line."[56] To prevent the possibility of artificially increased MFP reimbursements, CMS should define that that MFP refunds cannot exceed the SDRA (i.e., WAC minus the MFP).

3) CMS Should Exclude Selected Medicines from Inflation Rebates

CMS contends that "[t]he Part B and Part D inflation rebate programs apply to selected drugs, regardless of the status of the medicine as a selected medicine. Alternatively, whether a drug is a selected drug will have no bearing as to whether the drug is also subject to the Part B and Part D inflation rebate programs."[57]

CMS's contention is troubling because it is untrue. Selected drugs are not subject to inflation rebates, and Lilly urges CMS to clarify that this is the case. Under the statute, the Part B inflation rebate calculation is based on the amount by which "106 percent of the amount determined under paragraph (4) of [section 1847A(b) of the SSA] for [a Part B rebatable drug] during the calendar quarter . . . . exceeds . . . the inflation-adjusted payment amount . . . for such Part B rebatable drug during the calendar quarter."[58]

Importantly, the circumstances under which an amount is "determined" under paragraph (4) of section 1847A(b) is dictated by section 1847A(b)(1).[59] Section 1847A(b)(1) dictates a payment amount of, "in the case of a single source drug or biological . . . , 106 percent of the amount determined under paragraph (4) of section 1847A(b) *or* in the case of such a drug or biological product that is a selected drug . . . , with respect to a price applicability period . . . , 106 percent of the maximum fair price . . . applicable for such drug and a year during such period."[60]

In other words, a selected drug's payment must be determined under section 1847A(b)(1), and such payment amount must be determined without regard to paragraph (4) of section 1847A(b). Taken together, this means paragraph (4) defines the payment amount only for a non-selected drug. Accordingly, by statute, the Part B inflation rebate cannot be applicable to a selected drug – because there is no amount "determined under paragraph (4)," and therefore Part B inflation rebates cannot be applicable.

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[56] Reply Mem. (Doc. 24) at p. 17, *Albany Med. Health Sys. v. HRSA*, No. 23-3252 (D.D.C. Apr. 19, 2024).
[57] *See* Guidance at 186.
[58] SSA § 1847A(i)(3) (emphasis added).
[59] *See Id.* § 1847A(b)(1).
[60] *Id.* § 1847A(b)(1)(B) (emphasis added).

There is also every reason to believe such outcome was intended by Congress. There is no policy reason for application of inflation rebates to selected drugs. The MFP already constrains Medicare expenditures for selected drugs, and thus it would be illogical for Congress to apply inflation rebates in addition to the MFP.[61] This is especially true because the MFP already shields Medicare from price increases outpacing inflation, which is the very situation that inflation rebates were designed to address. Accordingly, we ask CMS to clarify that a selected drug is not subject to an inflation rebate, consistent with both the language of the statute and sound public policy.

III. Fix the Broken Mechanics of MFP Implementation

As CMS implements the Medicare Drug Price Negotiation Program across both Parts B and D, it is critical that the agency adopt a clear, consistent, and clinically informed approach to operationalizing the MFP, particularly for physician-administered Part B drugs. These therapies are often biologically complex, used in life-threatening conditions such as cancer, autoimmune disease, and diabetes complications, and are administered within highly coordinated care settings that differ significantly from the pharmacy benefit model in Part D.

Failure to account for these differences risks disrupting provider reimbursement, narrowing patient access, and destabilizing the innovation ecosystem that supports long-term therapeutic development. In particular, CMS must articulate how it will reconcile ASP-based reimbursement under Part B with negotiated MFPs, ensure that price reporting and ceiling calculations are appropriately tailored, and preserve incentives for lifecycle innovation—especially for therapies that receive new approvals years after initial launch. Additionally, CMS must safeguard against unintended operational consequences, including confusion in claims adjudication, blended dosage distortions, and compliance conflicts with statutory requirements such as the 340B program's non-duplication rule. Without thoughtful implementation and stakeholder alignment, the program risks imposing blunt pricing controls that penalize the very areas of high-need innovation it seeks to make more affordable. Lilly urges CMS to take the following actions to preserve clinical integrity, support provider sustainability, and ensure equitable patient access across both Parts B and D.

A. 340B Nonduplication

CMS correctly identified that the only feasible way to identify eligible MFP sales is through a post-transaction rebate. CMS correctly notes that pharmacies and their partners are not set up for point-of-sale identification of MFP eligible purchases, and that employing other forms of inventory management that may have been suggested would be prone to mismanagement, fraud, gamesmanship, and above all provide no assurance that patients would benefit.

This selection of rebate model was surely informed by the well-publicized issues in 340B program caused by its opaque, convoluted, often-abused alternative to post-transaction rebates known as the product replenishment model. As HRSA and 340B covered entities have admitted, in the product replenishment model a unit of medicine is purchased at 340B-pricing, but instead of being earmarked to go to an eligible 340B patient, the medicine is instead re-routed to "neutral inventory," where it is stripped of its status and identification as a 340B-priced unit and dispensed to the next patient, regardless of 340B status. This transfer to "neutral inventory" also removes any effective means to track later purchases, or critically to ensure that manufacturers are not subject

[61] *Id*. §§ 1847A(b)(1)(B); 1860D-2(d)(1)(D).

to unlawful duplicate discounts, which are already rampant in the Medicaid space and will certainly only grow with expanded areas of unlawful duplication under the IRA.

Instead of owning the statutory responsibility of oversight, CMS has instead left it up to manufacturers to figure out how to ensure they are not subject to unlawful duplicate discounts under two irreconcilable systems. Several manufacturers, including Lilly, recognized the only effective way to ensure they were protected from duplicate discounts was to exercise their statutory ability to make the 340B price available as a rebate, thereby gaining the necessary transparency and timing of effectuation to compare MFP claims to 340B claims and prevent duplicate discounts on the front end, as opposed to identifying the unlawful payments weeks or months later and then hoping to receive payment from the covered entity to make up the difference. Unfortunately, HRSA has to date refused to approve any rebate models that would allow manufacturers to ensure they are not subject to unlawful duplicate discounts. HRSA has indicated it will issue guidance on this topic, but it is unclear when this will come, what the guidance will say, and even if it permits rebates, if covered entities will comply.

For these reasons, CMS's statement that it is "considering ways to incorporate asynchronous 340B data into MTF processes in the future" is troubling. This reads as potentially adopting the post-transaction identification of 340B units through the "neutral inventory" fiction, despite the well-known issues described above. The IRA's statutory text is clear that manufacturers "shall not be required" to provide both the MFP and 340B price on the same unit. An "asynchronous" approach to 340B unit identification would directly contradict this statutory protection, as it would be predicated on covered entities and their vendors deidentifying 340B-purchases and opaquely identifying whatever units they wish as eligible purchases. We encourage CMS to support the manufacturer-funded 340B rebate models currently pending HRSA approval and identify such as the only valid—indeed, possible—way to comply with the IRA's prohibition on 340B/MFP duplication.

B. Request Clear, Aligned, and Clinically Informed Implementation of MFPs Across Parts B and D

As CMS moves forward with implementing drug price negotiation under the IRA, the inclusion of Medicare Part B drugs introduces critical policy challenges that demand careful and deliberate action. Many Part B therapies are complex, provider-administered biologics that treat life-threatening conditions like cancer and require precise coordination across clinical, operational, and reimbursement systems. The Trump administration has rightly emphasized the need to protect innovation, preserve physician and patient choice, and avoid government-imposed price structures that could lead to care disruptions—principles that remain highly relevant today.

Lilly strongly urges CMS to clarify how it will harmonize methodologies for determining and effectuating the MFP across Medicare Parts B and D. The fundamental differences in payment mechanisms—Part B's Average Sales Price (ASP)-based buy-and-bill model versus Part D's negotiated pharmacy benefit structure—necessitate a tailored, transparent approach. Without this, there is a real risk of undermining access and innovation in areas where medical need is most acute.

Finally, CMS must provide clarity and consistency in how MFPs will be applied across benefit designs. A consistent, clinically informed approach to implementing MFPs is essential to preserving continuity of care, avoiding disincentives for high-risk research, and supporting American medical innovation leadership.

The inclusion of Part B drugs—many of which are complex, provider-administered biologics critical to treating disease states like cancer—raises operational and policy challenges that, if not addressed thoughtfully, risk unintended consequences for patient access and medical innovation.

Lilly urges CMS to provide clarity regarding how it intends to harmonize methodologies for determining and effectuating the Maximum Fair Price (MFP) across Medicare Parts B and D. Given the fundamentally different reimbursement frameworks and operational considerations under Part B (ASP-based reimbursement, provider billing, buy-and-bill model) versus Part D (negotiated prices through PBMs and plan sponsors), a clear and detailed articulation of how CMS will account for these differences in MFP determination and implementation is critical.

CMS should adopt an (ASP + 6%) minus (MFP + 6%) methodology for calculating the SDRA under Medicare Part B as it ensures consistency in provider reimbursement while maintaining access to the MFP. This approach recognizes the various purchasing prices of providers and preserves margins relative to the status quo.

In addition, we request that CMS address:

- How the agency will reconcile the existing Average Sales Price (ASP) reimbursement system with an MFP for Part B drugs, particularly in relation to provider acquisition and reimbursement flows;
- Whether the ceiling price calculation methodology will differ between Part B and Part D products, and if so, how those differences will be reflected in the negotiation process;
- How CMS plans to ensure that providers and beneficiaries maintain access to Part B drugs under the new pricing structure, without creating access barriers or administrative burden on providers;
- Whether CMS will apply uniform rules for price reporting and enforcement across the two Parts or implement Part-specific adjustments;
- Ensuring that policies do not unintentionally penalize single-source therapies that span multiple indications or evolve through line extensions and lifecycle innovation.

This is especially relevant in oncology, where therapies often gain approval for additional indications years after their initial FDA approval. For example, pembrolizumab, originally approved for melanoma in 2014, was subsequently approved for 18 additional cancer indications. Similarly, ipilimumab, first approved in 2011, went on to be approved in nine additional cancer types over the next 11 years. Nearly 60% of oncology drugs approved a decade ago received further approvals, most of which occurred seven or more years post-approval. This underscores the need for MFP policy to support, rather than disincentivize, long-term clinical development.[62,63]

We believe a thoughtful and aligned approach is essential to preserving continuity of care and safeguarding beneficiary access. A consistent, transparent, and clinically informed approach to implementing MFPs across Parts B and D will be essential to maintaining both medical progress and patient-centered care.

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[62] Based on interim results from PhRMA analysis of FDA data conducted by Partnership for Health Analytic Research, July 2022.

[63] PhRMA analysis of Drugs@FDA: FDA-Approved Drugs

C. Executing the MFP in Part B: Avoiding Disruption to Care and Innovation

Lilly appreciates CMS's efforts to outline how the MFP will be effectuated across a broad range of provider settings, including hospitals, physicians, and other entities furnishing Part B drugs. However, we remain concerned that without detailed operational guidance, the implementation of MFPs in the Part B context risks significant disruptions to provider reimbursement, beneficiary access, and continued innovation in high-need therapeutic areas.

1) Establish a Per-Unit Pricing Methodology for Part B Drugs

We support CMS's proposal to consider a per-unit basis for calculating MFPs rather than the default 30-day equivalent supply model, which is more applicable to orally administered Part D therapies. The 30-day supply model introduces significant distortion in cases where:

- Dosing is infrequent or highly individualized, as in many oncology biologics (e.g., administered every 2–4 weeks, weight-based, or disease-segment adjusted);
- Drugs are episodically administered, such as in certain immunizations or injection-based diabetes complication therapies, where the average days-between-administration metric may be unrepresentative;
- Products are used in rare or complex disease settings, where dosing varies by indication or clinical status, risking undervaluation if based on average utilization patterns across a small and heterogeneous population.

A per-unit approach, tailored by drug and based on FDA-approved dosing regimens, would better align with clinical practice and allow for more accurate provider reimbursement.

2) Address Provider Reimbursement Challenges Under MFP Implementation

Part B providers, particularly in oncology and endocrinology, already operate on thin margins in the buy-and-bill model. Applying an MFP that is not appropriately reflected in reimbursement under the ASP + 6% system (or its sequestration-adjusted equivalent) could result in reimbursement rates below acquisition cost, which may:

- Disincentivize providers from stocking or administering MFP drugs;
- Shift care to hospital outpatient departments or vertically integrated systems, increasing total system costs and fragmenting care;
- Reduce participation in Medicare altogether in high-burden specialties or geographic areas.

This is particularly concerning for oncology, where drugs have an average development cost of $4.46 billion—more than four times the cost of nervous system drugs—and a success rate of just 3.4% from Phase I to approval, compared to a 13.8% average across all therapeutic areas. These dynamics highlight the importance of adequate and predictable reimbursement mechanisms.[64],[65],[66]

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[64] Aylin Sertkaya, & Franz, C. (2022, December 16). *DEVELOPMENT AND APPROVAL COST ANALYSIS*. Nih.gov; Office of the Assistant Secretary for Planning and Evaluation (ASPE). https://www.ncbi.nlm.nih.gov/books/NBK603192/
[65] U.S. Research and Development Funding and Performance: Fact Sheet | Congress.gov | Library of Congress
[66] *The Returns to Government R&D: Evidence from U.S. Appropriations Shocks*. (2024). Dallasfed.org. https://www.dallasfed.org/research/papers/2023/wp2305

3) Ensure Transparency and Fairness in Pricing Across Dosage Forms and Strengths

We remain concerned about CMS's approach of calculating a single MFP across all dosage forms and strengths of a selected drug. This "blended" pricing approach may:

- Penalize innovation where dose-ranging strategies or titratable formulations exist;
- Fail to reflect the true cost and value of higher-strength or indication-specific presentations;
- Create confusion for billing systems when units of measure are not clearly defined or consistent with real-world prescribing patterns.

We strongly recommend CMS require manufacturers to report National Drug Codes (NDCs) for Part B drugs, enabling more granular price tracking and ensuring MFP implementation reflects actual product use.

4) Special Considerations for Rare Diseases and Complex Indications

For drugs with multiple indications or dosing regimens—particularly those used in rare cancers, genetic conditions, or biologically targeted therapies—CMS's current methodology risks undervaluing treatment options that do not conform to average utilization patterns. An overly rigid or average-based MFP calculation could create disincentives for label expansion, lifecycle development, and investment in therapies serving underserved populations.

IV. Establish Clear Operational Standards and a Fair Dispute Resolution Framework

A robust and fair dispute resolution process is foundational to any government program—especially one as consequential and complex as the Medicare Drug Price Negotiation Program. As CMS prepares to implement the Program, it must do more than simply outline operational mechanics; it must institutionalize procedural safeguards that respect due process, preserve transparency, and ensure administrative accountability. Without clearly defined timelines, personnel standards, and decision-making structures, the risk of bureaucratic overreach, inconsistent enforcement, and stakeholder confusion grows exponentially.

A. CMS Should Clearly Define the Timelines and Processes for Complaint and Dispute Resolution, Including CMS Review Structure, Personnel Involved, and Criteria for Evaluating Information

To ensure the effective processing of disputes and complaints, it is imperative to clearly define the timelines and processes involved. We encourage CMS to provide more clarity on the complaints and disputes process, including more specificity for the complaints and disputes processes and more clarity about CMS' role. To guarantee an effective process, it is imperative to adhere to best practices, which encompass:

1) Due Process. The process should be conducted in a reasonable timeframe to prevent unnecessary delays and ensure that parties can move forward with resolution or enforcement of the decision. This encompasses providing access to claims-level data, a fair and orderly presentation of evidence, and genuine opportunities to contest inaccuracies.

2) Objectivity and Freedom from Conflicts of Interest. The individuals tasked with evaluating dispute claims should be neutral decisionmakers, not be part of the same group responsible for the design and execution of the program. Otherwise, these individuals may possess biases, positions, or other objectives that extend beyond the specific facts of the dispute in question. The entity administering the MTF must not have a vested financial interest based on whether more or fewer eligible claims for manufacturer refunds are honored.

3) Accountability. The MTF should not be permitted to impose, through "program administration rules" or likewise *de facto* regulations that alter the rights and obligations of stakeholders. CMS must ensure that a government entity is the arbiter of any dispute and that these disputes are governed by rulemaking related to the MFP program and implemented through appropriate administrative procedures.

4) Ability, Training, and Efficiency. The individuals responsible for determining the result should be trained with skillsets designed to resolve administrative disputes fairly and professionally.

5) Efficiency. Those responsible for responding to disputes should be a fully dedicated resource, not one appointed on an *ad hoc* basis. Moreover, they must apply the same routine over and over and able to handle procedural matters more expeditiously.

6) Transparency. The outcome and the process leading to a decision should be transparent, providing a clear understanding of the rationale behind the ultimate determination. These determinations should be summarized in a file identifying the result of the dispute and when the funds were returned to the manufacturer in a file format that is easily accessible.

7) Confidentiality. In some cases, it may be important to maintain the confidentiality of certain information. This can help protect sensitive information.

8) Finality. The dispute resolution process must have clear timeframes for resolving conflicts so that these disputes do not remain unresolved.

Additionally, to prevent these complaints or disputes from going un-resolved, a timeline for resolution should be indicated. We propose that CMS use the same resolution deadlines as the Coverage Gap Discount Program: sixty (60) calendar days after the dispute submission deadline date.

V. Conclusion

As currently designed and implemented, the IRA's Medicare Drug Price Negotiation Program risks undermining the very goals it claims to serve: meaningful innovation, equitable access, and long-term affordability. The disparate treatment of small molecule medicines under the IRA's statutory timelines—coupled with CMS's expansive aggregation policies and vague "bona fide marketing" criteria—compounds investment uncertainty and penalizes precisely those therapies that hold the most promise for broad, oral-based patient access. This asymmetry sends a chilling signal to the R&D ecosystem and diverges sharply from President Trump's stated policy priorities: rewarding differentiated value, accelerating competition, and preserving market-based innovation.

Moreover, CMS's current implementation approach fails to reflect the real-world clinical and economic value of medicines. It treats innovation as a one-time event, not a dynamic and cumulative process. By disregarding survival gains, patient-reported outcomes, and lifecycle investments—particularly in oncology and other high-need therapeutic areas, the program reduces complex scientific achievements to one-dimensional pricing benchmarks. This structural bias risks distorting care delivery, narrowing treatment options, and diminishing incentives for the very breakthroughs Medicare patients will need in the coming decades.

To fulfill the IRA's intended purpose without destabilizing the innovation pipeline, CMS must take decisive corrective action. This includes:

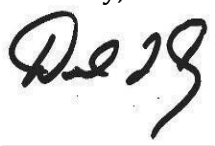
- Revising the QSSD aggregation and BFM standards to ensure statutory consistency and protect small molecule investment;
- Adopting a clinically grounded and operationally aligned MFP implementation strategy across Parts B and D, including protections for provider reimbursement, accurate unit pricing, and 340B non-duplication compliance;
- The assessment of therapeutic alternatives should remain specific to pharmaceutical products and not include healthcare services payable under Medicare Part A or Part B;
- Institutionalizing a robust dispute resolution framework with clear timelines, transparency standards, and administrative safeguards to ensure accountability and due process.

Only through such course corrections can CMS preserve the delicate balance between affordability and innovation and ensure that the Medicare Drug Price Negotiation Program truly serves the patients it was designed to protect.

***

Lilly is grateful for the opportunity to comment on certain sections of the Draft Guidance. We sincerely appreciate your thoughtful consideration of the issues discussed in this letter and look forward to working with you in the future to help ensure that patients have meaningful access to affordable health care benefits and prescription drug coverage. Please do not hesitate to contact Derek Asay at Asay_Derek_L@Lilly.com with any questions.

Sincerely,



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June 26, 2025

Submitted via email to: IRARebateandNegotiation@cms.hhs.gov

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
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RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Director Klomp:

The Massachusetts Biotechnology Council ("MassBio") appreciates this opportunity to submit comments on the Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price ("MFP") in 2026, 2027, and 2028 (the "IPAY 2028 Draft Guidance").

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 1,800+ 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. Given the potential impact on innovation and thus on vulnerable patient access to life-saving therapies, we continue to urge CMS to adopt a "do no harm" approach in implementing this program that errs on the side of mitigating against the potential disincentives created by the program's framework, and that allows the agency to make corrections as needed to preserve innovation.

In particular, with respect to the IPAY 2028 Draft Guidance, we urge CMS to:

- Explore opportunities to preserve incentives to develop innovative therapies;
- Expeditiously implement processes for MFP effectuation that facilitate manufacturer compliance without resulting in duplicate discounts; and
- Evaluate the impact of the IRA on the innovation ecosystem, particularly in Massachusetts.

I. CMS Should Explore Opportunities to Preserve Incentives to Develop Innovative New Therapies.

***Orphan Drugs*.** MassBio remains concerned that the narrow scope of the orphan drug exclusion creates a strong disincentive for developers to continue to develop new indications and formulations for existing orphan therapies.

Rare diseases, as defined by the FDA, are conditions that impact fewer than 200,000 patients nationwide, and are inherently under-researched, under-diagnosed, and under-treated. Although much progress has been made since the enactment of the Orphan Drug Act (ODA) 40 years ago, over 90 percent of known rare diseases still do not have therapies or treatments.

This scarcity in therapies is due to a variety of reasons, including the resource and time investment needed to generally design, develop and bring a drug to market,[1] as well as the low success rate of this process.[2] There are also plethora of challenges specific to developing drugs for rare diseases, as the low number of actual patient numbers for certain diseases makes it difficult to establish an adequately sized and diverse patient population for a clinical trial, as well as obtain the high-quality patient data necessary to evaluate clinical trial outcomes.

That said, there has fortunately been a recent surge in the development of drugs for rare disease populations,[3] with much of this development occurring in Massachusetts.[4] Today 40 percent of therapies in the pipeline are in rare disease. Furthermore, given the nature of rare diseases, therapies developed for a particular rare disease can often be the starting point in the translation of new scientific discoveries to clinical medicine.

However, the narrow scope of the orphan drug exclusion creates a strong disincentive to undertake these investments, even though the science is there and could benefit vulnerable populations. Furthermore, because of the limited scope of the exclusion, companies may be

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[1] It can take 10 to 15 years and $1-2B for a drug to be designed, developed and approved for use in patients. I.V. Hinkson, B. Madej, E.A. Stahlberg, *Accelerating therapeutics for opportunities in medicine: a paradigm shift in drug discovery*, Front Pharmacol, 11 (2020), p. 770.

[2] 90 percent of developed drugs are unsuccessful. H. Dowden & J. Munro, *Trends in clinical success rates and therapeutic focus*, Nat Rev Drug Discov, 18 (2019), pp. 495-496.

[3] L. J. Fermaglich & K. L. Miller, *A comprehensive study of the rare diseases and conditions targeted by orphan drug designations and approvals over the forty years of the Orphan Drug Act*. Orphanet J Rare Dis. (June 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10290406/.

[4] D. Seiffert, *Massachusetts owns the orphan drug market. Here's the proof,* Boston Business Journal (Nov. 9, 2015), https://www.bizjournals.com/boston/blog/bioflash/2015/11/massachusetts-owns-the-orphan-drug-market-here-s.html.

disincentivized from developing therapies for rare diseases to begin with, and to instead prioritize indications with larger patient populations from the outset.

For these reasons, we are concerned that CMS has not proposed any policies in the IPAY 2028 Draft Guidance to ensure that implementation of the Negotiation Program will not undermine orphan drug development. Notably, in the past CMS has stated that it would "consider[] whether there are additional actions the agency can take in its implementation of the Negotiation Program to best support orphan drug development."[5] However, the IPAY 2028 Draft Guidance is noticeably silent with respect to this important issue.

MassBio continues to urge CMS to implement the orphan drug exclusion in a way that promotes and is consistent with the underlying purposes and goals of the ODA: to create the necessary financial incentives to accelerate the development of rare disease drug development. For example, CMS should exercise its regulatory discretion to start the pre-negotiation period for orphan drugs upon loss of the orphan drug exclusion (i.e., when the product obtains approval for a new indication for a different disease or condition), rather than when the product was initially approved. In addition, once an orphan drug is selected for negotiation, CMS should ensure that its consideration of the statutory factors adequately values the benefit the therapy brings to patients with rare disease.

Pill Penalty. MassBio also remains concerned with the "pill penalty" inherent in the IRA, pursuant to which small molecule drugs may be subject to negotiation under the Program four years earlier than biological products. This unequal treatment will have serious consequences for vulnerable patients who rely on these drugs. Recent reports indicate that the pill penalty has resulted in a significant decline in R&D investment in small molecule medicines.[6] Furthermore, Medicare Part D plans have indicated that they plan to increase utilization management practices and patient cost-sharing for small molecule drugs selected for IPAY 2026.[7]

In the April 15, 2025 Executive Order "Lowering Drug Prices by Once Again Putting Americans First,"[8] the Trump Administration acknowledged this disparate treatment and its potential harm, and calls on HHS and Congress to "to modify the Medicare Drug Price Negotiation Program to align the treatment of small molecule prescription drugs with that of biological products, ending the distortion that undermines relative investment in small molecule prescription drugs…."

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[5] Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027.

[6] D. G. Schulthess et al., *The Inflation Reduction Act's Impact Upon Early-Stage Venture Capital Investments*, Ther Innov Regul Sci (April 2025), https://link.springer.com/article/10.1007/s43441-025-00773-3.

[7] Magnolia Market Access, *Inflation Reduction Act Payer Insights Report* (Summer 2024), www.magnoliamarketaccess.com/wp-content/uploads/MMA_IRA-Payer-Insights-Survey4.0_Chartbook_2024.07.31.pdf.

[8] Exec. Order No. 14,273, 90 Fed. Reg. 16441 (April 18, 2025), https://www.govinfo.gov/content/pkg/FR-2025-04-18/pdf/2025-06837.pdf.

MassBio strongly supports legislative efforts to address this issue and welcomes the opportunity to work with the Administration and Congress to ensure swift passage.

II. CMS Should Establish Processes for MFP Effectuation that Facilitate Manufacturer Compliance Without Resulting in Duplicate Discounts.

MassBio appreciates CMS's efforts to support the effectuation of the MFP, including through the creation of the Medicare Transaction Facilitator (MTF). We are concerned, however, that CMS has yet to outline a specific proposal for MFP effectuation with respect to Medicare Part B. While CMS has proposed to adopt a similar effectuation approach as Part D, this approach overlooks the various ways in which Part B and Part D differ in materials ways. These include, for instance, the number of dispensing entities, the manner in which drugs are purchased and dispensed, and the unique coding and reimbursement systems across the two parts. We urge CMS to consider these factors and engage closely with a variety of stakeholders, including manufacturers, to develop a workable effectuation approach for Part B drugs.

We are similarly concerned that, even in the Part D context, elements of CMS's existing framework may impose undue burden on manufacturers or complicate manufacturers' ability to effectuate the MFP without resulting in duplicate discounts. We therefore urge CMS to take proactive steps to prevent duplicate discounts between the Negotiation Program and the 340B drug discount program.

The Negotiation Program statute exempts manufacturers from providing access to the MFP to covered entities when the 340B ceiling price is lower than the MFP for a given selected drug.[9] Although the statute requires manufacturers to provide access to the MFP if it is lower than the 340B ceiling price, this provision further requires that the MFP be offered in a "nonduplicated amount."[10] The proper implementation of this provision is necessary to ensure the proper functioning of the MFP as contemplated by Congress.

However, although IPAY 2026 is fast approaching, in the IPAY 2028 Draft Guidance, CMS has not proposed any specific policies in response to manufacturer concerns about preventing 340B duplicate discounts. CMS instead states that it "will not, at this time, assume responsibility for nonduplication of discounts between the 340B ceiling price and MFP." Instead, CMS states that it is "continuing to explore" the feasibility of incorporating 340B-related transactional data from 340B covered entities identifying such claims, including "considering ways to incorporate asynchronous 340B data into MTF processes in the future."

MassBio urges the prompt adoption of a framework that incorporates 340B-related transactional data into MTF processes. As we have stated in previous comment letters, a process that requires manufacturers to work out deduplication directly with covered entities, without any involvement

[9] SSA § 1193(d)(1).
[10] SSA § 1193(d)(2).

from CMS, is simply not realistic. As such, one approach CMS can take to actively implement the 340B nonduplication provision is to require covered entities to identify 340B claims at the point-of-sale using available 340B claims modifiers. CMS can also impose requirements on Part D plans regarding the types of claims that they may adjudicate. Specifically, CMS could designate the lack of a 340B claims modifier as a "defect" that prevents the claim from being a "clean claim" subject to the prompt payment standard.

We stress that it is critical that CMS expeditiously adopt such a framework governing the identification of 340B claims ahead of IPAY 2026. Manufacturers are required to submit their plans for implementing MFP by September 1, 2025, and clarity with respect to the identification of 340B claims is an essential component of this process.

III. CMS Should Evaluate the IRA's Impact on the Innovation Ecosystem in Massachusetts.

We continue to urge CMS to carefully examine the impact of the law in Massachusetts. In light of Massachusetts' unique role as the hub of companies directly engaged in research, development, and manufacturing of innovative products, Massachusetts will be a "canary in the coal mine" in terms of changes to the system, and will thus be a good test case to see how IRA implementation affects the biotech industry.

In early 2023, MassBio surveyed its membership regarding the IRA's immediate impacts, and member perspectives regarding certain regulatory and legislative policies that could mitigate those impacts. MassBio plans to continue to survey our membership and perform other data-driven approaches to monitor the impact of the law, and we hope to have the opportunity to be a resource for CMS as it begins to track the impact of the IRA.

Likewise, as CMS proceeds with implementation of the law, MassBio urges the agency to similarly prioritize building the necessary infrastructure to track the impact of the IRA on the innovation ecosystem. This will be vital given the long-standing relationship between innovation and increased access to life-saving therapies, and the need for the agency to "do no harm" in the ongoing implementation of this program. For instance, CMS could track the following metrics, using CMS's own data and certain data available from the FDA, to assess the IRA's impact over time:

- Number of new technology add-on payment applications for drugs and biologicals;
- Requests for pass-through status under the Hospital Outpatient Prospective Payment System;
- Number of new NDCs in average sales price (ASP) reporting data;
- Number of NDA/BLA submissions (tracking proportion of small-molecule vs. large molecule over time);
- Number of supplemental NDA/BLA submissions;
- Number of applications for orphan drug designation (ODD);

- Percent of products with an ODD that are approved by FDA;
- Number of applications for breakthrough therapy designation;
- Number of applications for fast-track designation; and
- Number of applications for regenerative medicine advanced therapy designation.

We further urge CMS to publicly report data to inform both the public and policymakers in Congress, and to establish a dynamic framework pursuant to which significant decreases in relevant metrics trigger reconsideration of the negotiation process implemented by the agency.

IV. Conclusion

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.

Best regards,

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June 26, 2025

Chris Klomp
Deputy Administrator and Director of the Center for Medicare
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Department of Health and Human Services
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Sent electronically via: IRARebateandNegotiation@cms.hhs.gov
RE: Draft Guidance on the Medicare Drug Price Negotiation Program

Dear Deputy Administrator Klomp:

McKesson Corporation ("McKesson") appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS), Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028.

About McKesson

McKesson is a global leader in healthcare supply chain management solutions, community pharmacy, community oncology and specialty care, and healthcare information technology solutions. McKesson partners with pharmaceutical manufacturers, providers, pharmacies, payers, federal, state, and local governments, and other organizations in healthcare to advance health outcomes for *all*.

As a diversified healthcare leader, our solutions help patients access life-changing therapies, create a real difference for patients with cancer, and equip pharmacies, health systems and clinics with technologies to operate more effectively. Our provider and pharmacy partners operate in communities that include some of the most underserved urban and rural areas of the U.S. As we work across our partners and customers, McKesson strives to ensure that its views on improving healthcare prioritize what is best for the patient.

General Comments

McKesson shares CMS's commitment to ensuring that Medicare beneficiaries have access to affordable, high-quality medicines. We support the agency's efforts to implement the Inflation Reduction Act (IRA) in a way that lowers drug costs while preserving patient access, provider sustainability, and innovation. As a healthcare partner serving patients across the care continuum, we appreciate the opportunity to provide feedback and recommendations on operationalizing the Medicare Drug Negotiation Program for Part B drugs to help CMS achieve its goals in a manner that is operationally feasible and minimizes disruption to care delivery.

Foundational Differences Between Part D and Part B

We appreciate CMS's intent to align policies and operations across Medicare programs. However, we strongly believe that applying a uniform maximum fair price (MFP) effectuation model across both Part D and Part B fails to account for critical structural, operational, and statutory differences between the two programs. These differences are not merely technical—they are foundational and have direct implications for patient access, provider sustainability, and the integrity of the Medicare benefit. Accordingly, we urge CMS to consider a more differentiated approach that reflects the unique

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characteristics of each program in order to avoid operational complexities and unintended consequences for beneficiaries and stakeholders.

Part B (FFS & MA) Lacks Part D Uniformity

Unlike Part D, where both stand-alone Prescription Drug Plans (PDPs) and Medicare Advantage Part D plans (MA-PDs) follow a unified claims and pricing model, Medicare Part B operates under two distinct administrative and payment frameworks—fee-for-service (FFS) and Medicare Advantage (MA)—that introduce additional complexity for MFP implementation.

In the FFS context, Part B claims, inclusive of drugs and related administration services, are submitted using Healthcare Common Procedure Coding System (HCPCS) codes and processed through the standard Medicare Administrative Contractors (MACs). These claims are retrospective and often delayed, but they are relatively standardized and auditable. Providers are reimbursed at average sales price (ASP) + 6%[1] for Part B drugs, and the claims data is used directly for program integrity, pricing, and policy evaluation.

In contrast, CMS only receives encounter data from MA plans, which is often submitted months after services are rendered and varies widely in completeness and accuracy. Unlike the standardized, auditable claims in FFS, this data is not used for direct payment and lacks the timeliness and granularity needed for effective MFP reconciliation. MA plans are paid on a capitated basis, with drug reimbursement embedded in actuarial benchmarks—there is no ASP + 6% mechanism as in FFS. These differences create operational fragmentation: the disparate adjudication and reimbursement processes across FFS and MA make a single MFP model impractical. Implementing distinct reconciliation mechanisms for each FFS MAC and MA clearinghouse would introduce significant administrative burden on providers.

Part B Lacks Part D's Real-Time Claims Infrastructure and Prompt Payments

Part D claim adjudication operates through a near real-time, National Drug Code (NDC)-level infrastructure that enables precise tracking of drug utilization and supports the timely reconciliation of MFP refunds. Pharmacies submit claims to pharmacy benefit managers (PBMs) at the point of sale, and prescription drug event (PDE) data flows through established systems that support accurate, auditable, and streamlined effectuation.

In contrast, Part B claims are processed retrospectively, often with delays of 30 to 90 days or more as providers have up to one year to submit a claim for services rendered. This lag makes real-time MFP pricing infeasible. Further, Part B billing relies on HCPCS codes, which typically encompass multiple NDCs. The lack of NDC-level granularity in Part B claims complicates the reconciliation of MFP refunds and introduces a significant risk of error if a near real-time solution is contemplated. These structural differences make it impractical to replicate the Part D model in the Part B context.

Part B Lacks Part D's Uniform and Centralized Operational Framework

Under the Part D program, all PDE data is submitted by plans to CMS within 30 days of the dispense date regardless of whether the patient is covered by a standalone PDP or a MA-PD. **No such uniformity or source of truth exists in the claims processing under Part B.**

[1] https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_PartB_FINAL_SEC.pdf

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Claims are submitted either to CMS in the case of FFS or to the appropriate plan in the case of MA. FFS claims are processed by one of twelve different MACs depending on geography; MA claims data is retained by each plan. Part B MFP effectuation will accordingly require a significant investment in data collection and should not place an additional administrative burden on providers, who are already manually tracking the status of each claim to ensure appropriate and timely plan reimbursement. Multiple clearing houses in the Part B processing flow aggregate claims across multiple providers and payers and would need to update systems for readiness for Part B MFP effectuation.

IRA Part B Negotiation Effectuation: Key Considerations

As CMS continues to refine its approach to MFP implementation, it is essential to recognize that Part B presents unique operational and statutory dynamics that require tailored solutions.

Retrospective Refunds to Providers

The Part B program is currently largely managed via buy-and-bill, where physicians, hospitals, and outpatient clinics acquire and administer drugs and are subsequently reimbursed by Medicare at ASP + 6%. These providers are not equipped to manage reduced upfront reimbursement coupled with delayed or uncertain MFP refunds. Requiring them to front the cost of drugs and wait for retrospective refunds would create significant cash flow challenges, particularly for smaller practices and rural providers. This could lead to reduced willingness to stock negotiated drugs, ultimately threatening patient access.

We urge CMS to ensure that any manufacturer refund payments to providers are not subject to meaningful delays relative to current reimbursement, which currently occurs within about 45 days in the Part B space. Because Part B claims are adjudicated retrospectively—unlike the near real-time processing in Part D—CMS must ensure that manufacturer refund payments are not delayed beyond the standard 45-day window due to payer-side administrative processes, while also avoiding added burden on providers.

Prospective Purchasing

The proposed use of wholesaler chargebacks for Part B MFP implementation is untested. While this mechanism may offer a theoretical pathway for effectuation of manufacturer discounts to providers, it lacks the infrastructure maturity and regulatory clarity needed to ensure accuracy, compliance, and timely payment under the IRA Medicare Drug Price Negotiation Program.

For example, the use of wholesaler chargebacks would require wholesalers to fund MFP discounts prospectively. The manufacturer would then pay the WAC - MFP chargeback to the wholesaler based on their contracted agreements. However, this model assumes a level of coordination and data transparency that does not currently exist in the Part B ecosystem as MFP eligibility would not be known by the wholesaler at the time of sale. Wholesalers are responsible for the distribution of medical products and supplies, and their role does not involve handling or accessing sensitive patient data. Additionally, the current guidance makes clear that CMS and its contractors will not be responsible for funding or guaranteeing MFP refunds. This places the full burden of operationalizing the refund process on wholesalers, without the safeguards or enforcement mechanisms necessary to ensure reliability.

Moreover, the operational burden of maintaining dual inventories—necessary under a prospective purchasing model—would be infeasible for most providers and could result in diversion, misuse, or abuse of MFP discounted product.

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Retrospective Rebate Model Between CMS and Manufacturer

We recommend that CMS adopt a retrospective rebate model for effectuating the MFP in Part B, structured as a transaction between CMS and the manufacturer. This approach mirrors the operational design of the inflationary rebate mechanism already in place under the IRA. A recent analysis by Milliman of similar legislative provisions found that adopting a retrospective rebate model between manufacturers and Medicare could generate $3.3 billion in federal savings over ten years—without affecting projected patient savings or premiums.[2]

Under this model, providers would continue to acquire and administer drugs as they do today and be reimbursed through existing Medicare payment systems—without disruption to cash flow, inventory management, or claims processing. Patient cost-sharing could be adjusted based on the MFP, ensuring beneficiaries benefit from lower prices at the point of care. On the back end, CMS would reconcile any overpayments by collecting the difference between total reimbursement and MFP directly from manufacturers.

This structure offers several advantages:

- **Operational Continuity:** Providers are paid as they are today, preserving the integrity of the buy-and-bill model and avoiding the need for dual inventory systems or new billing workflows.
- **Administrative Simplicity**: Because CMS already processes claims and has visibility into utilization, it is well-positioned to calculate and collect rebates without requiring providers to manage or track MFP-related adjustments.
- **Patient Affordability:** Cost-sharing can be calculated based on the MFP, ensuring that patients see the benefit of negotiated prices without requiring providers to alter their billing practices.
- **Precedent:** This model is consistent with how inflationary penalties are administered; CMS reimburses providers based on ASP with patient coinsurance reflecting an inflation-adjusted amount at point-of-sale, and manufacturers refund the difference retrospectively. It is a proven, scalable approach that minimizes disruption.

Under this model, patient coinsurance would be calculated at point of sale based on the negotiated MFP: that is, patient out-of-pocket costs would be capped at their cost-sharing amount of MFP + 6%. The Medicare plan would ensure that total reimbursement to the provider would align to statutory (ASP + 6%) or MA negotiated rates. Manufacturers would then accordingly reimburse CMS for the difference between Medicare statutory reimbursement of ASP + 6% and the IRA negotiated price of MFP + 6%. This approach would ensure predictability for providers to avoid disrupting patient access to care. We note that continuing to rely on ASP-based reimbursement metrics for negotiated drugs would only be appropriate if manufacturer MFP refunds are excluded from the ASP price calculation (to ensure that ASP continues to accurately reflect provider acquisition costs). This is discussed in more detail in the subsequent section.

Standardized Default Rebate Amounts (SDRA) Must Reflect Payment Context

As discussed in a previous section, **if retrospective refunds are reconciled between manufacturers and CMS**, the standardized rebate amount should be calculated as the difference between ASP + 6% and MFP + 6%. ASP + 6% most accurately captures the total reimbursement cost by CMS or the MA plan.

[2] Impact of the Inflation Reduction Act on Part B Provider Payment and Patient Access to Care, Milliman, May 9, 2025, https://www.milliman.com/en/insight/ira-impact-on-part-b-provider-payments

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However, **if retrospective refunds are reconciled between providers and manufacturers**, the rebate basis must shift to Wholesale Acquisition Cost (WAC) – MFP. A WAC-based refund to providers ensures alignment with provider acquisition costs and preserves provider financial stability and predictability. We urge CMS to proceed cautiously in developing any SDRA for Part B and recognize that ASP does not consistently reflect provider acquisition costs. Unlike WAC in Part D, ASP's averaging methodology may underrepresent the prices paid by many providers as these calculations include all commercial discounts on the drug, not just those extended to providers.

A Centralized Approach to Part B Implementation

To avoid misaligned incentives, we recommend that CMS serve as the central authority overseeing all aspects of MFP implementation in Part B. CMS should be the purveyor of truth—ensuring data integrity, managing reconciliation, and maintaining program oversight. This centralized approach promotes transparency, accountability, and operational consistency.

Use Existing Modifier for 340B

CMS should require covered entities to use the established 340B claims modifier. This approach enables clear identification of 340B claims and eliminates the need for post-claim reconciliation. It is already in use, familiar to providers, and minimizes administrative burden while supporting compliance.

Program Integrity and Market Stability

Providers rely on predictable reimbursement and streamlined acquisition processes to deliver timely care. Introducing uncertainty into this system—through delayed refunds, inventory segregation, or unclear reconciliation protocols—risks undermining provider participation and patient access.

Disruptions to Access in Local Communities Must be Avoided

Specialists, like oncologists and ophthalmologists, generally incur substantial upfront costs associated with the acquisition, storage, and handling of specialty drugs. Should the reduced reimbursement rates prove insufficient to adequately cover these essential drug acquisition and operational expenses, specialty practices will experience heightened financial strain. This increased financial distress may lead to a greater likelihood of consolidation with larger health systems, potential closures, or restricted patient access to vital therapies. Administrative burden and reimbursement hurdles could accelerate site-of-care shifts away from community-based settings, undermining access for patients in rural and underserved areas. Small community practices, which allow patients to access treatment close to home, will be least equipped to manage the financial and operational burden of Part B negotiation effectuation and may be forced to refer patients to large treatment centers which benefit from higher Medicare reimbursement on administrative services.

Disruptions in Access to Preferred Products Must be Avoided

We strongly recommend that MFP refunds be excluded from ASP calculations to avoid introducing significant disruption to providers. ASP is a critical benchmark for provider reimbursement, and altering its composition could have unintended consequences for provider sustainability and patient access outside of Medicare. Since Part B IRA negotiation does not impact the acquisition price of negotiated drugs for providers, erosion of ASP-based reimbursement may inadvertently reduce patient access to preferred therapeutics.

Importantly, the IRA is silent on whether MFP must be included in ASP calculations, giving CMS clear discretion to exclude it — a step we strongly encourage to preserve the integrity of the ASP-based

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reimbursement system and avoid unintended consequences for provider sustainability. Further, this approach would not impact the cost of Medicare reimbursement on these negotiated drugs as Medicare patients and payers would continue to benefit from MFP-based reimbursement.

Conclusion

In light of these considerations, we urge CMS to adopt a tailored approach to MFP effectuation in Part B that:

- Reconciles MFP discounts between manufacturers and CMS to avoid placing undue burden on providers;
- Excludes MFP from ASP calculations;
- Maintains CMS as the central oversight body for implementation; and
- Most importantly, **ensures patients realize savings without disrupting access to providers or treatments.**

We remain committed to working with CMS to develop a workable, patient-centered approach to MFP implementation in Part B that preserves access, supports providers, and upholds the integrity of the Medicare program. If you have questions or need further information, please contact Fauzea Hussain, Vice President of Public Policy, at Fauzea.Hussain@McKesson.com.

Sincerely,

Rich Buckley

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June 26, 2025

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RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp:

Merck Sharp & Dohme LLC, a subsidiary of Merck & Co. Inc., Rahway, NJ, U.S.A. (collectively, "Merck"), is writing to submit comments on the Centers for Medicare & Medicaid Services' (CMS's) draft guidance on the Medicare Drug Price Negotiation Program (the Program), including draft guidance on manufacturer effectuation of the maximum fair price (MFP) for initial price applicability years (IPAYs) 2026, 2027, and 2028 (the Draft Guidance).[1]

Merck is a global research-based pharmaceutical and health care company. Through a combination of the best science and state-of-the art clinical development, Merck has produced many important medicines and vaccines. Today, the company is actively developing a broad portfolio of small molecules, vaccines, and biologic products, with the goal of improving worldwide patient access to important and life-saving therapies. Merck continues to firmly believe that the Program is unconstitutional. Specifically, the Program coerces manufacturers under threat of severe penalties to "negotiate" and "agree" to "fair" prices, in violation of the

[1] Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 (May 12, 2025), https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf (Draft Guidance).

First and Fifth Amendments. If manufacturers are required to participate in this unconstitutional price-setting program and provide access to the government-set price, CMS must administer the program in a way that ensures the integrity and operational feasibility of MFP effectuation.

Merck generally supports the comments of our trade associations, the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Industry Organization (BIO).[2] Merck is concerned about certain aspects of CMS's proposed revisions to the Guidance, and, as one of the manufacturers with a selected drug for both IPAY 2026 and IPAY 2027, is also concerned with the feasibility of the proposed MFP effectuation. Merck writes separately to address these key issues. Our comments are summarized as follows:

- CMS Should Abandon Its Proposed Guidance Change Related to Fixed Dose Combination Drugs. Merck urges CMS to abandon its proposal in the Draft Guidance to aggregate certain "fixed combination drugs" with their component active moieties or active ingredients.[3] CMS's proposal is impermissible under *Loper Bright* – which compels agencies to adopt the single, best reading of a statute – and violative under the Administrative Procedure Act (APA) as arbitrary and capricious and not adequately explained. CMS's proposal also would create rampant uncertainty and thus undermine incentives for manufacturers to develop fixed combination drugs for the benefit of patients.

- CMS Should Use Accurate and Consistent 30-day Equivalent Supply Price Calculations to Calculate Prices of Selected Drugs and Therapeutic Alternatives. When calculating 30-day equivalent supplies to determine the price of a selected drug or therapeutic alternative, CMS should divide all days between service by 30 and should use the dosing information on a product's label to determine the days between service. While this is particularly important in Part B where drugs frequently have complex dosing regimens, the same principles are applicable to Part D drugs. In addition, for instances where a product has different dosages or strengths and is priced at parity (e.g., non-linear pricing), CMS should ensure the proposed methodology accurately calculates the 30-day equivalent supply price for the selected drug and accurately applies the 30-day equivalent MFP to each NDC-11 drug and to each billable unit.

- Manufacturers Should Not Be Required to Provide "Forward Looking" Market Data. While the statute permits CMS to collect market data about a selected drug, it does not permit the agency to collect speculations about future market conditions. Moreover, compelling manufacturers to report and certify projections (which are inherently inaccurate as no one can accurately predict the future) would create undue risk and burden to manufacturers.

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[2] In particular, we emphasize PhRMA's comment that CMS lacks legal authority to include MFP in ASP calculations and has the legal authority to exclude the MFP from ASP reporting requirements. CMS should confirm that MFP is not included in ASP in order to avoid market disruptions, provide critical stability to provider payments, and ensure continued patient access to selected drugs. We note that including MFP in ASP would be particularly disruptive if an MFP is applied across HCPCS Codes.

[3] CMS, *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028*, at 13 (May 12, 2025) (Draft Guidance).

- CMS Must Facilitate 340B Nonduplication to Enable Statutory Compliance. The Program statute requires manufacturers to make available the lesser of MFP or the 340B price for a selected drug, but not both. As Merck has stated in prior comments, CMS has both the authority to implement the 340B nonduplication requirement and the obligation to help facilitate the statutory intent. CMS should do so by requiring dispensers to use a claim-level modifier that affirmatively indicates whether each claim is 340B-eligible or not 340B-eligible. To assure compliance with the Program's nonduplication requirement, CMS should require modifiers on all claims subject to the MFP (including Part B drugs paid by Medicare Advantage plans) and must enforce use of the modifiers.

- CMS Should Not Require a Manufacturer to Increase the MFP Retrospective Refund Amount to Account for Third-Party Fees or Other Supply Chain Costs. As Merck has stated in prior comments, to ensure the integrity of MFP effectuation and mitigate supply chain incentives to inflate the MFP discount amount, CMS should clarify that the manufacturer will not be required to increase the MFP retrospective refund to account for third-party fees or other supply chain costs.

- Manufacturers Should Not Be Penalized for Medicare Transaction Facilitator (MTF) Operational or Technical Issues. While Merck supports CMS's efforts to establish the MTF Data Module (DM) and MTF Payment Module (PM), we are concerned about whether the MTF DM and PM will be operational by January 1, 2026. CMS should affirmatively state that it will not impose civil monetary penalties (CMPs) on manufacturers as a result of operational or technical issues with the MTF DM or PM that are outside of the manufacturer's control.

I. CMS Should Abandon Its Proposed Guidance Change Related to Fixed Dose Combination Drugs

A. Background on the Drug Price Negotiation Program and CMS's Treatment of Fixed-Combination Drugs

For both IPAY 2026 and IPAY 2027, CMS treated "distinct combinations of active moieties / active ingredients as one active moiety / active ingredient for the purpose of identifying potential [QSSDs]" such that they would not be aggregated with products containing the individual active moieties or active ingredients.[4] In the Draft Guidance, CMS generally retains this approach, but proposes to reverse course as to certain fixed combinations:

[4] CMS, *Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026*, at 100 (June 30, 2023) (IPAY 2026 Final Guidance); I CMS, *Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027*, at 169 (Oct. 2, 2024) (IPAY 2027 Final Guidance).

> [T]here may exist fixed combination drugs for which one of the active ingredients or active moieties contained is not ***biologically active*** against the disease state(s) the drug is indicated for and thus does not result in ***a clinically meaningful difference***. An example might include the addition of active moiety / active ingredient X to a different active moiety / active ingredient Y, where active moiety / active ingredient X affects the bioavailability of active moiety / active ingredient Y but is not ***therapeutically active*** against the disease state that active moiety / active ingredient Y is indicated for. In this example, the addition of active moiety / active ingredient X does not result in ***a clinically meaningful difference***.[5]

Merck urges CMS to abandon the new proposed interpretation and to maintain the aggregation approach set forth in the IPAY 2026 and 2027 final guidance documents.

B. The Proposed Interpretation Reflects an Erroneous Statutory Construction

The U.S. Supreme Court held in *Loper Bright* that "[i]n the business of statutory interpretation, if [an Agency's interpretation] is not the best, it is not permissible."[6] Far from being the "single, best reading" of the QSSD definition,[7] CMS's proposed interpretation has no basis in the Inflation Reduction Act (IRA) text and is an incoherent and internally inconsistent statutory interpretation.

CMS's proposal defies any plain language reading of Section 1192(e)(1), which ties QSSD status to the product that FDA approved or licensed.[8] FDA approves fixed combinations and single active moiety or single active ingredient products separately. Nevertheless, under the Draft Guidance, CMS proposes to aggregate some of these separately approved products based on its own, *post hoc* analysis of whether individual components of a fixed combination drug are "biologically active" or "therapeutically active" and "result in a clinically meaningful difference." None of these terms appear in the IRA. CMS is clearly not authorized or qualified to make determinations about the pharmacologic or therapeutic activity of components of small molecule drugs or biologics. Instead, the statute requires CMS to identify QSSDs based on the drug or biological product approved or licensed by FDA.

CMS's proposed interpretation also conflicts with 21 C.F.R. § 300.50, which CMS recognizes must guide identification of QSSDs.[9] That regulation states that "[t]wo or more drugs

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[5] Draft Guidance, *supra* n.3, at 13 (emphasis added).
[6] *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 400 (2024).
[7] *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 400 (2024).
[8] SSA § 1192(e)(1) (defining QSSD as (1) a drug product "approved [by FDA] under section 505(c)" of the FDCA, for which 7 years have elapsed since "the date of such approval," and that is not "the listed drug for any drug that is approved and marketed under section 505(j)"; and (2) a biological product "licensed [by FDA] under section 351(a)" of the PHSA, for which 11 years have elapsed since "the date of such licensure," and that is not "the reference product for any biological product that is licensed and marketed under section 351(k)").
[9] IPAY 2026 Final Guidance, *supra* n.4, at 100; IPAY 2027 Final Guidance, *supra* n.4, at 169; Draft Guidance, *supra* n.3, at 13.

may be combined in a single dosage form when *each component makes a contribution* to the claimed effects."[10] Thus, FDA's approval of a fixed combination drug reflects an FDA conclusion that each component contributes to the product's safety and effectiveness and therefore is "therapeutically active" and results in "clinically meaningful differences." Merck can identify no statutory or regulatory authority that allows CMS to second guess FDA on such scientific matters that are properly within FDA's ambit.

Further, per CMS's proposal, the terms "drug product" and "biological product" would each have multiple meanings, contrary to *Loper Bright*. To date, CMS has interpreted these terms to mean the active moiety or active ingredient or combination thereof from the same application holder. In identifying active ingredients and moieties, CMS has used sources such as RxNorm, OpenFDA, and FDALabel.[11] CMS now proposes, for some products, to interpret "drug product" and "biological product" to instead require consideration of "therapeutic" and "biological act[ivity]," and "clinically meaningful differen[ces]."[12] Such a result is incompatible with *Loper Bright*, which mandates that a term must have a "*single*, best meaning."

Further, CMS's interpretation would create unresolvable tension with the orphan drug exclusion, which says that a QSSD "does not include…a drug that is designated as a drug for only one rare disease or condition under Section 526 of the [FDCA]," among other things.[13] FDA has long interpreted "drug" in Section 526 to mean the "active moiety" or combination of active moieties for small molecules and the "principal molecular structural features" or combination thereof for large molecules.[14] FDA also has long considered fixed combinations and single ingredient products to be different drugs under Section 526.[15] CMS (correctly) does not second-guess this approach and instead says it will rely on FDA's orphan database to apply the orphan drug exclusion.[16]

Yet, by defining QSSDs to mean active moieties or active ingredients in one context (the orphan drug exclusion) and not in another (the proposed interpretation) – and deferring to FDA's treatment of fixed combinations in the first but not the second context – CMS violates the requirement that the provisions of a statute "be interpreted in a way that renders them compatible, not contradictory."[17] Under CMS's proposed interpretation, a fixed combination drug could be aggregated with one of its individual components for QSSD identification purposes, even if FDA treated these products as different "drugs" and designated them separately under Section 526 of the FDCA. It cannot be that the "single, best meaning" of "drug product" and "biological product" requires separate CMS evaluation for purposes of the orphan drug exclusion and QSSD definition that appear in the same subsection of the SSA.

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[10] 21 C.F.R. § 300.50(a).
[11] Draft Guidance, *supra* n.2, at 11–12.
[12] *Id.* at 13.
[13] SSA § 1192(e)(3)
[14] 80 Fed. Reg. at 79788.
[15] FDA, Office Director's Decisional Memorandum, NDA 21-844, at 1 (Dec. 12, 2005).
[16] Draft Guidance, *supra* n.2, at 16–17.
[17] Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 180 (2012).

C. CMS's Proposed New Aggregation Approach Violates the APA

CMS's proposed interpretation violates the APA.[18] As the D.C. Circuit has affirmed, "[g]overnment is at its most arbitrary when it treats similarly situated people differently."[19] Here, CMS's interpretation would result in discrepant treatment of the same products by sister HHS agencies wherever CMS concludes that a fixed combination drug should be aggregated with its individual components. As noted, through its approval or licensure of a fixed combination drug, FDA would have concluded that each component has an independent effect on the drug's safety and effectiveness, but CMS would disregard this conclusion for one of the active ingredients under the proposed interpretation.

Agency action also is arbitrary and capricious when an agency reverses position without providing adequate explanation.[20] In this case, CMS proposed and finalized its approach to aggregation of fixed combination drugs twice in IPAYs 2026 and 2027, rejecting comments that called for CMS to not count as separate QSSDs "combination products that would not differ significantly from the original single product, not contribute directly to the drug's therapeutic effect, and provide minimal additional patient benefit."[21] In other words, less than a year ago, CMS rejected a proposal similar to the one that it now advances. CMS's departure from its own settled interpretation was based on a single paragraph of discussion and no meaningful explanation of its rationale. We do not agree that "the addition of drugs payable under Part B" to the Program justifies this departure, given that the same statutory QSSD definition applies for both Part B and D drugs.[22] This meager approach does not satisfy CMS's requirement to provide a reasoned explanation of its proposed change in position.

D. CMS's Proposed Interpretation Reflects Unsound Policy

Aggregation of fixed combination drugs with individual active moieties or active ingredients would disincentivize manufacturers from investing in R&D to develop fixed combination drugs, to the detriment of patients and the public health. FDA has recognized the growing importance of fixed combination drugs to improve treatment response, minimize development of resistance, reduce adverse events, and improve patient convenience and medication adherence.[23] Manufacturers may begin developing fixed combination drugs after approval of one or more of the active ingredients or active moieties, and development of these important medical advances often takes several years. Aggregation would shorten the runway for manufacturers to recoup their investment in development of fixed combinations and may

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[18] *See* 5 U.S.C. § 706(2)(A), (C).
[19] *Etelson v. Office of Personnel Management*, 684 F.2d 918, 926 (D.C.Cir.1982); *see also Bracco v. Shalala*, 963 F. Supp. 20, 27-28 (D.D.C. 1997); *Independent Petroleum Association of America v. Babbitt,* 92 F.3d 1248, 1258 (D.C.Cir.1996); *National Association of Broadcasters v. FCC,* 740 F.2d 1190, 1201 (D.C. Cir. 1984).
[20] *See, e.g., Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016).
[21] IPAY 2027 Final Guidance *supra* n.4, at 14.
[22] *See* SSA § 1192(e).
[23] *E.g.*, FDA, Guidance for Industry, *Codevelopment of Two or More New Investigational Drugs for Use in Combination*, at 2 (June 1013); 80 Fed. Reg. at 79779.

render some fixed combination drugs eligible for selection immediately upon approval or licensure.

Moreover, CMS's proposal in the Draft Guidance leaves critical questions unanswered, which makes it impossible for manufacturers to determine how their fixed combination drugs and single-entity active moieties and active ingredients will be treated under the IRA. For example:

- **What does CMS mean by "biologically active," "therapeutically active" and "clinically meaningful difference"?** As discussed above, these terms do not appear in the IRA, and CMS does not define them. CMS appears to use "biologically active" and "therapeutically active" interchangeably, but this relationship is never clearly stated. It is also unclear whether CMS will utilize all three of these criteria to determine if a specific fixed combination is a separate QSSD or only some of them in certain cases.

- **Which products will be aggregated together?** If CMS concludes that certain components in a combination are active and certain are "inactive," will CMS aggregate dosage forms and strengths of products containing the "inactive" components or only the ones that CMS determines to be active? Relatedly, can CMS use the date of approval of an "inactive" ingredient to start the 7- or 11-year eligibility clock?

- **Will CMS engage in a case-by-case evaluation of all fixed combination drugs?** CMS indicates that it "generally" will not aggregate, but that "there may exist" situations where aggregation is appropriate. However, it is not clear whether CMS will evaluate every fixed combination for potential aggregation, or whether it intends to confine its inquiry to certain types of fixed combination drugs and if so, which ones.

This uncertainty is exacerbated by the inherent subjectivity associated with CMS's proposed approach. Manufacturers have almost no insight into how CMS will apply its aggregation methodology in any given case. CMS's proposed policy, if adopted, will sow uncertainty that will harm innovation and investment in fixed combinations.

E. CMS Should Return to Prior Principles

CMS should abandon its proposal to aggregate certain fixed combination drugs with their component active moieties or active ingredients in the Draft Guidance. This proposal is contrary to the IRA and would have negative policy implications. We urge CMS to return to its aggregation principles for fixed combinations adopted in the IPAY 2026 and 2027 final guidance documents.

II. CMS Should Use Accurate and Consistent 30-day Equivalent Supply Price Calculations to Calculate Prices of Selected Drugs and Therapeutic Alternatives

Merck appreciates the Agency's solicitation for comment in Section 60 of the Draft Guidance regarding the calculation of a single MFP and ceiling price. CMS's methodology uses a 30-day equivalent supply to establish the ceiling price, initial offer, and MFP for selected

drugs, as well as the price of a selected drug's therapeutic alternatives. Given the complexities and unique differences across selected drugs and their therapeutic alternatives, especially those in Part B, Merck is providing comments to ensure CMS uses accurate and consistent 30-day equivalent supply price calculations to calculate prices of selected drugs and therapeutic alternatives. Merck is concerned that CMS's proposed approach would establish inconsistent and inaccurate pricing for products dosed at 34-day intervals or less. We also believe that CMS's approach may result in inaccuracies and distortions when comparing products with different dosages or strengths and non-linear pricing.

As described in further detail below, Merck recommends that when calculating the 30-day equivalent supply for selected drugs or therapeutic alternatives, CMS divide the days between service by 30, no matter the interval; use the dosing information described in the label rather than claims data to determine days between service; and ensure the methodology calculates an accurate 30-day equivalent supply price for products that have different dosages or strengths with non-linear pricing. Additionally, CMS should apply the same considerations to the calculation of 30-day equivalent supply and prices for the selected drugs' therapeutic alternatives. While this is particularly important in Part B where drugs frequently have complex dosing regimens, the same principles are applicable for Part D drugs.

A. When Determining 30-Day Equivalent Supply for Selected Drugs and Therapeutic Alternatives, CMS Should Divide by 30 for All Days Between Service Amounts

Under the Draft Guidance for IPAY 2028, for a selected drug, CMS would calculate a single ceiling price per 30-day equivalent supply across all dosage forms and strengths of the drug.[24] To determine the 30-day equivalent supply for a Part B claim, CMS would "calculate a 'days between service' amount by counting the days between the first Part B claim's date of service and the immediately subsequent Part B claim or [prescription drug event (PDE)] record's date of service."[25] CMS would then "use the 'days between service' amount calculated for each Part B claim to calculate the 30-day equivalent supply…."[26] Specifically, CMS explains that "[i]f the 'days between service' is less than or equal to 34, the number of 30-day equivalent supplies equals one [and] [i]f the 'days between service' is greater than 34, the number of 30-day equivalent supplies is equal to the days between service divided by 30."[27] While we recognize this approach was used for selected drugs in IPAY 2026 and IPAY 2027, and aligns to the 30-day equivalent supply calculations per 42 C.F.R. § 423.104(d)(2)(iv)(A)(2), it is not clear why CMS takes this approach rather than dividing by 30 for all days between service amounts, and we are concerned the existing approach presents a real concern when applied to Part B drugs for which dosing varies considerably from the once-daily dosing more typical of Part D oral medications.

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[24] Draft Guidance § 60.2.1.1.
[25] *Id.*
[26] *Id.*
[27] *Id.*

Using rounding for days of service that are less than or equal to 34 can lead to inconsistent and inaccurate values. For example, based on the hypothetical dosing regimens and prices described in Table A below, using CMS's rounding methodology would lead to inconsistent and arbitrary 30-day equivalent supply prices for a 21-day regimen compared to the 42-day regimen (shown in italics). Although the 21-day regimen and the 42-day regimen are proportionally-priced (i.e., the Wholesale Acquisition Cost (WAC) of the 21-day regimen is half the WAC of the 42-day regimen), CMS's rounding methodology distorts the data, resulting in a significantly lower 30-day equivalent supply value for the 21-day regimen. In contrast, the bottom two rows (highlighted by shading) show the calculation when dividing both the 21-day regimen and 42-day regimen by 30, respectively, which correctly results in the same 30-day equivalent supply for both regimens.

Table A: One hypothetical product with multiple NDCs with different dosing intervals

Dosing regimen	**NDC 1** **Every 21 days**	**NDC 2** **Every 42 days**
Hypothetical WAC price per dose	$70 for 100 mg dose	$140 for 200 mg dose
CMS calculation of 30-day equivalent supply (DES)	21 days ≤ 34 days → one (1) 30-day equivalent	42 days / 30 = 1.4 → 1.4 30-day equivalents
CMS calculation of 30-day supply price	$70 / 1 30-day equivalent = ***$70 per 30-day supply***	$140 / 1.4 30-day equivalents = ***$100 per 30-day supply***
Dosing interval when divided by 30 for all days between service intervals to convert to 30-DES	21 days / 30 days = 0.7	42 days / 30 days = 1.4
Recommended calculation of 30-day supply price	($70 / (21 days divided by 30)) **= $100 per 30-day supply**	($140 / (42 days divided by 30)) **= $100 per 30-day supply**

As shown in Table A, the proposed approach introduces unintended inconsistencies and inaccuracies in pricing by only dividing claims with days of service greater than 34 by 30. To prevent such inconsistencies and ensure accurate pricing, CMS should divide all days between service by 30, regardless of whether they are less than, equal to, or greater than 34. While Part B presents a particular concern due to high dosing variability, we note that the same calculation anomaly is present for Part B and Part D drugs, and we recommend the same correction (to divide by 30 regardless of dosing interval) be applied to both Part B and Part D drugs.

B. When Determining 30-Day Equivalent Supply for Selected Drugs, CMS Should Use the Dosing in a Product's Label

In addition, using Part B claims data or Part D PDE data to determine days between service does not necessarily accurately reflect the typical dosing for a product. For example,

cancer patients may be prescribed a perioperative regimen with doses taken before surgery and then pause treatment (sometimes for several months) and later start the adjuvant portion of their treatment, or patients may appropriately temporarily pause their cancer treatment due to adverse reactions or poor lab values. Such pauses in treatment are already accounted for in reimbursement because the cancer medicine would not be administered or dispensed and billed for during the pause. In effect, the Draft Guidance proposes to account for this pause *twice* by also using claims data to determine the dose interval.

To facilitate a more accurate comparison between different products, Merck recommends that CMS rely on the dosing described in the dosing and administration section of a product's label rather than claims data to determine the number of days between service. Also, given the complexity and variation among products, Merck recommends that CMS add an optional question to the Negotiation Data Elements Information Collection Request (ICR) to permit a Primary Manufacturer to provide additional information about the dosing of the selected drug to enable CMS to appropriately factor such dosing into 30-day equivalent supply calculations.

C. If Products Have Different Dosages or Strengths and Non-Linear Pricing, CMS Should Ensure the Methodology Calculates an Accurate 30-Day Equivalent Supply Price for the Selected Drug and Appropriately Applies the MFP to Each NDC-11 Drug and to Each Billable Unit

A selected drug may have multiple NDCs that contain different quantities of the same unit (e.g., milligrams (mgs)) but deliver a therapeutically equivalent dose to a patient. In such instances, if the manufacturer has elected to offer those NDCs at a parity price for a therapeutically equivalent dose, rather than linearly price the NDCs according to the unit quantity, it is important that CMS ensure an accurate calculation for the 30-day equivalent supply price. Otherwise, the calculation methodology could result in dramatically distorted pricing across the NDCs/therapeutically equivalent doses. This issue is applicable when calculating the 30-day equivalent supply price for the selected drug and when CMS applies the MFP to each NDC-11 package and to the billable unit. It is unclear whether CMS's proposed methodology appropriately accounts for different dosages or strengths with non-linear pricing. Merck requests clarity on this issue along with illustrative examples in the final guidance of the application of CMS's methodology to NDC-11s of a selected product that are not linearly priced but are adjusted to ensure accurate and intended pricing.

Table B shows a hypothetical example of a selected drug with multiple NDCs that contain different quantities of the same unit (e.g., mgs) but deliver a therapeutically equivalent dose to a patient and are WAC priced at parity (i.e., non-linear).

Table B: One hypothetical product with multiple NDCs at therapeutically equivalent doses with non-linear pricing[28]

	NDC 1 **200 mg dose** **42 day interval**	**NDC 2** **400 mg dose** **42 day interval**
WAC price per dose	$140 for 200 mg dose ($0.70 / mg)	$140 for 400 mg dose ($0.35 / mg)
Calculation of 30-day equivalent supply (DES)	42 days / 30 = 1.4	42 days / 30 = 1.4
WAC per 30-DES	$100 per 30-DES	$100 per 30-DES
WAC per 30-DES per billing unit (1 mg)	$0.70 per 30-DES per billing unit (1 mg)	$0.35 per 30-DES per billing unit (1 mg)

For a product as shown in Table B, it is unclear whether the proposed methodology in Section 60.5 of the Draft Guidance would ensure that the same MFP discount would be applied accurately to each NDC or billable unit. If CMS were to use a single weighted per-unit (e.g., per mg) price to allocate back to each NDC-11 or to each billable unit, the resulting MFP, as applied, would not reflect market realities or the therapeutic impact of products to patients, and could artificially cause the MFPs for certain NDCs to be more expensive to Medicare and patients than the actual WAC pricing set by the manufacturer.

This issue is demonstrated in Table C where a single weighted per-unit (e.g., per mg) MFP (at 25% discount to WAC) is calculated at the 30-DES unit level and then applied to an NDC and to a billing unit. This example illustrates how the applied MFP would be inaccurate, not representative of parity pricing across doses, and could result in a price greater than WAC.

Table C: Application of a single weighted per-unit MFP to hypothetical product with multiple NDCs at therapeutically equivalent doses with non-linear pricing

	NDC 1 **200 mg dose** **42 day interval**	**NDC 2** **400 mg dose** **42 day interval**
WAC price per dose	$140 for 200 mg dose ($0.70 / mg)	$140 for 400 mg dose ($0.35 / mg)
WAC per 30-DES per billing unit (1 mg)	$0.70 per 30-DES per billing unit (1 mg)	$0.35 per 30-DES per billing unit (1 mg)
Assumed utilization by NDC	90 doses	10 doses

[28] There are a number of instances where manufacturers have elected not to price medications linearly based on the quantity of product contained in the NDC11; for example, manufacturers have flat priced loading and maintenance doses of a product and different formulations of a product that deliver a therapeutically equivalent dose.

Blended single WAC price per 30-DES	\$0.67 per 30-DES per billing unit (1mg)	
Blended single MFP per 30-DES (assumes 25% discount from WAC)	\$0.50 per 30-DES per billing unit (1mg)	
MFP per dose	\$99.75 for 200 mg dose	\$199.50 for a 400 mg dose

Table D demonstrates Merck's view of a correct application of the hypothetical single MFP to a package or NDC-11 level (as shown in the highlighted row), such that the same MFP discount applies to both NDCs. For this example, the fix is to apply the 25% discount off MFP to the WAC at unit level.

Table D: Application of adjustment factor to apply a single MFP for a hypothetical product with multiple NDCs at therapeutically equivalent doses with non-linear pricing

	NDC 1 **200 mg dose** **42 day interval**	**NDC 2** **400 mg dose** **42 day interval**
WAC price per dose	\$140 for 200 mg dose (\$0.70 / mg)	\$140 for 400 mg dose (\$0.35 / mg)
Assume MFP at 25% discount to WAC MFP per mg	\$0.525 / mg	\$0.2625/ mg
MFP per dose	\$105.00 for 200 mg dose	\$105.00 for a 400 mg dose

For situations where manufacturers have elected not to price medications linearly based on the quantity of product contained in the NDC-11, this example shows how distorted pricing could occur (i.e., Table C). Such distorted pricing is inconsistent with Congress's intent for there to be a single MFP that is consistently applied to each dosage form and strength of the selected drug.[29] Moreover, Merck is concerned that such an approach could inadvertently limit patient access to selected drugs if their pricing was distorted such that physicians would be unable or unwilling to purchase such drugs or Medicare plans would seek to limit their utilization. Therefore, to the extent that CMS uses a single weighted per unit price to apply the MFP to each NDC-11 or each billable unit, Merck recommends that the agency apply appropriate adjustments to ensure that the MFP is consistently and accurately applied to different dosages or strengths with non-linear pricing.

[29] Social Security Act (SSA) § 1196(a)(2).

D. All the Above Considerations Also Apply to CMS's Calculation of 30-Day Equivalent Supply and Prices for the Selected Drugs' Therapeutic Alternatives

Under Section 60.3.2 of the Draft Guidance, CMS considers the price of a selected drug's therapeutic alternatives in developing the starting point for the initial offer.[30] However, a selected drug and its therapeutic alternatives may have different dosage forms or strengths that deliver therapeutic equivalence for patients. For example, a selected drug that is a tablet may have a different strength than a therapeutic equivalent that is an IV formulation. Merck recommends that the same recommendations described in Section II.A through II.C of this letter also apply to CMS's calculation of 30-day equivalent supply and prices for the selected drugs' therapeutic alternatives.

CMS also notes that "[t]o inform a starting point for the initial offer, CMS may use an alternative methodology to calculate the 30-day equivalent supply as appropriate for the therapeutic alternatives to ensure comparability with the selected drug."[31] CMS does not specify the details of this "alternative methodology." While it is unclear what "alternative methodology" CMS intends to use to calculate the 30-day equivalent supply for therapeutic alternatives, Merck recommends that when determining the 30-day equivalent supply for therapeutic alternatives, CMS divide all days between service by 30. Appropriate calculation of 30-day equivalent supply addresses this concern across dosage forms.

To ensure CMS is correctly comparing 30-day equivalent prices across a selected drug and its identified therapeutic alternatives, it is important that CMS adopt the same recommendations described in Section II.A through II.C of this letter for CMS's calculation of 30-day equivalent supply and prices for the selected drugs' therapeutic alternatives.

III. CMS Should Not Require Manufacturers to Submit Forward-Looking Market Data

In the Draft Guidance, CMS solicits "comment on the collection of additional, forward-looking 'market data' for the selected drug that pertain to periods that overlap with the negotiation period and/or the price applicability period."[32] CMS indicates that "this data could include, for example, forecasted net revenue and volume data for the selected drug for these future periods."[33] CMS should not require manufacturers to submit information on forward-looking market conditions for the following legal and policy reasons.

First, CMS does not have the authority to require manufacturers to submit such information. The IRA enumerates specific data and information that CMS may consider as "the

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[30] Draft Guidance § 60.3.2.
[31] *Id.* ("For example, if a therapeutic alternative has an indication for which it is typically prescribed for a period meaningfully shorter than 30 days…, and the selected drug does not have a similar prescribing pattern, CMS may use an alternative methodology to calculate 30-day equivalent supply for the therapeutic alternative to ensure that its price is expressed on comparable terms to a 30-day equivalent supply of the selected drug.").
[32] Draft Guidance § 50.1.
[33] *Id.*

basis" for MFP initial offers and counteroffers.[34] In relevant part, the statute permits CMS to require manufacturers to submit the selected drug's "[m]arket data and revenue and sales volume data," but not "forward-looking" market projections.[35] Data and projections are fundamentally different concepts. "Data" means "factual information (such as measurements or statistics)."[36] Therefore, "market data" plainly refers to factual information related to a drug's revenue and sales performance in the market, such as Medicaid Best Price or the wholesale acquisition cost, *not*, for example, forward-looking sales or pricing because this information is an estimate not "factual information." Furthermore, because forward-looking information has the potential to significantly change, such information is not suitable for CMS to take into consideration when setting the MFP.

Second, adding a requirement for forward-looking market data would increase the administrative burden facing manufacturers that must respond to the Data Elements ICR. In response to several directives from the White House,[37] CMS is in the process of identifying regulatory requirements to "streamline" and "reduce unnecessary administrative burdens."[38] The Data Elements ICR is a perfect example of a form that is overly burdensome and could be streamlined – in IPAY 2027, the instructions and prompts were nearly 80 pages long.[39] Thus, consistent with the Administration's broader deregulatory initiatives, Merck urges CMS not to finalize additional reporting requirements to this already complex and unwieldy form.

Finally, Merck is concerned that if CMS requires manufacturers to provide speculative information and then requires manufacturers to certify to the accuracy of such information, it could put manufacturers at legal risk. Merck particularly is concerned about such risk because CMS previously has required manufacturers to certify that they understand that any misrepresentations provided in response to the Data Elements ICR "may…give rise to liability, including under the False Claims Act."[40] Forward-looking estimates are just that – estimates based on underlying assumptions and judgment. They potentially could change over time as new information comes to light and thus a projection that seemed accurate at one point in time could not materialize due to mistaken assumptions and/or factors outside of the manufacturer's control. As a result, requiring forward-looking information is not helpful to this process and could

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[34] SSA § 1194(e).
[35] SSA § 1194(e)(1)(E) (emphasis added).
[36] "Data", Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/data.
[37] Exec. Order No. 14192, 90 Fed. Reg. 9065 (Feb. 6, 2025); Presidential Memorandum Directing the Repeal of Unlawful Regulations (Apr. 9, 2025), https://www.whitehouse.gov/presidential-actions/2025/04/directing-the-repeal-of-unlawful-regulations/; Guidance Implementing the President's Memorandum Directing the Repeal of Unlawful Regulations (May 7, 2025), https://www.whitehouse.gov/wp-content/uploads/2025/02/M-25-28-Guidance-Implementing-the-Presidents-Memorandum-Directing-the-Repeal-of-Unlawful-Regulations.pdf.
[38] CMS, Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information, https://www.cms.gov/files/document/unleashing-prosperity-through-deregulation-medicare-program-request-information.pdf.
[39] 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) Forms (CMS-10849, OMB 0938-1452).
[40] *Id.* § H.

unfairly put manufacturers at legal risk if asked to certify projections which are inherently inaccurate as no one can accurately predict the future.

IV. CMS Should Take Additional Steps to Prevent 340B/MFP Duplicate Discounts

CMS explains in the Draft Guidance that the agency "will not, at this time, assume responsibility for nonduplication of discounts between the 340B ceiling price and MFP."[41] CMS asserts that the agency "is not charged with verifying or otherwise reviewing whether a particular drug claim is 340B-eligible."[42]

As we explained in our comments on the IPAY 2027 Draft Guidance, we disagree with CMS's position. Section 1196 of the Social Security Act requires CMS to administer the Program, including effectuation of the MFP. The 340B nonduplication requirement is a central part of MFP effectuation because no MFP discount is required if the 340B ceiling price is lower than the MFP.[43] Accordingly, since CMS must administer the MFP effectuation process, CMS has the authority to implement the 340B nonduplication requirement and the obligation to help facilitate the statutory intent. Additionally, given that the Government Accountability Office (GAO) and the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) have attributed 340B/Medicaid duplicate discount violations, in part, to "[l]imitations in federal oversight," it is important that CMS take a more active role in the de-duplication of 340B/MFP discounts.[44]

As an initial matter, CMS should *require* both an affirmative claim-level 340B indicator and a claim-level indicator for *non-340B* claims, so that manufacturers can identify claims subject to the IRA's nonduplication requirement. Dual 340B and non-340B-modifiers would be aligned with CMS's approach for the Medicare Part B discarded drug refund, where providers and suppliers submitting claims for single-dose container or single-use package drugs that are payable under Part B must include the "JW" modifier to show the amount of drug that was discarded or the "JZ" modifier to indicate that no amount of drug was discarded.[45] In addition, for Part B drugs, CMS should ensure that these claim-level indicator requirements apply to all claims that may be MFP-eligible, including claims paid under fee-for-service and by Medicare Advantage plans.

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[41] Draft Guidance § 40.4.5.
[42] *Id.*
[43] SSA § 1193(d).
[44] GAO, 340B Drug Discount Program: Oversight of the Intersection with the Medicaid Drug Rebate Program Needs Improvement, GAO-20-212, at 27 (Jan. 2020), https://www.gao.gov/assets/gao-20-212.pdf (finding that "[l]imitations in federal oversight impede CMS's and HRSA's ability to ensure compliance with the prohibition on duplicate discounts"). *See also* OIG, State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates, OEI-05-14-00430, at 16 (June 2016), https://oig.hhs.gov/oei/reports/oei-05-14-00430.pdf.
[45] Medicare Program, Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy, Frequently Asked Questions, https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf.

Although the Draft Guidance includes a proposal for a "voluntar[]y" 340B identifier,[46] Merck does not believe that this will be sufficient to enable manufacturers to identify 340B-eligible claims because studies show that, when 340B modifiers are voluntary, they are infrequently used.[47] Without a mandatory affirmative 340B modifier and non-340B indicator, and enforcement of their use, we are concerned that 340B/MFP duplicate discounts will not be able to be detected and avoided. Thus, to ensure compliance with modifier use and the IRA's nonduplication requirement, CMS should reject claims without either indicator and also require plans to reject such claims.

Mandatory affirmative 340B and non-340B modifiers would also align with HHS OIG and CMS's recommendations for preventing duplicate discounts in the Medicaid program. In a 2016 report, HHS OIG stated that CMS should "require States to use claim-level methods to identify 340B claims," which could include a 340B indicator, noting that this could "help States more accurately identify 340B claims, and thus reduce the risk of duplicate discounts."[48] And CMS responded to this recommendation by including a 340B claim-level modifier as one of its suggested "best practices" for States to prevent 340B/Medicaid duplicate discounts.[49]

In the absence of mandatory affirmative 340B and non-340B claim modifiers, and enforcement of their use, it is unclear how manufacturers will be able to identify claims subject to the IRA's 340B nonduplication requirement. The Draft Guidance states that "CMS strongly encourages manufacturers to work with dispensing entities, covered entities and their 340B TPAs, and other prescription drug supply chain stakeholders (e.g., wholesalers) to facilitate access to the lower of the MFP and the 340B ceiling price, wherever applicable."[50] CMS "anticipates this will include utilizing data available from covered entities and their 340B TPAs, and other prescription drug supply chain stakeholders to ensure the process is not unduly burdensome for dispensing entities, 340B covered entities, and patients."[51] CMS, however, does not explain how a manufacturer could identify whether a claim is 340B-eligible, and thus effectuate the statute's intended nonduplication, if a dispenser or other supply chain stakeholder declines to provide sufficient information in a timely manner. Therefore, if CMS does not require affirmative 340B and non-340B claim modifiers, Merck requests that CMS and HRSA jointly state that dispensers must provide manufacturers with claim-level data for all 340B-eligible utilization with respect to selected drugs for which an MFP is in effect.

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[46] Draft Guidance § 40.4.2.1.
[47] IQVIA, *Can 340B Modifiers Avoid Duplicate Discounts in the IRA?* (Feb. 21, 2023), https://www.iqvia.com/locations/united-states/library/white-papers/can-340b-modifiers-avoid-duplicate-discounts-in-the-ira ("For Medicare Part B claims in 340B hospitals involving pass-through and separately payable drugs…when [340B modifier] reporting was optional, rates fell below 20%. For self-administered drugs across all payers, only 4% of branded, 340B-eligible pharmacy claims used a 340B modifier, rising to 50% for Medicaid claims at entity-owned pharmacies and falling to less than 1% at contract pharmacies.").
[48] OIG, State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates, OEI-05-14-00430, at 16 (June 2016), https://oig.hhs.gov/oei/reports/oei-05-14-00430.pdf.
[49] CMS, Best Practices for Avoiding 340B Duplicate Discounts in Medicaid, at 4-5 (Jan. 8, 2020), https://www.medicaid.gov/federal-policy-guidance/downloads/cib010820.pdf.
[50] Draft Guidance § 40.4.5.
[51] *Id.*

V. CMS Should Not Require a Manufacturer to Increase the MFP Retrospective Refund Amount to Account for Third-Party Fees or Other Supply Chain Costs

In Section 90.2 of the Draft Guidance, CMS has indicated that it will undertake a

> fact-specific assessment that will consider the following, among other factors, as applicable: whether the retrospective refund amount authorized for payment or paid by the Primary Manufacturer is sufficient to account for commercially reasonable costs the dispensing entity is likely to encounter in the supply chain [and] the invoice amount from the dispensing entity (if available)….[52]

As Merck indicated in its prior comments, we believe CMS's proposal could create incentives for supply chain entities to artificially inflate the MFP discount amount, including potentially through fees and other arrangements that do not involve the manufacturer (and about which the manufacturer may lack knowledge). The statute requires manufacturers to provide access to the MFP – not more.[53] CMS should ensure integrity in the MFP effectuation process and mitigate the potential for abusive practices and incentives for supply chain entities to manipulate the MFP discount amount by clarifying that in no case should a manufacturer be required to increase the MFP refund to offset fees or other costs charged to a dispenser by a third-party.

VI. Merck Supports Establishment of the MTF DM and MTF PM, But Is Concerned That They May Not Be Fully Operational by January 1, 2026

Merck supports CMS's efforts to facilitate MFP effectuation through the establishment of the MTF DM and MTF PM. However, Merck has concerns about whether the MTF DM and MTF PM will be fully operational by January 1, 2026, and the resulting risk to manufacturers. For example, as of the date of this letter, the MTF has not yet initiated testing with manufacturers. Additionally, after testing is complete, manufacturers will need sufficient time to test and build internal controls to ensure that their processes work as intended. CMS acknowledges in the Draft Guidance that the payment transfer process is "to be developed"[54] and that in the event of a "technical breakdown in the transmission process," the Primary Manufacturer "must continue to attempt to transmit the claim-level payment elements in good faith until successful transmission of the claim-level payment elements and must maintain documentation of the Primary Manufacturer's good faith effort in case there is a related complaint or dispute."[55] However, it is unclear how a manufacturer could facilitate MFP payments outside of the MTF DM and MTF PM, because to our knowledge, no private market solutions will be available as of the IPAY 2026 implementation date.

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[52] Draft Guidance § 90.2.
[53] SSA § 1193(a)(3).
[54] Draft Guidance § 40.4.3.2.
[55] Draft Guidance § 40.4.3.1.

Given the uncertainty about whether the MTF DM and MTF PM will be operational by January 1, 2026, CMS should affirmatively state that it will not hold the Primary Manufacturer responsible for operational or technical issues with the MTF that, outside of the Primary Manufacturer's control, prevent the MFP from being transmitted to a dispensing entity. While Merck appreciates that CMS will "consider…any technical failures outside the control of the Primary Manufacturer related to the transmission of payment," before imposing CMPs,[56] we request that CMS confirm that it will not impose penalties on a Primary Manufacturer if the MTF DM and/or MTF PM systems are not functional by January 1, 2026 and for technical failures outside the manufacturer's control.

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Merck appreciates the opportunity to comment on the Draft Guidance. Please feel free to contact Erin Darling, AVP, Federal Policy, at erin.darling@merck.com if you have any questions.

Sincerely,

Robert Filippone

[56] Draft Guidance § 100.1.

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

June 26, 2025

Chris Klomp
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

Submitted via email: IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191-1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028

Dear Deputy Administrator Klomp:

The National Association of Chain Drug Stores (NACDS) thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Draft Guidance on the Medicare Drug Price Negotiation (MDPN) Program.

As a threshold matter, under §40.4, CMS is seeking comments on potential private market solutions that could offer an alternative to the Medicare Transaction Facilitator (MTF) and the extent to which interested parties perceive a need for an ongoing MTF support over time. In light of the continuing concerns NACDS has expressed about CMS' intention to use a MTF DM and MTF PM and their associated functions, we appreciate CMS' willingness to consider potential alternatives to the MTF. Presently, industry is discussing possible alternatives and we look forward to engaging the CMS on this issue in the future.

Summary of NACDS' Recommendations:

- **The Inflation Reduction Act (IRA) requires that pharmacies be reimbursed for negotiated drugs with no price concessions plus a dispensing fee.**

- **NACDS believes that the effectuation, implementation, and processes for providing access to the MFP for Part B drugs should consider and account for the differences between Part B and Part D drugs due the substantial structural differences between the benefits. However, since Part B payments are already slower than most payers as they do not adjudicate in real time, we urge CMS to accelerate pharmacies' refunds for Part B claims so that they take no**

longer than the amount of time required for a Part D claim.

- **Irrespective of the approval process, however, we ask that CMS impose a timeline that manufacturers must notify pharmacies of changes to WAC (as the standard default refund amount (SDRA)) six months in advance, so that pharmacies may financially plan for the impact of the WAC change.**

- **NACDS agrees with CMS that the SDRA best approximates the acquisition cost of pharmacies and offers a reliable refund amount for both manufacturers and pharmacies. NACDS further agrees with CMS that the SDRA should be calculated based on WAC as published in pharmaceutical pricing database compendia on the date of dispensing. We also agree with CMS that manufacturers and pharmacies should be allowed to negotiate whether some other amount is appropriate to make the MFP available.**

- **NACDS urges CMS to require the manufacturer to use the SDRA (i.e., WAC) unless the pharmacy and manufacturer agree on a different amount or calculation method. With respect to WAC, we ask that CMS enforce WAC as the SDRA and prohibits any WAC reductions that are beyond fluctuations seen in a typical year.**

- **NACDS strongly agrees that pharmacies should not be required to fund any administrative functions that manufacturers engage in to provide the MFP to pharmacies nor should pharmacies be required to provide funds for transmission or administrative functions related to the plan sponsors or PBMs providing the PDE file or any other information to the MTF as part of the MDPN Program. These guardrails should be explicitly stated in the final guidance to prevent harmful PBM practices from spreading into the MDPN program MTF process.**

- **To ensure pharmacies are properly reimbursed, NACDS supports CMS' proposal that certain manufacturer requirements and obligations shall survive termination as specified in the MTF DM User Agreement**.

- **CMS intends to maintain a list of DDPS edits that directly relate to the determination and verification of MFP eligibility for the purposes of the MDPN Program, such as missing service provider ID or missing or invalid date of service, which will be posted on the CMS website. NACDS supports CMS making sure this information is publicly available**.

- **In situations in which a claim has edits that have not cleared all of the DDPS edits on CMS' list of relevant edits, the pharmacy can't be expected to advance funding for 90+ days' supply of medication nor can the pharmacy wait that long for the issue to be resolved. In these situations, the MTF DM must submit the claim within 14 days regardless and then the issue can be corrected after the fact by either (1) charging the plan back if the plan incorrectly determined that the claim was eligible or there was another procedural problem, or (2) charging the pharmacy back only if they fraudulently or inaccurately billed a claim.**

- **NACDS supports CMS' proposal that manufacturers cannot impose reporting requirements on pharmacies beyond what is required by CMS regulations and guidance. CMS should expand this reporting prohibition to include PBMs.**

- **CMS must require that somewhere within the MTF DM or manufacturer Effectuation Plan there is provided correct contact information for the manufacturer so that the pharmacy has the proper contact to remediate any payment issues.**

- **NACDS supports CMS' proposal that the MTF PM will not require affirmative election of pharmacies for the MTF PM to pass along MFP refund payments submitted by the manufacturer.**

- **NACDS believes that WAC should serve as the SDRA for both Medicare Part D and Medicare Part B drugs.**

- **NACDS asks that CMS require that the agreement between the MTF DM and pharmacy specify under what specific circumstances funds will be returned to the manufacturer.**

- **NACDS supports CMS' proposal that if the manufacturer is unable to transmit the claim-level payment elements, for example, if there is a technical breakdown in the transmission process, the manufacturer must continue to attempt to transmit the claim-level payment elements in good faith until successful transmission of the claim-level payment elements.**

- **NACDS supports CMS' proposal that the manufacturer must document why a refund is not provided or is different from the SDRA, including because the claim is 340B eligible.**

- **NACDS supports CMS' proposals that receipt of payment by the pharmacy does not constitute the pharmacy's agreement that access to the MFP has been provided by the manufacturer; and that chain pharmacies may designate a single or central pay option.**

- **NACDS would like to reinforce our concern that manufacturers must participate in the MTF PM. However, should CMS not agree, then NACDS supports CMS' proposals that manufacturers are required to describe the details of their approach to MFP effectuation outside of the MTF PM in their MFP Effectuation Plans, including accounting for claims reversals and adjustments; and that the manufacturer must make these processes transparent to pharmacies. NACDS also supports CMS' proposal that pharmacies must agree on the process to receive their refund payments—manufacturers cannot determine this unilaterally.**

- **CMS should be clear that all costs to dispense are "commercially reasonable costs….in the supply chain." Pharmacies should not be expected to dispense MFP drugs below their full and complete cost to acquire and dispense. Moreover, pharmacies should not be forced to submit invoices for any reason.**

- **CMS should clarify that manufacturers shall not use other pharmacies' acquisition costs, costs being provided from wholesalers that a pharmacy does not have access to, or costs on NDCs off of lists like Predictive Acquisition Cost (PAC), Maximum Allowable Cost (MAC), or National Average Drug Acquisition Cost (NADAC) that are no longer available at the pharmacy's wholesaler.**

- **Although NACDS appreciates CMS' proposal to bifurcate the manufacturers' Effectuation Plans to include a June 1 deadline for certain information, NACDS urges CMS to move up the deadline for the manufacturers' entire Effectuation Plan to June 1.**

- **NACDS supports CMS' proposal that the manufacturer's MFP Effectuation Plan must include information about the manufacturer's approach for calculating MFP refund amounts for MFP-eligible claims where the MTF DM will not provide the manufacturer a calculated SDRA.**

- **NACDS would like to reinforce our concern that manufacturers must participate in the MTF PM.**

The IRA Requires that Pharmacies Be Reimbursed for Negotiated Drugs with No Price Concessions

The IRA directs the HHS Secretary to select MFP drugs and to negotiate agreements with manufacturers to set the MFPs for the selected drugs. The manufacturer is then required to "provide access to such price . . . to maximum fair price eligible individuals who . . . are dispensed such drug (and to pharmacies, mail order services, and other dispensers, with respect to such maximum fair price eligible individuals who are dispensed such drugs)."[1] In addition, the basic definition of "maximum fair price" means the amount negotiated between the Secretary and a manufacturer for a selected drug—in other words, the ingredient cost of that drug.[2] **Since manufacturers must make selected drugs available for pharmacies at MFP, the IRA equates MFP with a pharmacy's ingredient cost.**

CMS should confirm that the IRA requires that pharmacies must be reimbursed by PDP sponsors at MFP (i.e., ingredient cost) plus a dispensing fee without price concessions. CMS should arrive at this conclusion for several reasons: First, as discussed above, the IRA is constructed around treating MFP as the ingredient cost, and it uses a single definition for MFP throughout. Second, the amended definition of "negotiated prices" supports this conclusion. The total amount of the negotiated price for a non-MFP drug includes (1) the ingredient cost, (2) any "price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered part D drugs," and (3) "any

[1] 42 U.S.C. § 1320f-2(a)(1) (NCPA emphasis added); *accord id.* § 1320f-2(a)(2), (a)(3).
[2] *Id.* § 1320f(c)(3); *see also id.* § 1320f-3 (describing the negotiating process for the "maximum fair price").

dispensing fees for such drug[ ]."[3] In contrast, for MFP drugs, the negotiated price is simply a payment of (1) "no greater than the maximum fair price" for the drug and (2) "any dispensing fees."[4] Thus, unlike non-MFP drugs, where Congress acknowledged the existence of "concessions" in addition to ingredient costs, Congress did not provide PDP sponsors explicit authorization to extract "concessions" for MFP drugs. Again, this leads to the conclusion that PDP sponsors should reimburse pharmacies at ingredient cost plus a dispensing fee.

Although Congress provided that the PDP sponsors should make payments to pharmacies at an amount "no greater than the maximum fair price,"[5] which could be construed to mean that PDP sponsors could reimburse less than MFP, this is not an accurate interpretation of the IRA. The IRA consistently treats MFP as the ingredient cost, and the fact that manufacturers must provide pharmacies with access to MFP when those pharmacies dispense to an MFP-eligible individual strongly indicates that no price concessions are to be extracted from the MFP. Moreover, as noted above, if Congress had wished to allow PDP sponsors to extract additional concessions, it could have said so when it came to defining "negotiated prices" for MFP drugs. But it deliberately excluded concessions from that definition. It makes sense that Congress would have wanted to reimburse pharmacies no greater than MFP—to ensure that taxpayers are maximizing their savings—while at the same time ensuring that pharmacies at least break even on their ingredient costs while providing for a dispensing fee. NACDS has concerns that pharmacy access will become even more restricted and reimbursement will fall below the MFP without any protections from CMS, especially if DIR Fees are applied to these drugs. As of current, major PBMs often compensate pharmacies far below the acquisition cost and below the actual cost to dispense, as low as $0 or lower, by using emerging tactics and "transaction" fees.

CMS should take note that the IRA does not expressly prohibit the Secretary from ensuring that pharmacies are reimbursed at not *less* than MFP. It simply says pharmacies may not be reimbursed greater than MFP. The "not greater than" language serves a purpose, because ultimately, a PDP sponsor's costs factor into how much CMS pays it under the Part D program. Consequently, it was necessary for Congress to clarify both that manufacturers would sell MFP drugs at a maximum fair price and PDP sponsors would reimburse pharmacies no more than that same price plus a dispensing fee.

§40.4 Providing Access to the MFP in 2026, 2027, and 2028

The manufacturer is required to provide access to the MFP beginning in 2028, for drugs selected for initial price applicability year 2028 or with a renegotiated MFP for initial price applicability year 2028, if payment may be made for such dosage forms, strengths, and package sizes under Medicare Part B. CMS seeks comment on Medicare Part B effectuation of providing access to the MFP. When developing its implementation plan for Part B drugs, CMS should consider and account for the differences between Part B and Part D drugs due the substantial structural differences between the benefits (i.e., inconsistent claims processing and payment times), and foundational differences between MA and FFS

[3] *Id*. § 1320w-102(d)(1)(B).
[4] *Id*. § 1320w-102(d)(1)(D).
[5] *Id*. § 1320w-102(d)(1)(D).

(I.e., encounter data vs claims, contract specific reimbursement for drugs vs standardized ASP plus 6%). Any effectuation approach must account for these differences, to ensure consistency and accountability, CMS should serve as the central authority overseeing all aspects of MFP implementation in Part B, including data integrity, reconciliation, and program oversight.

Irrespective of the process, however, we ask that CMS impose a timeline that manufacturers must notify pharmacies of changes to WAC (as the SDRA) six months in advance, so that pharmacies may financially plan for the impact of the WAC change.

§40.4.1 Retrospective Refund Amount to Effectuate the MFP and the Standardized Default Refund Amount

CMS will allow the manufacturer to determine its preferred methodology for calculating pharmacies' refund payments. NACDS urges CMS to require the manufacturer to use the SDRA (i.e., WAC) unless the pharmacy and manufacturer agree on a different amount or calculation method. NACDS agrees with CMS that the SDRA best approximates the acquisition cost of pharmacies and offers a reliable refund amount for both manufacturers and pharmacies. NACDS further agrees with CMS that the SDRA should be calculated based on WAC as published in pharmaceutical pricing database compendia on the date of dispensing.

With respect to WAC, we ask that CMS enforce WAC as the SDRA and prohibits any WAC reductions that are beyond fluctuations seen in a typical year, Doing so would prevent manufacturers from significantly reducing WAC to game the system in their favor. For example, CMS should set a floor of WAC-2% per year to reduce the potential of manufacturers artificially reducing WAC closer to MFP.

While we support a SDRA, and that is should always be WAC, we also agree with CMS that manufacturers and pharmacies should be allowed to negotiate whether some other amount is appropriate to make the MFP available. We would like to stress that this determination of another amount should be the result of a negotiation between the manufacturer and the pharmacy and should not be solely a manufacturer's decision or determination. The draft guidance as written does not restrict a manufacturer from unilaterally deciding to use a metric that may not adequately reflect a pharmacy's acquisition cost, or otherwise may not be acceptable to a pharmacy. We ask that CMS clearly emphasize that the determination of another amount should be the result of a negotiation between the manufacturer and the pharmacy.

CMS expects that a manufacturer will include in their written plan for making the MFP available that is submitted to CMS whether it will use the dispensing entity's actual acquisition cost or a reasonable proxy for such a cost, such as WAC (i.e., the SDRA). Moreover, CMS proposes to require that a manufacturer indicate that an amount other than the SDRA was made available and provide the amount of payment determined to be the MFP refund when reporting claim-level payment elements to the MTF DM. While NACDS supports making this information available in the manufacturer's Effectuation Plan and when reporting claim-level payment elements to the MTF DM, this should not preclude a

requirement that the manufacturer must use the SDRA (i.e., WAC) unless the pharmacy and manufacturer agree on a different amount or calculation method.

§40.4.2 Medicare Transaction Facilitator Data Facilitation

CMS is proposing that neither manufacturers nor pharmacies shall be required to pay any fees to participate in the MTF DM, including but not limited to user fees or transaction fees, as CMS intends to bear the cost of operationalizing the MTF. NACDS thanks CMS for bearing the cost of operationalizing the MTF. Moreover, NACDS strongly agrees that pharmacies should not be required to fund any administrative functions that manufacturers engage in to provide the MFP to pharmacies nor should pharmacies be required to provide funds for transmission or administrative functions related to the plan sponsors or PBMs providing the PDE file or any other information to the MTF as part of the MDPN Program. These guardrails should be explicitly stated in the final guidance to prevent harmful PBM practices from spreading into the MDNP program MTF process.

§40.4.2.1 Primary Manufacturer Participation in the MTF DM

CMS proposes that notwithstanding the termination of the MTF DM User Agreement with respect to a selected drug, certain requirements and obligations shall survive termination as specified in the MTF DM User Agreement. Because there is a runout of claims for selected drugs dispensed prior to the effective date of termination for which the manufacturer remains responsible under the statute for providing access to the MFP, the manufacturer will still have access to the MTF to address any claims with dates of service prior to termination until such claims are resolved. NACDS supports this proposal and asks that CMS include it in the final guidance, as it would help ensure pharmacies are provided access to the MFP after the termination of the MTF DM User Agreement with respect to a selected drug.

CMS intends to maintain a list of DDPS edits that directly relate to the determination and verification of MFP eligibility for the purposes of the MDPN Program, such as missing service provider ID or missing or invalid date of service, which will be posted on the CMS website. NACDS supports CMS making sure this information is publicly available.

CMS proposes that if a claim has DDPS edits that are on CMS' list of edits directly related to MFP-eligibility or has not yet cleared all of the DDPS edits that are on such CMS list of edits, the MTF DM will not transmit the claim-level data elements to the manufacturer because it has not been verified that the selected drug was dispensed to an MFP-eligible individual. The MTF DM will monitor for resolution of these edits. If all such edits directly related to MFP-eligibility are resolved within 90 days of the rejection, then the MTF DM will transmit the claim-level data elements to the manufacturer to initiate the 14-day prompt MFP payment window. If the edits are not resolved within this timeframe, the MTF DM will notify the dispensing entity that no refund payment has been paid for the claim through a remittance.

Although we appreciate these CMS proposals as a set a step in the right direction to help pharmacies receive timely reimbursement, it is beyond pharmacies' control whether a claim clears DDP edits. Consequently, NACDS has deep concerns that this proposed policy will cause pharmacies unsustainable reimbursement delays that would challenge their financial viability, as pharmacies operate on continuously thinning margins.

The pharmacy is purchasing the drug at full price from the manufacturer/wholesaler in advance of filling the prescription. Pharmacies will submit the claim using live eligibility to the PBM with the expectation that if there is an issue the PBM will reject at the POS. Pharmacies don't receive a premium or other upfront payments like the Part D plan. In a case where there is a procedural issue with the file submitted by the PBM to CMS, the pharmacy can't be expected to advance funding for 90+ days' supply of medication nor can we wait that long for the issue to be resolved. In these situations, the MTF DM must submit the claim within 14 days regardless and then the issue can be corrected after the fact by either (1) charging the plan back if the plan incorrectly determined that the claim was eligible or there was another procedural problem, or (2) charging the pharmacy back only if they fraudulently or inaccurately billed a claim. It is unconscionable and absurd for a pharmacy to be expected to dispense up to another two months of medication unwittingly and with no knowledge that there is a risk of loss on the original and, presumably, the subsequent claims.

Finally, under this section of the draft guidance, NACDS supports CMS' proposal that manufacturers cannot impose reporting requirements on pharmacies beyond what is required by CMS regulations and guidance. However, NACDS asks that CMS expand this reporting requirement prohibition to PBMs as well. PBMs should not impose reporting requirements beyond what is required by CMS regulations and guidance.

§40.4.2.2 Dispensing Entity Enrollment in the MTF DM

Pharmacies are encouraged to remediate with the manufacturer directly if they believe that they have not received a retrospective refund payment that effectuates the MFP. If remediation between the parties cannot be reached, manufacturers and pharmacies may use the complaints process.

To facilitate pharmacies ability to remediate with the manufacturer, CMS must require that somewhere within the MTF DM or a manufacturer Effectuation Plan there is provided correct contact information for the manufacturer so that the pharmacy has the proper contact to remediate any payment issues. Not all pharmacies will have a direct contact at each manufacturer and using generic telephone numbers or emails to reach them will be challenging and delay resolution.

§40.4.3 MTF Payment Facilitation

CMS proposes that the MTF PM will not require affirmative election of pharmacies for the MTF PM to pass along MFP refund payments submitted by the manufacturer. NACDS supports this proposal as it should

help reduce administrative burdens on pharmacies.

CMS seeks comment on how payment flow for Part B claims would differ from Part D. NACDS believes that the payment flow for Part B claims should not differ from Part D. Moreover, the SDRA should be WAC for both Part D and Part B drugs. However, Part B payments are already slower than most other payers as they do not adjudicate in real time. The divergence in data infrastructure between Medicare Advantage Part D plans and fee-for-service programs—particularly the delays and inconsistencies in encounter data—underscores the immense differences between Part B and Part D. To help remedy Part B reimbursement delays, we urge CMS to accelerate pharmacies' refunds for Part B claims so that they take no longer than the amount of time required for a Part D claim. Finally, NACDS seeks clarification on which entity will be responsible on Part B claims for passing the data to the manufacturer—will it be a technology vendor, the MTF DM, or CMS?

Finally, with respect to changes in WAC, as we commented above under §40.4, we ask that CMS impose a timeline that manufacturers must notify pharmacies of changes to WAC six months in advance, so that pharmacies may financially plan for the impact of the WAC change.

Under this section of the draft guidance, CMS recognizes that there will be scenarios in which there are unclaimed funds. CMS proposes that such unclaimed funds will be returned to the manufacturer. NACDS asks that CMS require that the agreement between the MTF DM and pharmacy specify under what specific circumstances funds will be returned to the manufacturer. For example, we are concerned that a paper check could be directed to a pharmacy, with no tracking for what it is or where it goes. As a result, checks may be inappropriately voided due to a time lapse.

§40.4.3.1 Required Primary Manufacturer Reporting of Claim-Level Payment Elements for MFP Refund Payments When Primary Manufacturer Passes Payment through the MTF PM

CMS is proposing that if the manufacturer is unable to transmit the claim-level payment elements, for example, if there is a technical breakdown in the transmission process, the manufacturer must continue to attempt to transmit the claim-level payment elements in good faith until successful transmission of the claim-level payment elements and must maintain documentation of the manufacturer's good-faith effort in case there is a related complaint or dispute. Failure by the manufacturer to transmit all claim-level payment elements to the MTF DM consistent with the timing of the 14-day prompt MFP payment window will be considered a violation and may cause the manufacturer to be subject to monetary penalties. NACDS supports this proposal as it should help pharmacies receive their refunds as promptly as possible.

CMS is proposing that the manufacturer must document why a refund is not provided or is different from the SDRA, including because the claim is 340B eligible. NACDS supports this proposal as it should help pharmacy transparency of their refund and refund status, as well as help pharmacies remediate any issues with their refunds.

§40.4.3.3 Pass Through Payment to Dispensing Entity When the Primary Manufacturer Participates in the MTF PM

CMS proposes that receipt of payment by the pharmacy does not constitute the pharmacy's agreement that access to the MFP has been provided by the manufacturer. NACDS appreciates this clarification from CMS. Pharmacies should not be required to reject an inadequate payment or otherwise face an allegation by the manufacturer that acceptance of payment equals assent that the payment is correct.

CMS proposes that chain pharmacies may designate a single or central pay option. NACDS appreciates CMS providing chain pharmacies the option of a single or central payment option as this should help streamline pharmacy reconciliation processes.

§40.4.4 MFP Refund Payments When Primary Manufacturer Makes Payment Outside the MTF PM, §40.4.4.3 Dispensing Entity Receipt of Payment Outside of the MTF PM, and §40.4.4.4 Primary Manufacturer and MTF PM MFP Refund Payment Adjustments due to Claim Amendments When Primary Manufacturer Makes Payment Outside of the MTF PM

CMS proposes that manufacturers are required to describe the details of their approach to MFP effectuation outside of the MTF PM, including any specific arrangements with pharmacies outside of the MTF, in their MFP Effectuation Plans. In addition, when the manufacturer makes payment outside of the MTF PM, accounting for claims reversals and adjustments must be detailed in a manufacturer's MFP Effectuation Plan, and the manufacturer has an obligation to make these processes transparent to pharmacies that receive MFP refunds outside of the MTF PM. NACDS would like to reinforce our concern that manufacturers must participate in the MTF PM. Allowing manufacturers not to participate in the MTF PM could potentially require pharmacies to negotiate alternative and unique payment arrangements with each manufacturer. Such a scenario would be unduly burdensome and costly for pharmacies. However, should CMS not accept our recommendation that manufacturers must participate in the MTF PM, then NACDS supports these proposals as they would help pharmacies plan ahead, with transparent information, for how they will receive their refund payments.

With respect to the requirement that manufacturers are required to describe the details of their approach to MFP effectuation outside of the MTF PM, we ask CMS to clarify how this requirement is not in conflict with CMS' statements made under §90.2.1 that alternative arrangements made with a manufacturer outside of the MTF PM are private contracts between the manufacturer and the dispensing entity.

§40.4.4.1 Primary Manufacturer Payment Outside of the MTF PM

For payments made outside of the MTF PM, CMS proposes that manufacturers and pharmacies must agree on the process for pharmacies to receive their refund payments. As above, NACDS would like to reinforce our concern that manufacturers must participate in the MTF PM. However, should CMS not accept our recommendation that manufacturers must participate in the MTF PM, then NACDS supports this proposal as it will prevent manufacturers from unilaterally deciding how pharmacies will receive their refund payments.

§90.2 Monitoring of Access to the MFP in 2026, 2027, and 2028

CMS proposes that when assessing whether a manufacturer provided access to the MFP to a pharmacy with respect to a selected drug, CMS will undertake a fact-specific assessment that will consider the following, among other factors, as applicable:

- whether the retrospective refund amount authorized for payment or paid by the manufacturer is sufficient to account for commercially reasonable costs the pharmacy is likely to encounter in the supply chain,
- the invoice amount from the pharmacy (if available),
- the delta between the MFP refund amount provided and the SDRA (if available), and
- any agreements or communications between the pharmacy and the manufacturer regarding the availability of the MFP to the dispensing entity.

CMS also proposes that when a refund amount other than the SDRA is paid, manufacturers will be required to maintain supporting documentation demonstrating why MFP refunds were provided at an amount other than the SDRA, or were not provided. CMS expects manufacturers to maintain documentation that includes evidence reflecting the pharmacy's actual acquisition cost or demonstrating a better approximation than WAC of the pharmacy's acquisition cost. This could include, but would not be limited to,

- Invoices from the dispensing entity,
- a contractual agreement with the pharmacy establishing an acquisition cost agreed to between the manufacturer and the dispensing entity, or
- other evidence of the dispensing entity's acquisition cost for the selected drug**.**

With respect to whether the retrospective refund amount authorized for payment or paid by the manufacturer is sufficient to account for commercially reasonable costs the pharmacy is likely to encounter in the supply chain, NACDS requests that CMS clarify in the final guidance how the agency will define "commercially reasonable costs." As CMS considers this, the agency should be clear that all costs to dispense are "commercially reasonable costs….in the supply chain." Pharmacies should not be expected to dispense MFP drugs below their full and complete cost to acquire and dispense.

CMS should clarify that pharmacies should not be forced to submit invoices for any reason. For example, we request that CMS issue guidance to clarify that manufacturers may not require a pharmacy invoice for drugs purchased indirectly through a wholesaler. However, CMS should also clarify that manufacturers shall not use other pharmacies' acquisition costs, costs being provided from wholesalers that a pharmacy does not have access to, or costs on NDCs off of lists like Predictive Acquisition Cost (PAC), Maximum Allowable Cost (MAC), or National Average Drug Acquisition Cost (NADAC) that are no longer available at the pharmacy's wholesaler.

Moreover, CMS should clarify that pharmacies should not be required to submit private contractual agreements between pharmacies and manufacturers, as such contractual agreements contain confidential, proprietary information.

Under this section of the draft guidance, CMS also delineates the minimum manufacturer documentation demonstrating that a claim is 340B-eligible. NACDS supports CMS' proposal for minimum documentation and also asks that CMS develop and impose a complaint and dispute process for 340B claim identification. Doing so will be especially necessary should CMS acquire responsibility for oversight of the 340B program from HRSA.

§90.2.1 Manufacturer Plans for Effectuating MFP

CMS is soliciting comments on the types of information that should be included in MFP Effectuation Plans for drugs payable under Part B. NACDS does not believe there should be any significant differences in the types of information that should be included in MFP Effectuation Plans for drugs payable under Part B versus drugs payable under Part D, except that any differences should be reflective of the differences between the two programs.

CMS proposes that starting with initial price applicability year 2027, CMS will split the MFP Effectuation Plan into two sections, with the following information to be provided by June 1 of the calendar year before the MFP goes into effect, (and the remainder of the information in the MFP Effectuation Plan due September 1 of the calendar year before the MFP goes into effect):

- the manufacturer's election whether or not to use the MTF PM,
- the manufacturer's communication plan,
- the manufacturer's approach to dispensing entities who indicate they anticipate having material cashflow concerns at the start of the initial price applicability year, and
- information about the manufacturer's plan if they do not intend to use the MTF PM.

Although NACDS appreciates CMS' proposal to bifurcate the manufacturers' Effectuation Plans to include a June 1 deadline for the information outlined above, NACDS urges CMS to move up the deadline for the manufacturers' entire MFP Effectuation Plans to June 1. Doing so will give pharmacies more time to prepare for the Effectuation Plans, which are likely to differ among manufacturers. Moreover, doing so

will provide CMS and manufacturers more time to resolve any questions or concerns CMS has about a Plan before implementation. Given that both CMS and industry will have the benefit of the data and payment systems being fully in place and operational in 2026, manufacturers should not need as much time to submit their plans in subsequent years.

If CMS does not adopt our recommendation to move the deadline for a manufacturer's entire MFP Effectuation Plan to June 1, then NACDS asks that CMS require manufacturers also to submit by June 1 information about whether they will use the SDRA, or another mechanism to determine a pharmacy's cost when providing retrospective reimbursements. This should include a description of the manufacturer's methodology for determining the amounts it will reimburse pharmacies when it is not using the SDRA to calculate the refund. These elements of a manufacturer's Plan will directly impact a pharmacy's finances. Having this information sooner will enable a pharmacy to better forecast financial impact and to plan accordingly. In addition, NACDS supports CMS' encouraging manufacturers to provide this information in their Effectuation Plans for initial price applicability year 2026. Finally, we would like to reinforce to CMS our concern that the manufacturer must use the SDRA (i.e., WAC) unless the pharmacy and manufacturer agree on a different amount or calculation method

CMS proposes that each manufacturer's MFP Effectuation Plan will also need to indicate its general plan and procedures for contacting and receiving communications from pharmacies. NACDS appreciates and supports this CMS proposal, and urges CMS to require this information in the Effectuation Plan information that is due on June 1 should CMS not adopt our recommendation to move up the deadline for a manufacturer's entire MFP plan to June 1.

CMS proposes that a manufacturer's decision to participate in the MTF PM does not preclude it from negotiating separate agreements with pharmacies to provide access to the MFP outside of the MTF PM; however, the manufacturer is required to ensure that its MFP Effectuation Plan's description of these alternative arrangements is kept up-to-date, including through submission of updates.

CMS also proposes that if a manufacturer declines to use the MTF PM, then it is required to provide, at a minimum, a functionally equivalent electronic reimbursement mechanism to that offered by the MTF PM. NACDS support this CMS proposal to help ensure that pharmacies are reimbursed electronically via a mechanism that is functionally equivalent to the MTF PM.

In light of the foregoing, and as stated above, NACDS would like to reinforce our concern that manufacturers must participate in the MTF PM. Allowing manufacturers not to participate in the MTF PM could potentially require pharmacies to negotiate alternative and unique payment arrangements with each manufacturer. Such a scenario would be unduly burdensome and costly for pharmacies.

Conclusion

In conclusion, NACDS thanks CMS for this opportunity to submit comments and for considering our recommendations. We urge CMS to continue to engage with NACDS, especially as CMS pursues the next steps to finalize this draft guidance. Moreover, we look forward to continuing to work with CMS's IRA team on informing pharmacies about MTF enrollment, on implementing processes to help ensure beneficiary access, and on ensuring a smooth transition and sustainable reimbursement for the pharmacy community. If we can provide any additional information, please do not hesitate to contact Dr. Christie Boutte, Senior Vice President, Reimbursement, Innovation, and Advocacy, at cboutte@nacds.org.

Sincerely,

Steven C. Anderson, FASAE, IOM, CAE
President and Chief Executive Officer

NATIONAL ASSOCIATION OF Community Health Centers

June 26, 2025

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
7500 Security Boulevard
Baltimore, Maryland 21244-1859

RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Submitted via: IRARebateandNegotiation@cms.hhs.gov

Dear Deputy Administrator Klomp:

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers or health centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of the primary health care system in America.

Community Health Centers are the best, most innovative, and resilient part of our nation's health system. For sixty years, health centers have provided high-quality, comprehensive, affordable primary and preventive care. In addition to medical services, CHCs provide dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved communities in urban, rural, suburban, frontier, mountain, and island communities. Today, health centers serve more than 32.5 million people at over 16,000 locations, ensuring patients receive the care they need and pay what they can based on a sliding fee scale.

NACHC maintains its role as the national voice for health centers and believes that high-quality primary health care is essential in creating healthy communities and preventing chronic conditions. The collective mission and mandate of NACHC and the 1,496 health centers nationwide are to close the primary care gap and provide access to high-quality, cost-effective primary and preventive medical care.

For 32 years, the 340B program has been crucial to helping safety net providers like health centers purchase outpatient medications at significantly reduced costs, enabling them to provide affordable, discounted, or free medications to uninsured and underinsured patients. By law and policy, health centers must invest every penny of 340B savings into activities that expand access to care for their patients. The 340B program generates savings that are reinvested in the health center to meet the unique needs of their communities, such as dental care, behavioral health, specialty care, translation services, food banks, housing support, and co-pay assistance programs. Health centers rely heavily on contract pharmacies to expand their community reach and provide patients with affordable, accessible medications. Additionally, health centers operate on razor-thin margins and cannot afford to lose access to 340B-priced medications. NACHC and our health centers support the intent of the IRA as it lowers drug prices. We seek to provide constructive

feedback on the effectuation of the Medicare Drug Price Negotiation Program to ensure health centers' opportunities for participation in the 340B program remain intact and do not unduly burden our pharmacies, including contract pharmacies.

Health centers strive to make medications affordable for all their patients. Because patients aged 65+ are the fastest growing patient population for health centers, we applaud CMS as it implements the Inflation Reduction Act (IRA) provisions to help decrease financial barriers for Medicare patients for prescription drugs and seek to continue partnering with the agency. However, NACHC remains concerned about how health centers will maintain access to prospectively 340B-priced drugs, especially with the implementation of the Medicare Transaction Facilitator (MTF), and how manufacturers will reconcile differences in the Maximum Fair Price (MFP) and the 340B price.

NACHC would like to reiterate our concern that the mechanism for setting a fair professional dispensing fee (PDF) has not been described in statute, regulation, or guidance. The average Medicare Part D dispensing fee was $0.65 in 2022,[1] falling well below the 2023 national cost of $13.67 for an independent pharmacy to dispense a prescription.[2] We are concerned about the detrimental economic impact of the failure to define the MFP professional dispensing fees on all independent pharmacies, particularly those owned by health centers. We encourage CMS to consider a similar PDF methodology to that used with the Medicaid billing requirement when passing on the 340B ceiling price to Fee-For-Service Medicaid. By using a metric that considers the accurate cost of dispensing when determining professional dispensing fees, CMS can ensure independent pharmacies are compensated fairly for the cost of dispensing the negotiated drugs. This will be of the utmost importance, considering the lost profit margins on the growing number of these medications in the years to come. If unchanged, the independent pharmacies will not only lose their current profit margin on negotiated drugs but could also stand to lose an additional $13.00 per Medicare Part D prescription (at present rates), which will be financially unsustainable in years to come. **NACHC respectfully requests that CMS proactively create regulations setting fair professional dispensing fees, reflecting the cost of dispensing, or create a formal mechanism for dispensers to file grievances related to unfairly low PDFs.**

NACHC has significant concerns regarding the lack of prompt payment expectations for negotiated drugs that are ultimately deemed 340B eligible when the 340B Ceiling Price is lower than the MFP. Based on language from Section 40.4.5 of the guidance:

"*Nonduplication with 340B Ceiling Price" (emphasis added)*

> *Section 1193(a)(3) of the Act establishes that **access to the MFP** shall be provided by the manufacturer to dispensing entities, subject to section 1193(d) of the Act, which **contains a limited exception to accommodate** otherwise applicable **340B pricing obligations** that applies only **if certain express conditions are met**.*
> *In particular, section 1193(d)(1) of the Act applies only if: **(1) the claim for the selected drug is a 340B-eligible claim**; and **(2) the 340B ceiling price is lower than the MFP for the selected drug**. As described in sections 40.4.3.1 and 40.4.4.2 of this draft guidance, in cases **where a Primary Manufacturer** receives claim-level data elements for a selected drug that it **reasonably believes is subject to the exception** under section 1193(d)(1) of the Act, the Primary Manufacturer **would indicate so when reporting** claim-level payment elements to the MTF **and declining to transmit payment** in an amount that provides access to the MFP **within the 14-day prompt MFP payment window**. In this scenario, the Primary Manufacturer would be required to*

[1] Medicare Part D Dispensing Fees (PY2022) https://milligram-health.com/insights/2022-02-medicare-part-d-dispensing-fees
[2] 2024 Nation Community Pharmacy Association (NCPA) Digest, https://pharmacybookshelf.cardinalhealth.com/view/491779965/

provide documentation demonstrating the claim was 340B-eligible and the 340B ceiling price was lower than the MFP upon request from CMS as described further in section 90.2 of this draft guidance."

At current pricing, all negotiated National Drug Codes (NDCs) of Entresto and Stelara, and 2 NDCs for both Farxiga and Novolog, are below the 340B Ceiling Price. This leaves 80% of the negotiated drugs on the market with MFPs higher than the 340B ceiling price.

NACHC encourages CMS to require confirmation, beyond the 340B eligibility documentation, that the 340B ceiling price has been extended to the dispenser before the Manufacturers' MFP obligations are considered satisfied. NACHC is concerned that CMS's proposed process fails to hold manufacturers accountable for effectuating the MFP in a timely manner, in the event a 340B price is not extended to a covered entity. We suggest that if a claim is identified as 340B eligible, but the manufacturer fails to pay the 340B discount, then the dispenser is, at a minimum, due to the MFP rebate. Since 2020, covered entities have reported a rising number of instances where manufacturers identify 340B-eligible claims but deny access to 340B pricing, often using non-transparent methodologies to justify the denial. To date, the standard purchasing model for all covered entities, except AIDS Drug Assistance Programs electing to use a rebate model, is to prospectively purchase 340B medications at the 340B ceiling price. In preparation for effectuating MFP, several manufacturers (Eli Lilly, BMS, Novartis, Johnson & Johnson) have litigated to require the Office of Pharmacy Affairs to allow them to switch the purchasing of their covered outpatient drugs to a retrospective pricing (rebate model). If adopted, these rebate models will mean that the health centers are required to spend significantly more to acquire their inventory than they would have if they had been purchased prospectively or replenished at a 340B price. This concern is further compounded by the lack of a prompt payment requirement for manufacturers under the 340B program when operating within a rebate model. **NACHC encourages CMS to require confirmation, beyond the 340B eligibility documentation, that the 340B ceiling price has been extended to the dispenser before the Manufacturers' MFP obligations are considered satisfied.**

We recommend implementing clear accountability measures for manufacturers who fail to extend appropriate pricing for either the 340B ceiling price or the MFP to covered entities. Section 40.4.5 of the guidance states, *"Unless the claim for the selected drug is a 340B-eligible claim and the 340B ceiling price is lower than the MFP for the selected drug or unless access to the MFP was provided prospectively, the Primary Manufacturer is required to transmit payment of an amount that provides access to the MFP of a selected drug to the dispensing entity within the 14-day prompt MFP payment window."* However, the guidance does not establish strict timelines or consequences when neither the MFP nor the lower 340B ceiling price is effectuated. **We would request a 14-day prompt payment requirement for prospectively identified 340B eligible claims submitted to the MTF and a 45-day payment window for retrospectively identified 340B eligible claims.**

Additionally, we urge CMS to:

- Clearly define the dispute resolution process;
- Specify which federal agency will be responsible for adjudicating complaints related to the denial of MFP or 340B ceiling pricing, especially in cases where the 340B price is lower, and;
- Provide enforcement mechanisms to ensure timely and accurate manufacturer compliance, especially in rebate scenarios.

NACHC recommends CMS continue working toward options that enable entities to identify 340B drugs through a retroactive process. We believe most of the data processed through the MTF is reasonable; we further appreciate CMS allowing dispensing entities the option of including a prospective 340B Claims Indicator for the MTF Data Module. NACHC respectfully asks CMS to require the prospective 340B claims identifier be utilized as the 340B claim eligibility determinant when provided by the 340B covered entity, in line with the statutory obligation to only provide 340B medications to individuals who are patients of the entity.[3]

Determining whether a prescription can and should be filled with a 340B purchased drug can be a complicated, data-intensive process that often cannot be completed when the prescription is filled, and the claim is submitted to the payer or at the point of sale. Under the 340B program, pharmacies have the discretion to use a variety of inventory models, including for tracking drugs at contract pharmacies. A covered entity will work with a third-party administrator (TPA) to implement a 340B drug inventory system for contract pharmacy arrangements, usually implementing the pre-purchased "physical" inventory model or the replenishment inventory model.[4] Both systems can run a compliant 340B program to avoid duplication of discounts while tracking inventory differently.

We appreciate the ability for pharmacies to prospectively identify 340B prescriptions and request retrospective claim identification to accommodate all types of pharmacy models. Oregon has a model for nonduplication that utilizes both prospective and retrospective prescription claims data, and we appreciate CMS's acknowledgment of exploring similar concepts. Oregon's retroactive 340B claims file process allows 340B covered entities to avoid duplicate discounts when contracting with retail pharmacies to dispense 340B-stocked medications to patients of the covered entity. Retroactively identifying which pharmacy encounter claims were filled with 340B drugs allows those claims to be excluded from the Medicaid Drug Rebate process by the Oregon Health Authority.[5] This type of asynchronous data submission "clearinghouse" model can enhance accurate claims identification while easing provider burden by minimizing disruptions to pharmacy workflow and allowing claim identification after submission, given the difficulty of placing a claims modifier on 340B drugs at the point of sale.

NACHC appreciates the added language in Section 90.2, "Monitoring of Access to the MFP in 2026, 2027, and 2028," addressing the nonduplication of 340B and MFP discounts and the effectuation of discounts when MFP is lower than 340B."

> *Documentation demonstrating that the claim is 340B eligible should include, at a minimum**,** either the Primary Manufacturer's process and conclusion from its 340B nonduplication process,* ***or confirmation from a 340B covered entity or any vendor the 340B covered entity employs to determine 340B status, that the Part D claim was 340B eligible.***

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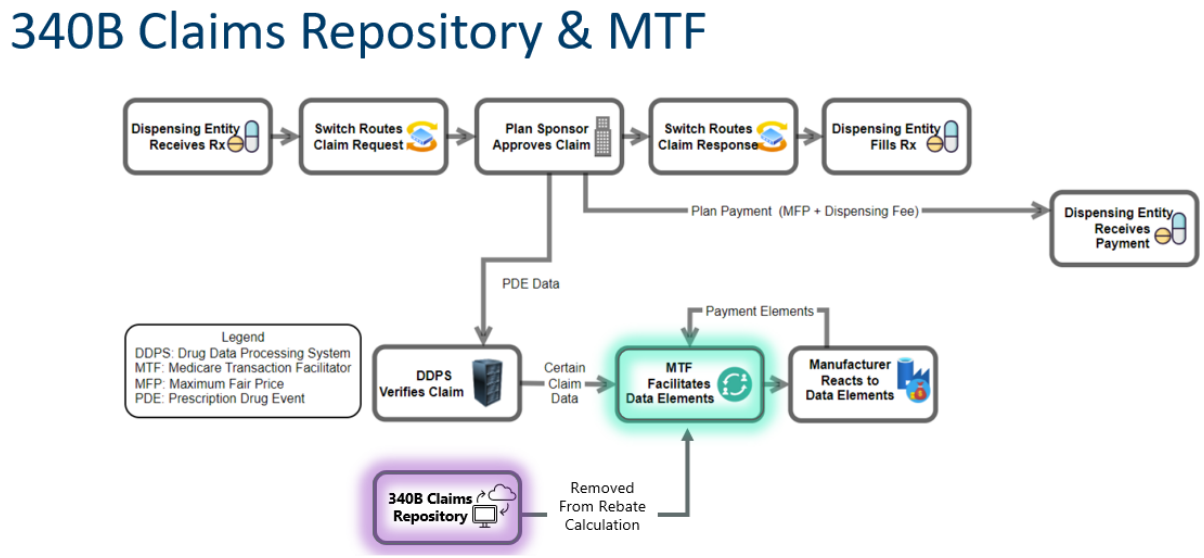
[3] "*340B(a)(5)(B) PROHIBITING RESALE OF DRUGS.—With respect to any covered outpatient drug that is subject to an agreement under this subsection,* ***a covered entity shall not resell or otherwise transfer the drug to a person who is not a patient of the entity****."*

[4] https://oig.hhs.gov/oei/reports/oei-05-13-00431.pdf.

[5] https://www.oregon.gov/oha/HSD/OHP/Tools/340B%20State%20Policy.doc.

We support the agencies' plan to utilize 340B eligibility data provided by the 340B covered entities and their vendors. NACHC would appreciate CMS providing additional guidance and explanation on the language above, as well as other references within the guidance to future enhancements, which would allow 340B covered entities to provide 340B data to the MTF in an asynchronous manner. We welcome the opportunity to work closely with CMS to develop actionable plans to ensure timely submissions of required data to prevent the duplication of 340B and MFP discounts.

Another consideration would be leveraging the credit/debit ledger system in conjunction with the proposed 340B Data Repository described in the Inflationary Penalty portions of the regulations.[6] In this methodology, we would anticipate that when covered entities were not able to prospectively identify their claims as 340B eligible at the time of dispense through the voluntary process, and 340B prices were not made available prospectively, the manufacturer could initially remit to the dispenser the amount due to effectuate the MFP. Then, when the quarterly 340B data was submitted for the data repository, the manufacturer would reconcile with the covered entity to provide access to the remainder of the eligible discount down to the 340B ceiling price. See the interaction between the 340B claims repository and the MTF in the chart below.



NACHC requests that CMS clarify the inconsistent language used in footnote 77.[7] Section 340B(a)(1) of the Public Health Service Act[8] establishes the construct for the 340B Program and

[6] https://public-inspection.federalregister.gov/2024-25382.pdf

[7] "CMS does not determine nor verify 340B eligibility and expects manufacturers and covered entities to continue to be responsible for statutory obligations pursuant to section 340B(a)(1) of the PHS Act regarding proper identification of 340B-eligible patients and covered outpatient drugs dispensed to such patients."

[8] *"(a) REQUIREMENTS FOR AGREEMENT WITH SECRETARY. (1) IN GENERAL.—The Secretary shall enter into an agreement with each manufacturer of covered outpatient drugs under which the amount required to be paid (taking into account any rebate or discount, as provided by the Secretary) to the manufacturer for covered outpatient drugs (other than drugs described in paragraph (3)) purchased by a covered entity on or after the first day of the first month that begins after the date of the enactment of this section, does not exceed an amount equal to the average manufacturer price for the drug under title XIX of the Social Security Act in the preceding calendar quarter, reduced by the rebate percentage described in paragraph (2). Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered outpatient drug*

ceiling price effectuation but imparts no authority to the manufacturers to make any determinations regarding the proper identification of 340B-eligible patients. The current 340B eligibility determination for individuals is discussed in Sections 340B(a)(5)(B).[9] However, it only refers to the covered entity's responsibility in patient eligibility determination. Footnote 77 currently suggests a manufacturer privilege of patient 340B eligibility determination, which is not congruent with the 340B statute and has the potential to create confusion or conflict between manufacturers and health centers about determining 340B eligible individuals. **NACHC requests clarity regarding this inconsistency to ensure compliance with future guidance.**

NACHC continues to harbor significant concerns about health center pharmacies receiving retrospective reimbursement (i.e., MFP rebates) and needing to pay a higher price for drugs upfront, given the thin financial margins health centers operate on. We appreciate CMS's plan for dispensing entities to be able to self-identify as anticipating material cashflow concerns at the start of a price applicability period with respect to a selected drug as a result of potential delays created by reliance on retrospective MFP refunds within the 14-day prompt MFP payment window and requiring primary manufacturers to include a process for mitigating material cashflow concerns for dispensing entities MFP Effectuation Plan. Furthermore, we appreciate that the time for claims to be transmitted from Medicare Plan Sponsors to the Drug Data Processing System (DDPS) has been shortened to 7 days for MFP drugs. Each of these efforts should help address some of the cash flow concerns, and all attempts to mitigate these proactively are essential to ensuring Health Centers can continue to deliver quality care to Medicare patients.

Many 340B covered entities, including health centers, operate with a physical inventory. They seek to ensure they have the medications their patients need, highlight any recurring inventory issues, reduce waste, and identify differences between inventory stock and actual stock.[10] Additionally, health centers operate on razor-thin financial margins while serving some of the most vulnerable, lower-income populations. Health center patients are four times more likely to have income at or below the Federal Poverty Level (FPL) and twice as likely to have income under 200% of FPL as compared to the U.S. population. Health center patients are also more than twice as likely to be uninsured as compared to the U.S. population. Around 11% of patients at a health center have Medicare, with over 4% being dually eligible for Medicaid as well.[11,12] Health centers provide healthcare services to all patients, regardless of their ability to pay, and evaluate patients, both those without insurance and those underinsured, on a sliding fee scale to help lower the cost they pay for services based on family size and income.

Moreover, health center entity-owned and contract pharmacies offer prescription assistance programs to help patients with lower incomes afford their medications. Another way health centers

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subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the 'ceiling price'), and shall require that the manufacturer offer each covered entity covered outpatient drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price."

[9] "*340B(a)(5)(B) PROHIBITING RESALE OF DRUGS.—With respect to any covered outpatient drug that is subject to an agreement under this subsection,* ***a covered entity shall not resell or otherwise transfer the drug to a person who is not a patient of the entity****."*

[10] https://dclcorp.com/blog/inventory/physical-inventory-count/#:~:text=Physical%20inventory%20counts%20can%20help,help%20to%20improve%20customer%20satisfact.

[11] https://www.nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf.

[12] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2022.

help ensure access is through co-pay assistance programs, which lower the co-pay patients see when acquiring their prescriptions at the pharmacy. Health centers prioritize their patients, stretching their scarce federal resources as far as possible while adjusting services to ensure healthcare remains affordable and accessible to all. More than half of CHCs operate with margins below 5%, and 11 million patients were served by health centers operating with negative margins in 2022.[13] These facts show that forcing a rebate model would not be economically or financially feasible for health center pharmacies. All pharmacies, but especially the safety-net 340B covered entities, should have the opportunity to purchase MFP drugs prospectively at their discretion, not at the individual manufacturer's discretion.

NACHC respectfully suggests that CMS consider the use of voluntary claims identifiers for prospectively purchased MFP drugs, e.g. Submission Clarification Code (SSC) or Basis of Cost (BOC) Determination Code. While we recognize that the large chains or health systems will not likely be interested in participating in this workflow, it is an option that would be desirable to CHCs and independent pharmacies.

There are 1,496 CHCs across the country, with more than half of those having one or more pharmacies. Over 90% of those pharmacies operate with a physical inventory model and, where required by state law, regularly submit the 340B related submission clarification code 20. The CHCs and independent pharmacies are two groups that are anticipated to have significant financial impacts from the economic changes anticipated under the MFP rebate structure.

This concern was emphasized in the Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes…, published in the Federal Register on December 10, 2024.[14] "Under the current general Prescription Drug Event (PDE) submission timeliness requirements, dispensing entities could wait up to approximately six weeks to receive access to the MFP (e.g., 30 calendar days for the Part D sponsor to submit PDE data to the DDPS, plus approximately one to three days for the PDE data to move from DDPS to the MTF to the Primary Manufacturer, plus up to an additional 14 days for the Primary Manufacturer to transmit an MFP refund payment). If the Primary Manufacturer does not prospectively make the MFP available to the dispensing entity, then the lag between when the dispensing entity receives payment from the Part D plan and when the dispensing entity receives the MFP refund payment from the Primary Manufacturer could impose a financial strain on dispensing entities given that anticipated MFP refunds could be a material percent of the dispensing entity's purchase price."

Even with the shortened timeline for submitting PDE data, it is still anticipated that the lead time required to be made whole to the initial purchase price, coupled with the loss of profit and potentially an insufficient dispensing fee, will leave health centers in unintended financial hardship.

The 340B program has been prospectively priced for over 30 years. Now, with the addition of IRA's MFPs, manufacturers are discussing the need for it to move to a rebate if the dispensations are not prospectively identified as 340B. Based on this, it is unlikely we would see any

[13] https://www.nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf.
[14] https://www.federalregister.gov/documents/2024/12/10/2024-27939/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare#print

manufacturers willing to offer a prospective Maximum Fair Price at the time of purchase if the dispensers did not have a mechanism to identify the claims as such in the MTF. Given that the pharmacies will be serving both Medicare and non-Medicare patients, if the manufacturers do opt to extend the MFP prospectively, the pharmacies will still be purchasing both inventories, and so it would not be appropriate for assumptions to be made about what was dispensed, especially in light of the 14-day prompt payment expectation.

Large chains and health systems have the economic means to eliminate the manual workflow of prospectively identifying MFT claims and the financial resources to sustain them through the delays in rebate timing. The health centers and independent pharmacies do not. For the smaller, more economically vulnerable dispensers, the opportunity to purchase at MFP and prospectively identify the claims would be a welcome option. We fear that not creating a need for voluntary claims identifiers for prospectively purchased MFP drugs may inadvertently disincentivize manufacturers from considering prospective MFP, especially as a method to mitigate cash flow concerns for dispensing entities. **NACHC respectfully asks that CMS consider the creation of an NCPDP clarification code that would allow for the prospective identification of medications purchased at the MFP.**

As the Administration continues to restructure the Department of Health and Human Services, we request specific guidance about which agency will have enforcement authority responsible for 340B claim verification and dispute resolution. Current federal budget proposals report that HRSA's Office of Pharmacy Affairs (OPA), which oversees the 340B program, will merge with CMS. The 340B Program and federal grantees that participate in the program have been under the oversight of HRSA since the 340B law was enacted in 1992. CMS has not previously had authority over the program. In fact, the final guidance states at 40.4.59 (page 231) that "CMS is not charged with verifying or otherwise reviewing whether a particular drug claim is a 340B-eligible claim", meaning that the identification of the claims at the pharmacy to CMS is voluntary. The implication of voluntary claims identification is that individual manufacturers could create unique policies on how data is sent to them to differentiate claims. This could be extremely administratively burdensome and confusing to health centers to adhere to different manufacturer policies, and overall hinder the process of getting their rebate, if eligible. Depending on whether OPA is moved under CMS, it is essential that there is one clear, established set of rules as the future number of manufacturers and drugs covered under the IRA grows.

We have seen how varying manufacturer policies have been impacting 340B covered entities, as 37 manufacturers have restricted the distribution of 340B-priced medications to contract pharmacies (and in some recent cases, entity-owned pharmacies off-site), with some only unlocking 340B pricing when claims data are submitted and others not at all. Twenty-four of these restrictions currently impact health centers. Numerous health centers that have chosen to submit data relay that having to comply with manufacturers' various policies is extremely burdensome, time-consuming, and creates limited success in restoring 340B-pricing to contract pharmacies, despite their adherence to manufacturers' policies. Additionally, there seem to be few enforcement mechanisms holding manufacturers accountable for ensuring 340B-related rebates are given to health centers. It is for this reason that health centers have concerns about manufacturers appropriately extending the statutorily required 340B and MFP discounts and rebates. We request

further guidance from the department on the plan going forward to address the 340B program's overlap with the Medicare Drug Price Negotiation Program.

NACHC appreciates the opportunity to respond to this draft guidance and looks forward to continuing to engage with CMS on this prominent issue. Health centers are eager to work in concert with CMS to implement provisions of the IRA and provide affordable medications to Medicare patients. If you have any questions, please contact Elizabeth Linderbaum, Deputy Director of Regulatory Affairs, at elinderbaum@nachc.org.

Sincerely,

Joe Dunn
Chief Policy Officer

Charles Crain

Managing Vice President,
Policy

June 26, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: *Medicare Drug Price Negotiation Program Draft Guidance for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028*

Dear Administrator Oz:

The National Association of Manufacturers ("NAM") appreciates the opportunity to provide comments on the Medicare Drug Price Negotiation Program Draft Guidance for Initial Price Applicability Year ("IPAY") 2028 and Manufacturer Effectuation of the Maximum Fair Price ("MFP") in 2026, 2027, and 2028 ("draft guidance").

The NAM is the largest manufacturing association in the United States, representing manufacturers of all sizes, in every industrial sector and in all 50 states. The manufacturing industry employs nearly 13 million people, contributes $2.94 trillion annually to the U.S. economy and accounts for nearly 53% of all private-sector research in the nation.

Biopharmaceutical companies are innovative manufacturers that discover and bring to market incredible new medicines to treat and cure challenging conditions. The average investment by a biopharmaceutical company to bring a medicine to market is approximately $2.3 billion[1] over 10 to 15 years.[2] Further, just 12% of the investigational drugs that enter a phase I clinical trial are ultimately approved by the FDA, meaning the other 88% fail along the way[3]—to say nothing of the hundreds of discoveries that never make it into clinical trials. This cycle of discovery and development makes biopharmaceutical manufacturers economic engines, accounting for $355 billion in value-added output to the U.S. economy in 2021 and supporting an additional 4.1 jobs for every person employed by a biopharmaceutical manufacturer.[4]

The Inflation Reduction Act ("IRA") directed the Centers for Medicare and Medicaid Services ("CMS") to implement the Medicare Drug Price Negotiation Program via instruction or other forms of guidance. Manufacturers strongly oppose this program, as it has imposed devastating price controls

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[1] Deloitte. "Seize the digital momentum: Measuring the return from pharmaceutical innovation 2022" (January 2023). Available at https://www2.deloitte.com/content/dam/Deloitte/uk/Documents/life-sciences-health-care/deloitte-uk-seize-digital-momentum-rd-roi-2022.pdf

[2] Pew Charitable Trusts. "From Lab Bench to Bedside: A Backgrounder on Drug Development" (March 2014). Available at https://www.pewtrusts.org/en/research-and-analysis/articles/2014/03/12/from-lab-bench-to-bedside-a-backgrounder-on-drug-development

[3] DiMasi, Joseph A., Grabowski, Henry G., and Hansen, Ronald W. "Innovation in the pharmaceutical industry: New estimates of R&D costs." J Health Econ. 2016; 47:20-33.

[4] National Association of Manufacturers. "Creating Cures, Saving Lives: The Urgency of Strengthening U.S. Pharmaceutical Manufacturing" (October 2023). Available at https://documents.nam.org/COMM/NAM-Creating%20Cures,%20Saving%20Lives_FINAL3.pdf

on biopharmaceutical innovators. Price controls, and even the threat of price controls, stifle innovation and erode the United States' standing in biopharmaceutical research and product development. Further, shifting the balance of incentives away from innovation and R&D may ultimately harm patients. The United States' leadership in biopharmaceutical innovation could be at significant risk if government price controls persist. Manufacturers urge policymakers to reconsider the potentially disastrous effects of this program and the threats it could pose to patient access to innovative medications.

As CMS considers the draft guidance for IPAY 2028, it is critical that patients not be disadvantaged by the price controls implemented on prescription drugs. The structure of the program already disincentivizes pharmaceutical manufacturers from developing small molecule drugs and seeking additional indications for orphan drugs. The NAM respectfully encourages CMS to make changes to the draft guidance to remove these disincentives, and to avoid additional potential ramifications for patients—including higher patient cost-share, more restrictive formulary placement, and pharmacists no longer being able to afford to carry drugs.

Impacts on Patient Access

With respect to patient access, after price controls take effect, pharmacy benefit managers ("PBMs") may place negotiated drugs on non-preferred tiers or use utilization management ("UM") to restrict usage, as they would no longer be able to benefit from manufacturer rebates. Instead, PBMs may steer patients to other drugs for which they do receive rebates. A change in tier could mean a higher cost-share for patients; meanwhile, UM, such as step therapy, could mean greater difficulty in accessing drugs. These PBM practices impede patient access to prescription drugs.

Additionally, pharmacists may be forced to discontinue stocking negotiated drugs due to inadequate reimbursements and reimbursement delays. According to a study conducted by 3 Axis Advisors,[5] community pharmacists would likely no longer be able to stock negotiated drugs or may even be forced to close because of payment delays leading to a lack of cash flow. Pharmacies no longer carrying certain drugs or closing entirely will reduce access to prescription drugs—not just for Medicare beneficiaries, but for anyone with a prescription that they will no longer be able to get filled at that pharmacy.

For Part B drugs, price controls will create a spillover effect that will impact reimbursement rates for the non-Medicare population. Physicians are currently reimbursed the Average Sales Price ("ASP") plus an add-on fee to cover associated costs for Part B drugs. The MFP will lower the ASP over time and thus decrease the amount providers are reimbursed for negotiated Part B drugs administered to non-Medicare populations. This will lead to financial and operational challenges for physicians, potentially leading to changes in treatment for patients.

As CMS continues to implement the price controls program, the NAM respectfully encourages you to remain mindful of these potential impacts on patient access, and to ensure that price controls do not harm patients' ability to utilize life-changing and life-saving treatments.

Pill Penalty: Disparity Between Small Molecule Drugs and Biologics

Under the price controls program, pharmaceutical manufacturers are disincentivized from developing small molecule drugs, as they are eligible for negotiation four years sooner than large molecule biologics—and thus have a shorter time frame for manufacturers to recoup the high costs of

[5] 3 Axis Advisors. "Unpacking the Financial Impacts of Medicare Drug Price Negotiation: Analysis on Pharmacy Cash Flows"(January 2025). Available at https://www.ncpa.co/pdf/2025/January2025-ThreeAxisAdvisors-Unpacking-the-Financial-Impacts-of-Medicare-Drug-Price-Negotiation.pdf

research and development ("R&D"). Parity between small molecule drugs and biologics at thirteen years of exclusivity for both would remove this disincentive. This is particularly important for patients—small molecule drugs are often the first line of prevention and treatment, as they can be taken at home rather than administered in a hospital setting. For certain therapeutic areas, small molecule drugs may be the only method for treating a disease or condition.

Data shows that negative consequences of the IRA, and the pill penalty in particular, are materializing when it comes to investment in drug development. A Vital Health report published in the Therapeutic Innovation and Regulatory Science journal showed an overall decline in the development of therapies for patient populations over the age of 65 and an even greater decline in small molecule therapies.[6] Vital Health's report also revealed that investments in small molecule therapies decreased 68% after passage of the IRA. Pharmaceutical manufacturers are proud of the innovative, life-saving, and life-improving treatments they develop. Disparity in the exclusion periods before eligibility for price controls is already harming patients counting on manufacturers to develop the therapies they need. Parity should be a top priority to mitigate negative ramifications for patients.

Exemption for Orphan Drugs

Congress recognized the importance of drugs that treat rare diseases by exempting drugs with one orphan indication from IRA price controls. Manufacturers have long supported efforts to ensure that companies have appropriate incentives to develop medicines for orphan conditions in order to ensure that patients suffering from these rare diseases have treatment options. However, once a drug with an orphan indication receives a second orphan indication, it is no longer exempt from negotiation. As a result, pharmaceutical manufacturers are disincentivized from pursuing subsequent orphan indications for existing orphan drugs. Adding new indications to existing treatments is a promising development pathway, given that these drugs have already been tested and approved for both safety and efficacy—drastically reducing the time needed to pursue approval. Disincentivizing companies from pursuing additional indications by subjecting them to price controls severely disadvantages patients with rare diseases who may not have any other treatment options.

According to the National Organization for Rare Disorders, 90% of rare diseases do not have an FDA approved treatment. Pharmaceutical manufacturers want to help patients with rare diseases, but need the orphan drug exemption expanded to include multiple orphan indications and thus remove the current disincentive. The federal government should not be adding an additional barrier to discovering and developing treatments for rare diseases when so many patients are without cures.

"Qualifying Single Source Drugs" Definition

As discussed in the NAM's April 2025 letter to Secretary of Health and Human Services Robert F. Kennedy, Jr. regarding Executive Order 14219, CMS's novel definition of qualifying single source drugs ("QSSDs") is at odds with the criteria in the statute. The IRA's criteria for a QSSD includes approval by the FDA at least seven years (for drugs) or eleven years (for biologics) prior to selection for negotiation, the drug being marketed under a New Drug Application ("NDA"), and there being no approved and marketed generic or biosimilar competition.

In its draft guidance for IPAY 2028, however, CMS stated that it would aggregate as a QSSD any drugs marketed under separate NDAs when determining drugs eligible for selection and negotiation. Specifically, the guidance states that "all dosage forms and strengths of the drug with the same active moiety and the same holder of an NDA" would be considered one drug under this QSSD

[6] Vital Transformation. "The Inflation Reduction Act's Impact Upon Early-Stage Venture Capital Investments" (April 2025). Available at https://link.springer.com/article/10.1007/s43441-025-00773-3

definition, even if the drugs are marketed under different NDAs. For biologics, the guidance states that all dosage forms and strengths of a biologic "with the same active ingredient and the same holder of a Biologics License Application (“BLA”)" would be considered the same QSSD, even if the products are marketed under different BLAs. While the IRA permits aggregated data to be used in determining a QSSD, it does not require that all dosage forms and strengths be considered the same QSSD nor does it mention moieties or active ingredients. Unlike using aggregated data to *identify* a QSSD, aggregating multiple individual NDAs or BLAs to *define* them as a single QSSD eligible for negotiation undermines both the text and the intent of the statute.

CMS’s use of erroneous criteria has led to drugs being selected for negotiation that would otherwise not have been, expanding the reach of the drug price control program. Additionally, the criteria disincentivizes innovation in a way that will be detrimental to patients. By treating distinct products as interchangeable, CMS overlooks the unique benefits that tailored treatments can provide and will reduce manufacturer incentives to develop important innovations that have significant benefit to patients and caregivers. Manufacturers ask that CMS use only the criteria for defining a QSSD included in the statutory text to prevent such negative impacts to treatments and patients.

“Marketed” Definition

CMS has further diverged from the statutory text of the IRA by narrowing the meaning of “marketed” with regard to generic or biosimilar competition in its draft guidance for IPAY 2028. The IRA’s price controls only apply to treatments without approved *and marketed* generic or biosimilar competition—so narrowing what categories of competitors qualify as “marketed” effectively broadens the reach of the program.

In the draft guidance, CMS stated that it would “consider a generic drug or biosimilar to be marketed when…the manufacturer of that approved generic drug or licensed biosimilar is engaging in bona fide marketing of that drug or biosimilar.” To implement this requirement, CMS stated that it would monitor generic drug and biosimilar manufacturers to determine whether they are engaging in “bona fide marketing.” The memo lacks sufficient detail to define what constitutes bona fide marketing, instead relying on case-by-case judgement calls by CMS. This “the government will know it when it sees it” standard creates significant uncertainty for biopharmaceutical manufacturers, which could easily be obviated by relying on marketing definitions already found in other programs. As with the criteria used for QSSDs, the use of the “bona fide marketing” requirement has led to the inclusion of drugs in the program that would otherwise not have been subjected to price controls.

Manufacturers respectfully encourage CMS to terminate its use of the “bona fide marketing” requirement and instead to use the term “marketed” as directed by the IRA. Adhering to the statutory text in implementing this requirement would prevent CMS from expanding the price controls program and its threats to innovation beyond what Congress intended.

* * * *

The NAM appreciates the opportunity to comment on this draft guidance, and manufacturers look forward to working with CMS to ensure that innovators across our industry can develop—and patients can access—life-saving treatments and cures.

Sincerely,

Charles Crain
Managing Vice President, Policy

NATIONAL HEALTH COUNCIL

June 26, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Draft Guidance for the Medicare Drug Price Negotiation Program: Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) draft guidance for the Medicare Drug Price Negotiation Program for Initial Price Applicability Year (IPAY) 2028.

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 180 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.

This latest guidance reflects CMS' continued efforts to operationalize the Inflation Reduction Act (IRA) through a negotiation framework that has expanded significantly in scope and complexity. As the program evolves, it is essential that cost-containment strategies are carefully balanced with safeguards that preserve timely, appropriate access to care. Ensuring that implementation remains transparent, predictable, and responsive to patient needs is critical to achieving these dual goals.

The NHC supports the efforts to reduce out-of-pocket costs for Medicare beneficiaries and appreciates CMS' work to establish a process that seeks to incorporate patient perspectives into drug pricing policy. We offer the following comments to help ensure that negotiated prices translate into meaningful affordability gains without undermining access to medically necessary treatments for people with chronic conditions and disabilities.

The NHC appreciates CMS' continued efforts to refine implementation details in this draft guidance. At the same time, we emphasize that such refinements must not come at the expense of patient access. As the program expands to include Part B drugs, it is especially important to ensure that changes to reimbursement and program mechanics do not inadvertently disrupt access to clinically appropriate treatments. These developments present important opportunities to improve affordability and access—provided that the program is designed and implemented in a way that centers patient needs. Our comments are organized around key themes in the guidance, with emphasis on areas where additional clarity, patient engagement, or policy safeguards may be warranted. Across all sections, we prioritize the principles of meaningful patient input, clinical appropriateness, access preservation, and real-world transparency.

Inclusion of Part B Drugs: Scope, Challenges, and Opportunities

The addition of provider-administered therapies covered under Medicare Part B to the IPAY 2028 cycle introduces a fundamentally different reimbursement and care delivery context than that of pharmacy-dispensed Part D drugs. These therapies—often infused or injected biologics used to treat cancer, autoimmune conditions, and neurologic or rare diseases—are acquired by providers under the buy-and-bill model and reimbursed based on Average Sales Price (ASP) plus a percentage add-on. Applying the Maximum Fair Price (MFP) to these treatments will require significant adjustments to workflows related to drug acquisition, claims processing, and patient cost-sharing.[1,2]

If MFP-based reimbursement falls below actual acquisition costs—or introduces new uncertainties into revenue forecasting—providers, particularly those in smaller practices or rural areas, may face disincentives to administer these drugs. CMS should monitor for early disruptions to access and consider implementing temporary acquisition cost protections or transition payments. At the same time, the NHC recommends that CMS avoid incorporating the MFP into ASP calculations, as doing so could depress reimbursement rates across both Medicare and commercial markets, compounding access risks and straining provider viability.[3]

The NHC urges CMS to issue implementation guidance that accounts for the operational realities of Part B. A first priority is clarifying how providers should submit claims for drugs subject to the MFP. Because these therapies will no longer be reimbursed based on ASP + 6%, CMS must establish clear, practical billing instructions—including updated coding protocols, reconciliation pathways, and integration requirements for Medicare Administrative Contractors (MACs). These

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[1] Centers for Medicare & Medicaid Services, "Medicare Program; Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program Draft Guidance; Comment Request," *Federal Register* 90, no. 95 (May 15, 2025): 20674, https://www.federalregister.gov/d/2025-08607.

[2] Congressional Budget Office, *Estimated Budgetary Effects of H.R. 5376, the Inflation Reduction Act of 2022: As Amended in the Nature of a Substitute (ERN22335) and Posted on the Website of the Senate Majority Leader on July 27, 2022*, August 3, 2022, https://www.cbo.gov/system/files/2022-08/hr5376_IR_Act_8-3-22.pdf.

[3] Centers for Medicare & Medicaid Services, *Medicare Part B Drug Average Sales Price*, March 12, 2025, https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price.

instructions should be released alongside a dedicated FAQ and include illustrative examples, edge-case scenarios, and transition considerations for off-cycle or multidose claims.[4] CMS must also clearly articulate how the MFP will be operationalized at the point of sale, including through mechanisms such as the Medicare Transaction Facilitator (MTF). Without timely implementation guidance on effectuation systems—including claim-level reconciliation, data reporting standards, and real-time pricing updates—stakeholders across the supply chain, particularly community-based providers and pharmacies, face heightened risk of reimbursement errors, delays, and administrative burden. These disruptions could cascade into patient access barriers if not addressed before MFP-based pricing takes effect. Without such guidance, providers may face billing challenges that could delay reimbursement and patient care.

CMS must also clarify how overpayments—instances where provider reimbursement exceeds the MFP—will be reconciled. The draft guidance is vague on critical operational details, including the timeline for refunds, the responsible parties, and patient involvement in any refund process. Retroactive claims processing is common in Part B, so reconciliation mechanisms must be prompt and automated. CMS should specify whether coinsurance refunds to patients will be automatic or beneficiary-initiated and define the oversight mechanisms for ensuring consistency and timeliness.

Another area of concern is the potential impact of MFP reimbursement levels on provider participation, which in turn may create unintended consequences for patient access. If reimbursement under the MFP falls below the acquisition cost for a drug, or introduces new uncertainties into revenue forecasting, providers—particularly in smaller practices or rural areas—may opt not to stock or furnish these therapies.[5] Past CMS experiences have demonstrated that even modest shortfalls between ASP and acquisition costs during periods of volatility or shortage have resulted in reduced provider uptake.[6] CMS should monitor for such dynamics and consider whether temporary transition payments or acquisition cost safeguards are needed to preserve meaningful access for all patients, particularly during the early phases of implementation. As CMS explores reimbursement and refund mechanisms for Part B drugs subject to negotiation, it should also consider retrospective rebate models that do not depend on modifying ASP-based payment structures. For example, using a more stable benchmark—such as the difference between Wholesale Acquisition Cost (WAC) and the MFP—as the basis for a CMS-administered rebate could help preserve financial predictability for providers without distorting ASP. This approach may be particularly beneficial for community-based or rural providers that lack the margin flexibility to absorb discrepancies between acquisition cost and reimbursement.

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[4] Centers for Medicare & Medicaid Services, *National Provider Communication Standards*, April 15, 2025, https://www.cms.gov/files/document/national-provider-communication-standards.pdf.

[5] T. Joseph Mattingly II, Anthony A. Esterly, and Anna Kaltenboeck, “Implementing Maximum Fair Price Without Hurting Pharmacies,” *JAMA Health Forum* 5, no. 5 (May 10, 2024): e240921, https://doi.org/10.1001/jamahealthforum.2024.0921.

[6] Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, Chapter 2, “Medicare Part B Drug Payment Policy Issues” (Washington, DC: MedPAC, June 2017), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch2.pdf.

CMS must further assess the downstream effects of MFP implementation on patient access. While lower coinsurance is a stated goal, it may be offset by service disruptions if providers reduce availability or shift patients to alternate sites of care.[7] CMS should proactively identify high-risk access scenarios—such as high-cost therapies with limited provider margins or geographic areas with fewer providers—and implement safeguards including ombudsperson support, real-time appeals processes, and monitoring of site-of-care utilization trends. In particular, independent and community pharmacies may face significant cash flow challenges if they are reimbursed at the MFP but must continue purchasing products at higher pre-negotiation prices.[8] CMS should evaluate whether advance payments, payment timing adjustments, or other interim protections are warranted to ensure that patients retain access to medications in these high-risk pharmacy settings during the transition period. Public reporting on provider participation rates and patient-reported access barriers would improve transparency and accountability.

To ensure a smoother transition, CMS should collaborate with patient and provider organizations to develop educational materials that explain the MFP's implications for Part B therapies. These materials should be made available in multiple formats and languages and cover billing practices, coinsurance changes, and patient rights in plain language. CMS should draw on lessons from previous transitions, including biosimilar coverage rollouts and site-of-care policy shifts, to avoid known implementation pitfalls. Even well-intentioned policies can create access disparities if communication and operational support are lacking.

Renegotiation of Previously Selected Drugs

The IRA anticipated that the clinical and economic value of a drug could evolve over time due to factors such as new FDA-approved indications, biosimilar entry, or shifts in real-world utilization. The IPAY 2028 guidance introduces a preliminary framework for addressing this evolution through potential renegotiation of MFPs. While the NHC acknowledges the rationale for establishing such a process, we emphasize that any renegotiation must be conducted with full transparency and careful monitoring of potential downstream effects on access. In particular, reductions in MFPs may have unintended consequences for formulary design, provider reimbursement, and patient cost-sharing, potentially deterring pharmacies or providers from offering affected

[7] Gabriella M. McLoughlin et al., “Mending the Gap: Measurement Needs to Address Policy Implementation Through a Health Equity Lens,” *Translational Behavioral Medicine* 14, no. 4 (February 25, 2024): 207–14, https://doi.org/10.1093/tbm/ibae004.

[8] Three Axis Advisors, *Unpacking the Financial Impacts of Medicare Drug Price Negotiation: Analysis on Pharmacy Cash Flows*, prepared for the National Community Pharmacists Association, January 2025, https://ncpa.org/sites/default/files/2025-01/January2025-ThreeAxisAdvisors-Unpacking-the-Financial-Impacts-of-Medicare-Drug-Price-Negotiation.pdf.

therapies.[9,10] It is critical that CMS weigh both clinical and access-related factors when considering renegotiation and take steps to mitigate any risks to timely and appropriate care.

CMS outlines four circumstances under which a drug may become eligible for renegotiation: the approval of a new FDA indication; a shift in exclusivity status; a material change in a statutory factor such as clinical benefit or unmet need; or a discretionary determination by CMS based on new evidence. While these triggers align with the statute's intent, the operational details remain underdeveloped and warrant further clarification.

The process by which CMS will determine that a drug qualifies for renegotiation should be more transparent. It is unclear how CMS will communicate this determination or whether stakeholders will be notified and invited to contribute evidence before a new price is set. CMS should commit to issuing public notices of intent to renegotiate, followed by a defined comment period to allow patients, clinicians, and other affected parties to submit updated clinical data, real-world outcomes, and patient perspectives.[11] The role of patient-centered evidence in the renegotiation process also requires greater definition. Although the statute references therapeutic benefit and unmet need, the draft guidance is silent on how CMS will gather and weigh patient-reported outcomes, registry data, or treatment experience narratives. Integrating these data sources would enable a more accurate reflection of a drug's real-world impact, particularly for individuals with rare, complex, or poorly studied conditions.[12]

Another area of concern is the phrase "material change," which appears throughout the guidance but is never defined. Stakeholders may interpret this threshold differently, leading to confusion or inconsistent application. CMS should develop and publish illustrative examples—drawn from clinical, economic, and operational contexts—to clarify the types of changes that would meet the threshold for triggering renegotiation.

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[9] National Community Pharmacists Association, "NCPA to CMS: A Third of Independent Pharmacies Won't Carry Drugs Subject to Government Price Controls," *NCPA Newsroom*, January 27, 2025, https://ncpa.org/newsroom/news-releases/2025/01/27/ncpa-cms-third-independent-pharmacies-wont-carry-drugs-negotiated.

[10] Julie A. Patterson, Hanke Zheng, and Jon D. Campbell, "Impacts of the Inflation Reduction Act on 2025 Formulary Coverage in Medicare Part D Plans," *Value in Health* 28, no. S1 (May 2025): ISPOR 2025, Montréal, Quebec, Canada, National Pharmaceutical Council, https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session-2/impacts-of-the-inflation-reduction-act-on-2025-formulary-coverage-in-medicare-part-d-plans.

[11] National Health Council, *Policy Recommendations for Reducing Health Care Costs*, September 2021, https://nationalhealthcouncil.org/additional-resources/policy-recommendations-for-reducing-health-care-costs/#:~:text=The%20NHC%20strongly%20opposes%20policies,as%20defined%20by%20the%20patient.

[12] U.S. Food and Drug Administration, *FDA Patient-Focused Drug Development Guidance Series for Enhancing the Incorporation of the Patient's Voice in Medical Product Development and Regulatory Decision Making*, March 21, 2025, https://www.fda.gov/drugs/development-approval-process-drugs/fda-patient-focused-drug-development-guidance-series-enhancing-incorporation-patients-voice-medical.

The timing and cadence of renegotiation reviews is also unclear. The guidance references future IPAY cycles but does not specify whether CMS will review eligibility for renegotiation on a set schedule or only on an ad hoc basis. A regular review timeline—such as annual or biennial assessments—would promote consistency and allow stakeholders to anticipate upcoming changes, while still permitting expedited review in exceptional cases.

Renegotiation may also result in unintended consequences that extend beyond price. Changes in the MFP could influence formulary design, provider reimbursement, or patient cost-sharing. Without careful monitoring, a new price could prompt plans to reclassify a drug, alter utilization management policies, or introduce other access barriers. CMS should evaluate these downstream impacts and adopt safeguards to prevent disruptions in coverage or care continuity.[13]

Finally, CMS should ensure that the renegotiation process includes structured opportunities for stakeholder engagement beyond manufacturers. The current framework does not indicate whether public listening sessions, stakeholder briefings, or appeals pathways will be available to patient organizations, clinicians, or public health experts. Establishing a dedicated input process—separate from the manufacturer negotiation—would help ensure that decisions reflect not only cost data but also the lived experience of those affected by pricing changes.[14]

The inclusion of a renegotiation framework is an essential and forward-looking feature of IPAY 2028. However, to fully realize its promise, CMS must clarify its criteria, enhance transparency, and institutionalize patient engagement. A predictable, evidence-based, and participatory approach will ensure that the program remains responsive to evolving therapeutic landscapes while protecting uninterrupted patient access to care.

Inflation Rebate Integration with Negotiation

The IPAY 2028 draft guidance confirms that inflation-based rebates under the IRA will continue to apply to drugs selected for negotiation, even after the establishment of a MFP. This policy direction reflects Congress's dual strategy to restrain drug price growth through complementary mechanisms: negotiated ceilings on drug prices for certain high-spend products and mandatory rebates for any drug—whether negotiated or not—that exceeds the inflation-adjusted price growth threshold.[15]

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[13] Skylar Jeremias, "The IRA's Unintended Consequences for Drug Pricing and Coverage," *The American Journal of Managed Care*, April 2, 2025, https://www.ajmc.com/view/the-ira-s-unintended-consequences-for-drug-pricing-and-coverage.

[14] National Health Council, *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement*, March 2024, https://nationalhealthcouncil.org/wp-content/uploads/2025/05/Amplifying-the-Patient-Voice-Roundtable-and-Recommendations-on-CMS-Patient-Engagement-new-1.pdf.

[15] *Inflation Reduction Act of 2022*, Pub. L. No. 117–169, 136 Stat. 1818 (2022). https://www.congress.gov/bill/117th-congress/house-bill/5376.

The continued application of the inflation rebate provision to drugs selected for negotiation reflects the IRA's layered approach to managing costs within Medicare and the broader prescription drug market. While we recognize that this may introduce overlapping compliance requirements, the provisions serve complementary functions: the MFP sets a ceiling on Medicare reimbursement, while the inflation rebate provision is intended to promote long-term pricing stability. CMS should monitor the interaction of these mechanisms to ensure they do not inadvertently disrupt patient access or provider participation. In doing so, CMS must also remain attentive to the potential impact on future therapeutic development, particularly in areas of high unmet need or limited market competition. A balanced implementation approach—grounded in transparency, flexibility, and engagement—will be essential to advancing affordability while preserving incentives for continued innovation.

CMS should clarify how inflation rebate benchmarks will be maintained or recalculated when a drug transitions into or out of the negotiation program. For instance, if a previously rebated drug becomes subject to negotiation, it is unclear whether its inflation penalty benchmark would be frozen as of the MFP's effective date or allowed to continue adjusting annually. Similarly, if a drug exits the negotiation program, it remains uncertain whether the benchmark would reset or revert to a prior methodology. Without clear parameters, stakeholders—including manufacturers, payers, and patient advocates—may be unable to anticipate the full pricing impact of program transitions.[16]

Further clarity is also needed on how CMS will reconcile violations involving both inflation rebate caps and MFP compliance. A manufacturer could, for example, fail to make the MFP available to dispensing entities while simultaneously triggering a rebate liability due to inflation-based price growth. The draft guidance does not specify whether such infractions are treated cumulatively, prioritized, or subject to adjustment. To minimize confusion and support consistent enforcement, CMS should publish a formal penalty reconciliation framework accompanied by practical examples.

The NHC also recommends that CMS enhance transparency around inflation rebate liabilities to support broader stakeholder understanding of the Inflation Reduction Act's pricing provisions. Although the guidance outlines data collection and reporting obligations for MFP enforcement, it does not clarify whether manufacturers' inflation rebate liabilities will be made publicly available or shared with non-manufacturer stakeholders. Greater visibility into these rebate trends could enable oversight of affordability trends, foster more informed public discourse, and allow patients and advocates to better anticipate the evolving cost burden on the Medicare program. However, this information should remain analytically distinct from the renegotiation process, which must continue to focus on clinical and statutory factors as defined under the law.

Publishing case-based illustrations would further enhance stakeholder understanding. Examples could include: a drug newly selected for negotiation after previously incurring inflation rebates; a renegotiated drug experiencing a midyear price spike; or a product that shifts formulations or market position while remaining subject to both rebate and

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[16] National Health Council, *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement*.

negotiation requirements. Illustrative case studies would help demystify the interaction of these provisions for manufacturers, providers, and beneficiaries alike.

Regular publication of enforcement metrics would also benefit the advocacy community. Semiannual reports should disclose the number of drugs assessed inflation penalties, total rebate amounts collected, and the portion of those totals attributed to MFP-selected drugs. Such metrics would enhance oversight, facilitate research into policy effectiveness, and enable patient advocates to better anticipate the impact of enforcement on care access.[17]

Finally, CMS should assess whether certain therapeutic areas—such as oncology or rare diseases—may be disproportionately affected by the cumulative impact of rebates and price caps. In markets with limited competition or high variability in dosing, even well-intentioned policies could lead to distorted plan behavior or adverse formulary decisions. A proactive analysis of these potential effects is warranted to ensure safeguards are in place to preserve access and avoid disincentivizing innovation.[18]

The continued application of inflation rebates to negotiated drugs reflects a coherent cost-containment strategy. However, its success depends on operational clarity, consistent enforcement, and open communication with affected stakeholders. By refining its guidance and sharing actionable examples, CMS can align these mechanisms in a way that delivers on the IRA's goals without introducing unnecessary barriers or uncertainty.

Effectuation of the MFP: Operational Mechanisms and Patient Communication

Among the most technically complex—and most consequential—aspects of the IPAY 2028 draft guidance is CMS' expanded discussion of how the MFP will be implemented at the point of care. This includes leveraging systems such as the MTF to manage payment flows, enforce price ceilings, and process refunds across both Medicare Part D and Part B drugs. While these backend functions may receive less attention than drug selection criteria or negotiation methodologies, they are pivotal to determining whether patients actually experience the financial protections promised under the IRA.

The NHC supports CMS' ongoing investment in these infrastructure systems and appreciates the additional operational details included in the draft guidance. However, several unresolved issues remain—particularly in the areas of transparency, accountability, and procedural safeguards when the MFP is incorrectly applied.

CMS should clearly articulate how beneficiaries will be notified if they are charged cost-sharing based on an amount that exceeds the applicable MFP. Although beneficiaries are not typically responsible for the full MFP amount, current guidance does not require

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[17] John (Xuefeng) Jiang, Max Jiang, and Ge Bai, "Enforcing Hospital Price Transparency: Lessons From CMS Actions," *Health Affairs Forefront*, December 3, 2024, https://doi.org/10.1377/forefront.20241202.645014.

[18] Hanke Zheng, Julie A. Patterson, and Jonathan D. Campbell, "The Inflation Reduction Act and Drug Development: Potential Early Signals of Impact on Post-Approval Clinical Trials," *Therapeutic Innovation & Regulatory Science*, published April 22, 2025, https://doi.org/10.1007/s43441-025-00634-7.

plans or providers to notify them when cost-sharing exceeds what would be owed under the MFP. Nor are refund processes standardized or consistently communicated across payers and providers. For many Medicare beneficiaries—particularly those with limited health literacy, digital access, or language proficiency—relying on self-monitoring or post hoc claims review is not feasible. CMS should require that point-of-sale systems include standardized alerts when patient cost-sharing exceeds the MFP-based amount and mandate that refund notices be issued in plain language, through both mail and electronic formats, as appropriate.[19]

Greater specificity is also needed regarding the refund and reconciliation process. The draft guidance mentions the possibility of retrospective refunds but does not outline how such refunds are initiated, how patients will receive them (e.g., direct deposit, mailed check, or copay credit), or how long processing will take. Without defined timelines or error thresholds, the system risks delays and inconsistencies that could erode public trust and deter patients from accessing needed therapies. CMS should also consider the operational realities faced by providers in implementing MFP-related processes. For example, requiring providers to maintain dual inventories under a prospective pricing model would likely be infeasible in many clinical settings—particularly community-based practices—and could divert resources away from patient care. Clear, consistent guidance on timing and reconciliation processes will be critical to avoiding unintended disruptions in therapy availability.

CMS should also establish a patient-facing error correction and appeals process. This should include a centralized portal and toll-free hotline that allows beneficiaries to report discrepancies, obtain assistance, and navigate dispute resolution. To ensure meaningful access for all patients, support staff should be trained in health literacy and disability communication standards.[20]

The NHC further recommends that CMS require Medicare Advantage (MA) plans and Part D sponsors to distribute standardized educational materials explaining MFP protections and refund procedures. These materials should be provided at the point of care, included with each Explanation of Benefits (EOB), and made available in both print and digital formats. They should be written in plain language and tailored to meet the needs of patients receiving physician-administered Part B drugs as well as pharmacy-dispensed Part D prescriptions.[21]

From the patients' perspective, the value of the MFP lies in its consistent and reliable application. CMS should ensure that systems are in place to minimize errors and

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[19] Centers for Medicare & Medicaid Services, *Medicare Communications and Marketing Guidelines (MCMG)*, February 9, 2022, https://www.cms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf.

[20] "CMS.gov Accessibility and Compliance with Section 508," Centers for Medicare & Medicaid Services, September 10, 2024, https://www.cms.gov/about-cms/web-policies-important-links/accessibility-compliance.

[21] Centers for Medicare & Medicaid Services, *Marketing Models, Standard Documents, and Educational Material*, November 5, 2024, PDF file, https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/models-standard-documents-educational-materials.

simplify the correction process when discrepancies occur. CMS should minimize the burden on beneficiaries by ensuring that refund and correction processes are clearly communicated, accessible, and timely. This concern is particularly acute for low-income and medically complex patients who may lack the time, resources, or familiarity with Medicare processes to resolve such issues.[22]

To promote accountability and system-wide learning, CMS should regularly publish metrics on MFP implementation. These should include the frequency of overcharges, average refund timelines, number of beneficiary complaints, and compliance rates among plans and providers. Public reporting of these data will support transparency, identify operational bottlenecks, and guide future improvements to the MTF and related systems.

In designing these systems, CMS should draw on lessons from past implementation challenges in other Medicare programs. Persistent issues with inaccurate copay collection and delayed reimbursements in Medicare Part D—particularly for dual-eligible individuals and beneficiaries with limited English proficiency—demonstrate how implementation gaps can disproportionately harm vulnerable populations.[23] Applying these lessons to the MFP rollout is essential to prevent similar disparities.

Ultimately, implementing the MFP is not a peripheral administrative task—it is central to fulfilling the law's promise of improved affordability. CMS must ensure that operational systems are seamless, transparent, and firmly rooted in the patient experience. Only then can the negotiated prices under the IRA be translated into meaningful, real-world access for the millions of Medicare beneficiaries who depend on these therapies.

Patient Listening Sessions

The NHC commends CMS for continuing to convene patient-focused listening sessions as part of the Medicare Drug Price Negotiation Program. These forums are among the only formalized mechanisms for patients and caregivers to share their lived experiences with selected drugs directly with federal regulators. As such, they serve a unique and irreplaceable function in shaping negotiation decisions beyond what clinical trial data and cost models can reveal.

Patient listening sessions are especially critical in surfacing perspectives on treatment burden, adherence challenges, quality-of-life impacts, and other patient-centered outcomes that may not be reflected in the evidence submitted by manufacturers. These sessions provide insight into how drugs function in real-world conditions—information

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[22] Rahul Aggarwal, Suhas Gondi, and Rishi K. Wadhera, "Comparison of Medicare Advantage vs Traditional Medicare for Health Care Access, Affordability, and Use of Preventive Services Among Adults With Low Income," *JAMA Network Open* 5, no. 6 (June 2022): e2215227.

[23] *Medicare Part B Drug Average Sales Price*, Centers for Medicare & Medicaid Services, March 12, 2025, https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price.

that is vital to determining whether a treatment's price reflects its true value across various patient populations.[24]

To ensure that listening sessions yield actionable, patient-centered insights, the NHC recommends the following process improvements focused on accessibility, clarity, and broad participation of stakeholders:

1. **CMS should provide a minimum of 30 days' advance notice and allow scheduling flexibility for all listening sessions.** This lead time enables patients, caregivers, and advocacy organizations to prepare comments, arrange time off work, and secure necessary support services such as transportation or caregiving. Many individuals managing complex conditions require advance logistical coordination to participate meaningfully.[25]
2. **CMS should publish thematic guidance and clearly defined expectations in advance of each session.** Publishing themes—such as "treatment burden," "side effect management," or "impact on caregiving"—will help participants prepare more tailored and relevant input. These prompts should also include examples of narratives that are particularly useful in informing negotiation-related decisions.[26]
3. **CMS should improve and expand asynchronous input opportunities to supplement live oral testimony.** While CMS has provided written comment periods for listening sessions in the past, these opportunities have been limited in duration and hosted on platforms that are difficult to navigate. To increase accessibility, CMS should extend the length of written comment windows, improve the user interface of submission platforms, and conduct proactive outreach to encourage participation from a diverse range of patients. Additionally, CMS should accept alternative formats such as audio and short video submissions to accommodate individuals who may be unable to submit traditional written input due to fatigue, speech limitations, or other barriers.[27]
4. **CMS should provide accessibility and language services by default for all listening sessions.** Sign language interpretation, closed captioning, multilingual translation, and accommodations for cognitive or sensory impairments should be standard features, not contingent upon special requests. Establishing these supports by default reflects CMS' commitment to broad patient participation and minimizes the administrative burden on patients already navigating serious health challenges.[28]

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[24] National Health Council, *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement*.

[25] National Health Council, *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement*.

[26] U.S. Food and Drug Administration, *FDA Patient-Focused Drug Development Guidance Series*, March 21, 2025.

[27] National Health Council, *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement*.

5. **CMS should provide private, de-identified submission options for patients who are not comfortable disclosing their identity.** These options are particularly important for individuals with stigmatized conditions who may be reluctant to share personal stories in public forums. Allowing anonymous or non-identifiable input ensures that privacy concerns do not prevent patients from contributing valuable insights.

Beyond participation mechanics, CMS must also improve transparency regarding how patient input is used. The current process lacks adequate public feedback loops. While CMS may state that patient insights are "considered," this phrasing is insufficient to assure stakeholders that their contributions have influenced policy outcomes.

The NHC urges CMS to publish post-session summaries that include the following elements:

- De-identified participant quotes organized by theme (e.g., barriers to access, treatment fatigue, adverse effects);
- A high-level summary of key insights shared during the session;
- A description of how these insights were incorporated into the negotiation process or where they influenced considerations about therapeutic alternatives, patient subgroups, or dosing variations;
- A discussion of any themes that were noted but ultimately not acted upon, along with rationale for their exclusion.

Providing this level of transparency will build public trust, demonstrate procedural fairness, and reinforce that CMS is committed to evidence-informed, patient-centered decision-making—not just technical pricing models. Transparency in government engagement processes has been shown to increase both participation and perceived legitimacy, especially in high-stakes or politically sensitive programs.[29]

Furthermore, CMS should develop a centralized, publicly accessible archive of all patient listening session materials—including agendas, guidance prompts, anonymized summaries, and, where consent is granted, recordings. This will allow other stakeholders (e.g., academic researchers, patient organizations, and clinicians) to review patterns in patient-reported data and understand how those perspectives inform Medicare drug pricing decisions.[30]

Finally, we encourage CMS to formally invite participation from patient organizations, including those representing underserved and low-incidence populations who may

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[28] Centers for Medicare & Medicaid Services. *CMS Framework for Healthy Communities*. U.S. Department of Health and Human Services. February 28, 2025. https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework.

[29] Lisa Ann Baumann, Anna Katharina Reinhold, and Anna Levke Brütt, "Public and Patient Involvement in Health Policy Decision-Making on the Health System Level: A Scoping Review," *Health Policy* 126, no. 11 (November 2022): 1156–1171, https://doi.org/10.1016/j.healthpol.2022.07.007.

[30] U.S. Food and Drug Administration, *FDA-Led Patient-Focused Drug Development (PFDD) Public Meetings*, March 21, 2025, https://www.fda.gov/industry/prescription-drug-user-fee-amendments/fda-led-patient-focused-drug-development-pfdd-public-meetings.

otherwise be excluded from mainstream data collection. These groups can help identify unique patient experiences and ensure that less prevalent diseases and conditions are not overlooked during the negotiation process.

In sum, patient listening sessions represent one of the most tangible, high-impact ways that individuals and families can shape federal drug pricing decisions. CMS should continue to strengthen these forums as foundational elements of the program's evidence base, ensuring that patient voices are meaningfully integrated into decision-making. By strengthening the format, ensuring meaningful access for all patients, and demonstrating a transparent link between testimony and policy action, CMS can uphold the spirit of the IRA and improve the health and financial well-being of Medicare beneficiaries nationwide.

Manufacturer Agreements and Compliance Requirements

The IPAY 2028 draft guidance builds on CMS' authority under the IRA by outlining specific compliance expectations for manufacturers participating in the drug price negotiation program. These include timely execution of agreements, submission of required data, and accurate implementation of MFP across all Medicare Part B and Part D settings. While these measures are essential to program integrity, aspects of the compliance framework remain underdeveloped. Without greater procedural clarity and transparency, there is a risk that administrative errors—particularly those outside the control of the health care system's end users, including patients—could lead to avoidable disruptions in access or affordability.

CMS states that manufacturers may face civil monetary penalties if the MFP is not made available to dispensing entities; however, the guidance does not specify whether enforcement actions will be automatic or discretionary, nor does it outline the severity thresholds that would trigger such penalties. This ambiguity may create uncertainty among manufacturers regarding the consequences of minor or unintentional errors, potentially discouraging timely participation or resulting in overly conservative implementation practices.[31]

In addition, the guidance does not explain how CMS will differentiate between systemic noncompliance and isolated, good-faith administrative mistakes—especially in cases where third parties (such as pharmacies, claims processors, or health systems) may have contributed to errors in MFP application. Patients should be protected from the downstream consequences of backend operational failures—including those stemming from third-party or manufacturer errors—that could result in delays, denials, or unexpected cost-sharing.

To improve the clarity and effectiveness of the compliance framework, the NHC recommends the following enhancements:

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[31] Centers for Medicare & Medicaid Services, *Compliance Program Policy and Guidance*, September 10, 2024, https://www.cms.gov/medicare/audits-compliance/part-c-d/compliance-program-policy-and-guidance.

1. **CMS should establish a clear escalation and remediation pathway for enforcement.** A tiered model should outline informal correction opportunities, formal notices, and civil penalties, with each step triggered by well-defined criteria. This structure, modeled after compliance regimes in other Medicare programs such as the Shared Savings Program, would promote early resolution of issues and reduce unnecessary punitive actions. CMS should also clarify whether internal dispute resolution or appeals processes will be available for manufacturers facing enforcement actions.[32]
2. **CMS should implement patient-focused remediation measures when compliance failures occur.** If patients experience higher out-of-pocket costs or treatment disruptions due to MFP misapplication, CMS should require retroactive refunds and a mechanism for expedited redress. Such failures should automatically trigger additional patient protections and targeted oversight of the responsible entities. It is critical that beneficiaries—especially those with life-threatening conditions—not be left to absorb consequences stemming from system-level lapses.[33]
3. **CMS should consider publishing de-identified, aggregate compliance data to support continuous program improvement and foster stakeholder confidence.** This could include summary statistics on the number and types of compliance issues, average resolution timelines, and corrective actions taken—disaggregated by program year and therapeutic area where appropriate. A regularly updated public dashboard or report would enhance transparency, help identify systemic challenges, and inform future policy refinements, while safeguarding proprietary and reputational interests.[34]
4. **CMS should provide clear guidance on what constitutes "good faith" compliance efforts.** While the draft references this term, it offers no detail on what behaviors qualify. CMS should clarify that good faith includes timely reporting of technical problems, cooperation with affected entities, proactive correction of known issues, and demonstrable attempts to comply despite extenuating circumstances. This clarity would reduce legal ambiguity and encourage open communication between manufacturers and the agency.

A well-calibrated compliance regime must balance firm oversight with fairness and operational realism. Enforcement approaches that lack transparency or patient-centered safeguards could unintentionally discourage participation or introduce legal uncertainty, ultimately reducing the availability of negotiated drugs. By contrast, a predictable, transparent framework that includes remediation for affected patients will promote both compliance and confidence in the negotiation process.[35]

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[32] Centers for Medicare & Medicaid Services, *Compliance Program Policy and Guidance*.

[33] Centers for Medicare & Medicaid Services, *Medicare Managed Care Appeals & Grievances*, September 10, 2024, https://www.cms.gov/medicare/appeals-grievances/managed-care/grievances.

[34] Centers for Medicare & Medicaid Services, *Compliance Program Policy and Guidance*.

[35] David N. Bernstein and Jonathan R. Crowe, "Price Transparency in United States' Health Care: A Narrative Policy Review of the Current State and Way Forward," *Inquiry* 61 (May 26, 2024): 00469580241255823, https://doi.org/10.1177/00469580241255823.

The NHC remains committed to working with CMS to develop these guardrails and urges the agency to treat patients as central—not incidental—stakeholders in all phases of MFP enforcement and oversight.

Balancing Confidentiality and Transparency in Data Submission

The NHC supports CMS' efforts to protect proprietary data while also ensuring that stakeholders have sufficient insight into the rationale behind pricing decisions. We believe that a balanced approach can foster both innovation and accountability. CMS' reaffirmation of its confidentiality policies for manufacturer data submissions raises important questions about how the agency will balance the protection of proprietary information with the transparency needed to sustain public trust and stakeholder engagement. Under the IRA, CMS is authorized to collect sensitive data from manufacturers as part of the drug price negotiation process, including financial projections, cost structures, clinical benefit assessments, and research and development expenditures. The IPAY 2028 guidance reiterates CMS' commitment to safeguarding trade secrets and proprietary commercial information, consistent with statutory obligations. The NHC supports the appropriate protection of confidential business information to encourage manufacturer participation and prevent anti-competitive misuse. However, we remain concerned that a confidentiality framework that is overly expansive or inconsistently applied could obstruct stakeholder engagement, limit public accountability, and weaken the legitimacy of MFP determinations. If transparency is the foundation of accountability, then CMS must ensure that stakeholders have sufficient visibility into the evidence and reasoning behind each pricing decision.

Several key concerns should be addressed to strike the appropriate balance:

1. **Excessive confidentiality may obscure the rationale behind MFP determinations.** Stakeholders—including clinicians, researchers, and patient organizations—need access to high-level summaries of the non-proprietary or confidential data and assumptions informing MFPs. Without such transparency, it becomes difficult to evaluate whether pricing decisions reflect real-world value, policy objectives, and patient needs. Broad redactions can erode trust in the negotiation process and invite skepticism about CMS' decision-making framework.[36]
2. **Patient groups may be excluded from meaningful participation in the negotiation process.** The ability of patient organizations to offer informed input depends on access to relevant information, including utilization patterns, cost-offset assumptions, and comparative effectiveness data. Without this, groups cannot speak to issues such as treatment adherence, financial toxicity, or unmet need. Transparency, when appropriately balanced with confidentiality, is essential to fostering trust and informed engagement across all stakeholder groups, including manufacturers, patients, and providers.[37]

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[36] National Health Council, *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement*.

[37] National Health Council, *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement*.

3. **Insufficient data disclosure may hinder program evaluation and iterative improvement.** CMS has committed to refining the negotiation framework over time, but future adjustments require meaningful external evaluation. If core data are withheld, oversight bodies and independent researchers will be unable to assess program effectiveness or recommend improvements, limiting the IRA's long-term success.[38]

To ensure appropriate transparency without compromising proprietary interests, CMS should adopt the following procedural safeguards when it does not compromise confidential or proprietary data:

- **Ensure confidentiality claims are justified at the question level, consistent with the IPAY 2027 ICR.** CMS should standardize the redaction process across all negotiation-related submissions by requiring justification of confidentiality claims at the question level, as outlined in the IPAY 2027 Information Collection Request (ICR). This approach balances transparency with administrative feasibility.
- **Publish aggregate or de-identified data summaries.** CMS should release anonymized ranges or summaries of key non-confidential or proprietary data points—such as projected Medicare spending, estimated cost savings, or clinical assumptions—even when individual figures must remain confidential. This allows for meaningful oversight without exposing proprietary detail.
- **Create a petition process to reconsider redactions.** CMS should allow recognized patient organizations to formally petition for the limited disclosure of redacted data categories, with the option to propose safeguards such as nondisclosure agreements. All petitions should be evaluated using consistent and transparent criteria.

Commercial confidentiality and public transparency are not mutually exclusive. Precedents from domestic and international programs demonstrate that drug pricing frameworks can protect sensitive business interests while maintaining enough transparency to foster public trust.[39] International experience confirms that transparent decision-making is essential to the legitimacy, credibility, and durability of negotiation-based pricing systems.[40]

The NHC urges CMS to calibrate its confidentiality policies to reflect these dual imperatives. Drug price negotiation is not only a regulatory task—it is a public trust exercise. Without meaningful transparency, that trust cannot be earned or sustained.

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[38] National Health Council, *Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement*.

[39] Sarosh Nagar, Leah Z. Rand, and Aaron S. Kesselheim, "What Should US Policymakers Learn From International Drug Pricing Transparency Strategies?" *AMA Journal of Ethics* 24, no. 11 (2022): 1083–1090, https://doi.org/10.1001/amajethics.2022.1083.

[40] Eliana Barrenho and Ruth Lopert, *Exploring the Consequences of Greater Price Transparency on the Dynamics of Pharmaceutical Markets*, OECD Health Working Papers No. 146 (Paris: OECD Publishing, 2022), https://dx.doi.org/10.1787/c9250e17-en.

Oversight of Part D Formulary Changes and Access Protections

The IPAY 2028 draft guidance provides a comprehensive update on the operational aspects of the Medicare Drug Price Negotiation Program across Parts B and D. However, it gives limited attention to how Part D plan sponsors might adapt to the implementation of MFPs, particularly with respect to formulary tiering, utilization management, and access protections. Additional clarity in these areas would be valuable, as plan decisions play a critical role in determining whether negotiated prices translate into meaningful improvements in patient access.

While lower list prices are designed to reduce out-of-pocket costs for beneficiaries, they may also result in unintended shifts in benefit design. Under current market dynamics, higher-cost therapies are often placed on non-preferred tiers because their elevated list prices enable larger manufacturer rebates. With the introduction of MFPs, the economic incentives surrounding these drugs may shift. As a result, some plans may reevaluate formulary placement or utilization management strategies based on updated cost structures. Without appropriate guardrails, such changes—though financially rational—may inadvertently limit access to clinically appropriate therapies.[41]

To support transparent and patient-centered implementation, CMS should reinforce expectations for plan behavior following MFP adoption. Specifically:

- **Plans remain accountable for ensuring timely and appropriate access to medically necessary therapies.** CMS should reiterate that Part D sponsors are expected to maintain compliance with long-standing benefit design requirements, including therapeutic category representation and network adequacy, regardless of whether a drug is subject to an MFP.[42]
- **Utilization management changes should be clinically justified.** CMS should clarify that the introduction of an MFP alone does not warrant new prior authorization, step therapy, or tiering adjustments without appropriate clinical rationale. Promoting transparency around such changes will help ensure that utilization management tools remain aligned with patient needs.[43]
- **Beneficiary protections must remain in place.** A reduced drug price does not diminish a patient's right to appeal coverage determinations. CMS should reaffirm that beneficiaries continue to have access to existing grievance and appeals

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[41] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2020. Washington, DC: MedPAC.

[42] Centers for Medicare & Medicaid Services, *Medicare Prescription Drug Benefit Manual*, Chapter 6 – Part D Drugs and Formulary Requirements (Baltimore, MD: U.S. Department of Health and Human Services), https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefit-Manual-Chapter-6.pdf.

[43] Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*. Chapter 6, "Provider Networks and Prior Authorization in Medicare Advantage." Washington, DC: MedPAC, June 2024. https://www.medpac.gov/document/june-2024-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

processes under 42 CFR § 423 Subpart M.[44] In addition, CMS should take steps to ensure that these protections are clearly communicated to beneficiaries and that grievance and appeals processes are timely, accessible, and minimally burdensome to avoid unnecessary delays in access to needed medications.

In addition, CMS should consider establishing a proactive monitoring framework to assess plan responses to MFP implementation. Publicly reporting on changes to prior authorization policies, tier placement, and coverage decisions—particularly for drugs newly subject to MFPs—can help promote transparency and inform future policy adjustments.

Finally, CMS should acknowledge that price reductions, while critical, do not automatically resolve all access challenges. Administrative complexities, such as prior authorization or language barriers, may still delay or hinder treatment, especially among older adults or those with limited digital literacy.[45] Ongoing monitoring and stakeholder engagement can help identify and mitigate these challenges.

To ensure that the program's intended cost savings translate into real-world patient benefit, CMS should work collaboratively with plans and other stakeholders to prevent unintentional access barriers and uphold high standards of patient care.

Implementation of MFPs for Part B Drugs: Challenges and Safeguards

The IPAY 2028 cycle marks a significant expansion of the Medicare Drug Price Negotiation Program, encompassing—for the first time—drugs reimbursed under Medicare Part B. This extension introduces a fundamentally different implementation environment from that of Part D. Whereas Part D drugs are typically dispensed at retail pharmacies and managed by private plans, Part B drugs are primarily administered in clinical settings and reimbursed directly to providers through the buy-and-bill model. This operational distinction is more than procedural—it has real implications for how negotiated prices will be implemented, how providers will be informed, and how patients will experience the benefits of price reductions.

However, the inclusion of Part B raises urgent operational questions that must be addressed to ensure the program functions as intended. Without targeted safeguards and implementation supports, both patient access and provider participation may be jeopardized.

First, CMS must establish a clear, structured process for communicating MFP implementation details to providers—especially those practicing outside of major health systems. While large hospitals may have dedicated reimbursement departments and billing vendors with direct access to CMS updates, smaller or rural practices often

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[44] U.S. Code of Federal Regulations, Title 42, § 423 Subpart M (2024), https://www.ecfr.gov/current/title-42/part-423/subpart-M.

[45] Ariel D. Stern, Michael E. Chernew, Adam L. Beckman, and J. Michael McWilliams, “Patient, Provider, and Health Plan Perspectives on Prior Authorization,” *JAMA Network Open* 5, no. 6 (2022): e2219943, https://doi.org/10.1001/jamanetworkopen.2022.19943.

depend on Medicare Administrative Contractors (MACs) and third-party systems for claims processing guidance. The IPAY 2028 guidance does not yet clarify when or how MFP-related billing instructions will be issued, nor whether providers will receive advance access to revised payment files, new codes, or billing modifiers. Absent clear communication protocols and advance notice, providers risk billing at incorrect rates, resulting in reimbursement denials or overcharges for patients.

Second, CMS must put in place accessible remedies for patients who are billed incorrectly for MFP-covered drugs. Under Part B, patients often receive bills post-service and may have no way of knowing whether the MFP was applied. CMS should implement a formal correction and refund process that includes standardized patient notices, dispute instructions, and active outreach in cases of systemic overbilling. Requiring patients to initiate corrections—particularly those with cognitive, language, or technological barriers—would place an unfair burden on those least able to navigate administrative complexity.

Third, CMS must anticipate and address the administrative burden on MACs and billing software vendors. These entities will play a pivotal role in implementing MFPs for Part B drugs, and their readiness will directly affect patient access. CMS should publish a detailed implementation calendar and an operational guidebook specific to Part B, including timelines for provider education, MAC coordination, software updates, and dispute escalation procedures. Clear delineation of responsibilities among CMS, MACs, providers, and plans is essential for effective implementation.

Additionally, CMS should ensure that technical assistance is available to smaller and rural practices, which are often under-resourced and more vulnerable to administrative disruption. These providers historically face greater difficulty adapting to major billing changes and may be at higher risk of withdrawing from Part B drug administration altogether if the MFP implementation proves overly complex.[46]

To monitor for downstream effects, CMS should collect and publish data on provider behavior following the implementation of Part B MFPs. This includes tracking whether physicians reduce or stop offering affected drugs, switch to alternative therapies, or shift care to different sites, such as hospital outpatient departments, which may impose higher burdens on patients. Site-of-care shifts can have significant implications for access, cost-sharing, and continuity of care.[47]

Finally, CMS should commit to regular public reporting on key metrics related to Part B MFP implementation, such as billing accuracy, refund frequency, provider uptake, and changes in beneficiary access. Transparent reporting will not only support stakeholder confidence but also provide actionable insights to inform future negotiation cycles.

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[46] National Rural Health Association, “NRHA Regulatory Comment Letter Update,” August 2018, noting concerns that “the push for site-neutral payments for Part B drugs is essentially a simple rural hospital cuts where alternative sites for administration are unavailable,” accessed via Rural Health Information Hub, https://www.ruralhealth.us/blogs/2018/08/nrha-regulatory-comment-letter-update.

[47] Dana P. Goldman, Geoffrey F. Joyce, and Yuhui Zheng, “Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health,” *JAMA* 298, no. 1 (July 4, 2007): 61–69, https://doi.org/10.1001/jama.298.1.61.

The success of MFP implementation for Part B drugs will depend on CMS' ability to operationalize the policy with clarity, fairness, and patient-focused safeguards. Structured communication, meaningful patient protections, and accountability for all implementation partners are essential to ensure that negotiated prices translate into real-world benefits for Medicare beneficiaries.

Considerations for Future Drug Selection and Renegotiation

The NHC acknowledges CMS' decision to outline a process for the potential renegotiation of previously selected drugs, as changes in clinical evidence and market conditions may warrant future price adjustments. While such a process could help ensure that MFPs remain aligned with therapeutic value and real-world use, it must include strong safeguards to prevent unintended consequences for patient access. However, the draft guidance leaves several important questions unresolved—particularly around the transparency of the process, criteria for triggering review, and mechanisms for stakeholder input.

To promote predictability, legitimacy, and meaningful patient engagement, the NHC recommends the following enhancements:

1. **CMS should formalize patient participation in all renegotiation proceedings and trigger assessments.** This is particularly important for therapies with high treatment burden or evolving real-world impacts. Direct patient input can illuminate changes in adherence, side effects, or comparative outcomes not captured in published literature.[48]
2. **CMS should define clear and objective criteria for initiating renegotiation.** While the draft guidance lists potential triggers, it does not establish thresholds for determining when a "material" change has occurred. CMS should identify specific metrics—such as defined utilization changes, the introduction of new indications, or emerging comparative data—to guide consistent decision-making.
3. **CMS should institute a public comment period before finalizing any new MFP.** A minimum 60-day window for public input should be established, with outreach to affected patient groups. This step would ensure that real-world considerations, such as off-label uses and quality-of-life impacts, are factored into revised pricing decisions.
4. **CMS should provide advance notice and detailed justification for any downward adjustment in the MFP.** Renegotiation must not become a mechanism for retroactive cost-cutting absent due process. Notifications should include the basis for the change, supporting data, and an assessment of likely effects on patient access and cost-sharing.[49]
5. **CMS should evaluate the access implications of revised MFPs for therapies used across multiple populations.** Drugs that serve as last-line treatments or are indicated for multiple conditions must remain accessible regardless of pricing

[48] U.S. Food and Drug Administration, *FDA Patient-Focused Drug Development Guidance Series*, March 21, 2025.

[49] Barrenho and Lopert, *Exploring the Consequences of Greater Price Transparency*.

adjustments. CMS should issue guidance to mitigate unintended consequences such as formulary exclusion or site-of-care restrictions.

6. **CMS should publish anonymized summaries and aggregate statistics on renegotiation outcomes.** This should include the number of renegotiations initiated, reasons for each, and summaries of the resulting decisions. Public transparency is essential to building trust in the integrity of the renegotiation process**.**

While renegotiation is a critical mechanism for ensuring pricing reflects evolving evidence, it must be structured to reinforce—not undermine—trust in the Medicare Drug Price Negotiation Program. Clear criteria, transparent processes, and robust stakeholder involvement are essential to preserving access and legitimacy as the program matures.

Cross-Cutting Concerns: Transparency, Predictability, and Patient Trust

Despite the technical detail included in the IPAY 2028 draft guidance, many aspects of the Medicare Drug Price Negotiation Program remain opaque to patients, providers, and other external stakeholders. Implementation decisions—ranging from data confidentiality to enforcement priorities—often rely on internal processes that lack clear avenues for public insight or input. This lack of transparency poses a risk to the program's credibility, particularly as the scope of negotiation expands and the number of affected drugs, beneficiaries, and provider types grows.

The long-term success of the program depends not only on generating cost savings for Medicare, but also on fostering trust with the public and ensuring that affected communities understand how the program works, why certain decisions are made, and how their input is used. Without a consistent structure for stakeholder engagement and public accountability, CMS may inadvertently undermine support for a program that is otherwise designed to promote patient affordability.

A continuing area of concern raised in the NHC's previous comments relates to how CMS defines a potentially qualifying single source drug (QSSD).[50,51] Specifically, CMS is considering whether to group together drugs that share "at least one active ingredient" when determining QSSD status for the purposes of negotiation. While intended to prevent gaming or patent extension strategies, this approach could inadvertently aggregate products that serve distinct therapeutic purposes or are used in different clinical contexts. Such grouping could limit transparency into how MFPs are derived and obscure distinctions that are highly relevant to patients.

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[50] National Health Council. *NHC Comments on 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.* July 2, 2024. https://nationalhealthcouncil.org/wp-content/uploads/2024/07/NHC-Comments-RE-IPAY-2027_07.02.24.pdf.

[51] National Health Council. "NHC Comments on IRA Guidance Response." April 14, 2023. https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-ira-guidance-response/.

The NHC is particularly concerned that overly broad grouping could discourage the development of new indications, forms of administration, or combination products that are meaningful to patients. For example, long-acting formulations, less painful injection methods, and fixed-dose combination therapies have each played a critical role in improving adherence and outcomes in conditions such as diabetes, autoimmune diseases, and HIV. These innovations often stem from incremental advances that would not be reflected in a grouping methodology focused narrowly on shared ingredients. Therefore, the NHC urges CMS to engage patients directly to understand whether such advances constitute meaningful therapeutic improvements. Patient perspectives can help distinguish between clinically relevant innovation and superficial reformulations, guiding a more transparent and patient-centered application of QSSD criteria.

While CMS currently publishes MFP updates and related policy guidance, the NHC recommends that CMS further strengthen transparency by producing an annual summary report that includes plain-language explanations of negotiation methodology, incorporation of stakeholder feedback—particularly from patients—and data on downstream effects such as access and adherence trends.

CMS should also host public debriefing sessions following the close of each IPAY cycle. These sessions would offer an opportunity for beneficiaries, clinicians, manufacturers, and advocates to provide feedback on the negotiation process, including the effectiveness of communication materials, clarity of guidance, and any operational issues experienced during implementation. Feedback from these sessions should be incorporated into future guidance and shared through public summaries.

Finally, CMS should consider establishing a standing Patient Advisory Council to provide structured, ongoing input into the Medicare Drug Price Negotiation Program. This Council should reflect the diversity of the patient community and offer insights on proposed policy changes, listening session formats, educational materials, and implementation challenges. A formal advisory mechanism would help ensure that patient perspectives are consistently and meaningfully integrated into program development and refinement.

Programs that succeed in balancing regulatory rigor with stakeholder collaboration tend to enjoy stronger public legitimacy and compliance. When affected communities—especially patients and caregivers—can see how their insights shape outcomes, they are more likely to support program goals, adhere to new rules, and serve as trusted messengers to others in their networks. Conversely, when policy decisions appear opaque or unresponsive, skepticism and disengagement increase. Transparency and accountability are therefore not just governance principles—they are necessities for durable, patient-centered implementation of the negotiation program. [52,53]

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[52] Caelesta Braun and Madalina Busuioc, “Stakeholder Engagement as a Conduit for Regulatory Legitimacy?” *Journal of European Public Policy* 27, no. 11 (2020): 1599–1611, https://doi.org/10.1080/13501763.2020.1817133.

[53] Laura Esmail, Emily Moore, and Alison Rein, “Evaluating Patient and Stakeholder Engagement in Research: Moving from Theory to Practice,” *Journal of Comparative Effectiveness Research* 4, no. 2 (2015): 133–145, https://doi.org/10.2217/cer.14.79.

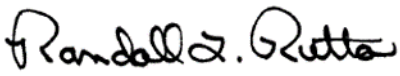
Conclusion

The IPAY 2028 draft guidance reflects an important evolution in the Medicare Drug Price Negotiation Program. The NHC acknowledges CMS' efforts to expand the program to encompass physician-administered drugs under Part B, to clarify enforcement and compliance expectations, and to formalize criteria for renegotiating previously selected drugs. We also value the agency's sustained focus on incorporating patient input and real-world evidence into the negotiation framework.

While commendable, we urge CMS to take further steps to embed the patient perspective in all facets of implementation. Whether through clearer operational protocols, transparent communication with beneficiaries, or access safeguards, the program's long-term credibility will depend on how well it delivers not only fiscal savings, but also tangible improvements in care, access, and outcomes.

The NHC remains committed to supporting CMS in the successful implementation of this historic program and stands ready to work together to ensure that people with chronic diseases and disabilities are at the center of every decision the program affects. Thank you again for the opportunity to provide input on this draft guidance. Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs at kbeer@nhcouncil.org or Shion Chang, Senior Director, Policy & Regulatory Affairs at schang@nhcouncil.org, if you or your staff would like to discuss these comments in greater detail.

Sincerely,



Randall L. Rutta
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June 25, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program Draft Guidance - Initial Price Applicability Year 2028

Dear Administrator Oz:

The National Infusion Center Association (NICA) is a nonprofit organization formed to support non-hospital, community-based infusion centers caring for patients in need of provider-administered medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in safe, more efficient, and cost-effective alternatives to hospital care settings. NICA supports policies that improve drug affordability for beneficiaries, increase price transparency, reduce disparities in safety across care settings, and foster patient access to the highest-quality, lowest-cost setting.

NICA's members administer medications to patients – including Medicare beneficiaries – with serious conditions. These conditions, including autoimmune and other chronic diseases, are lifelong and can result in permanent disability if not managed appropriately upon diagnosis. Fortunately, the treatment of autoimmune disease, including such conditions as rheumatoid arthritis, psoriasis, and lupus, has come a long way. There are now specialty biologics that enable patients to manage their condition, in many cases with such success that these patients are able to fully engage in activities of daily living and/or remain employed in the same way they were prior to diagnosis.

We appreciate the opportunity to provide comments on the Medicare Drug Price Negotiation Program Draft Guidance for the Initial Price Applicability Year 2028. As providers of Part B medications, NICA is acutely aware that Part B drugs are eligible for negotiation under the program beginning in 2028. We would like to share some concerns we hope you will take into consideration as CMS finalizes this guidance.

Maximum Fair Price Influence on ASP

Office-based and ambulatory infusion centers play a key role as the most efficient setting for drug administration, compared to hospital outpatient departments and, in many cases, even compared to the

home. The Employee Benefit Research Institute (EBRI) quantified the cost differences in healthcare services by site of treatment, including for the delivery of specialty medications, and determined that employers and workers could save as much as 36 percent on their medication if administered in a physician's office compared to a hospital outpatient department.[1] Therefore, it is clearly beneficial to advance policies that support our nation's in-office drug administration capacity to further Congress and the Administration's goals to reduce the overall cost of prescription medications for both the federal government and for patients.

Non-hospital, community-based infusion practices source their medications through "buy-and-bill" in which the medical practice purchases medications in advance and later bills the health plan for the medication once administered to the patient. The cost of these medications is based on the Average Sales Price (ASP), plus a six percent add-on payment which allows our members to account for acquisition costs. However, these margins are incredibly slim. NICA strongly encourages CMS to refrain from including the Maximum Fair Price (MFP) within the calculation for ASP as it would significantly reduce the percentage-based add-on payment that infusion providers rely on to administer these essential medications. Proposals that do not also adjust the add-on payment for infused medications will make it untenable for our members to provide these critical services within their communities.

At a time when medical practices are already struggling due to recurring Medicare reimbursement cuts, inflation and sequestration, an insufficient add-on payment due to the incorporation of MFP within the ASP calculation could put some infusion centers underwater. Infusion centers will be unable to offer services if left underwater, which could cause a reduction in capacity. A loss or consolidation of community-based infusion access points would have the effect of driving patients into the hospital for infusion treatment, which is by far the most expensive setting. According to the EBRI study,[2] the hospital outpatient department charges were more than double those of office-based administration. This has an impact on overall drug spending, but it also impacts patients, whose cost-sharing reflects these differentials. Our members serve a valuable role in the community, providing localized care at a safe and cost-effective site, and it's critical that CMS does not adopt policies that threaten the viability of these sites of care.

Manufacturer Models for MFP Sales

CMS has suggested two possible pathways for drug manufacturers to provide access to the MFP for Part B medications, including a prospective payment and a retrospective payment. Through the prospective method, manufacturers would ensure that the price paid by the dispensing entity or Part B provider is no greater than the MFP. In the retrospective method, Part B providers would purchase the drug and then the manufacturer would provide a retrospective reimbursement for the difference between the acquisition cost and the MFP.

NICA believes both models are problematic as they put the provider and infusion center in the middle of drug negotiations between the federal government and pharmaceutical manufacturers. If our previously outlined concerns with the ASP are not addressed, the prospective method would put infusion providers underwater because they would not be adequately reimbursed for the medications they administer due to the decreased add-on payment. However, the retrospective method would create extreme hardship

[1] EBRI Issue Brief No. 525. "Location, Location, Location: Cost Differences in Health Care Services by Site of Treatment — A Closer Look at Lab, Imaging, and Specialty Medications." February 2021.
[2] Ibid.

for infusion centers as they would be responsible for floating the difference between the acquisition cost and the MFP until they receive a reimbursement from the drug manufacturer.

Equally important, it is unclear how manufacturers could operationalize these models. Because drug acquisition costs are proprietary and vary by provider, it would be operationally infeasible for manufacturers to ensure the price paid is no greater than the MFP under a prospective model. Similarly, the retrospective model would require disclosure of confidential pricing data and impose significant financial and administrative burdens on providers, making it unworkable in practice. In addition, the retrospective model forces providers to absorb the opportunity cost of tying up capital while waiting for reimbursement, further threatening the financial viability of infusion centers.

As the most cost-effective sites for infusion treatment, non-hospital, community-based infusion practices operate on thin margins and would not have the capital to maintain this type of business model. Instead, NICA supports policies that stabilize Part B drug reimbursement for providers, including Sen. John Barrasso's (R-Wy.) *Protecting Access to Cancer and Complex Therapies Act*, and encourages CMS to work with Congress to find solutions that remove providers from the middle of government negotiations with manufacturers.

MA Plan Formulary Design

Through the Inflation Reduction Act, medications selected for drug negotiation are required to remain on formulary. However, the statute and subsequent CMS statements confirm that MA plans will not be held accountable for placing those medications on a desirable tier or eliminating utilization management barriers to medications. We find this highly concerning and believe this could seriously jeopardize timely patient access to medications after the medication is subject to the Maximum Fair Price.

A drug's placement on formulary directly affects a patient's ability to access that drug. If, for example, a medication is placed on a specialty tier with a 50% coinsurance, it is unlikely that the patient will be able to afford the drug. Manipulating the drug's formulary tier disproportionately impacts patients prescribed complex specialty medications, such as patients with chronic, complex conditions like Crohn's Disease or rheumatoid arthritis. Patients with chronic, complex conditions have lifelong medication needs and this formulary manipulation can significantly reduce their access or cause them to pay more out-of-pocket.

Furthermore, since medical benefit drugs, such as biologic infusions or injections, can be very expensive, these products are often prime targets for aggressive utilization management tactics, including step therapy and prior authorizations. According to the American Medical Association, 93% of responding physicians reported care delays due to prior authorization. Shockingly, almost a quarter of physicians (24%) responded that extensive prior authorization requirements had led to a patient's hospitalization.[3] Unfortunately, these tactics are often used as delay tactics and are actually unfounded. The Office of the Inspector General (OIG) examined Medicare Advantage denial rates and found that of the denied requests, 13% actually met Medicare coverage rules and should not have been denied. The study also found that 18% of the denied payment requests actually met billing rules and were denied due to manual claims-processing reviews and system processing errors.[4] OIG confirmed that denials were made

[3] American Medical Association. "2024 AMA Prior Authorization Physician Survey." 2025.

[4] U.S. Department of Health and Human Services Office of Inspector General. "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care." April 2022.

because insurers used clinical criteria not contained in Medicare coverage rules and inaccurately stated that some prior authorization requests lacked sufficient documentation for approval.

These utilization management tactics can be extremely harmful to patients who require these infused medications to live healthy, pain free and functional lives. Many of our patients live with chronic autoimmune conditions and require regular medication for the rest of their lives to engage in daily activities. In the case of a progressive autoimmune disease, even a treatment delay of a few weeks can mean irreversible damage to the patient's health. NICA strongly encourages CMS to hold health plans accountable and ensure that drugs selected for negotiation remain accessible on a desirable tier and are not subject to utilization management barriers. NICA also encourages CMS to work with Congress to advance proposals that remove prior authorization burdens through policies such as the *Improving Seniors' Timely Access to Care Act*.

Thank you for the opportunity to comment on this important issue. We would welcome the opportunity to connect with you if we can provide any other information about our concerns. Please do not hesitate to contact me, should you have any questions or wish to further discuss this issue: Brian.nyquist@infusioncenter.org

Sincerely,

Brian Nyquist, MPH
Chief Executive Officer
National Infusion Center Association

National
Multiple Sclerosis
Society

June 26, 2025

Mehmet Oz, MD, MBA
Administrator - Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 2124

Comments submitted electronically via IRARebateandNegotiation@cms.hhs.gov

RE: Draft Guidance for the Medicare Drug Price Negotiation Program: Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Administrator Oz:

The National Multiple Sclerosis Society (Society) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) draft guidance for the Medicare Drug Price Negotiation Program for Initial Price Applicability Year (IPAY) 2028. As the implementation of the Inflation Reduction Act (IRA) enters its third negotiation cycle, this draft guidance marks a significant evolution in CMS's approach to balancing cost control with patient access. We commend CMS for its efforts to improve affordability for Medicare beneficiaries, and we respectfully offer the following comments to support the implementation of a sustainable, transparent, and patient-centered approach.

Multiple Sclerosis (MS) is an unpredictable disease of the central nervous system. Currently, there is no cure. Symptoms vary from person to person and may include disabling fatigue, mobility challenges, cognitive changes, and vision issues. An estimated 1 million people live with MS in the United States. Early diagnosis and treatment are critical to minimizing disability. Significant progress is being made to achieve a world free of MS.

The Society, founded in 1946, is the global leader of a growing movement dedicated to creating a world free of MS. The Society provides global leadership, funds research for a cure, drives change through advocacy, and provides programs and supports to help people affected by MS live their best lives. Additionally, the Society sees itself as a partner to the government in many critical areas. While we advocate for the government's involvement in accelerating the discovery, development, and delivery of new treatments, we do so as an organization that has invested over $1.2 billion in research to date.

The Society is encouraged by CMS's continued refinement of the Medicare Drug Price Negotiation Program, particularly its expanded scope and greater attention to implementation details. These developments present significant opportunities to improve affordability and access for Americans living with chronic diseases, like MS. Our comments are organized around key policy themes in the draft

guidance, with attention to areas where additional specificity or stakeholder engagement may be warranted. Throughout, we emphasize the core principles of meaningful patient input, clinical relevance, access preservation, and real-world transparency.

Inclusion of Part B Drugs: Scope, Challenges, and Opportunities

The inclusion of drugs reimbursed under Medicare Part B in the IPAY 2028 cycle represents a significant evolution in the Medicare Drug Price Negotiation Program. This expansion brings into scope infused therapies, biologics, and other physician-administered treatments commonly used by individuals living with MS. By extending negotiations beyond pharmacy-dispensed drugs, CMS is aligning the program more closely with the IRA's goal of targeting the highest-impact therapies that contribute to Medicare spending.[1]

The inclusion of Medicare Part B drugs in the Medicare Drug Price Negotiation Program will require CMS to develop new procedures to make these essential drugs more affordable for a larger number of Americans. Medicare Part D drugs are typically dispensed through pharmacies and managed by plans and pharmacy benefit managers (PBMs), with well-established payment workflows. In contrast, Part B drugs are generally administered in clinical settings and reimbursed using a buy-and-bill model, where providers purchase the drug upfront and are later reimbursed at Average Sales Price (ASP) plus 6%.[2] Applying the Maximum Fair Price (MFP) to these therapies requires a fundamental rethinking of how reimbursement, cost-sharing, and point-of-service claims processing will operate.

The Society urges CMS to provide detailed implementation guidance specific to the operational realities of Part B. We request that the Agency clarify how providers should submit claims for drugs subject to the MFP. Because these therapies will no longer be reimbursed based on ASP + 6%, CMS must establish clear, practical billing instructions—including updated coding protocols, reconciliation pathways, and integration requirements for Medicare Administrative Contractors. CMS should release a dedicated FAQ and billing guidance document that includes illustrative use cases, edge scenarios, and transition instructions for off-cycle or multi-dose claims. [3] In the absence of such guidance, providers may encounter billing challenges that could impact timely reimbursement and patient access to care.

The Society acknowledges that including Part B drugs in the negotiation program offers significant potential to reduce out-of-pocket costs for Medicare beneficiaries, and ensuring that these savings are realized at the point of care is essential to the program's success. Additionally, CMS must address how overpayments to providers (i.e., when reimbursement exceeds the Medicare Fee Schedule) will be reconciled. The draft guidance suggests that overpaid amounts may be subject to refund or adjustment mechanisms, but it lacks clarity on timelines, responsible parties, and patient involvement. We request that CMS explicitly define whether patient-facing coinsurance refunds will be automatic or if they must be initiated by the beneficiary and clarify the oversight process for such cases.

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[1] Congressional Budget Office, Estimated Budgetary Effects of H.R. 5376, the Inflation Reduction Act of 2022: As Amended in the Nature of a Substitute (ERN22335) and Posted on the Website of the Senate Majority Leader on July 27, 2022, August 3, 2022, https://www.cbo.gov/system/files/202208/hr5376_IR_Act_8-3-22.pd

[2] Centers for Medicare & Medicaid Services, Medicare Part B Drug Average Sales Price, March 12, 2025, https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price.

[3] Centers for Medicare & Medicaid Services, National Provider Communication Standards, April 15, 2025, https://www.cms.gov/files/document/national-provider-communication-standards.pdf.

Another area of concern is the level of provider participation. If reimbursement under the MFP falls below the acquisition cost of a drug or introduces new uncertainties into revenue forecasting, providers, particularly those in smaller practices or rural areas, may opt not to stock or furnish these therapies.[4] Past CMS experiences have demonstrated that even modest shortfalls between ASP and acquisition costs during periods of volatility or shortage have resulted in reduced provider uptake.[5] CMS should monitor these dynamics and consider whether temporary transition payments or acquisition cost safeguards are needed to preserve meaningful access for all patients, particularly during the early phases of implementation.

CMS should also anticipate patient-level consequences. While lower coinsurance through the MFP is a core benefit of the program, it may be offset by downstream access disruptions if providers withdraw or shift administration to more profitable alternatives or sites of care. CMS should identify high-risk access scenarios (e.g., therapies with thin provider margins or rural market concentration) and implement safeguards, including beneficiary ombudsperson support, streamlined appeals, and regular monitoring of site-of-care utilization. Public updates on provider participation rates, regional access patterns, and patient-reported issues would provide needed transparency and accountability.

To further support the transition, CMS should partner with patient organizations to codevelop and disseminate educational materials that explain the implications of MFP implementation for Part B drugs. These materials should include plain-language explanations of billing expectations, coinsurance protections, and steps to take if overcharges occur. Given the complexity of these therapies and the populations they serve, materials should be culturally competent, linguistically accessible, and available in multiple formats to ensure effective communication.

Lessons from prior transitions, including the rollout of biosimilar coverage and site-of-service reimbursement changes, underscore the risks associated with insufficient operational planning and stakeholder education. If clarity and support are lacking, even well-designed policies can create implementation gaps that disproportionately affect patients.[6] CMS must prioritize a patient-centered and provider-informed rollout strategy for Part B MFP implementation that supports the program's cost-containment goals without sacrificing continuity of care.

Renegotiation of Previously Selected Drugs

The IRA anticipated that the clinical and economic value of a drug could evolve, due to factors such as new FDA-approved indications, biosimilar entry, or shifts in real-world utilization. The IPAY 2028 draft guidance takes a necessary step toward operationalizing this vision by establishing a formal framework for renegotiating Minimum Floor Prices. The Society is encouraged by this development and supports

[4] T. Joseph Mattingly II, Anthony A. Esterly, and Anna Kaltenboeck, "Implementing Maximum Fair Price Without Hurting Pharmacies," JAMA Health Forum 5, no. 5 (May 10, 2024): e240921, https://doi.org/10.1001/jamahealthforum.2024.0921.

[5] Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System, Chapter 2, "Medicare Part B Drug Payment Policy Issues" (Washington, DC: MedPAC, June 2017), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/defaultsource/reports/jun17_ch2.pdf.

[6] Gabriella M. McLoughlin et al., "Mending the Gap: Measurement Needs to Address Policy Implementation Through a Health Equity Lens," Translational Behavioral Medicine 14, no. 4 (February 25, 2024): 207–14, https://doi.org/10.1093/tbm/ibae004.

CMS's intent to keep negotiated prices aligned with therapeutic value, market dynamics, and patient needs.

CMS outlines four circumstances under which a drug may become eligible for renegotiation: the approval of a new FDA indication, a shift in exclusivity status, a material change in a statutory factor such as clinical benefit or unmet need, or a discretionary determination by CMS based on new evidence. While these triggers align with the statute's intent, the operational details remain underdeveloped and warrant further clarification. It is unclear how CMS will communicate this determination or whether stakeholders will be notified and invited to contribute evidence before a new price is set. CMS should commit to issuing public notices of intent to renegotiate, followed by a defined comment period to allow patients, clinicians, and other affected parties to submit updated clinical data, real-world outcomes, and patient perspectives.[7]

The role of patient-centered evidence in the renegotiation process also requires greater definition. Although the statute references therapeutic benefit and unmet need, the draft guidance does not include how CMS will gather and weigh patient-reported outcomes, registry data, or treatment experience narratives. Integrating these data sources would enable a more accurate reflection of a drug's real-world impact, particularly for individuals with rare, complex, or poorly studied conditions.[8]

Renegotiation may also result in unintended consequences that extend beyond price. Changes in the MFP could influence formulary design, provider reimbursement, or patient cost-sharing. Without careful monitoring, a new price could prompt plans to reclassify a drug, alter utilization management policies, or introduce other access barriers. CMS should evaluate these downstream impacts and implement safeguards to prevent disruptions in coverage or continuity of care.[9]

Finally, CMS should ensure that the renegotiation process includes structured opportunities for stakeholder engagement beyond the manufacturer. The current framework does not indicate whether public listening sessions, stakeholder briefings, or appeals pathways will be available to patient organizations, clinicians, or public health experts. Establishing a dedicated input process, separate from the manufacturer negotiation, would help ensure that decisions reflect not only cost data but also the lived experience of those affected by pricing changes.[10]

Effectuation of the MFP: Operational Mechanisms and Patient Communication

Among the most technically complex and most consequential aspects of the IPAY 2028 draft guidance is CMS's expanded discussion of how the MFP will be implemented at the point of care. This includes leveraging systems such as the Medicare Transaction Facilitator (MTF) to manage payment flows,

[7] National Health Council, Policy Recommendations for Reducing Health Care Costs, September 2021, https://nationalhealthcouncil.org/additional-resources/policy-recommendations-for-reducing-health-carecosts/#:~:text=The%20NHC%20strongly%20opposes%20policies,as%20defined%20by%20the%20patie nt.
[8] U.S. Food and Drug Administration, FDA Patient-Focused Drug Development Guidance Series for Enhancing the Incorporation of the Patient's Voice in Medical Product Development and Regulatory Decision Making, March 21, 2025, https://www.fda.gov/drugs/development-approval-process-drugs/fdapatient-focused-drug-development-guidance-series-enhancing-incorporation-patients-voice-medical.
[9] Skylar Jeremias, "The IRA's Unintended Consequences for Drug Pricing and Coverage," The American Journal of Managed Care, April 2, 2025, https://www.ajmc.com/view/the-ira-s-unintended-consequencesfor-drug-pricing-and-coverage.
[10] National Health Council, Amplifying the Patient Voice.

enforce price ceilings, and process refunds across both Medicare Part D and Part B drugs. While these backend functions may receive less attention than drug selection criteria or negotiation methodologies, they are pivotal to determining whether patients experience the financial protections promised under the IRA. The Society supports CMS's ongoing investment in infrastructure and appreciates the additional operational details included in the draft guidance. However, several unresolved issues remain, particularly in the areas of transparency, accountability, and procedural safeguards when the MFP is incorrectly applied. The Society recommends the following:

- CMS should clearly articulate how beneficiaries will be notified if they are charged more than the MFP. Currently, CMS does not have a specific requirement for plans or providers to inform beneficiaries when they are charged more than the MFP, nor are refund processes standardized or uniformly communicated. For many Medicare beneficiaries—especially those with limited health literacy or digital access—relying on self-monitoring or claims review is not feasible.
- CMS should require that point-of-sale systems generate standardized alerts for overcharges and that refund notices be issued in plain language through both mail and electronic formats, where applicable.[11]
- Greater specificity is needed regarding the refund and reconciliation process. The draft guidance mentions the possibility of retrospective refunds but does not outline how such refunds are initiated, how patients will receive them (e.g., direct deposit, mailed check, or copay credit), or how long processing will take. Without defined timelines or error thresholds, the system risks delays and inconsistencies that could erode public trust and deter patients from accessing needed therapies.
- CMS should establish a patient-facing error correction and appeals process. This should include a centralized portal or toll-free hotline that enables beneficiaries to report discrepancies, obtain assistance, and navigate the dispute resolution process. To ensure meaningful access for all patients, support staff should be trained in health literacy and disability communication standards.[12]
- CMS should minimize the burden on beneficiaries by ensuring that refund and correction processes are communicated, accessible, and timely. This concern is particularly acute for low-income and medically complex patients who may lack the time, resources, or familiarity with Medicare processes to resolve such issues.

Ultimately, implementing the MFP is central to fulfilling the law's promise of improved affordability. CMS must ensure that operational systems are seamless, transparent, and firmly rooted in the patient experience. Only then can the negotiated prices under the IRA be translated into meaningful, real-world access for the millions of Medicare beneficiaries who depend on these therapies.

Patient Listening Sessions

The Society commends CMS for continuing to convene patient-focused listening sessions as part of the Medicare Drug Price Negotiation Program. These forums are among the only formalized mechanisms for

[11] Centers for Medicare & Medicaid Services, Medicare Communications and Marketing Guidelines (MCMG), February 9, 2022, https://www.cms.gov/files/document/medicare-communications-andmarketing-guidelines-3-16-2022.pdf.

[12] "CMS.gov Accessibility and Compliance with Section 508," Centers for Medicare & Medicaid Services, September 10, 2024, https://www.cms.gov/about-cms/web-policies-important-links/accessibilitycompliance.

patients and carepartners to share their lived experiences with selected drugs directly with federal regulators. As such, they serve a unique and irreplaceable function in shaping negotiation decisions beyond what clinical trial data and cost models can reveal. Patient listening sessions are especially critical in surfacing perspectives on treatment burden, adherence challenges, quality-of-life impacts, and other patient-centered outcomes that may not be reflected in the evidence submitted by manufacturers. These sessions offer insight into how drugs function in real-world conditions—information vital to determining whether a treatment's price accurately reflects its value across various patient populations. The patient listening sessions represent one of the most tangible and high-impact ways that individuals and families can influence federal drug pricing decisions. CMS should continue to strengthen these forums as foundational elements of the program's evidence base, ensuring that patient voices are meaningfully integrated into the decision-making process. By strengthening the format, ensuring meaningful access for all patients, and demonstrating a transparent link between testimony and policy action, CMS can uphold the intent of the IRA. The Society recommends the following process improvements, focusing on accessibility, clarity, and broad stakeholder participation:

- CMS should provide a minimum of 30 days advance notice and allow scheduling flexibility for all listening sessions. Many individuals managing complex conditions require advanced logistical coordination to participate meaningfully.[13] This lead time enables patients, carepartners, and advocacy organizations to prepare comments, arrange time off work, and secure necessary services (e.g., transportation, childcare).
- CMS should offer thematic guidance and clearly defined expectations for each session. Publishing advance notice of themes, such as "treatment burden," "side effect management," or "impact on caregiving," will help participants prepare more tailored and relevant input. These prompts should also include examples of narratives that are particularly useful in informing negotiation-related decisions.
- CMS should expand participation formats beyond live oral testimony. Asynchronous input options, such as written comments, audio submissions, or short video statements, should be accepted both before and after the session. These formats are crucial for patients living with fatigue, speech limitations, or limited internet access who are unable to participate in real time.
- CMS should provide accessibility and language services by default for all listening sessions. Sign language interpretation, closed captioning, multilingual translation, and accommodations for cognitive or sensory impairments should be standard features, not contingent upon special requests. Establishing these supports by default reflects CMS's commitment to broad patient participation and minimizes the administrative burden on patients already navigating serious health challenges.

Beyond participation mechanics, CMS must also improve transparency regarding how patient input is used. The current process lacks adequate public feedback loops. While CMS states that patient insights are "considered," this phrasing is insufficient to assure stakeholders that their contributions have influenced policy outcomes. The Society urges CMS to publish post-session summaries that include the following elements:

- De-identified participant quotes organized by theme (e.g., barriers to access, treatment fatigue, adverse effects)

[13] National Health Council, Amplifying the Patient Voice.

- A high-level summary of key insights shared during the session
- A description of how these insights were incorporated into the negotiation process or where they influenced considerations about therapeutic alternatives, patient subgroups, or dosing variations
- A discussion of any themes that were noted but ultimately not acted upon, along with rationale for their exclusion

Providing this level of transparency will build public trust, demonstrate procedural fairness, and reinforce that CMS is committed to evidence-informed, patient-centered decision-making, not just technical pricing models. Transparency in government engagement processes has been shown to increase both participation and perceived legitimacy, especially in high-stakes programs.

Furthermore, CMS should develop a centralized, publicly accessible archive of all patient listening session materials, including: agendas, guidance prompts, anonymized summaries, and, where consent is granted, recordings. This will allow other stakeholders (e.g., academic researchers, patient organizations, and clinicians) to review patterns in patient-reported data and understand how those perspectives inform Medicare drug pricing decisions.

Finally, we encourage CMS to formally invite participation from patient organizations, including those representing underserved and low-incidence populations who may otherwise be excluded from mainstream data collection. These groups can help identify unique patient experiences and ensure they are not overlooked during the negotiation process.

Oversight of Part D Formulary Changes and Access Protections

The IPAY 2028 draft guidance provides a comprehensive update on the operational aspects of the Medicare Drug Price Negotiation Program across Parts B and D. However, it gives limited attention to how Part D plan sponsors might adapt to the implementation of MFPs, particularly with respect to formulary tiering, utilization management, and access protections. Additional clarity in these areas would be valuable, as plan decisions play a crucial role in determining whether negotiated prices result in meaningful improvements in patient access.

While lower list prices are designed to reduce out-of-pocket costs for beneficiaries, they may also result in unintended shifts in benefit design. Under current market dynamics, higher-cost therapies are often placed on non-preferred tiers because their elevated list prices enable larger manufacturer rebates. With the introduction of MFPs, the economic incentives surrounding these drugs may shift. As a result, some plans may reevaluate formulary placement or utilization management strategies based on updated cost structures. Without appropriate guardrails, such changes, though financially rational, may inadvertently limit access to clinically appropriate therapies.[14] To support transparent and patient-centered implementation, CMS should reinforce expectations for plan behavior following MFP adoption. Specifically:

- Plans remain accountable for ensuring timely and appropriate access to medically necessary therapies. CMS should reiterate that Part D sponsors are expected to maintain compliance with

[14] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System, June 2020. Washington, DC: MedPAC.

long-standing benefit design requirements, including therapeutic category representation and network adequacy, regardless of whether a drug is subject to an MFP.

- Utilization management changes should be clinically justified. CMS should clarify that the introduction of an MFP alone does not warrant new prior authorization, step therapy, or tiering adjustments without an appropriate clinical rationale. Promoting transparency around such changes will help ensure that utilization management tools remain aligned with patient needs.
- Beneficiary protections must remain in place. A reduced drug price does not diminish a patient's right to appeal coverage determinations. CMS should reaffirm that beneficiaries continue to have access to existing grievance and appeals processes under 42 CFR § 423 Subpart M.41

Additionally, CMS should consider establishing a proactive monitoring framework to assess plan responses to the implementation of MFP. Publicly reporting changes to prior authorization policies, tier placement, and coverage decisions, particularly for drugs newly subject to Medicare Part D Pharmacy MFP policies, can help promote transparency and inform future policy adjustments.

Finally, CMS should acknowledge that price reductions, while critical, do not automatically resolve all access challenges. Administrative complexities, such as prior authorization or language barriers, may still delay or hinder treatment, especially among older adults or those with limited digital literacy.[15] Ongoing monitoring and stakeholder engagement can help identify and mitigate these challenges. To ensure that the program's intended cost savings translate into real-world patient benefits, CMS should work collaboratively with plans and other stakeholders to prevent unintentional access barriers and ensure high standards of patient care.

Thank you again for the opportunity to comment on the draft guidance. We also look forward to continued collaboration with you as you implement the IRA and act as a partner in educating Americans about their healthcare benefits. If you have any questions, please contact Nicole Boschi, Director of Regulatory Affairs at nicole.boschi@nmss.org.

Sincerely,

Bari Talente, Esq.
Executive Vice President, Advocacy and Healthcare Access
National Multiple Sclerosis Society

[15] Ariel D. Stern, Michael E. Chernew, Adam L. Beckman, and J. Michael McWilliams, "Patient, Provider, and Health Plan Perspectives on Prior Authorization," JAMA Network Open 5, no. 6 (2022): e2219943, https://doi.org/10.1001/jamanetworkopen.2022.19943.

June 26, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Chris Klomp
Deputy Administrator and Director of the
Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Dear Administrator Oz and Deputy Administrator Klomp,

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 Initial Pay Applicability Year (2028) Medicare Drug Price Negotiation Program (MDPNP) guidance. 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 MDPNP and related programs have the opportunity to dramatically reduce patient out-of-pocket costs for rare disease patients. However, without careful consideration and intentional implementation, NORD is concerned about potential unintended consequences.

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.

The MDPNP will bring significant changes that are likely to impact rare disease patients in several complex ways, in particular given CMS' narrow interpretation of the orphan drug exclusion in the Inflation Reduction Act (IRA).[2,3] We greatly appreciated CMS' efforts to engage patients and health care providers as part of the 2027 MDPNP. We value the opportunity to recommend further changes 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

[2] *Inflation Reduction Act of 2022*, P.L. 117-269.

[3] *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections1191-1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027.* Section 30. CMS. (3 May, 2024). https://www.cms.gov/files/document/medicare-drug-price-negotiation-draft-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf

improvements to the solicitation and consultation processes with patients and health care providers through listening sessions and the Information Collection Request (ICR) for the 2028 MDPNP, as well as provide additional commentary on CMS' interpretation of the orphan drug exclusion, which empirical evidence has shown has led to reduced manufacturer interest in drug repurposing for orphan products. Recognizing the crucial role of patient and health care provider engagement in assessing the impacts of the MDPNP on patients and families, we are pleased to also provide specific recommendations for successful engagement around program implementation.

Recommendation 1: Reconsider interpretation of the orphan drug exclusion (Section 30)

While we appreciate CMS' clarification on the limitations of the statutory language on the timing of when an orphan product may become negotiation eligible, we remain concerned that CMS' interpretation of the number of designations that a product can receive before losing the orphan drug exclusion will have a chilling effect on innovation in drug repurposing moving forward. Today, about 60 percent of all orphan drugs have a single FDA-approved indication, whereas only about 20 percent are FDA-approved for both orphan and non-orphan indications.[4] Among the drugs that only have orphan indications, fewer than a quarter have more than one FDA-approved indication and fewer than 10 percent have three or more approved indications.[5] Similarly, among the drugs that have both orphan and non-orphan indications, less than 20 percent have 3 or more orphan indications. This demonstrates that to date, relatively few orphan drugs have been successfully developed for more than one disease.

Designating an orphan drug under section 526 of the FFD&C Act is done early in the drug development process and much earlier than submission of a New Drug Application (NDA) or Biological License Application (BLA). Orphan drug designation is necessary for unlocking ODA incentives such as funding and tax credits for clinical research to help de-risk early phases of drug development. However, an orphan drug designation does not allow the company to market the drug; it is only the first in many steps towards approval and marketing. In fact, FDA's Orphan Drug Designations and Approvals database currently contains 6,445 orphan drug designations (including withdrawn designations) compared to only 1,130 approved orphan indications, demonstrating that a vast majority of orphan drug designations do not result in any FDA-approved indications. As such, designation is largely irrelevant to the pricing considerations central to the Negotiation Program.

NORD understands that the language of section 1192(e)(3) is ambiguous due to the manner in which it was drafted, and therefore is open to CMS interpretation. CMS states that to qualify for the orphan drug exclusion, "the drug or biological drug must (1) be designated as a drug for only one rare disease or condition under section 526 of the FFD&C Act and (2) be approved by the FDA for only one or more indications within such designated rare disease or condition."[6] This two-prong test, embodying two separate and distinct criteria that must both be met, is a possible interpretation of the statute. But

[4] *IQVIA: Orphan Drugs in the United States*. 2020; Dec; available at: https://rarediseases.org/wp-content/uploads/2022/10/orphan-drugs-in-theunited-states-NRD-2020.pdf; accessed 6/2025

[5] Ibid

[6] Meena Seshamani, Memorandum to Interested Parties: 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, March 15, 2023, at 10- 11.

under the canons of legislative drafting, if the congressional authors had intended the two clauses to be read independently, the proper legislative drafting would have structured the two clauses separately and in sequence. Instead, Congress did not separate the clauses, intending them to be read together: that a drug designated for a given "rare disease or condition" has "only [one] approved indication" or multiple "approved... indications" within the scope of that designation. CMS substantiates this plain meaning[7] of the provision in accepting that an orphan drug with multiple ("one or more") FDA-approved indications qualifies for the exclusion provided all such approved indications are within the scope of a single ("only one") designation.

A two-prong test also does not best reflect and advance the purposes and function of the Negotiation Program. The cardinal rule of statutory construction is that the whole statute should be drawn upon as necessary, with its various parts being interpreted within their broader statutory context in a manner that furthers statutory purposes.[8] The proper interpretation of the orphan drug exclusion "in a manner consistent with [the] legislative purposes"[9] of the Negotiation Program preserves an intentionally narrow class of qualifying orphan drugs determined upon the basis of a drug's FDA approval history – *not* on orphan drug designations, which have no bearing on, or applicability to, prescription drug marketing or pricing.

Disincentivizing manufacturers to seek additional designations has the unintended consequence of pushing manufacturers to pursue research into new molecular entities (NMEs) rather than repurposing existing products.[10] Though NMEs play a crucial role in treatments and cures for rare diseases, drug repurposing is a crucial part of the treatment ecosystem. Drug repurposing takes less time, is less expensive for the manufacturer and the system, and is more frequently successful in bringing a new treatment option to market compared with NME development.[11] We have already seen a reduction in post-approval oncology trials since the passage of the IRA and publication of the CMS' interpretation of the orphan drug exclusion.[12] CMS' current interpretation of the orphan drug exclusion therefore runs contrary to the intent of the Medicare drug price negotiation program, as it may result in increased systemic and patient out of pocket costs in shifting manufacturers away from repurposing. As such, we urge CMS to reconsider their interpretation of the orphan drug exclusion to protect incentives to continue innovation for existing products.

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[7] E.g., Sebelius v. Cloer, 569 U.S. ___, No. 12-236, slip op. (May 20, 2013)

[8] See, e.g., King v. Burwell, No. 14-1158 (4th Cir. July 22, 2014) (various provisions of the Affordable Care Act sufficiently indicate an expectation that tax credits will be available to participants in all health exchanges to cast doubt on whether provision specifically making credits available to participants in state exchanges implicitly denies credits to participants in federal exchanges).

[9] 2 Robert A. Katzman, Judging Statutes 31 (2016), at 10.

[10] *Does Therapeutic Repurposing in Cancer Meet the Expectations of Having Drugs at a Lower Price?* Fierro et., al. National Library of Medicine. (8 March, 2023). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10097740/#:~:text=The%20total%20cost%20of%20bringing,repurposing%20averages%20US%248.4%20million.

[11] Ibid

[12] *Early Signs of Inflation Reduction Act Impact on Small Molecule versus Biologic Post-Approval Oncology Trials.* Zheng, Patterson, Campbell. National Pharmaceutical Council. (May, 2025) https://www.npcnow.org/resources/early-signals-inflation-reduction-act-impact-small-molecule-versus-biologic-post-approval

Recommendation 2: 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 (Section 50).

NORD appreciates the significant changes to the patient and health care provider listening sessions for the 2027 MDPNP. We have received considerable positive feedback from participants and observers in response to these changes, and we greatly appreciate CMS' continued commitment to partnering with patient communities to make further improvements where needed. To increase the positive effect of the listening sessions and written submission process moving forward, we are pleased to offer two specific recommendations. Our recommendations are based on learnings from these sessions, a review of the relevant literature, and our extensive patient engagement experience.[13] These recommendations are intended to be complementary to recommendations we have provided previously, including in a recent National Health Council (NHC) white paper to which NORD was honored to contribute.[14]

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.

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 among the selected products in the 2028 MDPNP as well as in future plan years.[15] 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.

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[13] *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

[14] *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

[15] *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/

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 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.

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 2028 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.

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. 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.

Moreover, while CMS may not be able to release the names of the selected drugs until February 1, 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.

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.

Live Public Engagement Sessions

Following the success of the second 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 continue with virtual engagement opportunities and supplement with in-person offerings. We commend CMS for including smaller focus group style sessions targeted at both patients and caregivers, which provided opportunities for more meaningful engagement between CMS staff and participants during the listening session. We believe the 2027 sessions can serve as a model to be replicated in future years, and future settings. To further strengthen the listening sessions moving forward, we encourage CMS to 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).

We encourage CMS to find ways to streamline public comment opportunities. Though we are encouraged by the private nature of the roundtables and the creation of a de-identified redacted transcript, not all patients feel comfortable sharing highly personal information about their disease or other aspects of their daily life on camera in public recorded settings. Offering opportunities for audio-only submissions in response to pre-provided questions could help to increase the level of comfort. Establishing a system where participants can provide responses that will be de-identified and/or aggregated before being publicly posted has been shown to improve the quality of responses.[16] We urge CMS to continue to work with the affected communities to provide options that meet their needs.

[16] *How Transparency Affects Survey Responses.* Connors, et. Al. Public Opinion Quarterly. (18 June 2019). https://academic.oup.com/poq/article/83/S1/185/5520299

Additionally, providing English-only engagement opportunities threatens to leave out important parts of the community. Establishing Spanish-language listening sessions or offering real time translation services could result in a broader, more representative, participant pool.

Written Submission Process

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 for engagement were missed. The short timeline remains a significant barrier to participation for many patients, together with the complexity of navigating the process of completing the necessary steps to engage through CMS' HPMS portal.

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.[17]

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.[18] 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.

Recommendation 3: Implement more stringent formulary oversight processes to ensure beneficiaries benefit from MDPNP changes (Section 110).

NORD appreciates CMS' commitment to monitoring plan formularies to ensure negotiated products are kept accessible to patients. Since plans benefit from drugs with higher rebates, manufacturers may be incentivized to seek better formulary tier placement for products with therapeutic alternatives by offering increased rebates. When rebates are reduced, plan sponsors may change the formulary tier, increasing patient cost sharing and decreasing access. Therefore, we have concerns that without requiring plans to place negotiated products on a preferred formulary tier, plans may place these products on a less preferred tier, and/or erect additional utilization management barriers, resulting in higher patient cost sharing for negotiated products.

[17] *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/

[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

Rare disease drugs are frequently already placed on the non-preferred or specialty tiers of Medicare Part D plan formularies, resulting in increased patient out-of-pocket liability and access delays. A 2020 study found that 85% of orphan drugs on a Part D formulary were placed on the highest cost-sharing tier.[19] A KFF analysis of 2023 Medicare Part D plans found that in 12 of the 16 national prescription drug plans, co-insurance amounts for non-preferred drugs range from 40-50%, with similar trends in prior plan years.[20] Indeed, we have seen a dramatic increase in the number of products subject to coinsurance in recent years. A 2025 study found that the proportion of plans using coinsurance for tier 3 has increased from 71.9% and 2.6% to 84.1% and 27.5% for PDP and MA-PD plans respectively.[21] While we recognize that patient out-of-pocket costs for Medicare Part D are set to be capped at $2,000 beginning in 2025, high out-of-pocket costs remain a barrier for many patients. This is particularly challenging for those just above the qualification level for the low-income subsidy, and the MDPNP is expected to have far-reaching implications beyond Medicare plans.

We encourage CMS to think critically about how best to balance patient out-of-pocket cost and access with potentially misaligned incentives. While 95 percent of rare diseases have no FDA approved treatment, some rare disease areas, such as rare cancers, have more than one treatment available. Certain therapies, particularly those that have been on the market for a significant number of years, may not be as clinically applicable as newer therapies, which may provide more benefit, a preferable route of administration, or fewer or lesser side effects. Inadvertently incentivizing physicians and patients to choose an inferior therapy due to cost and ensuring patient access to necessary medication is a delicate balance for which there is no easy solution.

NORD believes health care providers and their patients are best positioned to choose the medication that is right for them. Yet, patients trying to access medications on higher formulary tiers frequently run into utilization management barriers, such as prior authorization and step therapy. A 2020 study found that 76 percent orphan drugs on Medicare Part D formularies were subject to prior authorization.[22]

To rectify these cost and access issues for rare disease patients trying to access medications, we encourage CMS to consider implementing a requirement that significantly reduces or eliminates step therapy and prior authorization requirements for negotiated products. Additionally, we recommend requiring that formularies place negotiated therapies on a more preferential tier, to reduce patient cost and access burdens.

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[19] *Predictors of Orphan Drug Coverage Restrictions in Medicare Part D.* Yehia, et. Al. American Journal of Managed Care. (September, 2020). https://www.ajmc.com/view/predictors-of-orphan-drug-coverage-restrictions-in-medicare-part-d

[20] *Medicare Part D: A First Look at Medicare Drug Plans in 2023.* Cubanski et. Al. KFF. (10 November, 2022.) https://www.kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-medicare-drug-plans-in-2023/

[21] https://schaeffer.usc.edu/wp-content/uploads/2025/06/2025-06-Cost-Sharing-Burden-Medicare-Part-D.pdf

[22] *Predictors of Orphan Drug Coverage Restrictions in Medicare Part D.* Yehia, et. Al. American Journal of Managed Care. (September, 2020). https://www.ajmc.com/view/predictors-of-orphan-drug-coverage-restrictions-in-medicare-part-d

However, we also realize that monitoring and surveillance of formulary placement and utilization management will be key. We urge CMS to work with the patient, caregiver and provider communities to understand trends and changes in formulary placement, the use of utilization management, or other ways that may impact availability and access to these products.

Other notes

We recognize that CMS faces a significant operational challenge in identifying products covered under Part B that hit the minimum total expenditure threshold, beginning in 2028. Our understanding is that CMS would not incorporate data on utilization of Part B drugs by Medicare Advantage beneficiaries into total expenditure calculations.[23] As such, we are concerned that CMS' proposal to rely on Part B claims will not accurately reflect the actual utilization volume and associated costs of those served by both traditional Medicare and Medicare advantage.

Medicare Advantage represents roughly half of the insured Medicare population. Medicare Advantage prescribing patterns are distinct from traditional Medicare, largely due to the prevalence of step therapy and prior authorization requirements in Medicare Advantage plans. Studies have shown that Medicare Advantage beneficiaries are less likely to receive cancer drugs than those insured by traditional Medicare and are more likely to be steered towards a lower cost alternative.[24,25] Given the high cost of orphan therapies and the small patient populations, we therefore are concerned that orphan therapies could be disproportionately overrepresented in the total expenditure calculation if the sample were to rely exclusively on traditional Medicare data.

While patients with rare diseases consistently report cost as a major barrier to access to care, we are concerned that inadvertently including more orphan therapies than proportional to the actual spend experienced across both traditional Medicare and Medicare Advantage in the negotiation program could have a chilling effect on rare disease research and development moving forward. We encourage CMS to identify ways to include spend on Part B products utilized by beneficiaries covered by Medicare Advantage.

We also recognize that CMS and AHIP have recently announced a commitment to reform on prior authorization, a significant barrier to care for many rare disease patients covered by Medicare Advantage as discussed above. We would welcome the opportunity to work with relevant stakeholders

[23] *Administration Releases Medicare Drug Price Negotiation Program Draft Guidance for 2028.* Martin, Sachs. Health Affairs Forefront. (May, 2025). https://www.healthaffairs.org/content/forefront/administration-releases-medicare-drug-price-negotiation-program-draft-guidance-2028?utm_medium=social&utm_source=linkedin&utm_campaign=forefront

[24] *High-Cost Cancer Drug Use in Medicare Advantage and Traditional Medicare.* Bradley, Liang, Lindrooth. JAMA Health Forum. (January, 2025) https://jamanetwork.com/journals/jama-health-forum/fullarticle/2828814

[25] *Prescribing of low-versus high-cost Part B drugs in Medicare Advantage and traditional Medicare.* Anderson, et. Al. Health Services Research. (December, 2021). https://pmc.ncbi.nlm.nih.gov/articles/PMC9108062/

to ensure that any future changes to prior authorization requirements benefit the rare disease community.[26]

We thank CMS again for the opportunity to comment on this guidance 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 Mason Barrett, Policy Analyst at MBarrett@rarediseases.org.

Sincerely,

Pamela Gavin, Chief Executive Officer
National Organization for Rare Disorders

CC: Victoria Gemme, Director of Policy and Regulatory Affairs, National Organization for Rare Disorders

[26] *HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System.* HHS Press Office. (June, 2025). https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html#:~:text=Participating%20health%20insurers%20have%20pledged,authorization%20by%20January%201%2C%202026.

National Organization of Rheumatology Management

June 25, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program Draft Guidance - Initial Price Applicability Year 2028

Dear Administrator Oz:

On behalf of the National Organization of Rheumatology Management (NORM), we appreciate the opportunity to provide comments on the Medicare Drug Price Negotiation Program Draft Guidance for Initial Price Applicability Year 2028. NORM promotes education, expertise and advocacy for rheumatology managers and their practices. The Organization's members manage the day-to-day operations of rheumatology practices and have firsthand experience navigating regulatory obstacles facing successful healthcare practices and supporting the financial sustainability of rheumatology practices. NORM provides value across the nation by cultivating a thriving community of rheumatology managers and physicians who are focused on supporting our patients and pursuing excellence in medical practice management.

In addition to the clinical services rheumatology practices provide and are reimbursed for, rheumatology practices also generate revenue through the administration of prescription drugs that patients are not able to self-administer, including injections administered by a health care provider and infusions. Rheumatology infusions are intravenous treatments that manage and treat autoimmune and inflammatory conditions, such as rheumatoid arthritis. These infusions are administered by a licensed healthcare provider and can be a valuable option when oral medications or other treatments are not effective or clinically appropriate.

Medicare Part B reimburses rheumatology practices for these administered drugs based on manufacturer-reported average sales prices (ASPs), plus an add-on payment to account for practice acquisition costs. As currently outlined within the draft guidance, the ASP would significantly drop if the calculation of this *average* sales price were to include the Medicare negotiated Maximum Fair Price (MFP). According to CMS estimates, the MFP could lower the net spending on prescription drugs by 22%.[i] If applied to Part B drugs, a 22% drop in the ASP would also significantly drop our percentage-based add-on payment, leading to a detrimental cut to this essential provider reimbursement. Rheumatology practices already experience insufficient ASP-based payments for select biologic drugs, which are putting these practices "underwater" and making it extremely difficult for practices to offer these medications. Therefore, we have a very clear understanding of what underwater reimbursement would do to rheumatology practices across the country if the MFP were to be included within the ASP calculation.

As currently proposed, inclusion of the MFP within the ASP calculation would make it nearly impossible for rheumatology practices to continue to administer these medications without a *significant* change to the way in which the provider add-on payment is calculated. Underwater reimbursement forces practices to choose between administering therapies at a loss or referring patients to hospital outpatient departments,

which increases Medicare program spending and worsens patient access to care. They may also drive prescriptions to be filled by specialty pharmacies, further lining the pockets of pharmacy benefit managers that continue to drive up the price of prescription drugs.

Without adequate reimbursement that keeps pace with the actual cost of running a physician practice, our offices—particularly in rheumatology—face growing financial instability and even staff layoffs. Rising expenses for staffing, technology, medical supplies, and rent are compounded by increasing administrative burdens, placing significant strain on already stretched resources. These challenges are especially acute in smaller or rural settings, where margins are thin and resources are limited.

Unfortunately, this inadequate reimbursement model would exacerbate problems within the existing system that already increasingly disadvantages community-based rheumatology practices. Independent medical practices are under incredible financial pressure, which has contributed to medical practice consolidation and created access challenges for patients across the country. According to the American Medical Association, Medicare physician payment has declined 33% since 2001, adjusted for inflation. Insufficient reimbursement challenges also contribute to continued consolidation in the healthcare system, as physician practices are increasingly acquired by hospitals and large health systems with greater financial resources. The result is a shift of services into more expensive settings—raising total costs for the Medicare program and its beneficiaries, while reducing patient access and choice.

Furthermore, the draft guidance also suggests two potential methods by which the pharmaceutical manufacturer can provide access to the MFP for Part B drugs to medical practices. This includes a prospective process whereby the price paid by the dispensing entity or Part B provider when acquiring the drug is no greater than the MFP and a retrospectively process whereby reimbursement is calculated as the difference between the dispensing entity or Part B provider's acquisition cost and the MFP. As practice managers of rheumatology practices across the country, we have serious concerns with any method that would require the medical practice to carry the financial responsibility for drugs that will not be fully reimbursed. Rheumatology practices operate on extremely thin margins and cannot afford to purchase Part B drugs at a cost that is higher than reimbursement while they wait for the pharmaceutical manufacturer to reimburse the medical practice for that medication. We strongly caution CMS against adopting a retrospective method for negotiated drugs.

On behalf of rheumatology managers and their practices, we strongly urge CMS to exercise its authority to maintain ASP calculations without the inclusion of the MFP for Part B drugs and to implement procurement processes that do not place financial hardship on medical practices. Should you have any questions or would like to set a time to discuss our comments in more detail, please contact Andrea Zlatkus, CMPM, CRMS, CRHC, Executive Director of NORM, at andrea@normgroup.org.

Sincerely,

Michelle A. Owen, CPC
President, NORM

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[i] Centers for Medicare & Medicaid Services. "Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2026." August 2024.

National Pharmaceutical Council®
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June 26, 2025

The Honorable Chris Klomp
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

Submitted electronically to *IRARebateandNegotiation@cms.hhs.gov*

RE: Medicare Drug Price Negotiation Program Draft Guidance for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp:

The National Pharmaceutical Council (NPC) appreciates the opportunity to submit comments regarding the *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028*. NPC serves patients and society with policy-relevant research on the value of patient access to innovative medicines and the importance of scientific advancement. [1] We envision a world where advances in medicine are accessible to patients, valued by society, and sustainably reimbursed by payers to ensure continued innovation. We have rich experience conducting research and disseminating information about the critical issues of evidence, innovation and the value of medicines for patients.[2] Our research helps inform important healthcare policy debates and supports the achievement of the best patient outcomes in the most efficient way possible.

[1] National Pharmaceutical Council. About NPC. National Pharmaceutical Council. Accessed June 24, 2025. https://www.npcnow.org/about.
[2] National Pharmaceutical Council. Resources. National Pharmaceutical Council. Accessed June 24, 2025. https://www.npcnow.org/resources?f%5B0%5D=resource_type%3A45.

NPC has conducted extensive research on the Inflation Reduction Act (IRA) and the resultant Drug Price Negotiation Program (DPNP).[3,4,5,6,7,8] Given the potential broad-reaching impacts of the DPNP on access to medicines, we are committed to helping the Administration understand the effects of the program on seniors and disabled individuals. There is robust evidence demonstrating that access to medicines keeps Americans living healthier and longer lives, including associated improvements in life expectancy[9] and health outcomes[10] as well as reductions in total healthcare costs.[11] These are all consistent with the aims of Make America Healthy Again. Access to medicines, along with a healthy lifestyle, are important to achieving these aims. Therefore, an important goal in implementation of the DPNP should be to set guidance that, to every extent possible, minimizes the deleterious impact of the IRA on the incentives for the development of and patient access to today's treatments and tomorrow's cures. Unfortunately, we are seeing early signals of the impact of the way the Centers for Medicare and Medicaid Services (CMS) has to this point implemented the DPNP. Nearly half of every dollar that the US spends on brand medicines in the US goes to another party than the innovators,[12] and yet the biopharmaceutical industry invests over $276 billion in research and development annually.[13] Our research – which interviewed 31 investors – suggests that the IRA has already impacted investor strategies, deal values, exit values, and/or companies raising capital.[14]

We commend the CMS for the stated goal of improving transparency of the DPNP. We believe that transparency of the DPNP is critical to the integrity of the program.

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[3] Patterson J, Zhen H, Motyka J, Campbell J. Early Signals of the IRA on Orphan Drugs. National Pharmaceutical Council Policy & Evidence Brief. 2025:05. National Pharmaceutical Council. Published May 2025. Accessed June 24, 2025. https://www.npcnow.org/resources/early-signals-ira-orphan-drugs.

[4] Zheng H, Patterson JA, Campbell JD, Patterson J. Early Signals of Inflation Reduction Act Impact on Small Molecule versus Biologic Post-Approval Oncology Trials. Poster presented at: ASCO 2025 Annual Meeting, Chicago, IL. Accessed June 24, 2025. https://meetings.asco.org/abstracts-presentations/247423.

[5] Canestaro WJ, Campbell JD, Patterson JA. Early signals of Inflation Reduction Act impact on pharmaceutical investment. Poster presented at: ISPOR 2025 Annual Meeting; May 2025; Montréal, Canada. Accessed June 24, 2025. https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session-2/early-signals-of-inflation-reduction-act-impact-on-pharmaceutical-investment-and-prioritization-decisions.

[6] Zheng H, Patterson JA, Campbell JD. The Inflation Reduction Act and drug development: potential early signals of impact on post-approval clinical trials. *Ther Innov Regul Sci*. 2025;59:781-789. doi:10.1007/s43441-025-00774-2.

[7] Patterson JA, Motyka J, Salih R, Nordyke R, O'Brien JM, Campbell JD. Subsequent indications in oncology drugs: pathways, timelines, and the Inflation Reduction Act. *Ther Innov Regul Sci.* 2025;59:102-111. doi:10.1007/s43441-024-00706-6.

[8] Patterson JA, Zheng H, Campbell JD. Impacts of the Inflation Reduction Act on 2025 Formulary Coverage in Medicare Part D Plans. Poster presented at: ISPOR Annual Meeting, May 13-16, 2025, Montréal, QC, Canada. Accessed June 24, 2025. https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session- 2/impacts-of-the-inflation-reduction-act-on-2025-formulary-coverage-in-medicare-part-d-plans.

[9] 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;39(9):1546-1556. doi:10.1377/hlthaff.2020.00284. PMID: 32897792.

[10] Ho PM, Bryson CL, Rumsfeld JS. Medication adherence: its importance in cardiovascular outcomes. Circulation. 2009;119(23):3028-3035. doi:10.1161/CIRCULATIONAHA.108.768986.

[11] 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;30(1):91-99. doi:10.1377/hlthaff.2009.1087.

[12] Blalock E, Ferritto M, Taylor J. The pharmaceutical supply chain, 2013–2023. BRG. Published January 2025. Accessed June 24, 2025. https://cdn.aglty.io/phrma/global/blog/import/pdfs/PhRMA_Supply-Chain-2013-2023_White-Paper_V484.pdf.

[13] Chandra A, Drum J, Daly M, et al. Comprehensive measurement of biopharmaceutical R&D investment. *Nat Rev Drug Discov*. 2024;23(9):652-653. doi:10.1038/d41573-024-00131-2. PMID: 39107578.

[14] Canestaro WJ, Campbell JD, Patterson JA. Early signals of Inflation Reduction Act impact on pharmaceutical investment. Poster presented at: ISPOR 2025 Annual Meeting; May 2025; Montréal, Canada. Accessed June 24, 2025. https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session-2/early-signals-of-inflation-reduction-act-impact-on-pharmaceutical-investment-and-prioritization-decisions.

Our comments on the IPAY 2028 Draft Guidance focus on nine key areas:

I. NPC urges CMS to implement the IRA in a way that minimizes potential negative consequences on small molecule and orphan drug innovation, as supported by our research.
   a. Valuing evidence on the impacts of the IRA on post-approval clinical development and small molecule development
   b. Valuing evidence on the impacts of the IRA on orphan drug disease areas

II. CMS should prioritize a replicable and rigorous evidence evaluation process as a first step toward reducing the negative impact of the DPNP.
   a. Publishing the decision-making framework on the initial price determination
   b. Publishing CMS's decisions throughout the "negotiation" process

III. CMS should prioritize stakeholder feedback on aspects of the program, particularly aspects of the program void of guidance.
   a. Developing Medicare Part B effectuation plans

IV. CMS should ensure that Part D effectuation decreases the potential for errors and upholds the spirit of the IRA statute.
   a. Addressing potential duplicate 340B and maximum fair price "discounts"
   b. Implementing the refund system for Part D selected drugs

V. CMS should prioritize clinical standards throughout the program.
   a. Selecting qualifying single source drugs (QSSD) based on FDA approval
   b. Selecting and evaluating therapeutic alternatives based on clinical and comparative effectiveness research standards

VI. CMS should prioritize evaluating evidence that holistically accounts for the value of medicines.
   a. Weighing Section 1194(e)(2) factors more than Section 1194 (e)(1) factors
   b. Defining unmet medical need
   c. Defining therapeutic advance
   d. Abandoning forward-looking market data
   e. Analyzing the selected drugs as compared to therapeutic alternatives based on high quality and systematic methods

VII. CMS should prioritize patient input throughout the "negotiation" process.
   a. Broadening the scope of patient engagement through the program

VIII. CMS should develop policies that ensure that access to medicines is not impeded by the IRA.
   a. Developing more rigorous formulary oversight in Medicare Part D
   b. Working with community pharmacies, with stated concerns of stocking selected Part D medicines
   c. Monitoring patient access to selected Part B medicines

IX. CMS should ensure flexibility of data submission to reduce the administrative burden in the renegotiation process.
   a. Reducing the administrative burden
   b. Prioritizing transparency

Our full list of recommendations to CMS on the IPAY 2028 Draft Guidance are the following:

- **Valuing evidence on the impacts of the IRA on post-approval clinical development and small molecule development:**
    - We recommend that CMS work with Congress to implement President Trump's policy within the Executive Order, "Lowering Drug Prices by Once Again Putting Americans First," to modify the IRA to "align the treatment of small molecule prescription drugs with that of biological products."[15] We recommend that the IRA be modified to institute a parity of 11 years of FDA approval for small molecule and biologic treatments before eligibility for selection into the DPNP.
- **Valuing evidence on the impacts of the IRA on orphan drug disease areas:**
    - We encourage CMS to broadly interpret the IRA statute to exclude orphan drugs from negotiation and when determining the number of designations and indications that exempt an orphan product from selection. We believe that CMS should work to preserve incentives for orphan-drug research and development, consistent with Congress's mandate, for example, clarifying that for orphan drugs, the 7- or 11-year period that must elapse before a drug can be considered for negotiation begins upon the date that the orphan drug exclusion no longer applies.
- **Prioritizing a replicable and rigorous evidence evaluation process as a first step toward reducing the negative impact of the DPNP:**
    - CMS should commit to the use of transparent and reproducible methods, models, and results (including all calculations) to the extent possible, given the confidentiality required for proprietary information.
    - NPC reiterates that CMS should create and publish any decision-making framework it develops– both generally and for selected drugs. Specific elements of the framework, which we provide in more detail below, should be made public at distinct phases of evaluation.
    - We recommend that CMS move towards increased transparency of non-confidential data by releasing decisions throughout the "negotiation" process.
- **Prioritizing stakeholder feedback on aspects of the program, particularly aspects of the program void of guidance, including Part B effectuation plans:**
    - We recommend that CMS exclude MFP from ASP calculations.
    - CMS should provide greater clarity on how the Agency will consider drugs that are covered under Medicare Part B as additional preventive services. These drugs are covered under a service benefit category and have different payment and patient cost-sharing rules and requirements than most "traditional" Part B drugs. We also recommend that CMS provide greater clarity in how manufacturers will identify 340B claims, so that manufacturers meet the statutory requirement to provide 340B ceiling prices to the eligible entities (See Section IVa below, which also applies to Part B claims).

[15] Trump DJ. Lowering drug prices by once again putting Americans first. The White House. Published April 15, 2025. Accessed June 24, 2025. https://www.whitehouse.gov/presidential-actions/2025/04/lowering-drug-prices-by-once-again-putting-americans-first/.

- We recommend that the Agency also provide greater transparency and consider a different methodology to estimate 30-day equivalent dosing across different dosage forms and strengths of Part B drugs given potential inaccuracies. To avoid disruptions in Part B care, we also recommend that CMS develop and execute a robust stakeholder engagement plan (including patients, caregivers, physicians and other providers) as the Agency finalizes Part B effectuation policies

- **Ensuring that Part D effectuation decreases the chances for errors and upholds the spirit of the IRA statute:**
  - To avoid duplication of 340B and MFP discounts, CMS should require pharmacies to identify 340B units at the point of sale at the time of dispensing (when the claim is created) and prohibit identification of 340B units after that point for MFP drugs. As part of this, the Agency should also commit to ensuring that providers and pharmacies report a "minimally necessary" data set for the manufacturer or its vendor to be entitled to access the MFP to validate the 340B claim.
  - Given the complexity of 340B de-duplication, we recommend that CMS establish a 340B clearinghouse, which would act as a claims verifier, reviewing Part D PDE data as well as data submitted by 340B covered entities (or entities acting on their behalf) to confirm whether a claim is subject to a 340B agreement, similar to the role played by 340B third-party administrators (TPAs) and split-billing vendors today. If this clearinghouse is not established, CMS should develop a standardized process for manufacturers to coordinate with 340B TPAs.
  - We urge CMS to develop safeguards to thwart unnecessary errors in the program's refund system for Part D selected drugs.
  - We recommend the Guidance clarify that manufacturers are not required to provide increased MFP refund amounts to offset fees or other costs charged by third parties. We are concerned that CMS indicates in the IPAY 2028 Draft that it will assess if MFP retrospective refunds are sufficient to account for supply chain costs that a dispensing entity might encounter.
- **Defining qualifying single source (QSSD) drugs based on FDA approval:**
  - We believe that CMS does not have the authority to decide the definition of a drug; we recommend that CMS defer to the FDA and the regulatory approval process to determine drug definitions and not base QSSD identification on active moiety(ies).
  - We recommend that CMS rely on a FDA-aligned definition of a QSSD and discontinue aggregation across different NDAs and BLAs. Furthermore, we recommend that CMS limit application of the MFP only within the selected product (i.e., NDA or BLA), which better aligns with statute.
  - We recommend that CMS not interpret the classification of a QSSD and thereby rely on the FDA for drug distinction, which is the regulatory body for drug approvals in the US. We are concerned that CMS's proposal on how to classify fixed combination QSSDs lacks legal and scientific grounds.

- **Selecting and evaluating therapeutic alternatives based on clinical and comparative effectiveness research standards**:
    - We encourage CMS to select therapeutic alternatives based on clinical appropriateness.
    - Given the clinical rationale alone, the selection of therapeutic alternatives should be patient-centered and based on clinical appropriateness.
    - To better align with the Agency's goal of creating a more transparent DPNP, we also recommend that CMS 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 Information Collection Request 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 DPNP.
- **Prioritizing evaluating evidence that holistically accounts for the value of medicines:**
    - We recommend that CMS weigh the (e)(2) factors more heavily in the development of an initial price than the (e)(1) factors.
    - We recommend that CMS not introduce further subjectivity or inappropriate factors into the price-setting process and refrain from using a "range" of prices or any (e)(1) factors to determine the starting point for an initial offer.
    - Elements related to the value of a medicine, including the patient caregiver experience, should be emphasized in the evaluation of evidence, such as patient-centered outcomes and patient experience, therapeutic advance and unmet medical need, and comparative effectiveness in specific populations. For example, CMS should more thoroughly provide opportunities for patients to provide the submission of patient-centered and patient experience data (See Section VII for more details). CMS should also clearly articulate the types of evidence that are most compelling for the assessment of unmet medical need (See Section VIb), and CMS should emphasize data that displays the effectiveness of the drug in the respective Medicare populations.
- **Defining unmet medical need:**
    - NPC requests CMS clarify and provide greater specificity in the definitions and utilization of unmet medical need for MFP.
- **Defining therapeutic alternative and therapeutic advance:**
    - CMS should clarify how the cost a therapeutic alternative will impact the assessment of a therapeutic advance (quantitatively or qualitatively) in the Guidance.
    - NPC requests CMS clarify and provide greater specificity in the definition of therapeutic advance.
- **Abandoning forward-looking market data:**
    - We recommend CMS abandon any requirement for the submission of forward-looking market data.
- **Analyzing the selected drugs as compared to therapeutic alternatives based on high quality and systematic methods:**

- We recommend that CMS utilize resources recommended by NPC in the review of evidence on therapeutic alternatives.
- We recommend that CMS maintain the requirement to delineate if a study relied on quality-adjusted life year (QALY) estimates, which aligns with CMS's goal to improve transparency.

- **Prioritizing patient input throughout the "negotiation" process:**
  - We recommend CMS continue to evolve towards best practices for patient engagement and prioritize opportunities to hear a greater amount of patient-centered evidence directly from patients and their advocates, caregivers, and providers throughout the DPNP process. NPC makes specific recommendations on how to work towards this goal, including improving transparency around how patient input would be utilized in the price determination process, communicating that impact back to patients, prioritizing diversity and a multi-modal approach in outreach, and establishing a partnership with patients, their families, and their advocates, including ongoing and two-way dialogue with critical stakeholders.
- **Developing policies that ensure that access to medicines is not impeded by the IRA:**
  - We recommend that CMS bolster its formulary review and appeals process and continue to proactively monitor utilization management tools among Part D plans to ensure that seniors have adequate access to selected medicines and be transparent with the findings of the formulary evidentiary review processes.
  - We recommend that the Agency work alongside community pharmacies and other pharmacy dispensing entities (e.g., long-term care facilities) to determine the best mitigation strategies CMS can undertake to ensure that stocking and dispensing of selected medicines is not disrupted by cashflow concerns. We recommend that the Agency particularly partner with independent pharmacies in rural areas and pharmacy deserts, where the impacts will be felt most strongly among patients. CMS is best suited to address pharmacy cash flow concerns.
  - We recommend that CMS proactively monitor Part B plans' use of step therapy for selected drugs to ensure that patients have adequate access to selected medicines across plans, and that patient access to these medicines does not decrease as a result of the DPNP.
  - Given concerns around provider reimbursement for selected Part B medicines, we ask CMS to closely monitor changes in prescribing behavior, increases in consolidation, and shifts in sites of care, and to work closely with providers to address these challenges through a robust provider engagement strategy.
- **Ensuring flexibility of data submission to reduce the administrative burden for CMS and manufacturers in the renegotiation processes:**
  - We recommend that CMS set a standard that data submission for renegotiation is flexible and non-mandatory.

- We recommend that the Final Guidance provide clear answers to specific questions raised by NPC on the timeline of the renegotiation process and information provided to manufacturers to reduce administrative burden and improve transparency.
- To ensure that patients and other stakeholders know how to provide input into the renegotiation process, we recommend that CMS increase transparency into CMS's selection of renegotiated drugs and data that will inform the renegotiated MFPs.

Our full comments to CMS on the IPAY 2028 Draft Guidance are the following:

I. NPC urges CMS to implement the IRA in a way that minimizes potential negative consequences on small molecule and orphan drug innovation, as supported by our research.

a. Valuing evidence on the impacts of the IRA on post-approval clinical development and small molecule development

NPC research provides early evidence of the impact of reduced incentives under the IRA for manufacturer investment in research and development, including post-approval clinical development. Our analysis of Phase I-III trials in previously approved drugs found that, following the IRA's passage, the average monthly number of industry-sponsored trials on post-approval drugs decreased by 38.4%.[16] The IRA's passage was associated with immediate and ongoing reductions in industry-sponsored trials, with no statistically significant changes in government-funded trial initiation. These results, along with additional scenario and sensitivity analyses, suggest that the impact of the IRA was over and beyond residual effects of potential changes in clinical trial and financial environments during and after the pandemic.

This evidence builds upon past NPC research describing timelines of clinical development towards new indications. We analyzed subsequent indications among 30 small molecule medicines with multiple indications and high gross spending in Medicare Part D (2020).[17] We found that subsequent indications based on post-approval clinical trials or real world evidence were received on average, 7.5 years after a drug was initially approved by the FDA (range: 3.7 – 13.4 years), with over half (n = 23/42, 55.8%) receiving FDA approval more than 7 years after the initial approval. Together, these studies support concerns around IRA-related changes to clinical development in response to reduced incentives for investments in post-approval clinical research. Our research is bolstered by external evidence by IQVIA Institute, which evaluated the potential impact of the IRA on clinical development. It was found that if the IRA was approved over a time period of 2000 – 2020, 33% of subsequent drug approvals for biologic therapies and 34% of subsequent drug approvals for small molecule therapies may not have been achieved.[18]

Our research also supports concerns that the IRA may broadly reduce incentives for post-approval clinical development while disproportionately disincentivizing innovation in small molecule drugs. Among a large and representative sample of Phase I-III, industry-funded post-approval clinical trials for oncology drugs, we found a significant decline in post-approval trials following the IRA's passage (40.0%), with a greater reduction observed among small molecule drugs (45.3%) than biologics (32.5%).[19] Using a quasi-experimental study design (i.e., difference-

[16] Zheng H, Patterson JA, Campbell JD. The Inflation Reduction Act and Drug Development: Potential Early Signals of Impact on Post-Approval Clinical Trials. *Ther Innov Regul Sci*. 2025;59(4):781-789. doi:10.1007/s43441-025-00774-2.
[17] 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. doi:10.37765/ajmc.2024.89495.
[18] IQVIA Institute. Proliferation of Innovation Over Time. Published February 18, 2025. Accessed June 24, 2025. IQVIA. https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/proliferation-of-innovation-over-time.
[19] Zheng H, Patterson JA, Campbell JD. Early Signals of Inflation Reduction Act Impact on Small Molecule versus Biologic Post-Approval Oncology Trial. Poster presented at: ASCO 2025 Annual Meeting, Chicago, IL. Accessed June 24, 2025. https://meetings.asco.org/abstracts-presentations/247423.

in-differences) to isolate the effect of the shorter DPNP timeline for small molecule drugs, our analysis suggested small molecule drugs were associated with an additional decrease of 4.5 trials/month (95% C.I.: -7.1 to -1.9, $p < 0.01$), after the IRA's passage when compared to biologics.

Further, NPC research based on interviews with 31 life science investors across settings, fund sizes, and investment stages, found that 87% believed the IRA had made innovation more challenging; 77% reported the IRA had influenced their thinking away from investing in small molecules.[20] Finally, our research in a cohort of multi-indication oncology drugs (N = 56) [21] found that a third of small molecule drugs (33.3%) were approved for their most recent subsequent indication after the time at which they would be DPNP-eligible. Taken together, our research adds to the growing conversation around how the discrepancies in timelines towards DPNP eligibility between small molecule and biologic drugs may have disproportionate impact on disincentivizing small molecule drug development.

In addition, external research tested the impact of the IRA on early-stage investments of pharmaceuticals targeted for the Medicare-age population.[22] The research found that in 2024, the aggregated total of investments in biologics was ten-times higher than small molecules, which had a 68% decline after passage of the IRA.

We recommend that CMS work with Congress to implement President Trump's policy within the Executive Order, "Lowering Drug Prices by Once Again Putting Americans First," to modify the IRA to "align the treatment of small molecule prescription drugs with that of biological products."[23] We recommend that the IRA be modified to institute a parity of 11 years of FDA approval for small molecule and biologic treatments before eligibility for selection into the DPNP.

b. Valuing evidence on impacts of the IRA on orphan drug disease areas

The IRA's well-intended orphan drug exclusion (ODE) aimed to prevent the selection of orphan drugs used to help people living with rare diseases. Under CMS's current interpretation of the IRA's ODE, receipt of a second orphan designation disqualifies a drug from the ODE and restores its eligibility for DPNP selection.[24] While additional research is needed to support causality, our recent data suggest that the IRA is associated with decreased clinical development

[20] Canestaro WJ, Campbell JD, Patterson JA. Early signals of Inflation Reduction Act impact on pharmaceutical investment. Poster presented at: ISPOR 2025 Annual Meeting; May 2025; Montréal, Canada. Accessed June 24, 2025. https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session-2/early-signals-of-inflation-reduction-act-impact-on-pharmaceutical-investment-and-prioritization-decisions.

[21] Patterson JA, Motyka J, Salih R, Nordyke R, O'Brien JM, Campbell JD. Subsequent indications in oncology drugs: pathways, timelines, and the Inflation Reduction Act. *Ther Innov Regul Sci.* 2025;59:102-111. doi:10.1007/s43441-024-00706-6.

[22] Schulthess DG, O'Loughlin G, Askeland M, Gassull D, Bowen H. The Inflation Reduction Act's impact upon early-stage venture capital investments. *Ther Innov Regul Sci.* 2025;59:769-780. doi:10.1007/s43441-025-00773-3.

[23] Trump DJ. Lowering drug prices by once again putting Americans first. The White House. Published April 15, 2025. Accessed June 24, 2025. https://www.whitehouse.gov/presidential-actions/2025/04/lowering-drug-prices-by-once-again-putting-americans-first/.

[24] Centers for Medicare & Medicaid Services. Medicare Drug Price Negotiation Program: draft guidance, implementation of sections 1191–1198 of the Social Security Act for initial price applicability year 2028 and manufacturer effectuation of the maximum fair price in 2026, 2027, and 2028. CMS.gov. Published May 12, 2025. Accessed June 24, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

into multiple rare diseases. [25] We found that the number of drugs receiving a first orphan designation each year has remained largely consistent over time without clear signals of IRA-related impacts. However, following the passage of the IRA, the percentage of drugs with a first orphan designation that later received a second designation decreased by 48.0% (12.1% pre-IRA to 6.3% post-IRA).

Previous NPC research further illustrated the complexity and diversity of orphan drug development. One past study described the research and development timelines of 30 small molecule medicines with multiple indications and high gross spending in Medicare Part D (2020). We found that six of the included drugs (20%) were initially approved for an orphan-designated condition; all 6 were later approved for 1 or more additional orphan-designated indications, yielding a total of 18 orphan-designated subsequent indications.[26] Additional NPC research in recently approved oncology drugs first approved in an orphan-designated condition (N=64) found that nearly two-thirds of drugs (62.5%) pursued multiple designations. Among study drugs that would be disqualified from the ODE under its current interpretation (64.1%), nearly all would have been disqualified by a second orphan designation, often one that remains unapproved or was later withdrawn.[27] Together, our research raises concerns that the narrow scope and interpretation of the ODE may disincentivize research towards additional orphan-designated indications – likely resulting in fewer treatment options for patients with rare diseases.

We encourage CMS to broadly interpret the IRA statute to exclude orphan drugs from negotiation and when determining the number of designations and indications that exempt an orphan product from selection. We believe that CMS should work to preserve incentives for orphan-drug research and development, consistent with Congress's mandate, for example, clarifying that for orphan drugs, the 7- or 11-year period that must elapse before a drug can be considered for negotiation begins upon the date that the orphan drug exclusion no longer applies. We continue to advocate for this outcome, acknowledging that CMS has taken the position that it lacks the statutory authority to implement it and that a change in legislation might be the path forward.

II. CMS should prioritize a replicable and rigorous evidence evaluation process as a first step toward reducing the negative impact of the DPNP.

a. Publishing the decision-making framework on the initial price determination

[25] Patterson J, Zheng H, Motyka J, Campbell J. Early Signals of the IRA on Orphan Drugs. National Pharmaceutical Council Policy & Evidence Brief. 2025:05. National Pharmaceutical Council. Published May 2025. Accessed June 24, 2025. https://www.npcnow.org/resources/early-signals-ira-orphan-drugs.

[26] 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. doi:10.37765/ajmc.2024.89495.

[27] Motyka J, Patterson J, Salih R, Campbell JD, Patterson JA. Orphan oncology drug development: implications for the Inflation Reduction Act's Orphan Drug Exclusion. Poster presented at: AMCP 2025 Meeting, March 31-April 3, 2025, Houston, TX. Accessed June 24, 2025. https://www.jmcp.org/doi/epdf/10.18553/jmcp.2025.31.3-a.s1.

The statute requires CMS to use a "consistent methodology and process" for negotiation.[28] More clarity is needed than is provided in the Final IPAY 2028 Guidance to achieve that goal, especially related to the identification of clinical benefit and the weighting of factors used to determine the preliminary price and initial offer. Only when such clarity is provided can manufacturers and external stakeholders build their own models to anticipate, inform, and evaluate the process CMS operationalizes. Manufacturers in particular need more clarity to accurately prepare their submissions and meaningfully participate in the process.

We appreciate CMS's stated goal of increasing transparency in the Medicare DPNP. However, the DPNP cannot be transparent if CMS does not publish its decision-making framework for the price setting process. The credibility of CMS's process will be judged by the Agency's use of good evidence and appropriate methods in a transparent, reproducible, and patient-centered process. CMS should commit to the use of transparent and reproducible methods, models, and results (including all calculations) to the extent possible, given the confidentiality required for proprietary information.

Assumptions should be transparent to interested stakeholders. This transparency, combined with the ability to reproduce results, are prerequisites to building credibility and trust in the process.[29] NPC reiterates that CMS should create and publish any decision-making framework it develops– both generally and for selected drugs – which should include, at a minimum, information on:

1. The therapeutic alternative(s) considered for each indication for selected drugs and the rationale for selection;
2. The definition(s) of unmet need for each indication of selected drugs;
3. The full range of benefits and impacts considered for each indication;
4. The internal process and rationale for determining which benefits and impacts were included;
5. A list of each stakeholder consulted;
6. The source(s) of evidence considered, particularly clinicians and patients;
7. How each benefit and impact considered influenced the final MFP, to include any algorithms, calculations, or modeling that related to MFP determination, as well as rationale for evidence that was not considered; and
8. The limitations of the data collected and uncertainties in CMS's decision-making. As is common in any rigorous, evidence-based process, this information should also be made clear when reported to the public.

b. Publishing CMS's decisions throughout the "negotiation" process

[28] H.R. 5376, 117th Cong, Inflation Reduction Act of 2022. Public Law No. 117-169. August 16, 2022. Accessed June 24, 2025. https://www.congress.gov/bill/117th-congress/house-bill/5376/text.

[29] National Pharmaceutical Council. 2024 Guiding Practices for Patient-Centered Value Assessment. National Pharmaceutical Council. Published January 2024. Accessed June 24, 2025. https://www.npcnow.org/sites/default/files/2024-01/2024%20Guiding%20Practices%20for%20Patient-Centered%20Value%20Assessment%20January.pdf.

These elements of CMS's evaluation and MFP determination should be made public at distinct phases of evaluation. First, this draft framework should be made public as a scoping document prior to initiating stakeholder engagement and beginning data collection for CMS's evaluation process. Secondly, preliminary results should be shared with manufacturers of selected drugs at least 60 days prior to when CMS issues its initial offer. Finally, the results of this framework should be revealed to the public to explain the final MFP. While these comments are for the IPAY 2028 Draft Guidance, it would be valuable to have this information for the IPAY 2027 MFP explanations before the IPAY 2028 negotiations begin.

The lack of clarity on the evidence around the information that most influenced CMS's price setting process for the first and second round of price determinations increases the uncertainty of the utility of costly evidence collection and submission in the third year of implementation of the DPNP. However, CMS could increase transparency by streamlining the release of data related to the DPNP. We recommend that CMS move towards increased transparency of non-confidential data by releasing decisions throughout the "negotiation" process. CMS could publish non-confidential information on decisions on the DPNP website.

III. CMS should prioritize stakeholder feedback on aspects of the program, particularly aspects of the program void of guidance.

a. Developing Medicare Part B effectuation plans

CMS is seeking comments on how the effectuation of MFP payments and data flow for drugs payable under Part B might differ from those outlined in Part D. CMS has not provided detailed information on the effectuation of Part B medicines. The lack of guidance from CMS is concerning given that there is uncertainty in many aspects of Part B effectuation, such as issues related to use of average sales price (ASP) as the base price in MFP, lack of transparency of Part B claims in Medicare Advantage (MA) plans for manufacturer reimbursement, and provider stocking and reimbursement that are unclear and directly related to Part B effectuation.[30]

We are concerned with the numerous unanswered questions regarding Part B effectuation, in areas such as:

- Payment Flow
    - How will manufacturers provide the refund amount to providers outside of the Medicare Transaction Facilitator (MTF) system?
    - How will manufacturers identify 340B claims?
- Data
    - How will manufacturers determine accurate reimbursement amounts for Part B drugs within MA networks, where the initial payment is confidential across private networks?

[30] Sullivan M, Fruman B, Frazier L, et al. Stakeholder Considerations for MFP Effectuation in Part B. Avalere Health Advisory. Published April 28, 2025. Accessed June 24, 2025. https://advisory.avalerehealth.com/insights/stakeholder-considerations-for-mfp-effectuation-in-part-b.

- Part B Drugs that are covered as Additional Preventive Services
    - How will CMS consider Part B drugs that are covered under Medicare Part B as additional preventive services?
- 30-Day Equivalent Dosing Strategy
    - How will CMS accurately calculate 30-day equivalent dosing across different dosage forms and strengths of Part B drugs, given the potential inaccuracies?
- Provider Cashflow and Spillover
    - How will smaller provider entities remain financially solvent with lower reimbursement of MFP Part B drugs as compared to non-selected drugs?
    - If MFP is calculated into ASP, how will these prices spill over into Medicare Advantage and commercial contracts?

We are particularly concerned that effectuation of the MFP in the Part B market will erode the ASP, which will cause a decrease in negotiated reimbursement for Medicare Advantage and commercial markets. A study evaluated the impact of a decrease in ASP for ten Medicare Part B drugs that may be selected in the DPNP between 2028 and 2032.[31] The study found that a potential erosion of the ASP (as result of the IRA's DPNP) will result in $25 billion in loss of add-on payments for providers between 2028 and 2032. Loss of payment for providers can result in closure of health care practices, particularly practices that are owned independently and not vertically integrated with larger health care systems. A recent survey conducted by the American Medical Association found that there has been an eighteen percentage point drop in the number of physicians who were in private practice from 2012 (60%) as compared to 2024 (42%).[32] Given the decline in physician-led practices already in the market, decreases in provider payments will only result in more detriment to independent physician-provided care. For all these reasons, we recommend that CMS exclude the MFP from ASP calculations.

We also recommend that CMS provide greater clarity on how the Agency will consider drugs that are covered under Medicare Part B as additional preventive services. These drugs are covered under a service benefit category and have different payment and patient cost-sharing rules and requirements than most "traditional" Part B drugs. We also recommend that CMS provide greater clarity in how manufacturers will identify 340B claims, so that manufacturers meet the statutory requirement to provide 340B ceiling prices to the eligible entities (See Section IVa below, which also applies to Part B claims). In addition, we recommend that the Agency provide greater transparency and consider a different methodology to estimate 30-day equivalent dosing across different dosage forms and strengths of Part B drugs given potential inaccuracies. To avoid disruptions in Part B care, NPC also recommends that CMS develop and execute a robust stakeholder engagement plan (including patients, caregivers, physicians and other providers) as the Agency finalizes Part B effectuation policies. From ongoing and robust

[31] Sullivan M, Dilmanian M, Frazier L, Krupp G, Isaiah E. Commercial Spillover Impact of Part B Negotiations on Physicians. Avalere Health Advisory. Published September 16, 2024. Accessed June 24, 2025. https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians.

[32] Kane, CK. Physician Practice Characteristics in 2024: Private Practices Account for Less than Half of Physicians in Most Specialties. American Medical Association. Accessed June 24, 2025. https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf.

interactions with a diverse range of stakeholders, CMS can learn about the pain points and minimize unintended consequences of MFP effectuation in Part B.

IV. CMS should ensure that Part D effectuation decreases the potential for errors and upholds the spirit of the IRA statute.

a. Addressing potential duplicate 340B and maximum fair price "discounts"

The IRA statute is clear – manufacturers are responsible for providing eligible entities with the selected drug at the 340B ceiling price in a nonduplicative manner with the MFP, if the 340B ceiling price is lower than the MFP. However, manufacturers do not have a way to ascertain if a selected drug is being administered to a 340B eligible individual at the point-of-sale or retrospectively. Numerous factors also create significant potential for MFP and 340B duplicate discounts. These include a lack of transparency in the 340B Drug Pricing Program, the potential for mixing mechanisms of chargebacks and rebates of 340B and MFP on the same National Drug Code (NDC), and the inconsistent timeframe and methods by which pharmacy claims are determined to be 340B-eligible. Without additional verification from CMS, manufacturers will be required to validate that 340B entities are only providing the MFP to eligible individuals, without standard processes to do so or the required participation of 340B covered entities (or entities acting on their behalf) to provide sufficient information to determine whether a 340B or MFP discount is owed.

In the IPAY 2028 Draft Guidance, CMS reiterates the responsibility of the primary manufacturer to provide access to the MFP or 340B ceiling price, whichever is the least.[33] In the case where the MFP is lower than the 340B ceiling price (and the MFP was not provided proactively), the primary manufacturer must transmit payment of an amount that provides access to the MFP of a selected drug to the dispensing entity within a 14-day prompt MFP window.

There are three codes on the Prescription Drug Event (PDE) claims that could indicate a 340B claim:

- Starting January 1, 2025, payers may indicate a 340B claim (retrospectively) using the Submission Clarification Code and Submission Type Code
- MFP dispensing entities can indicate that a claim was 340B eligible using the "340B Claim Indicator"; however, data is not mandatory nor is it verified for accuracy by CMS
- National Provider Identifier is useful, but not sufficient to identify 340B claims

<u>To avoid duplication of 340B and MFP discounts, CMS should require pharmacies to identify 340B units at the point of sale at the time of dispensing (when the claim is created) and prohibit identification of 340B units after that point for MFP drugs</u>. If this approach is used, we ask the

[33] Centers for Medicare & Medicaid Services. Medicare Drug Price Negotiation Program: draft guidance, implementation of sections 1191–1198 of the Social Security Act for initial price applicability year 2028 and manufacturer effectuation of the maximum fair price in 2026, 2027, and 2028. CMS.gov. Published May 12, 2025. Accessed June 24, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

Agency to develop a cutoff for 340B identification to avoid duplicates. As part of this, the Agency should also commit to ensuring that providers and pharmacies report a "minimally necessary" data set for the manufacturer or its vendor to be entitled to access the MFP to validate the 340B claim.

Given the complex interactions of the processes described above, we recommend that CMS establish a 340B clearinghouse, which would act as a claims verifier, reviewing Part D PDE data as well as data submitted by 340B covered entities (or entities acting on their behalf) to confirm whether a claim is subject to a 340B agreement, similar to the role played by 340B third-party administrators (TPAs) and split-billing vendors today. If this clearinghouse is not established, CMS should develop a standardized process for manufacturers to coordinate with 340B TPAs. The IPAY 2028 Guidance states, "CMS understands that a majority of 340B claims are processed by a small number of 340B TPAs on behalf of 340B covered entities and dispensing entities...CMS strongly encourages manufacturers to work with dispensing entities, covered entities and their 340B TPAs, and other prescription drug supply chain stakeholders (e.g., wholesalers) to facilitate access to the lower of the MFP and the 340B ceiling price, wherever applicable."[34] We believe that CMS should take ownership and act as a coordinator between TPAs and manufacturers.

b. Implementing the refund system for Part D selected drugs

We appreciate the Administration's further clarification on how MFP refunds will be accounted for within and outside of the MTF Payment Module (MTF PM). However, there remains some unaddressed potential for errors in CMS's plan for tracking and crediting refunds for MFP drugs. Within the MTF PM, CMS clarified that the MTF will maintain a credit/debit ledger system to track credits and debits related to MFP refunds. However, the primary manufacturer is responsible for reviewing all such credits and debits to confirm their accuracy. CMS states that the MTF Data Module (MTF DM) will instruct the MTF PM to apply the specified credit or debit, and the primary manufacturer will submit the refund in the 14-day window. CMS states that the primary manufacturer participating in the MTF PM will authorize the payment; however, the Draft Guidance states that "the precise process of authorization surrounding payment transfer continues to be developed."[35]

While CMS asserts that the MTF is intended to support verification that the selected drug was dispensed to an MFP-eligible patient and to facilitate this process, we are concerned about the potential for errors. If a prescription was filled, billed, and returned to stock within the 14-day time frame proposed by CMS, the Part D plan would have the information necessary to reverse their payment to the pharmacy, but the manufacturer would not be aware of the need

[34] Centers for Medicare & Medicaid Services. Medicare Drug Price Negotiation Program: draft guidance, implementation of sections 1191–1198 of the Social Security Act for initial price applicability year 2028 and manufacturer effectuation of the maximum fair price in 2026, 2027, and 2028. CMS.gov. Published May 12, 2025. Accessed June 24, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.
[35] Centers for Medicare & Medicaid Services. Medicare Drug Price Negotiation Program: draft guidance, implementation of sections 1191–1198 of the Social Security Act for initial price applicability year 2028 and manufacturer effectuation of the maximum fair price in 2026, 2027, and 2028. CMS.gov. Published May 12, 2025. Accessed June 24, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

to reverse the MFP effectuation payment. This creates a significant economic incentive that could encourage inadvertent duplicate discounts or outright diversion or fraud that threatens the integrity of IRA implementation. We urge CMS to develop safeguards to thwart unnecessary errors in the program's refund system.

We are also concerned that CMS indicates in the IPAY 2028 Draft Guidance that it will assess if MFP retrospective refunds are sufficient to account for supply chain costs that a dispensing entity might encounter. We believe that an increase to the MFP Retrospective Refund that accounts for third-party fees could create an incentive for supply chain entities and middlemen to artificially inflate the MFP refund amount. We recommend the Guidance clarify that manufacturers are not required to provide increased MFP refund amounts to offset fees or other costs charged by third parties.

V. CMS should prioritize clinical standards throughout the program.

a. Selecting qualifying single source drugs based on FDA approval

Foundational to the DPNP is the definition of a qualifying single source drug (QSSD). The IPAY 2028 Draft Guidance states that CMS will identify a QSSD for drug products using all dosage forms and strengths of the drug with the same active moiety and the same holder of a New Drug Application (NDA), inclusive of products that are marketed pursuant to different NDAs. For biological products, CMS suggests that it will define a QSSD to encompass all dosage forms and strengths of the biological product with the same active ingredient and the same holder of a Biologics License Application (BLA), inclusive of products that are marketed pursuant to different BLAs.

The IRA statute defines qualifying single source drugs as drugs and biological products payable under Part D and B, respectively as: 1) "DRUG PRODUCTS.—A drug— '(i) that is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act and is marketed pursuant to such approval; ''(ii) for which, as of the selected drug publication date with respect to such initial price applicability year, at least 7 years will have elapsed since the date of such approval; and (iii) that is not the listed drug for any drug that is approved and marketed under section 505(j) of such Act."; 2) "BIOLOGICAL PRODUCTS.—A biological product— (i) that is licensed under section 351(a) of the Public Health Service Act and is marketed under section 351 of such Act; (ii) for which, as of the selected drug publication date with respect to such initial price applicability year, at least 11 years will have elapsed since the date of such licensure; and (iii) that is not the reference product for any biological product that is licensed and marketed under section 351(k) of such Act."[36]

[36] H.R. 5376, 117th Cong, Inflation Reduction Act of 2022. Public Law No. 117-169. August 16, 2022. Accessed June 24, 2025.https://www.congress.gov/bill/117th-congress/house-bill/5376/text.

We believe that CMS's current methodology to identify QSSDs is a misinterpretation of the statute. The statute defines a drug based on approval from the Food and Drug Administration (FDA). However, CMS interprets the QSSD based on "active moiety," a term not defined in the statute. We believe that CMS does not have the authority to decide the definition of a drug; we recommend that CMS defer to the FDA and the regulatory approval process to determine drug definitions and not base QSSD identification on active moiety(ies).

Based on the current reliance on active moieties, a drug with a different formulation or improved pharmacokinetic/ pharmacodynamic properties may be classified as the same QSSD. Furthermore, CMS states that in the case where multiple NDAs (or BLAs) are held for the same active moiety, CMS will aggregate all the products into a single QSSD. However, there are important clinical rationale for the classification of a drug based on formulation and pharmacokinetic priorities. We recommend that CMS rely on a FDA-aligned definition of a Qualifying Single Source Drug (QSSD) and discontinue aggregation across different NDAs and BLAs. Furthermore, we recommend that CMS limit application of the MFP only within the selected product (i.e., NDA or BLA), which better aligns with statute.

We appreciate that CMS is soliciting feedback on how to classify fixed combination products "when one of the active ingredients or moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference."[37] We are concerned that this proposal lacks legal and scientific grounds. In the Draft Guidance, CMS references the FDA's regulation 21 CFR § 300.50, "Fixed-combination prescription drugs for humans," to define a fixed-drug combination product.[38] This FDA regulation defines a fixed-combination prescription drug as a two or more drugs that may be combined in a single dosage-form when each component makes a contribution to the claimed effects and the drug is safe and effective. The regulation specifies that special cases of the general rule apply if a component is added to enhance the safety (or effectiveness) of a principal component to minimize abuse of the principal component. In each case, the FDA definition of a fixed combination product asserts that each component of the drug are necessary for the drug to be safe and/or effective. CMS's proposed aggregation of drugs based on a single shared active moiety disregards the FDA's framework, which CMS references as relevant to the definition of fixed combination QSSDs. Clinically, the selection of a drug based on one active ingredient will also improperly classify drug products that are distinct in treatment pathways and indicated populations. For example, in the treatment of diabetes and HIV, different fixed-combination drug products are common and widely utilized for different treatment populations.[39, 40] Therefore, if

[37] Centers for Medicare & Medicaid Services. Medicare Drug Price Negotiation Program: draft guidance, implementation of sections 1191–1198 of the Social Security Act for initial price applicability year 2028 and manufacturer effectuation of the maximum fair price in 2026, 2027, and 2028. CMS.gov. Published May 12, 2025. Accessed June 24, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.
[38] 21 CFR § 300.50. Fixed-combination prescription drugs for humans. Accessed June 24, 2025. https://www.ecfr.gov/current/title-21/chapter-I/subchapter-D/part-300/subpart-B/section-300.50.
[39] Department of Health and Human Services. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Updated September 12, 2024. Accessed June 24, 2025. https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/adult-adolescent-arv/guidelines-adult-adolescent-arv.pdf
[40] American Diabetes Association Professional Practice Committee. 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2024. *Diabetes Care*. 2024;47(Suppl 1):S158-S178. doi:10.2337/dc24-S009.

CMS aggregated fixed combination therapies (based on one active ingredient), it would be challenging for CMS to assess the selection of therapeutic alternatives (given different treatment populations and/or treatment pathways). Secondly, there are instances where a novel product is combined with a generic product(s) to create a new fixed-combination therapy. It is unclear how CMS would treat each active ingredient in the fixed-combination in relation to price-setting. Thirdly, it is unclear how CMS will treat monotherapies that are intended to be utilized in combination with other monotherapies, if/when such monotherapies are also ingredients included in other fixed combination therapies. For these reasons, we recommend that CMS not interpret the classification of a QSSD and thereby rely on the FDA for drug distinction, which is the regulatory body for drug approvals in the US.

b. Selecting and evaluating therapeutic alternatives based on clinical and comparative effectiveness research standards

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.[41] The use of a comparator that is not consistent with current clinical practice for given patients injects significant biases into the results and recommendations of a comparative assessment. Real world treatment decisions are based on numerous factors associated with the underlying disease and its severity, general health status or frailty, quality of life, and patient preferences.

The Agency for Healthcare Research and Quality (AHRQ) has developed guidance on selection of a comparator in observational comparative effectiveness research (CER).[42] In the guidance, AHRQ details how treatment selection bias (i.e., confounding by indication) may arise when there are differences between patients prescribed the drug being evaluated and patients prescribed the drug used as a comparator. Bias can be minimized by choosing a comparator that has the same indication, similar contraindications, similar adverse effects, and the same treatment modality, class, and mechanism of action. AHRQ notes that selection of a comparator of the same treatment modality and class may result in less bias than comparison across modalities or classes.[43]

Our team conducted an evaluation of the therapeutic alternatives selected in the first year of the DPNP as compared to the AHRQ guidance.[44] We compared the therapeutic alternatives for the selected drugs on three characteristics in the AHRQ guidance, including the mechanism of action, class as defined by the US Pharmacopoeia, and treatment modality, narrowly defined

[41] Berger ML, Sox H, Willke RJ, et al. 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. *Pharmacoepidemiol Drug Saf.* 2017;26(9):1033-1039. doi:10.1002/pds.4297.
[42] Agency for Healthcare Research and Quality. Developing a Protocol for Observational Comparative Effectiveness Research: A User's Guide. AHQR. Reviewed March 2021. Accessed June 24, 2025. https://effectivehealthcare.ahrq.gov/products/observational-cer-protocol.
[43]Agency for Healthcare Research and Quality. Developing a Protocol for Observational Comparative Effectiveness Research: A User's Guide. AHQR. Reviewed March 2021. Accessed June 24, 2025. https://effectivehealthcare.ahrq.gov/products/observational-cer-protocol.
[44] Wagner T, McRae J, Campbell JD, Patterson JA, Zheng H. Evaluating Therapeutic Alternative Selection in Medicare's Initial Drug Price Negotiation Explanations. Poster presented at: ISPOR Annual Meeting, May 13-16, 2025, Montréal Canada. Accessed June 24, 2025. https://www.npcnow.org/resources/evaluating-therapeutic-alternative-selection-medicares-initial-drug-price-negotiation.

in the study as route of administration. **Across 65 therapeutic alternatives in the first round of the DPNP, only 18.5% aligned with the respective selected drug on all three characteristics studied. From our analysis, CMS's choice of therapeutic alternatives is not transparent and may not be scientifically rigorous**. We are concerned about these findings.

We encourage CMS to select therapeutic alternatives based on clinical appropriateness, including the additional following recommendations:

- 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 guidance to gain this information, including NIH's National Center for Advancing Translational Sciences.[45,46]
- Utilize best practices for identifying therapeutic alternatives based on trusted, authoritative bodies, such as those developed by AHRQ.[47]
- Include patient preferences and priorities that inform shared decision-making between appropriate treatment options.[48]
- Exclude off-label use from being compared to FDA-approved indications of selected drugs and limit the choice of therapeutic alternative to drugs and biologics with FDA-approved indications.
- Consider the use of comparative effectiveness studies and real-world evidence to support the selection of therapeutic alternatives.
- Solicit feedback from manufacturers, clinicians with specific expertise in treating the disease, patients and caregivers, and other stakeholders before proceeding with comparative effectiveness analyses that inform the initial offer.

We appreciate that CMS is seeking feedback on whether CMS should consider therapeutic alternatives that are health care services; however, this provision is premature and lacks clarity for numerous clinical reasons. Clinically, health care services are often utilized in combination or in parallel to pharmacological treatments. The treatment of certain cancer types, such as advanced prostate cancer, often involves cycling between chemotherapy, other pharmacological treatments, and radiation.[49] Moreover, certain pharmacological treatments are indicated as second-line indications, where surgery or another procedure is indicated as first-line treatment. CMS should clarify how the Agency will account for sequencing and parallel health care services and pharmacological treatments. Furthermore, unlike the price of a 30-day or per-unit supply of

[45] Shekelle PG, Woolf SH, Eccles M, Grimshaw J. Clinical guidelines: developing guidelines. *BMJ.* 1999 Feb 27;318(7183):593-6. doi: 10.1136/bmj.318.7183.593.

[46] National Institutes of Health. Updating Clinical Care Guidelines – Guideline Development Process. NCATS website. https://toolkit.ncats.nih.gov/module/after-fda-approval/creating-clinical-care-guidelines/guideline-development-process/.

[47] Agency for Healthcare Research and Quality. Developing a Protocol for Observational Comparative Effectiveness Research: A User's Guide. AHQR website. Reviewed March 2021. Accessed June 24, 2025. https://effectivehealthcare.ahrq.gov/products/observational-cer-protocol.

[48] 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.

[49] Lowrance W, Dreicer R, Jarrard DF, et al. Updates to Advanced Prostate Cancer: AUA/SUO Guideline (2023). *J Urol.* 2023;209(6):1082-1090. doi:10.1097/JU.0000000000003452.

a drug or biologic, prices of health care services can vary based on health care settings or geography. Given the clinical rationale alone, the selection of therapeutic alternatives should be patient-centered and based on clinical appropriateness. As we have stated in prior comment letters to the Agency on the DPNP, the selection of therapeutic alternatives should not be based on the cost of treatment. To better align with the Agency's goal of creating a more transparent DPNP, we also recommend that CMS 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 Information Collection Request 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 DPNP.

VI. CMS should prioritize evaluating evidence that holistically accounts for the value of medicines.

a. Weighing Section 1194(e)(2) factors more than Section 1194(e)(1) factors

We appreciate the Agency's call for comments regarding which Section 1194(e)(2) and (e)(1) factors should be weighed more heavily in adjusting the starting point and preliminary price, respectively. This is a step towards transparency. However, we do not believe the Draft Guidance describes a satisfactory process to determine the value of a medicine or set its price and note that it resembles, with less transparency, processes used by countries outside of the United States that face significant delays in accessing innovation.[50,51] As we expressed in earlier comments on transparency (Section II), increasing transparency in the price setting process cannot be achieved if CMS does not release the decision-making framework for the price determinations.

Furthermore, Section 1194(e)(1) factors and other manufacturer-related costs, such as the cost of producing a drug, do not help to define the value of a treatment. We believe that only clinical benefits, health improvement, including public health and societal benefits, and cost offsets associated with the treatment may be used to determine the value of a medicine. Adjusting reimbursement by the elements described in the manufacturer data elements, which are unrelated to drug benefits, (e.g., R&D costs, cost of production, prior Federal financial support) ignores the complexity of drug development and the multitude of costs across the pharmaceutical supply chain for patients to receive their medicines. Doing so will have disastrous effects on innovation and deny patients future treatments or future indications for existing treatments. We recommend that CMS weigh the (e)(2) factors more heavily in the development of an initial price than the (e)(1) factors. Beyond our concerns about potential

[50] Newton M, Stoddart K, Travaglio M, Troein P. EFPIA Patients W.A.I.T. Indicator 2024 Survey. IQVIA. Published April 2025. Accessed June 24, 2025. https://rtl.ee/wp-content/uploads/2025/05/EFPIA-Patients-W.A.I.T.-Indicator-2024-Final-110425-1.pdf.

[51] Mulcahy, A. Comparing New Prescription Drug Availability in the United States and Other OECD Countries. RAND Corporation. Accessed June 24, 2025. https://www.rand.org/content/dam/rand/pubs/research_reports/RRA700/RRA788-4/RAND_RRA788-4.pdf.

adjustments to the initial starting point based on factors unrelated to the value of a medicine, we are concerned about CMS's definition of the starting point itself. CMS's decision to use the net price of therapeutic alternatives, incorporating discounts paid under the Medicare Part D Manufacturer Discount Program, is an inappropriate metric to use for the Medicare population. It is not a standard price reporting measure found elsewhere, which will increase burden, and Discount Program payments are highly variable and depend on the mix of drugs patients are taking.

NPC is concerned that CMS will consider a "range" of prices to determine the starting point if there are multiple therapeutic alternatives. A range of prices introduces further subjectivity in the analysis. NPC is also concerned that CMS is considering the use of "unit cost of production and distribution of the selected drug" and "other domestic reference prices" to determine the starting point for an initial offer for drugs with more than one therapeutic alternative (pg. 129).[52] These costs do not align with the value of a treatment, including the public health impacts, and the unit cost of production does not offer evidence on the value of a treatment. We recommend that CMS not introduce further subjectivity or inappropriate factors into the price-setting process and refrain from using a "range" of prices or any (e)(1) factors to determine the starting point for an initial offer.

However, elements related to the value of a medicine, including the Section 1194 (e)(2) factors and related elements, should be emphasized in the evaluation of evidence, such as patient-centered outcomes and patient experience, therapeutic advance and unmet medical need, and comparative effectiveness in specific populations. For example, CMS should more thoroughly provide opportunities for patients to provide the submission of patient-centered and patient experience data (See Section VII for more details). CMS should also clearly articulate the types of evidence that are most compelling for the assessment of unmet medical need (See Section VIb), and CMS should emphasize data that displays the effectiveness of the drug in the respective Medicare populations.

b. Defining unmet medical need

Unmet medical need is an important aspect of the DPNP's assessment of the value of the selected medicine as compared to therapeutic alternatives. Over the last two guidance periods, we have asked that CMS clarify the definition of unmet medical need to align with current research. In the IPAY 2028 Draft Guidance, CMS defines unmet medical need as: "A circumstance in which the relevant disease or condition is one for which no other treatment options exist, or existing treatments do not adequately address the disease or condition."[53] We are disappointed that CMS has not explicitly broadened the definition of unmet medical need to encompass

[52] Centers for Medicare & Medicaid Services. Medicare Drug Price Negotiation Program: draft guidance, implementation of sections 1191–1198 of the Social Security Act for initial price applicability year 2028 and manufacturer effectuation of the maximum fair price in 2026, 2027, and 2028. CMS.gov. Published May 12, 2025. Accessed June 24, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.
[53] Centers for Medicare & Medicaid Services. Medicare Drug Price Negotiation Program: draft guidance, implementation of sections 1191–1198 of the Social Security Act for initial price applicability year 2028 and manufacturer effectuation of the maximum fair price in 2026, 2027, and 2028. CMS.gov. Published May 12, 2025. Accessed June 24, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

patient-centered outcomes and views from clinicians[54] or provided transparency in how evidence on unmet medical need impacts the price determination.

A 2023 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.[55] 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]." CMS's definition of unmet medical need in 2023 is similar to the current definition. Other prior research on unmet medical need has elicited consensus from clinician experts to identify their views on unmet medical need.[56] The prior research found that 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 are critical to understanding the disease. A determination of unmet medical need should encompass all of these factors and more.

We believe assessments of unmet medical need should include a multifaceted definition informed by the patient perspective. 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.[57] 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. Failure to capture the value of treatments that address patient-centered unmet needs disincentivizes innovations that meet those needs, in turn exacerbating disparities in health outcomes among patients receiving treatments less effective in their subgroups and/or unaligned with their preferences.

CMS can also look to the FDA's definition of unmet need, as outlined in its guidance for expedited programs, which includes improved efficacy, reduced toxicity and/or potential drug-drug interactions, and improvements in other benefits such as adherence.[58] 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

[54] Danese S, Allez M, van Bodegraven AA, et al. Unmet medical needs in ulcerative colitis: an expert group consensus. *Dig Dis.* 2019;37(4):266-283. doi:10.1159/000496739.
[55] DeMattis C, Karmo M, Gawuga C, et al. Defining "Unmet Medical Need" in the Inflation Reduction Act for the Maximum Fair Price: Reflecting on Patient Input. Partnership to Fight Chronic Disease. June 2023. Accessed June 24, 2025. https://www.fightchronicdisease.org/unmet-medical-need.
[56] Danese S, Allez M, van Bodegraven AA, et al. Unmet medical needs in ulcerative colitis: an expert group consensus. *Dig Dis.* 2019;37(4):266-283. doi:10.1159/000496739.
[57] Danese S, Allez M, van Bodegraven AA, et al. Unmet medical needs in ulcerative colitis: an expert group consensus. *Dig Dis.* 2019;37(4):266-283. doi:10.1159/000496739.
[58] Food and Drug Administration. Guidance for Industry Expedited Programs for Serious Conditions – Drugs and Biologics. Food and Drug Administration. Published May 2014. Accessed June 24, 2024. https://www.fda.gov/regulatory-information/search-fda-guidance-documents/expedited-programs-serious-conditions-drugs-and-biologics.

unmet need despite existing treatments.[59]

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 from 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

To enhance transparency in assessing evidence on unmet medical need, NPC also requests that CMS revise the Guidance to adopt a two-phase approach to assessing unmet medical needs. In the first step, we request that CMS release the specific list of the baseline unmet medical needs that CMS deems relevant to each selected drug, based on the broadened and more specific definition of unmet medical need (requested above). CMS should be amenable to input from manufacturers, patients, and other stakeholders on broadening the definition of unmet medical need during the public engagement and other stakeholder engagement processes. Secondly, CMS should specify that a drug will only be evaluated against unmet medical needs within the scope of FDA-prescribing information. These combined elements will enhance the transparency and specificity of the evaluation of unmet medical needs.

c. Defining therapeutic advance

The IRA instructs CMS to consider "the extent to which [a selected drug] represents a therapeutic advance as compared to existing therapeutic alternatives **and the costs of such existing therapeutic alternatives**." However, the Draft Guidance is unclear regarding how the cost of existing therapeutic alternatives will be operationalized in the determination of a therapeutic advance. For example, the Draft Guidance does not provide clarity on how an improvement in a set of patient-reported outcomes for a lower cost therapeutic alternative will be weighed as compared to an improved in a set of patient-reported outcomes for a higher cost therapeutic alternative. CMS should clarify how the cost a therapeutic alternative will impact the assessment of a therapeutic advance (quantitatively or qualitatively) in the Guidance.

[59] Westrich K, Buelt L. The myth of average: why individual patient differences matter. National Pharmaceutical Council. Published January 2022. Accessed June 24, 2025. https://www.npcnow.org/sites/default/files/2022-01/The_Myth_of_Average_01.2022.pdf.

The statute also does not suggest that the cost of those alternatives should be used as a benchmark for an initial offer. [60] The Guidance diverges from the statute because CMS intends to rely on: "(1) the Net Part D Plan Payment and Beneficiary Liability, which reflects TGCDC net of DIR and CGDP or Manufacturer Discount Program payments, as applicable; or (2) the MFP for selected drugs negotiated for a prior initial price applicability year, if applicable" to determine the starting point of an initial offer for Part D drugs. CMS intends to rely on: "the lesser of ASP or WAC [Wholesale Acquisition Cost], in order to better align with the payment amount under section 1847A(b)(4) of the Act in circumstances where the WAC of a therapeutic alternative is lower than its ASP" to determine the starting point of an initial offer for Part B drugs.[61]

In addition, CMS describes evaluating evidence about the selected drug as compared to alternatives in a manner that is still unclear: "CMS intends to examine improvements in outcomes to determine the extent to which a selected drug represents a therapeutic advance as compared to its therapeutic alternative(s) (e.g., selected drug is curative versus a therapeutic alternative that delays progression) and will consider the costs of the selected drug and its therapeutic alternative(s). CMS may consider the magnitude of differences in outcomes of interest conferred by the selected drug compared to the selected drug's therapeutic alternative(s) for an indication(s) when determining the extent to which a selected drug represents a therapeutic advance."[62]

<u>NPC requests CMS clarify and provide greater specificity in the definition of therapeutic advance, including the following:</u>

- 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

d. Abandoning forward-looking market data

In the IPAY 2028 Draft Guidance, CMS is soliciting feedback on collecting additional, forward-looking "market data" for the selected drug that pertain to periods that overlap with the negotiation period and/or the price applicability period." We are concerned that forecasted sales and revenue data is at odds with the IRA statutory requirements for factual

[60] H.R. 5376, 117th Cong, Inflation Reduction Act of 2022. Public Law No. 117-169. August 16, 2022. Accessed June 24, 2025. https://www.congress.gov/bill/117th-congress/house-bill/5376/text.
[61] Centers for Medicare & Medicaid Services. Medicare Drug Price Negotiation Program: draft guidance, implementation of sections 1191–1198 of the Social Security Act for initial price applicability year 2028 and manufacturer effectuation of the maximum fair price in 2026, 2027, and 2028. CMS.gov. Published May 12, 2025. Accessed June 24, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.
[62] Centers for Medicare & Medicaid Services. Medicare Drug Price Negotiation Program: draft guidance, implementation of sections 1191–1198 of the Social Security Act for initial price applicability year 2028 and manufacturer effectuation of the maximum fair price in 2026, 2027, and 2028. CMS.gov. Published May 12, 2025. Accessed June 24, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

data submission. Forward-looking information has the potential to significantly change; therefore, such information is not suitable for CMS to take into consideration when setting the MFP. In addition, providing speculative, forward-looking market data could put manufacturers at legal risk when certifying the accuracy of such estimates. We recommend CMS abandon any requirement for the submission of forward-looking market data.

e. Analyzing the selected drugs as compared to therapeutic alternatives based on high quality and systematic methods

The results of an assessment depend on the evidence that underlies it, and the burden is on CMS to use and develop evidence in a systematic, transparent, and robust manner. To maximize credibility and trust in the assessment process, the procedures by which evidence is identified and included in the assessment should be objective, systematic, transparent, robust, reproducible, and made public as part of the scoping process. Not following widely accepted scientific best practices erodes trust in the process. Accordingly, we encourage CMS to develop robust, transparent standards for both submitted and internally generated data to ensure that evidence is methodologically rigorous and apply these same rigor and transparency standards to the Agency's internal claims analysis and review when adjusting the MFP initial starting point based on clinical evidence. These standards can be informed by using accepted rubrics for evaluating study quality[63,64,65] that are fit for purpose and most appropriate for the type of evidence (e.g., clinical vs. economic data).[66]

In our foregoing recommendations, we have emphasized methodological issues that are relevant to the price-setting process proposed by CMS. Therefore, we encourage CMS to follow and tailor as necessary consensus guidance on the conduct and evaluation of CER that is both submitted and internally conducted, and to adopt elements as high-quality research methods, aligned with principles of good CER.[67,68,69] We encourage CMS to review and, wherever possible, utilize the guiding principles listed below to ensure the transparency, validity, and credibility of the annual price-setting process.

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[63] Husereau D, Drummond M, Augustovski F, et al. Consolidated Health Economic Evaluation Reporting Standards (CHEERS) 2022 Explanation and Elaboration: A Report of the ISPOR CHEERS II Good Practices Task Force. *Value Health.* 2022;25(1):10-31. doi:10.1016/j.jval.2021.10.008. Erratum in: *Value Health.* 2022;25(6):1060. doi:10.1016/j.jval.2022.03.002.

[64] von Elm E, Altman DG, Egger M, et al; STROBE Initiative. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: guidelines for reporting observational studies. *Lancet.* 2007;370(9596):1453-1457. doi:10.1016/S0140-6736(07)61602-X.

[65] Dreyer NA, Bryant A, Velentgas P. The GRACE checklist: a validated assessment tool for high quality observational studies of comparative effectiveness. *J Manag Care Spec Pharm*. 2016;22(10):1107-1113. doi:10.18553/jmcp.2016.22.10.1107.

[66] National Pharmaceutical Council. 2024 Guiding Practices for Patient-Centered Value Assessment. National Pharmaceutical Council. Published January 2024. Accessed June 24, 2025. https://www.npcnow.org/sites/default/files/2024-01/2024%20Guiding%20Practices%20for%20Patient-Centered%20Value%20Assessment%20January.pdf.

[67] Berger ML, Sox H, Willke RJ, et al. 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. *Pharmacoepidemiol Drug Saf.* 2017;26(9):1033-1039. doi:10.1002/pds.4297

[68] Dreyer NA, Bryant A, Velentgas P. The GRACE checklist: a validated assessment tool for high quality observational studies of comparative effectiveness. *J Manag Care Spec Pharm* 2016;22(10):1107-1113. doi:10.18553/jmcp.2016.22.10.1107.

[69] National Pharmaceutical Council. 2024 Guiding Practices for Patient-Centered Value Assessment. National Pharmaceutical Council. Published January 2024. Accessed June 24, 2025. https://www.npcnow.org/sites/default/files/2024-01/2024%20Guiding%20Practices%20for%20Patient-Centered%20Value%20Assessment%20January.pdf.

We recommend that CMS utilize the following resources in the review of evidence on therapeutic alternatives:

- NPC's Guiding Practices for Patient-Centered Value Assessment includes 33 specific elements surrounding six key aspects of value assessment, including the assessment process, scientific methodology, benefits, costs, evidence, and dissemination and utilization.[70]
- The Myth of Average: Why Individual Patient Differences Matter, published by NPC, provides recommendations for ways improving the patient-centeredness of value assessment.[71]
- ISPOR – The Professional Society for Health Economics and Outcomes Research and the International Society for Pharmacoepidemiology (ISPE) have published good practices for real-word data studies of comparative effectiveness with the goal of providing a trustworthy foundation for the use of RWE in decision-making.[72]
- The National Health Council (NHC) has also developed resources related to patient-centeredness in value assessment that we ask CMS to glean from for the evidence review process.[73]

We also recommend that CMS take steps to ensure that information submitted in the ICR process does not inadvertently rely on the quality adjusted life year (QALY) metric. As aligned with statute, "The Secretary shall not use evidence from comparative clinical effectiveness research in a manner 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."[74] In the IPAY 2028 Draft Guidance, CMS proposes to remove the requirement in the Drug Price Negotiation ICR for IPAY 2028 that respondents indicate in their submissions whether a study includes the QALY metric. CMS stated the removal of this information in the ICR was prompted by responses to the ICR for IPAY 2026 and IPAY 2027, which indicated that certain respondents were not familiar with cost-effectiveness measures. We recommend that CMS maintain the requirement to delineate if a study relied on QALY estimates, which aligns with CMS's goal to improve transparency.

VII. CMS should prioritize patient input throughout the "negotiation" process.

[70] National Pharmaceutical Council. 2024 Guiding Practices for Patient-Centered Value Assessment. National Pharmaceutical Council. Published January 2024. Accessed June 24, 2025. https://www.npcnow.org/sites/default/files/2024-01/2024%20Guiding%20Practices%20for%20Patient-Centered%20Value%20Assessment%20January.pdf

[71] Westrich K, Buelt L. The myth of average: why individual patient differences matter. National Pharmaceutical Council. Published January 2022. Accessed June 24, 2025. https://www.npcnow.org/sites/default/files/2022-01/The_Myth_of_Average_01.2022.pdf

[72] Berger ML, Sox H, Willke RJ, et al. 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. *Pharmacoepidemiol Drug Saf.* 2017;26(9):1033-1039. doi:10.1002/pds.4297

[73] National Health Council. Value Classroom. National Health Council. Accessed June 24, 2025. https://nationalhealthcouncil.org/education/value-classroom/

[74] H.R. 5376, 117th Cong, Inflation Reduction Act of 2022. Public Law No. 117-169. Published August 16, 2022. Accessed June 24, 2025.https://www.congress.gov/bill/117th-congress/house-bill/5376/text.

a. Broadening the scope of patient engagement through the program

Patients' and caregivers' view of the drugs they take and the benefits they receive is essential to understanding "the full range of clinical and patient-centered outcomes,"[75] as the Patient-Centered Outcomes Research Institute (PCORI) stated in their multi-stakeholder research initiative. The centrality of direct patient input is echoed in best practices for CER and value assessment that underpin the concept that the price of pharmaceuticals should be based on the value they provide to patients, caregivers, health care systems, and society. Value encompasses the balance of benefits and costs experienced by patients and society over time.

Measures of "indirect costs" such as patient productivity, caregiver time, and treatment burden (such as travel times for repeated hospitalization) are very important to patients and their families but are often poorly captured in administrative claims databases. This misalignment between patient concerns and priorities surrounding the impact of a disease or its treatment and the outcomes data collected in research and care is well documented.[76] As stewards of the Medicare program accountable to the health of people with Medicare, CMS should include these issues throughout discussions with patients and patient groups and seek and utilize observational studies or real-world evidence that includes these outcomes.

Systematically and rigorously incorporating patient perspectives on the value of selected drugs is essential to ensure that patients have a voice in decisions that affect their health and wellbeing.[77] We are mindful of the federal prohibition on CMS's use of QALYs in coverage and reimbursement decisions. We also emphasize that direct engagement with patients identifies the measures of treatment benefit that patients and their families value and, therefore, can avoid the potentially discriminatory nature of aggregate and limited measures such as the QALY. Thus, CMS should take tangible steps to capture the patient voice with validity and fidelity, engaging with patient groups directly to understand their perspective on the value of different pharmaceuticals throughout the "negotiation" process, particularly when defining unmet need, selecting therapeutic alternatives, and determining clinical benefit.

NPC appreciates CMS's intent to improve upon the design of patient-focused listening sessions and has conducted research on the patient-focused listening sessions from IPAY 2026, focusing on the breadth of patient and stakeholder input in these sessions.[78] We believe CMS

[75] Khavjou O, Bradley C, D'Angelo S, Buell N, Giombi K, Honeycutt A. Landscape Review and Summary of Patient and Stakeholder Perspectives on Value in Health and Health Care. Patient-Centered Outcomes Research Institute (PCORI). Published August 2022. Accessed June 24, 2025. https://www.pcori.org/sites/default/files/PCORI-Landscape-Review-Summary-Patient-Stakeholder-Perspectives-Value-Health-Health-Care-August-2022.pdf.

[76] Perfetto EM, Oehrlein EM, Love TR, Schoch S, Kennedy A, Bright J. Patient-centered core impact sets: what they are and why we need them. *Patient.* 2022;15(6):619-627. doi:10.1007/s40271-022-00583-x

[77] Oortwijn W, Husereau D, Abelson J, et al. Designing and implementing deliberative processes for health technology assessment: a good practices report of a joint HTAi/ISPOR task force. *Int J Technol Assess Health Care.* 2022;38(1):e37. doi:10.1017/S0266462322000198

[78] Patterson J, Wagner TD, Salih RK, Shabazz G, Campbell J. HPR105 breadth of patient and stakeholder input in CMS's drug price negotiation program: a content analysis of the 2023 patient-focused listening sessions. *Value Health.* 2024;27(6)(Suppl):S213. doi:10.1016/j.jval.2024.03.1174.

should continue to evolve towards best practices for patient engagement[79,80] and prioritize opportunities to hear a greater amount of patient-centered evidence directly from patients and their advocates, caregivers, and providers throughout the DPNP process.

Our recommendations are below:

- **Improve transparency around how patient input would be utilized in the price determination process, communicating that impact back to patients.** Patient engagement may have been hampered by a lack of transparency surrounding how input would be used in the price determination process. As CMS considers new approaches to patient engagement for IPAY 2028, we encourage CMS to delineate the process by which clinical benefits and patient impacts would be considered and influence MFPs, and to promote transparency surrounding the patient perspective CMS gleans from these listening sessions and how it is incorporated in CMS's MFP offers for each selected drug.[81] We analyzed the patient engagement sessions from the first round of the DPNP. We found that while the Agency was able to obtain some perspective consistent with the intent of the sessions, the opportunity for patients to provide meaningful feedback on patient experience, including unmet need, drug benefits, and patient access, was hampered by the shortcomings. We found that while speakers often focused their time on patient experience and evidence, the median duration of input on patient-focused evidence about therapeutic alternatives per drug listening session was less than 15 minutes. A median of only 2.5 patients participated per session, providing CMS with a total of only seven total minutes of patient input per selected drug.[82] The duration of input received from the sessions was likely attenuated because only approximately half of the anticipated speaker slots (106 of 200) were filled. The Agency reported that it used a "process to randomly select" speakers from those who registered.[83] However, given that no session featured the full 20 anticipated speaker slots, and three sessions included fewer than 10 participants, uncertainty remains as to whether fewer than 20 speakers registered or whether the Agency selected only a subset of registered individuals. Clearly specifying the purpose of patient and stakeholder engagement as well as proving adequate time for patients and stakeholders to register for the

[79] Harrington RL, Hanna ML, Oehrlein EM, 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 Jun;23(6):677-688. doi: 10.1016/j.jval.2020.01.019

[80] National Pharmaceutical Council. 2024 Guiding Practices for Patient-Centered Value Assessment. National Pharmaceutical Council. Published January 2024. Accessed June 24, 2025. https://www.npcnow.org/sites/default/files/2024-01/2024%20Guiding%20Practices%20for%20Patient-Centered%20Value%20Assessment%20January.pdf.

[81] Patterson J, Wagner T, Salih, K, Shabazz G, Campbell, D. Breadth of Patient and Stakeholder Input in CMS's Drug Price Negotiation Program: A Content Analysis of the 2023 Patient-Focused Listening Sessions. Poster presented at: ISPOR Annual Meeting, May 5-8, 2024, Atlanta, GA. Accessed June 24, 2025. https://www.npcnow.org/sites/default/files/2024-05/Poster_ISPOR%202024%20Patient-Focused%20Listening%20Sessions%20FINAL.pdf.

[82] Patterson J, Wagner T, Salih, K, Shabazz G, Campbell, D. Breadth of Patient and Stakeholder Input in CMS's Drug Price Negotiation Program: A Content Analysis of the 2023 Patient-Focused Listening Sessions. Poster presented at: ISPOR Annual Meeting, May 5-8, 2024, Atlanta, GA. Accessed June 24, 2025. https://www.npcnow.org/sites/default/files/2024-05/Poster_ISPOR%202024%20Patient-Focused%20Listening%20Sessions%20FINAL.pdf.

[83] Centers for Medicare & Medicaid Services. Public Engagement Events. CMS.gov. Accessed June 24, 2025. https://www.cms.gov/priorities/medicare-prescription-drug-affordability/overview/medicare-drug-price-negotiation-program/public-engagement-events.

engagements, and articulating how evidence provided by participants will be used in CMS's price determination process could further strengthen the sessions.

- **Prioritize diversity and a multi-modal approach in outreach.** NPC and others have emphasized the need for CMS to prioritize diversity and a multi-modal approach in outreach at all phases of the DPNP implementation.[84,85] CMS should account for this heterogeneity in its feedback to manufacturers in addition to integrating it into the process for seeking patient input. Technological barriers to registration (e.g., requiring an email address for an online-only registration),[86] a lack of accommodations for patients with disabilities[87] or associated stigma with their disease (e.g., sexually transmitted disease, obesity), and English-only materials may have further reduced participation among patients who were older and/or members of underrepresented communities.
- **Strive to establish a partnership with patients, their families, and their advocates, including ongoing and two-way dialogue with critical stakeholders.** The patient-focused listening sessions provided an opportunity for one-sided communication rather than robust, two-way dialogue between CMS, patients, caregivers, providers, and patient advocacy organizations.[88,89] Patient engagement should communicate clear goals and strive to establish a partnership[90] with patients, their families, and their advocates, including ongoing and two-way dialogue[91] with these critical stakeholders. Future changes to the DPNP implementation process should prioritize more robust and meaningful engagement beyond time-limited, one-sided listening sessions to improve the patient-centricity of the DPNP.

VIII. CMS should develop policies that ensure that access to medicines is not impeded by the IRA.

a. Developing more rigorous formulary oversight in Medicare Part D plans

[84] 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;30(3):247-251. doi:10.18553/jmcp.2024.23278.
[85] National Health Council. Amplifying the patient voice: roundtable and recommendations on CMS patient engagement. National Health Council. Published March 2024. Accessed June 24, 2025. https://nationalhealthcouncil.org/wp-content/uploads/2025/05/Amplifying-the-Patient-Voice-Roundtable-and-Recommendations-on-CMS-Patient-Engagement-1.pdf.
[86] National Organization for Rare Diseases. NORD Recommendations: Future Medicare Drug Price Negotiation Program Patient and Provider Listening Sessions. National Organization for Rare Disorders. Published January 22, 2024. Accessed June 24, 2025. https://rarediseases.org/wp-content/uploads/2024/01/NORD-Recommendations-for-CMS-Listening-Sessions_vf.pdf.
[87] National Health Council. Amplifying the patient voice: roundtable and recommendations on CMS patient engagement. Published March 2024. Accessed June 24, 2025. https://nationalhealthcouncil.org/wp-content/uploads/2025/05/Amplifying-the-Patient-Voice-Roundtable-and-Recommendations-on-CMS-Patient-Engagement-1.pdf.
[88] Harrington RL, Hanna ML, Oehrlein EM, 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 Jun;23(6):677-688. doi: 10.1016/j.jval.2020.01.019
[89] National Pharmaceutical Council. 2024 Guiding Practices for Patient-Centered Value Assessment. National Pharmaceutical Council. Published January 2024. Accessed June 24, 2025. https://www.npcnow.org/sites/default/files/2024-01/2024%20Guiding%20Practices%20for%20Patient-Centered%20Value%20Assessment%20January.pdf.
[90] Harrington RL, Hanna ML, Oehrlein EM, 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 Jun;23(6):677-688. doi: 10.1016/j.jval.2020.01.019
[91] 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;30(3):247-251. doi:10.18553/jmcp.2024.23278. Epub 2024 Jan 30. PMID: 38289281; PMCID: PMC10906444

The IRA requires Part D plan sponsors to include on their formularies drugs for which an MFP is available. However, the perverse incentives that remain in the ecosystem could be exacerbated because the MFP process interacts with Part D redesign; more so if selected drugs are in competitive classes and may be priced below the ceiling price. This could lead to adverse tiering impacting patient copayments and/or formulary-driven switching, increased utilization management, or other reductions in beneficiary access thwarting the intent of the MFP process and undermining the competition that has made Medicare Part D a success. What a patient pays for a medicine is a function of the insurance card in their pocket. Insurers also determine whether patients must navigate barriers such as prior authorization or step therapy. Increased utilization management requirements, which are likely in response to the IRA, could reduce patient access — exactly the opposite of what the program intends to do.[92]

NPC research suggests widespread and significant reductions in beneficiary access to drugs in competitive classes in 2025, reflecting an ongoing need to monitor IRA-related changes in formulary design and the robustness of existing Part D formulary review processes in safeguarding beneficiary access. Increased plan liability may create incentives to restrict patient access, accelerating trends of increased exclusions and utilization management (UM) in Part D plans and early observations of shifts towards coinsurance cost-sharing for preferred brands in 2025.[93,94,95] Incentives to increase formulary exclusions may be highest in therapeutic classes with multiple branded prescription drugs, where plans can leverage formulary exclusion to negotiate higher rebates. Our recent study observed widespread and significant reductions in Medicare Part D beneficiary access to drugs in competitive classes in one year (2024 to 2025).[96] Among 48 drugs in nine included classes, 81.3% had a decline in coverage; 47.9% experienced a reduction in coverage for more than 2 million beneficiaries.

Specific to the DPNP, NPC remains concerned that plan sponsors may be incentivized to place selected drugs on less favorable tiers or apply utilization management to steer beneficiaries away from selected drugs if maximum fair prices (MFPs) reduce rebates while non-selected drugs in the same class retain the flexibility for higher rebates. Our past research found that among IPAY 2026 drugs, beneficiary access—including formulary coverage, access without utilization management, and favorable tier placement—was often high in 2019 and

[92] Patterson JA, Wagner TD, O'Brien JM, Campbell JD. Medicare Part D Coverage of Drugs Selected for the Drug Price Negotiation Program. *JAMA Health Forum.* 2024;5(2):e235237. doi:10.1001/jamahealthforum.2023.5237.
[93] Kyle MA, Dusetzina SB, Keating NL. Utilization management trends in Medicare Part D oncology drugs, 2010-2020. *JAMA.* 2023;330(3):278-280. doi:10.1001/jama.2023.10302.
[94] Cubanski JF. A current snapshot of the Medicare Part D prescription drug benefit. Kaiser Family Foundation. October 9, 2024. Accessed June 24, 2025. https://www.kff.org/medicare/issue-brief/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/.
[95] Joyce G, Blaylock B, Chen J, Van Nuys K. Medicare Part D plans greatly increased utilization restrictions on prescription drugs, 2011-20. *Health Aff (Millwood)*. 2024;43(3):391-397. doi.org/10.1377/hlthaff.2023.00999
[96] Patterson JA, Zheng H, Campbell JD. Impacts of the Inflation Reduction Act on 2025 formulary coverage in Medicare Part D plans. Poster presented at: ISPOR 2025, May 2025; Montréal, Quebec, Canada. *Value Health.* 2025;28(S1). Accessed June 24, 2025. https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-2025/poster-session-2/impacts-of-the-inflation-reduction-act-on-2025-formulary-coverage-in-medicare-part-d-plans

2023.[97] These findings support concerns about future access waning through increased utilization management and adverse tiering.

We are also concerned with the growing research suggesting that the multitude of changing plan dynamics and price setting could lead to increased utilization management and narrower formularies among Part D plans. In a 2024 survey of managed care professionals – representing 310 million US lives – 24% of payers said that they expect significantly narrower formularies as a result of the IRA's Part D changes. In addition, greater than one-third (42%) of payers expect greater utilization management among Part D plans.[98] This external research coupled with our team's research (described above in Section Id) demonstrate the disruptions in access to patient access of medicines in the Part D market.

CMS recently released a Health Plan Management System (HPMS) memo entitled, "CY 2026 Part D Formulary Submission Information," which provides plan sponsors with information on how CMS will monitor plans for formulary exclusions and utilization management on IPAY 2026 medicines.[99] We are concerned that CMS may not proactively release the findings of the new formulary review processes, including utilization management, step therapies, and other cost containment measures on selected drugs.

We recommend that CMS bolster its formulary review and appeals process and continue to proactively monitor utilization management tools among Part D plans to ensure that seniors have adequate access to selected medicines and be transparent with the findings of the formulary evidentiary review processes.

b. Working with community pharmacies, with stated concerns of stocking selected Part D medicines

We appreciate that the Agency will collect information about whether a dispensing entity will expect to experience a cash flow concern related to MFP. However, we are concerned that the National Community Pharmacists Association estimates that 90% of independent pharmacies may not sell drugs in the Medicare DPNP.[100] We are concerned that pharmacies, particularly independent pharmacies do not have the payment reimbursement systems or contracts they need to fill prescriptions for drugs selected for price determinations under the IRA, which will limit access to these medicines for millions of seniors. We are also concerned about the impacts of price-setting medicines on long-term care facilities, which rely on adequate

[97] Patterson JA, Wagner TD, O'Brien JM, Campbell JD. Medicare Part D Coverage of Drugs Selected for the Drug Price Negotiation Program. *JAMA Health Forum.* 2024;5(2):e235237. doi:10.1001/jamahealthforum.2023.5237.
[98] McCormick B. How Payers Expect the IRA to Financially Impact Medicare Part D Plans. *Am J Manag Care*. Published October 24, 2023. Accessed June 24, 2025. https://www.ajmc.com/view/payers-expect-the-inflation-reduction-act-to-financially-impact-medicare-part-d-plans.
[99] Centers for Medicare & Medicaid Services. CY 2026 Part D Formulary Submission Information. HPMS Memos for WK 3 April 14–18. Published April 2025. Accessed June 24, 2025. https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-3-april-14-18.
[100] National Community Pharmacists Association. Independent Pharmacies Reluctant to Stock Drugs in Medicare Negotiation Program, New Survey Shows. NCPA. Published October 15, 2024. Accessed June 24, 2025. https://ncpa.org/newsroom/news-releases/2024/10/15/independent-pharmacies-reluctant-stock-drugs-medicare-negotiation .

reimbursement to remain financially viable businesses. [101] We recommend that the Agency work alongside community pharmacies and other pharmacy dispensing entities (e.g., long-term care facilities) to determine the best mitigation strategies CMS can undertake to ensure that stocking and dispensing of selected medicines is not disrupted by cashflow concerns. We recommend that the Agency particularly partner with independent pharmacies in rural areas and pharmacy deserts, where the impacts will be felt most strongly among patients. CMS is best suited to address pharmacy cash flow concerns. Manufacturers are not health plans and cannot prefund cash to pharmacies for selected medicines. These expected challenges among pharmacies highlight the need for MFP effectuation to have a robust claims and disputes process (administered by CMS) to adjudicate MFP claims and comply with statutory guidelines.

c. Monitoring patient access to selected Part B medicines

NPC appreciates that CMS is soliciting comments on how to best monitor Medicare Advantage (MA) plans' use of Part B step therapy practices to ensure compliance with program rules and any data or policy clarifications that may be needed for implementation, given the impact of step therapy on patient access to Part B medicines.

A recent survey has shown that step therapy use in MA for Part B drugs is increasing, and that the use of step therapy places a high burden on patients and providers. [102] In this survey, 94% of providers surveyed stated that step therapy limits access to their preferred Part B treatments and 74% indicated that step therapy protocols for Part B medicines were not consistently based on established clinical guidelines, demonstrating concerns that step therapy requirements often do not align with clinical practices. Part B step therapy also impacts medicine stocking decisions for more than half of providers surveyed (56%). Moreover, patients face delays in accessing treatment due to step therapy for Part B medicines, with over 60% of providers characterizing the patient burden of step therapy as "high" or "extremely high," which adversely impacts patient care.

Differences in plans' step therapy requirements may lead to variable patient access to the same drug. For example, one study found that the frequency of step therapy protocols in Part B drug coverage varies across plans, with the frequency of application ranging from 26.1% to 63.7% across seven large MA plans.[103] We recommend that CMS proactively monitor Part B plans' use of step therapy for selected drugs to ensure that patients have adequate access to selected medicines across plans, and that patient access to these medicines does not decrease as a result of the DPNP.

[101] Senior Care Pharmacy Coalition. The Impact of Drug Price Negotiations on Seniors in Long-Term Care. Senior Care Pharmacy Coalition. Published July 2024. Accessed June 24, 2025. https://seniorcarepharmacies.org/wp-content/uploads/The-Impact-of-Drug-Price-Negotiations-on-Seniors-in-Long-Term-Care.pdf.
[102] Avalere Health Advisory. Step Therapy in Medicare Advantage: Insights from Provider Experiences. Avalere Health Advisory. Published June 4, 2025. Accessed June 24, 2025. https://advisory.avalerehealth.com/wp-content/uploads/2025/06/Step-Therapy-in-Medicare-Advantage_Insights-from-provider-experiences.pdf.
[103] Jenkins NB, Nichols DE, Enright DE, Chambers JD. Varied Use of Step Therapy Among Medicare Advantage Plans. *Am J Manag Care.* 2023;29(9):464-468. doi:10.37765/ajmc.2023.89426.

Beyond the burden of step therapy in MA and the impacts of patient access, there are also concerns around provider reimbursement for selected Part B medicines.[104] These concerns arise from the expected decrease in the ASP add-on payment for selected drugs, which may spillover to MA and commercial markets. A study shows that financial challenges could be most significant for providers who administer oncology/hematology medicines.[105] We ask CMS to closely monitor changes in prescribing behavior, increases in consolidation, and shifts in sites of care, and to work closely with providers to address these challenges through a robust provider engagement strategy.

IX. CMS should ensure flexibility of data submission to reduce the administrative burden in the renegotiation processes.

a. Reducing the administrative burden

The IPAY 2028 Draft guidance fills in some, but not all, of the details within the sparse statutory framework for renegotiation. The details on renegotiation specified burden on Primary Manufacturers while reserving all discretion for CMS. We are concerned that given the limited details on renegotiation, manufacturers will have administrative burden to complete the timeline for renegotiation. In the data collection process for IPAY 2027, CMS estimated that it would take each manufacturer 500 hours[106] to collect evidence for the ICR form. We believe that this is an underestimate. If CMS utilizes the same ICR collection form, then the data submission burden for manufacturers, patients, and other stakeholders will be compounded. We recommend that CMS set a standard that data submission for renegotiation is flexible and non-mandatory. We also recommend that primary manufacturers be able to attest whether there have been significant changes since the original ICR submission and only voluntarily submit new evidence.

We are also concerned that the administrative burden will be compounded given the lack of clarity on the renegotiation timeline. Figure 6 in the IPAY 2028 Draft Guidance provides a helpful overview of the renegotiation process, but neither Figure 6 nor the CMS Fact Sheet[107] clearly indicate the timeline for each stage or what information on CMS renegotiation decisions will be shared with Primary Manufacturers or the public prior to the selection of drugs for renegotiation, which is to be announced no later than February 1, 2026. The IPAY 2028 Draft

[104] Sullivan M, Dilmanian M, Frazier L, Krupp G, Isaiah E. Commercial Spillover Impact of Part B Negotiations on Physicians. Avalere Health Advisory. Published September 16, 2024. Accessed June 24, 2025. https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians.

[105] Sullivan M, Dilmanian M, Frazier L, Krupp G, Isaiah E. Commercial Spillover Impact of Part B Negotiations on Physicians. Avalere Health Advisory. Published September 16, 2024. Accessed June 24, 2025. https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians..

[106] 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). CMS.gov. Published July 2, 2024. Accessed June 24, 2025. https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/pra-listing/cms-10849.

[107] Centers for Medicare & Medicaid Services. Fact Sheet: Medicare Drug Price Negotiation Program Draft Guidance for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028. CMS.gov Published May 12, 2025. Accessed June 24, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance-fact-sheet.pdf.

Guidance thus does not give Primary Manufacturers sufficient detail on when they will need to voluntarily submit evidence to inform renegotiation eligibility and selection. The IPAY 2028 Draft Guidance, and the renegotiation process it describes, thus fall short of Secretary Kennedy's standard of "radical transparency."[108]

We recommend that the Final Guidance provide clear answers to the following questions to reduce administrative burden and improve transparency:

- When in "Summer 2025" will CMS issue the proposed information request on data for consideration when negotiating and renegotiating MFPs?
- When in "Late Fall 2025" will CMS issue the revised information request on data for consideration when negotiating and renegotiating MFPs?
- When in "Late 2025" will the deadline be set for manufacturers to voluntarily submit information to inform renegotiation eligibility and selection?
- Will CMS notify Primary Manufacturers that their drugs are eligible and selected for renegotiation based on a change in monopoly status? If so, when will this notification be provided?
- Will CMS notify Primary Manufacturers that their drugs are eligible for renegotiation based on new indications, including indications related to utilization in Medicare Part B for drugs previously selected based on indications related to utilization in Medicare Part D? If so, when will this notification be provided?
- Will CMS notify Primary Manufacturers that their drugs are eligible for negotiation based on material changes in section 1194(e) factors? If so, when will this notification be provided?
- Does CMS intend to include drugs selected for renegotiation in the planned public engagement opportunities, or will those be limited to newly selected drugs?

b. Prioritizing transparency

There are aspects of the Draft Guidance for IPAY 2028 which could better prioritize transparency in renegotiation. For example, CMS indicates that it will select renegotiation-eligible drugs for renegotiation based on two criteria: (1) CMS will consider the likelihood that the new indication or material change in a Section 1194(e) factor would result in a change in MFP of 15 percent or greater, (2) CMS will consider whether such a change in the MFP for the renegotiation-eligible drug would have a significant impact on the Medicare Program. We appreciate the specificity of the 15 percent threshold for "a significant change," which provides Primary Manufacturers and other stakeholders with predictability that is lacking in many other aspects of the Draft Guidance. It is unclear, however, how CMS chose the "15 percent" threshold for a change in the MFP. CMS should also clarify how it will estimate "a significant impact" on the Medicare program to trigger renegotiation. We are also concerned that CMS has not provided

[108] U.S. Department of Health and Human Services. Radical Transparency. HHS.gov. Accessed June 24, 2025. https://www.hhs.gov/radical-transparency/index.html.

significant details on the approach to assessing renegotiation over more than one negotiation cycle. To ensure that patients and other stakeholders know how to provide input into the renegotiation process, we recommend that CMS increase transparency into CMS's selection of renegotiated drugs and data that will inform the renegotiated MFPs.

Conclusion

The National Pharmaceutical Council appreciates the opportunity to submit comments in response to this Guidance and looks forward to additional opportunities to engage with CMS as it implements the third cycle of the Medicare DPNP. We appreciate CMS's focus on improving transparency of the DPNP in this round.

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

Submitted electronically to: IRARebateandNegotiation@cms.hhs.gov

June 26, 2025

Chris Klomp
Director of Medicare & Deputy Administrator, CMS
Senior Advisor to the Secretary, HHS
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Draft Guidance for IPAY 2028 and Manufacturer Effectuation of the MFP for 2026, 2027, and 2028 for the Medicare Drug Price Negotiation Program

Deputy Administrator Klomp,

The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) Draft Guidance for IPAY 2028 and Manufacturer Effectuation of the MFP for 2026, 2027, and 2028 for the Medicare Drug Price Negotiation Program.

NCPA represents America's community pharmacists, including 18,900 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care (LTC) settings. Together, our members employ 205,000 individuals, and provide an expanding set of healthcare services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers. NCPA submits these comments on behalf of both community and LTC independent pharmacies.

40.4 Providing Access to the MFP in 2026, 2027, and 2028

Payment should be paid to pharmacies within 14 days of adjudicating claim. CMS states in the draft guidance that: "If a retrospective refund is necessary to effectuate the MFP, CMS notes that the Primary Manufacturer must *transmit* (as described in section 40.4.2.1 of this draft guidance) an MFP refund amount within 14 days, as opposed to ensuring the dispensing entity has *received* the MFP reimbursement within 14 days, in order to comply with the 14-day prompt MFP payment window…" [CMS emphasis]. CMS later states that "While the 14-day prompt MFP payment window is intended to align with the timing requirements in the Part D prompt pay rules, dispensing entities should be aware that they may not receive payment from a Part D plan sponsor for the Part D claim on the same date that the Primary Manufacturer provides a retrospective MFP refund to the dispensing entity."

As it stands now, pharmacies will be waiting a minimum of 21 days, and likely longer, for the manufacturer refund payments. A time frame of 21 days is unsustainable when pharmacies have to pay their wholesalers twice every month, with some pharmacies needing to pay wholesalers every day. **Manufacturers should therefore pay pharmacies timely, within 14 days of the pharmacy adjudicating the claim with the plans/PBMs. Additionally, to facilitate timely payment, NCPA recommends daily transfers of PDE data to the MTF DM.**

CMS should require Manufacturers Adopt SDRA = WAC – MFP. CMS states that "The Primary Manufacturer may elect to use the Standard Default Refund Amount (SDRA), as appropriate, to calculate and make the retrospective MFP refund payment to dispensing entities. CMS maintains that WAC is the best option to calculate the SDRA for the MTF DM due to the support expressed by interested parties. The obligation to calculate and pay an appropriate amount to ensure the dispensing entity has access to the MFP rests with the Primary Manufacturer. A Primary Manufacturer can choose to refund an amount different than the SDRA if the Primary Manufacturer determines some other amount is appropriate and sufficient to make the MFP available."

NCPA agrees with CMS' recommendation of WAC-MFP as the SDRA. Manufacturers should use WAC to calculate the Maximum Fair Price (MFP) refund amount for pharmacies; as an equation: WAC – negotiated MFP = MFP Refund. Pharmacies need protection from manufacturers arbitrarily imposing refund amounts other than the Standard Default Refund Amount (WAC minus MFP) that do not appropriately effectuate the MFP. **NCPA believes that manufacturers should use WAC as the standardized metric, and that the WAC price should reflect the date of adjudication, not the date of the refund.**

The voluntary nature of WAC as a benchmark is especially concerning for dispensers, considering that pharmacies need to be reasonably compensated for these MFP drugs. **We advise CMS to require manufacturers to provide the MFP using the Standard Default Refund Amount and that dispensers have sufficient protections for reasonable reimbursement.**

40.4.2.1 Primary Manufacturer Participation in the MTF DM

NCPA supports CMS not requiring pharmacies to identify 340B claims. NCPA notes that in "Table 2: MTF DM Claim-Level Data Elements," the 340B Claim Indicator is a data element that is voluntarily reported by the dispensing entity, and that CMS states that "The MTF's provision of the '340B Claim Indicator' data element does not represent or imply that CMS verified the 340B status of the claim nor that dispensing entities are required to include this code on claim submissions." NCPA supports CMS policy to not require pharmacies to identify 340B claims, as CMS also stated in October 2024 *Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027*. NCPA re-emphasizes the infeasibility of pharmacies identifying those claims either proactively or retroactively. NCPA has found that the N1 transaction is not feasible as it is not adopted by pharmacy information systems. For NCPA's full comments on this matter, see our March 2023

feedback on CMS' *Medicare Part D Drug Inflation Rebates Paid by Manufacturers: Initial Memorandum, Implementation of Section 1860D-14B of Social Security Act, and Solicitation of Comments*.

MDPNP will have a chronic, not acute, negative impact on pharmacy. According to CMS:

> Based on comments received, CMS is concerned that [pharmacies' material cash flow concerns] will be most acute in the transition period when MFPs for selected drugs first become effective in January 2026 and at the start of each subsequent initial price applicability year when MFPs for new selected drugs first become effective (i.e., at the start of a price applicability period with respect to a selected drug). CMS does not anticipate this challenge to continue with respect to a selected drug once MFP refunds for that selected drug are flowing and dispensing entities become accustomed to the 14-day prompt MFP payment window.

NCPA stresses to CMS that pharmacies' carrying costs under the MDPNP will not go away and will be only exacerbated as the program is further implemented and additional selected drugs are added. Under the MDPNP, pharmacies find themselves in a continuous process where they need to pay their wholesalers before selected drug claim refunds are paid to them. Given that most MDPNP drugs are currently filled at a loss, pharmacies will never be made whole under the program. Additionally, as community pharmacies are filling additional prescriptions of these selected drugs at a potential loss from the closure of big chain drugstores, and more drugs will be coming into the MDPNP each year, cashflow issues will only be compounded. Moreover, if future MFP prices reflect even deeper discounts, such as those that could result from implementation of the President's Most Favored Nation pricing policy, the gap between acquisition cost and reimbursement could widen even further. That could amplify the cashflow impact, especially for pharmacies serving high Medicare populations.

A recent analysis by NCPA reveals that the MDPNP, as currently structured, imposes severe financial strains on pharmacies. The analysis found that pharmacies will experience payment delays of at least seven additional days for negotiated drugs, surpassing current Medicare Part D prompt pay requirements. These delays could lead to significant cash flow shortfalls, with independent pharmacies potentially losing nearly $11,000 in weekly cash flow and an average annual revenue loss of roughly $43,000.

These financial disruptions are occurring at a time when community pharmacies are already closing at an alarming rate, with over 7,000 closures in less than a decade. The consequences of these closures will be devastating for patients—especially seniors in rural communities—who depend on local pharmacies for their essential medications and healthcare services.

Furthermore, in a recent NCPA survey of independent pharmacy owners/managers, over 93% of respondents said they have already decided to not stock the drugs in the MDPNP or are considering not stocking them.

Additionally, Avalere released a study showing the impact of the MDPNP on independent pharmacies and beneficiaries alike. The study found that 34 percent of prescriptions (or 74 million prescriptions) slated for the MDPNP for 2026 or 2027 are currently filled at an independent or franchise pharmacy. Avalere defined franchise pharmacies as "independently owned pharmacies that operate under a franchisor's branding and business model within a specific region." The report found that 30 percent of Medicare Part D beneficiaries (or 12 million beneficiaries) received at least one of these prescriptions at an independent or franchise pharmacy. The study concluded that it is vital to understand impacts on dispensers and beneficiaries as manufacturers plan to submit effectuation plans under the MDPNP by September 2025.

And the MDPNP has a disproportionate effect on long-term care pharmacies. A recent study of long-term care pharmacies found that:

- 60% would be forced to close pharmacy locations,
- 91% would be forced to lay off pharmacy staff,
- 85% would be forced to limit essential services,
- 82% would be forced to shift costs to LTC customers, and
- 56% would be challenged to dispense certain medications.[1]

Pharmacies should have greater flexibility in self-identifying whether they anticipate having material cashflow concerns. In the draft guidance, CMS states that "…CMS will ask dispensing entities to self-identify whether they are a dispensing entity that anticipates having material cashflow concerns at the start of the initial price applicability year due to the reliance on retrospective MFP refunds within the 14-day prompt MFP payment window." As the cash flow of pharmacies can change dramatically from year to year, NCPA requests that CMS provide a mechanism where pharmacies can easily inform manufacturers and change their status regarding having "material cashflow concerns." That is, if in year one a pharmacy has not self-identified as having "material cashflow concerns," that pharmacy should be able to easily inform the manufacturers that it now has cash flow issues, and either in the next year, or mid-year, be able to easily change its status as now having "material cashflow concerns."

NCPA recommends that pharmacies would qualify for having material cashflow concerns if they have one or more of the following characteristics:

- **High percentage of total revenue from prescription sales;**
- **High percentage of total prescription revenue from Medicare Part D;**
- **High percentage of total prescription revenue from Medicaid;**
- **High percentage of total prescription revenue from MFP drugs; or**
- **If the pharmacy is serving a Medically Underserved Area.**

[1] See New SCPC Member Survey Shows More than Half of America's LTC Pharmacies May Close Locations Without Congressional Action. Senior Care Pharmacy Coalition. March 12, 2025.

NCPA, along with the American Society of Consultant Pharmacists (ASCP) has further provided manufacturers with Recommendations to Manufacturers to Effectuate Medicare's Maximum Fair Price (MFP) for Pharmacies with Material Cash Flow Concerns. Those full comments can be found here.[2]

Pharmacies must have protections under mitigation process. Additionally, CMS states that "Prior to the deadlines for the submission of MFP Effectuation Plans, CMS will provide Primary Manufacturers with a list of dispensing entities that have self-identified as anticipating material cashflow challenges. Primary Manufacturers *may* use this list to inform development and implementation of their mitigation processes for addressing material cashflow concerns." [NCPA emphasis]. NCPA is concerned with manufacturer discretion of granting such mitigation to dispensing entities, as it is problematic for pharmacy protections under this program.

NCPA is also concerned that manufacturers, in assessing if pharmacies have "material cashflow concerns," may send pharmacies a long list of requests or inquiries, or require an amount of information and data that is overly burdensome to provide. Consistent with our desire to not have multiple manufacturer effectuation plans, NCPA is concerned that such information requests would create a significant administrative burden. **Therefore, NCPA recommends that for pharmacies claiming material cashflow concerns, manufacturers should simply be allowed to ask these pharmacies to attest, under penalty of perjury, to having material cash flow concerns.**

Processing claims that are not clean. In the draft guidance, CMS states that

CMS intends to process claims in the following manner:

> 1. If a claim does not have any DDPS edits, the MTF DM will transmit the claim-level data elements to the Primary Manufacturer to initiate the 14-day prompt MFP payment window.
>
> 2. If a claim, through DDPS processing, cleared all of the DDPS edits that are on CMS' list of edits directly related to MFP eligibility and only has DDPS edits that are not on such CMS list, the MTF DM will transmit the claim-level data elements to the Primary Manufacturer to initiate the 14-day prompt MFP payment window because it has been verified that the selected drug of the Primary Manufacturer was dispensed to an MFP-eligible individual.
>
> 3. If a claim has DDPS edits that are on CMS' list of edits directly related to MFP-eligibility or has not yet cleared all of the DDPS edits that are on such CMS list of edits, the MTF DM will not transmit the claim-level data elements to the Primary Manufacturer because it has not been verified that the selected drug of the

[2] See Policy Document ASCP and NCPA's Recommendations to Manufacturers to Effectuate Medicare's Maximum Fair Price (MFP) for Pharmacies with Material Cash Flow Concerns. NCPA June 2025.

Primary Manufacturer was dispensed to an MFP-eligible individual. The MTF DM will monitor for resolution of these edits. If all such edits directly related to MFP-eligibility are resolved within 90 days of the rejection, then the MTF DM will transmit the claim-level data elements to the Primary Manufacturer to initiate the 14-day prompt MFP payment window. If the edits are not resolved within this timeframe, the MTF DM will notify the dispensing entity that no refund payment has been paid for the claim through a remittance. If a subsequent PDE record for the claim indicates these edits are resolved, the MTF DM will transmit the claim's data elements to the Primary Manufacturer and initiate the 14-day prompt MFP payment window. CMS is considering what role, if any, the MTF and/or Primary Manufacturers could play in notifying dispensing entities of claims that are not resolved within the time frame discussed above and requests interested parties submit comments on this issue.

NCPA is concerned about claims falling into category #3 above, in that these claims might not get resolved or will be otherwise stuck in DDPS cycles, ultimately affecting pharmacies' ability to get paid from manufacturers. In situations in which a claim has edits that have not cleared all of the DDPS edits on CMS' list of relevant edits, the pharmacy cannot be expected to advance funding for 90+ days' supply of medication nor can the pharmacy wait that long for the issue to be resolved. In these situations, the MTF DM must submit the claim within 14 days regardless and then the issue can be corrected after the fact by either (1) charging the plan back if the plan incorrectly determined that the claim was eligible or there was another procedural problem, or (2) charging the pharmacy back only if they fraudulently or inaccurately billed a claim.

40.4.2.2 Dispensing Entity Enrollment in the MTF DM

NCPA asks CMS to clarify how CMS will enforce plans/PBMs requiring dispensing entity enrollment in the MTF DM.

NCPA also believes that manufacturers have hired the same entity to process claims from the MTF DM. **NCPA asks CMS for assurances of how the data stored by this single entity will be safeguarded, especially to prevent a data breach, for example.**

40.4.3 MTF Payment Facilitation

Market-based alternatives to MTF PM. In the draft guidance, CMS states that "[p]articipation in the MTF PM will be voluntary for Primary Manufacturers, which will have the option of passing MFP refund payments to dispensing entities through the MTF PM or using their own processes outside of the MTF PM." NCPA is concerned that CMS has chosen to allow manufacturers to voluntarily effectuate the MFP via the MTF PM, which leads to greater uncertainty and potential administrative burden on independent pharmacies. NCPA believes that there is opportunity to leverage the existing market-based alternatives in the future in Medicare Part D payment generally, to transform pharmacy payment to a direct payment from manufacturers to pharmacies.

CMS or manufacturers must pre-fund the MDPNP. In the draft guidance, CMS states that

> Because the MTF PM will only pass payments between Primary Manufacturers and dispensing entities, under no circumstances will federal funds be used for these transactions or to resolve or make payment related to disputes that may arise between parties when the MTF PM is utilized, including with respect to nonpayment or insufficient payment by a particular party. Additionally, CMS will not float or issue funds to a dispensing entity on the Primary Manufacturer's behalf in anticipation of a future MFP refund payment from the Primary Manufacturer to the dispensing entity.

CMS additionally states:

> the following approaches might be pursued by interested parties to provide timely payment, potentially focused on dispensing entities that self-identify as anticipating having material cash flow concerns at the start of the initial price applicability year, and all of which could be paired with retrospective reconciliation once the Primary Manufacturer receives claim-level data elements from the MTF DM: (1) Primary Manufacturers could make prospective sales of selected drugs to dispensing entities at the MFP while leveraging virtual inventory management systems and pharmaceutical wholesaler chargebacks where applicable; (2) Primary Manufacturers could establish pre-funded MFP refund payment accounts directly with dispensing entities; and/or (3) Primary Manufacturers could leverage established relationships between dispensing entities and PSAOs to establish accounts that are pre-funded by the Primary Manufacturer for the PSAOs to use to disburse MFP refund payments to dispensing entities, with the PSAOs facilitating any necessary financial, reconciliation, and administrative services for the dispensing entity, thus minimizing the number of point of contacts for the Primary Manufacturer.

NCPA stresses that either CMS or manufacturers must float the MDPNP. NCPA recognizes that CMS has specifically stated that "Primary Manufacturers could establish pre-funded MFP refund payment accounts directly with dispensing entities." As stated in a letter that NCPA submitted to HHS' Office of General Counsel dated April 25, 2025, CMS has the authority to prefund the MTF or require the manufacturer to prefund the MTF. At the same time, CMS has no authority to require pharmacies to effectively prefund the MTF, and pharmacies should not be prefunding the MFP. The MDPNP in its current form essentially places an unfunded mandate on the pharmacy to prefund the MFP program.

No additional fees. CMS states in the draft guidance that "Separately, neither Primary Manufacturers nor dispensing entities shall be required to pay any fees to the MTF PM in connection with the pass through of MFP refund payments, including but not limited to user fees or transaction fees, as CMS intends to bear the cost of operationalizing the MTF PM." We support CMS' re-iteration that pharmacies cannot be charged any fees to participate as CMS would bear

the cost of operationalizing the MTF. **CMS must ensure that neither plans, PBMs, manufacturers, wholesalers, CMS nor any other entity be allowed to assess any fee on pharmacies to effectuate the MTF or any aspect of the MDPNP whatsoever. Pharmacies should not be required to fund any administrative functions that manufacturers engage in to provide the MFP to pharmacies, nor should pharmacies be required to provide funds for transmission or administrative functions related to the plan sponsors, or PBMs providing the PDE file or any other information to the MTF as part of the MDPN Program. NCPA believes that these guardrails should be explicitly stated in the final guidance to prevent harmful PBM practices from spreading into the MDPN program MTF process. Additionally, if manufacturers go outside the MTF-PM, pharmacies should not pay fees to access the manufacturer chosen PM. Further, any EFT fees should be borne by the manufacturer and not the pharmacy.**

40.4.3.2 Primary Manufacturer and MTF PM MFP Refund Payment Adjustments due to Claim Amendments Through the MTF PM

Credit/debit ledger system. In the draft guidance, CMS states

> For Primary Manufacturers that pass payments through the MTF PM, regardless of whether MFP refund payments are issued to dispensing entities electronically or through paper check, the MTF will maintain a credit/debit ledger system that tracks credits and debits related to MFP refunds at the dispensing entity NPI-level, for each selected drug based on information reported by the Primary Manufacturer in the claim-level payment elements. CMS has received many requests to provide clarification on how MFP refunds will be reconciled when MFP refund payment occurs for a claim that is subsequently reversed or adjusted. To address changes in MFP refund payments due to claim reversals, adjustments, or determinations that a claim is not MFP-eligible after issuance of an MFP refund payment, the MTF will maintain a credit/debit ledger system that tracks credits and debits related to MFP refunds at the dispensing entity NPI-level for each selected drug for Primary Manufacturers that participate in the MTF PM and where payment is facilitated through the MTF PM. The credit/debit ledger system will accommodate a variety of revisions to incoming PDE information, including reversals or adjustments originating from updated PDE information received from DDPS. The Primary Manufacturer is responsible for reviewing all such credit and debit amounts to confirm their accuracy.

NCPA requests that CMS clarify how the credit/debit ledger system connects back to CARC and RARC codes. NCPA requests that pharmacies know the specific claims for which pharmacies are owed credit or have a debit, and requests that pharmacies will know on their 835s if there were adjustments made by the credit/debit ledger system. NCPA does not think that existing codes are specific enough nor will they be reported in such a manner so that the pharmacy will know if there has been an adjustment on a specific claim. Otherwise, pharmacies receiving credits that are unapplied to specific claims would cause a significant administrative burden for reconciliation.

40.4.3.3 Pass Through Payment to Dispensing Entity When Primary Manufacturer Participates in the MTF PM

No additional fees. CMS states in the draft guidance that "Regardless of whether the MFP refund is passed through the MTF PM or outside of the MTF PM, neither Primary Manufacturers nor their third-party vendors shall charge dispensing entities any transaction or other fees for the pass through of the MFP refund to the dispensing entity." As stated above, we support CMS' re-iteration that pharmacies cannot be charged any fees to participate as CMS would bear the cost of operationalizing the MTF. **CMS must ensure that neither plans, PBMs, manufacturers, wholesalers, CMS nor any other entity be allowed to assess any fee on pharmacies to effectuate the MTF or any aspect of the Medicare Drug Price Negotiation Program whatsoever. Any EFT fees should be borne by the manufacturer and not the pharmacy.**

80.1 Direct Member Reimbursements and Access to the MFP for Selected Drugs in 2026, 2027, and 2028

CMS states that direct member reimbursement (DMR) requests are requests for reimbursement submitted by eligible individuals to Part D plan sponsors to be reimbursed for a claim in which the individual paid the cash price out-of-pocket for the drug at the dispensing entity and did not use Part D coverage when receiving the drug. CMS notes that DMR requests are exceedingly rare. In a recent CMS internal analysis, less than one-hundredth of a percent of final action claims submitted in 2024 for the ten drugs selected for initial price applicability year 2026 were submitted as DMR requests.

When an eligible individual submits a DMR request, the Part D benefit is not used at the point of sale, the dispensing entity does not bill the individual's Part D plan but rather charges the individual the cash price established by the dispensing entity, and the individual's status as an MFP-eligible individual is not determined until after the point of sale when the individual submits the DMR request to their Part D plan. In such cases, CMS will consider the MFP to have been made available to the dispensing entity through the cash payment by the individual and, as a result, will not require the Primary Manufacturer to pay an MFP refund to the dispensing entity in connection with a covered DMR request.

NCPA supports the above processes for DMR requests, as dispensing entities have already received cash payments from the individuals at the point of sale, at the cash prices established by the dispensing entities, and are not involved in the submission of the claim to the Part D plan or the transaction to reimburse the MFP-eligible individual.

90.2 Monitoring of Access to the MFP in 2026, 2027, and 2028

"Commercially reasonable costs." In the draft guidance, CMS states that in this section, "CMS adds clarifying language about the factors that will be considered when assessing MFP availability during case-specific monitoring and investigation activities." Such "clarifying language" includes CMS looking at whether the retrospective refund amount paid by the Primary Manufacturer is sufficient to account for **commercially reasonable costs** the dispensing entity may encounter:

> When assessing whether a Primary Manufacturer provided access to the MFP to a dispensing entity with respect to a selected drug, CMS will undertake a fact-specific assessment that will consider the following, among other factors, as applicable: whether the retrospective refund amount authorized for payment or paid by the Primary Manufacturer is sufficient to account for **commercially reasonable costs** the dispensing entity is likely to encounter in the supply chain, the invoice amount from the dispensing entity (if available), the delta between the MFP refund amount provided and the SDRA (if available), and any agreements or communications between the dispensing entity and the Primary Manufacturer regarding the availability of the MFP to the dispensing entity. [NCPA emphasis]

NCPA welcomes that CMS recognizes manufacturers' role in accounting for dispensers' "commercially reasonable costs." NCPA asks CMS for clarity if "commercially reasonable costs" pertain to costs associated with obtaining medications, costs associated with dispensing medications, or both. Pharmacies should not be expected to dispense MFP medications below their full and complete cost to acquire and dispense. NCPA worked with the American Society of Consultant Pharmacists (ASCP) to provide manufacturers with Recommendations to Manufacturers to Effectuate Medicare's Maximum Fair Price (MFP) for Pharmacies with Material Cash Flow Concerns. Those full comments can be found here.[3]

90.2.1 Manufacturer Plans for Effectuating MFP

Harmonize manufacturer due dates for effectuation plans to June 1. According to the CMS draft guidance:

> Starting with initial price applicability year 2027, CMS will split the MFP Effectuation Plan into two sections, with the Primary Manufacturer's election whether or not to use the MTF PM, the Primary Manufacturer's communication plan, the Primary Manufacturer's approach to dispensing entities who indicate they anticipate having material cashflow concerns at the start of the initial price applicability year, and information about the Primary Manufacturer's plan if they do not intend to use the MTF PM, required to be submitted via the MTF DM by June 1 of the calendar year before the MFP goes into effect, and the remainder of the information in the MFP Effectuation Plan due September 1 of the calendar year before the MFP goes into effect.

NCPA advocates that CMS should require all the above information of the MFP Effectuation Plans be due on June 1, 2026, to give pharmacies enough time to review that information and the basis for reimbursement from manufacturers. This information should include pharmacies knowing whether manufacturers are using the SDRA, or not, and what that amount either way is.

[3] See Policy Document ASCP and NCPA's Recommendations to Manufacturers to Effectuate Medicare's Maximum Fair Price (MFP) for Pharmacies with Material Cash Flow Concerns. NCPA June 2025.

90.2.2 Centralized Intake System for Complaints and Disputes Related to MFP Availability and MTF Functionality

Dispute resolution. As disputes will arise, NCPA recommends that manufacturers and dispensers submit any disputes using the specific X12 835 claim number. We appreciate CMS adding to its revised version of Appendix D the "MTF Internal Claim Number(s) or Reference ID(s) on X12 835" with an optional text field to Question 3: Selected Drug & Claim Information as information that can be provided if known. To facilitate continued pharmacy operation and access to medications by patients, we recommend that manufacturers do not interrupt payments to pharmacies during a dispute and that all claims be paid as the credit/debit ledger exists as a mechanism for manufacturers to recoup any over or incorrect payments.

To ensure disputes are rapidly addressed, we believe manufacturers and pharmacies should agree to binding arbitration if they are unable or unwilling to resolve the dispute within 30 days on the initial complaint by one party. Finally, we recommend that both parties identify a singular point of contact for all disputes.

NCPA thanks CMS for the opportunity to provide feedback, and we stand ready to work with the agency to offer possible solutions and ideas. Please let us know how we can assist further, and should you have any questions or concerns, please feel free to contact me at steve.postal@ncpa.org or (703) 600-1178.

Sincerely,

Steve Postal, JD
Senior Director, Policy & Regulatory Affairs
National Community Pharmacists Association

NOVARTIS

June 26, 2025

Chris Klomp
CMS Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington DC 20201

BY ELECTRONIC DELIVERY to *IRARebateandNegotiation@cms.hhs.gov*

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp:

Novartis Services, Inc. submits this letter on behalf of Novartis Pharmaceuticals Corporation and its affiliates, referred to collectively herein as "Novartis." We appreciate the opportunity to comment on the draft guidance regarding the Medicare Drug Price Negotiation Program ("DPNP") for Initial Price Applicability Year ("IPAY") 2028 and Manufacturer Effectuation of the Maximum Fair Price ("MFP") in 2026, 2027, and 2028 issued by the Centers for Medicare & Medicaid Services ("CMS") on May 12, 2025 (the "Draft Guidance").[1]

Novartis discovers and develops innovative medicines that address the evolving needs of patients and societies worldwide. We are concentrated on the core therapeutic areas of cardiology, immunology, neurology, and oncology. Through innovative science and technology, we address some of society's most challenging health care issues. We work to discover and develop breakthrough treatments and find new ways to deliver them to as many people who would benefit from them as possible. At Novartis, we are united by a single purpose: to reimagine medicine to improve and extend people's lives.

Novartis remains very concerned that the DPNP, as prescribed by the Inflation Reduction Act of 2022 ("IRA"), will have profoundly detrimental effects on the development of innovative medicines in the U.S.[2] The program is not a true negotiation, akin to the market-based negotiations that occur under Medicare Part D today, but rather is a blunt price-setting tool arbitrarily applied to innovative medicines after a certain number of years on the market. The far-reaching consequences of the IRA go well beyond impacts on the Medicare program and risk threatening the innovation ecosystem that has brought life-changing medicines to the U.S. market. By establishing arbitrary price caps, the IRA discourages the research and development ("R&D") that plays a large role in driving progress in fighting diseases. These disincentives are already impacting the research and investment decisions that determine which medicines are brought to market for patients.

Overview of Novartis' Comments

We recognize that the statute directs CMS to implement the DPNP. However, given the complexity of this program, its size and scope, and the significant consequences across the multitude of stakeholders in the

[1] CMS, Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 (May 12, 2025), *available at* https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

[2] Novartis believes that relevant aspects of the IRA are unlawful and by making this submission does not waive its rights with regard to any current or future legal challenges to the statute or guidance.

prescription drug supply chain and the patients they serve, it is critical that CMS prioritize transparency and make improvements to the program that will avoid further exacerbating the negative effects the law is already having on future innovation and access to medicines in the U.S. CMS must also support a smooth "maximum fair price" ("MFP") effectuation process starting in 2026 to ensure access to medicines subject to an MFP is not disrupted.

Novartis' recommendations focus on our core concerns with the DPNP and seek meaningful policy changes to protect innovation, ensure patients have broad access to selected drugs, construct robust safeguards to avoid diversion and duplicate discounts, and improve the process to facilitate access to the MFP as required under the law.

In addition to comments Novartis has submitted to CMS in previous IPAY years, our recommendations specific to the IPAY 2028 guidance include but are not limited to:

- CMS should not finalize its proposed approach to fixed combination products that include an ingredient CMS has determined is not "biologically active" against the disease when determining products that would qualify as a unique qualified single source drug ("QSSD")
- For selected Part B drugs, CMS should calculate the ceiling per unit rather than converting Part B units to a 30-day equivalent supply using a "days in between" approach to determine the ceiling price
- CMS should streamline and simplify data collection and reporting for manufacturers of selected drugs
- CMS should consider only clinically comparable therapeutic alternative(s) as comparators and provide companies with the selected therapeutic alternative(s) in advance of the manufacturer data submission
- CMS should articulate specific criteria for identifying and selecting renegotiation-eligible drugs and permit manufacturers to submit data from the original submission noting any material changes for renegotiation

With respect to effectuating the MFP:

- CMS should expedite the technology build for the Medicare Transaction Facilitator ("MTF"), MTF Data Module ("DM"), and MTF Payment Module ("PM") to ensure manufacturers have adequate time for system development, testing, and integration by January 1
- CMS should take a greater role in identifying 340B claims to assist manufacturers in preventing duplicate discounts, including allowing manufacturers to implement a 340B cash-rebate model and, in Part B, requiring the MTF to share whether a 340B Claims Modifier Field ("TB" modifier) was used on each Part B claim
- CMS should implement a safe harbor from Civil Monetary Penalties ("CMPs") in cases where the MTF is nonfunctional and manufacturers are unable to meet their MFP obligation for reasons outside of their control
- CMS should clarify that it does not intend for large dispensing retailers to self-identify as anticipating material cash flow concerns
- On Part B MFP effectuation, CMS should continue to work with stakeholders to better understand the unique challenges to operationalizing an MFP in Part B vs. Part D and should explicitly exclude the MFP from average sales price ("ASP") calculations

I. Drug Selection

CMS should identify distinct QSSDs based on distinct New Drug Applications ("NDAs") or Biologics License Applications ("BLAs") instead of active moiety or active ingredient, regardless of whether there is a common NDA or BLA holder.

As consistently noted in our prior comments, CMS's approach to identifying a QSSD by reference to a common active moiety or common active ingredient, without regard to whether the product(s) containing that active moiety or active ingredient are approved under a separate marketing application, cannot be reconciled with the plain language of the IRA. Further, this approach undermines patient access to innovative new medicines.

Under section 1192, only QSSDs are eligible for selection for the DPNP. Subject to certain exclusions, QSSDs are drugs or biologics for which there is no generic or biosimilar marketed and for which a statutorily prescribed time period has elapsed since approval or licensure. For drugs, "at least 7 years [must] have elapsed since the date of . . . approval" as of the selected drug publication date.[3] And, for biologics, "at least 11 years [must] have elapsed since the date of . . . licensure" as of the selected drug publication date.[4] By referencing each "approval" or "licensure" of a product in the QSSD definition, Congress made clear that it intended for each QSSD to correspond to a distinct approval or licensure—that is, a distinct NDA or BLA.

Congress's intent that a QSSD be identified by its distinct NDA or BLA is further evidenced through the statute's specific incorporation of the term "covered part D drug," as defined by the Medicaid statute, into the statutory QSSD definition. The definition of a "covered Part D drug," cross-references the definition of a "covered outpatient drug" in the Medicaid Drug Rebate Program ("MDRP") statute, which is defined in relevant part as a product that is approved pursuant to a distinct NDA or BLA. Novartis recognizes the exception to this rule under the MDRP with respect to line extensions but emphasizes that Congress specifically enabled CMS to group line extensions with innovator products across distinct NDAs or BLAs via a statutory amendment to the MDRP statute. Had Congress intended for CMS to group drugs across distinct NDAs or BLAs under the DPNP, Congress would have made this intent clear through an express statutory direction, as it did in the MDRP statute and other cases.[5]

The FDA's statutory framework for approving drugs and biologics likewise distinguishes between distinct marketing applications and supplements. The FDA specifies the types of changes to an approved product that should be submitted via a supplement, and which changes require a new NDA or BLA. Congress's grounding of the QSSD definition in the FDA's framework for approving and licensing drugs and biologics provides further evidence that Congress intended that CMS rely on such framework in distinguishing among QSSDs.

Under this statute, a distinct NDA or BLA is the central component of identifying and selecting a QSSD. Any other reading, including CMS's interpretation based on common active moiety or common active ingredient, flatly contradicts the statute's plain language. The period of time after approval or licensure, during which drugs and biologics are not eligible for selection, preserves the incentive for manufacturers to invest in researching and developing next-generation treatments for the benefit of patients, whereas CMS's policy disincentivizes investing in next-generation products.

For these reasons, Novartis urges CMS to change its approach to identifying QSSDs by instead focusing on whether the drug or biologic is marketed under a distinct NDA or BLA, consistent with the statute.

CMS should not finalize its proposed approach to fixed combination products that include ingredients CMS has determined are not "biologically active" against the disease.

CMS seeks feedback on how it might group fixed combination drug products with products containing at least one but not all of the active moiety(ies) / active ingredient(s) into the same potential QSSD. CMS proposes to group fixed combination drugs with a single ingredient product based on its determination that an active ingredient is not "biologically active" against the indicated disease or "therapeutically active" and "thus does not result in a clinically meaningful difference," without defining any of these terms.[6] This proposal marks a notable change from CMS's approach for IPAY 2026 and 2027. For previous IPAYs, CMS has treated all fixed combination drugs as distinct from single ingredient products containing a common active moiety or ingredient for selection purposes and stated that "[a] product containing only one (but not all) of the active moieties / active ingredients that is offered by the same NDA / BLA holder

[3] Social Security Act ("SSA") § 1192(e)(1)(A)(ii).
[4] *Id.* § 1192(e)(1)(B)(ii).
[5] Notably, Congress did so as to another provision of the IRA: The Part D inflation rebate provision specifically directs CMS to establish an inflation rebate formula for line extensions consistent with the formula under the MDRP. *See id.* § 1860D-14B(b)(5)(B).
[6] CMS, Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028, at 9–18 (May 12, 2025) [hereinafter "IPAY 2028 Draft Guidance"], *available at* https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

will not be aggregated with the formulations of the fixed combination drug and will be considered a separate potential [QSSD]."[7]

The proposal to aggregate across distinct NDAs or BLAs for a distinct combination of active ingredients or active moieties cannot be reconciled with the statute.[8] Setting aside that concern for the purpose of providing the requested feedback, Novartis believes CMS's proposed policy on fixed combination drugs cannot be reconciled with the agency's reliance on an "active moiety" or "active ingredient" standard for identifying a QSSD. Simply put, if CMS wants to rely on an "*active* moiety" or "*active* ingredient" standard for defining a QSSD, it is relying on the FDA's assignment of that status to a given molecule. Indeed, CMS looks to FDA databases and the FDA itself to identify the active moiety or active ingredient in a drug.[9] It would be arbitrary for the agency to then disregard that designation only in relation to fixed combination drugs, based on extra-statutory and undefined standards for what qualifies as "active" and ignore FDA's science-based determinations of how such active ingredients in combination with others work to deliver a safe and effective treatment.

The FDA identifies what qualifies as an "*active* moiety" or "*active* ingredient." The FDA's framework also draws a clear distinction between fixed combination drugs and their single ingredient product counterparts, precisely because of their differences in active ingredients. Among other things, the FDA directs sponsors to submit a new NDA or BLA for a new combination of active ingredients, their regulations assign a new initial U.S. approval date for a new combination of active ingredients and such products are marketed under separate labeling from their monocomponents.[10]

CMS's proposed approach has no basis in the text of the IRA or in the FDA's framework. The FDA does not distinguish between fixed combination drugs or active ingredients contained therein based on their *role* in the FDA-approved or licensed drug product, as CMS now proposes. The FDA's fixed combination drug regulations ensure that each component in an approved combination drug product contributes to its therapeutic effect, either by "mak[ing] a contribution to the claimed effect" or "enhance[ing] the safety or effectiveness of the principal component."[11] As the FDA interprets the term "component" in its regulation to refer to an active ingredient, a drug product deemed by the FDA to be a fixed combination drug has been determined to contain two or more *active* ingredients.[12] And, as "active ingredient" refers to "any component that is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body of man or other animals," CMS's position that a molecule approved as an *active* ingredient by the FDA does not contribute a "clinically meaningful effect" because, by itself, it does not directly act on the disease, flatly contradicts the FDA's approach to fixed combination drugs and active ingredients.[13] CMS has anchored its current expansive QSSD policy in the FDA's regulatory framework, and it cannot reasonably justify creating a new QSSD standard for fixed combination drugs that is incongruous with that same agency's regulations.

CMS's undefined standards for what qualifies as "active" are incompatible with science. In the example CMS uses in the Draft Guidance, a drug that increases bioavailability would enhance the effectiveness of the other active ingredient (e.g., by increasing the amount of active ingredient available in the body to act

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[7] CMS, Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027, at 166–74 (Oct. 2, 2024) [hereinafter "IPAY 2027 Final Guidance"], *available at* https://www.cms.gov/files/document/medicare-drug-price-negotiation-final-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf; CMS, Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026, at 98–104 (Jun. 30, 2023) [hereinafter "IPAY 2026 Revised Guidance"], *available at* https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf; *see also* IPAY 2028 Draft Guidance at 9–18.

[8] Notably, CMS's argument that the statute directs it to aggregate across dosage forms and strengths of a product supports its approach to identifying QSSDs based on active moiety or active ingredient cannot justify its new approach on fixed combination drugs. The statute cannot be construed as directing CMS to aggregate fixed combination drugs with a single ingredient product; the only argument analogous to that for aggregating across dosage forms and strengths requires CMS to argue that an active ingredient in a fixed combination drug approved by the FDA as safe and effective is not actually "biologically active" or "therapeutically active."

[9] *See* IPAY 2028 Draft Guidance at 12.

[10] Guidance for Industry, Submitting Separate Marketing Applications and Clinical Data for Purposes of Assessing User Fees 3 (Jan. 2005), *available at* https://www.fda.gov/media/72397/download; 21 C.F.R. § 201.57(a)(3).

[11] 21 C.F.R. § 300.50.

[12] 80 Fed. Reg. 79,776, 79,779 (Dec. 23, 2015).

[13] 21 C.F.R. § 210.3(b)(7).

on the target disease) or safety of the product (e.g., by reducing the amount of active ingredient required to achieve the same effect), resulting in a clinically meaningful effect. Accordingly, CMS's proposed approach incorrectly equates direct action on the indicated disease with a clinically meaningful benefit to patients.

Further, from an operational perspective, CMS's proposal neglects to fully consider the scenario where a fixed combination product contains three or more active ingredients and one or more active ingredient(s) is deemed not "active" enough under the agency's proposed standard. Grouping such a fixed combination drug with a product containing at least one common active moiety or active ingredient strays further from CMS's current approach to QSSDs.

Finally, this proposed approach, like CMS's approach to identifying QSSDs based on active moiety or active ingredient, disincentivizes pharmaceutical and biotechnology innovation to the detriment of patients. Based on its regulation, the FDA generally requires the sponsor to provide clinical data demonstrating that each of the components contributes to the therapeutic effect. Typically, at a minimum, this requires a comparison of A alone to A+B, if B alone does not have a direct effect on the disease. CMS's policy thus serves to discourage sponsors from investing in developing innovative new combinations that require costly clinical trials to support approval.

CMS should clarify that the 7- or 11- year period before a drug can be subject to negotiation begins upon the loss of the orphan drug exclusion rather than the approval of the drug's first orphan indication.

In constructing the IRA, Congress took an important and intentional step to continue to foster robust clinical research in rare diseases, which often face challenges in limited research funding, specialized clinical expertise, and fewer treatment options. The statute excludes from the definition of QSSD a drug that is "designated as [an orphan drug] for only one rare disease or condition . . . and for which the only approved indication (or indications) is for such disease or condition."[14] This exclusion is aligned with Congress's long-standing recognition of the government's deep interest in facilitating the development of orphan drugs to meet needs that would otherwise go unmet, including through the Orphan Drug Act ("ODA").[15] The ODA spurred the development of treatments in numerous rare diseases after its passage in 1983, demonstrating the strong correlation between clinical advancements and incentives in orphan drug development.[16]

Unfortunately, CMS has narrowly interpreted the statute with respect to the negotiation "clock" for a selected drug that has lost its orphan drug exclusion. Even where a drug previously qualified for an orphan drug exclusion, CMS erroneously anchors the selection timeline for the DPNP to "the date of earliest approval" of the drug or biological product, rather than at the time the drug loses the exclusion. CMS's interpretation of the statute takes a narrow view of the terms "date of such approval" or "date of such licensure, treating them as referring to the drug's initial approval. Under this interpretation, the 7- or 11- year exclusivity period would be considered to have started retroactively from that first approval date, even if the drug was initially protected by the orphan drug exclusion. As a result, the orphan drug exclusion would not be implemented consistent with Congressional intent, since the eligibility clock would have been running during the time the drug was supposed to be exempt.

This reading also limits the incentive for manufacturers to initially invest in small patient populations or to pursue approval for a second or subsequent orphan designation. Biopharmaceutical manufacturers commonly seek orphan designations and related indications sequentially as new clinical evidence is developed. Prior to the IRA, companies were incentivized to bring innovation to patients as quickly as possible. The flawed interpretation of the orphan exclusion has created disincentives for companies to pursue orphan indications early in a product's lifecycle when there may be a long lag time to a second orphan designation. CMS's determination that the IRA eligibility clock begins with the first approval, even in cases where a medicine has an orphan designation at approval, will have profound effects on the development of orphan drugs and devastating consequences for rare disease patients without a current

[14] SSA § 1192(e)(3)(A).
[15] ODA, Pub. L. No. 97-414, §§ 1, 2, 96 Stat. 2049, 2049-2051 (1983), as amended by Pub. L. 98-551, 98 Stat. 2815, 2817 (1984).
[16] National Pharmaceutical Council. "Continuing Innovation for Rare Conditions Under the Orphan Drug Act," April 2024. *Available at* https://www.npcnow.org/resources/continuing-innovation-rare-conditions-under-orphan-drug-act.

treatment option. A recent analysis found that following IRA enactment, there was a 48% decline in the percentage of drugs with an initial orphan designation that subsequently received a second designation, dropping from 12.1% pre-IRA to 6.3% post-IRA. These numbers suggest the IRA is already having an impact on rare disease development.[17]

CMS should clarify that a drug's eligibility timeline for the DPNP begins when the drug loses the orphan drug exclusion rather than an initial approval. This is the best reading of the underlying statutory framework and most closely aligns with Congress' goal with the orphan drug exclusion construct – to continue to promote drug development and access to new treatments for patients with rare diseases.

II. Establishing the MFP

CMS should negotiate the single MFP, subject to a single MFP ceiling, for Part B drugs on a per-unit basis.

Consistent with CMS's approach for IPAY 2026 and 2027, CMS proposes to calculate a single MFP ceiling across the different dosage forms and strengths of a selected drug.[18] For the previous IPAYS, CMS had calculated a single ceiling across the different dosage forms and strengths of a selected drug on a 30-day equivalent supply basis, used under Part D to determine the typical amount of a drug dispensed to patients each month.[19] As CMS was only concerned with making MFPs available for drugs under Part D for the first two IPAYs, and not Part B, this approach was reasonable.[20] For IPAY 2028, however, CMS will, for the first time, be directing manufacturers to give access to the MFP under both Part B and Part D.[21] As a result, CMS seeks feedback on whether it should consider an alternative approach to calculating the single MFP ceiling.[22] Novartis strongly encourages CMS to calculate the single ceiling and negotiate the single MFP at the Part B billing and payment code unit level, instead of the 30-day equivalent supply level; negotiate a single MFP under that ceiling; and subsequently convert that MFP to a payment rate under both Part B and Part D.[23] Calculating the single ceiling on the 30-day equivalent supply level may be appropriate for Part D drugs but does not work in the context of Part B drugs, where the standard unit of measure is the billing and payment code.

CMS's proposed approach to converting Part B data to the 30-day equivalent supply is unworkable and ignores key differences between Part B and Part D negotiation-eligible drugs. The 30-day equivalent supply calculation is currently calculated for Part D drugs such that "[i]f the days' supply reported on a PDE is less than or equal to 34, the number of 30-day equivalent supplies equals one."[24] Moreover, "[i]f the days' supply reported on a PDE is greater than 34, the number of 30-day equivalent supplies is equal to the number of days' supply reported on each PDE divided by 30."[25] For a Part B negotiation-eligible drug, CMS's proposal would convert the dose to a 30-day equivalent supply using the following proposed methodology:

- First, CMS would measure the "days between service" for a Part B-administered drug, defined as "the days between the first Part B claim's date of service and the immediately subsequent Part B claim or PDE record's date of service."[26]
- Second, CMS would calculate the 30-day equivalent supply by determining whether "days between service" is more or less than 34 (the same methodology CMS uses to convert the days' supply to the 30-day equivalent supply as referenced above).[27]

The proposed approach is not consistent with how Part B physician-administered drugs are dosed. "Days supply" under Part D measures the number of days of drug dispensed, where a patient may be taking

[17] National Pharmaceutical Council. "Early Signals of the IRA on Orphan Drugs," May 2025. *Available at:* https://www.npcnow.org/resources/early-signals-ira-orphan-drugs.
[18] *Id.* at 108-09.
[19] 42 C.F.R. § 423.104(d)(2)(iv)(A)(2).
[20] IPAY 2028 Draft Guidance at 159.
[21] *Id.* at 109.
[22] *Id.*
[23] *Id.*
[24] 42 C.F.R. § 423.104(d)(2)(iv)(A)(2).
[25] *Id.*
[26] IPAY 2028 Draft Guidance at 113.
[27] *See id.*

multiple doses per day. “Days between service” under Part B measures the period between doses of the drug, which may be days at a time. Moreover, a patient may receive a higher dose at the outset of treatment to generate a therapeutic response before lowering the dose for the duration of the therapy, fluctuations in weight may necessitate changes in weight-based dosing, or dosing may be titrated up or down by the physician to account for the particular patient’s clinical profile.

Given these distinctions, Novartis urges CMS to revise its approach to calculate the single MFP at the Part B unit level. Where there is Part D utilization of the same drug, CMS could convert Part D data to the unit level under Part B. CMS could then apply the single MFP negotiated under the single MFP ceiling to the relevant Part B and Part D payment units. In addition, to allow stakeholders time to review and comment on this methodology, Novartis requests that CMS publish it in full for comment by September 2025; this will allow stakeholders time to provide feedback before drugs are selected for IPAY 2028.

CMS should streamline and simplify data collection and reporting requirements for manufacturers of selected drugs.

We appreciate CMS’s interest in the Draft Guidance in streamlining the reporting of manufacturer-specific data elements, in particular the proposed consolidation of R&D costs in the upcoming Information Collection Request (“ICR”) and removal of acquisition costs in the context of R&D reporting. However, we remain concerned that the manufacturer reporting burden is significant and urge the agency to further streamline and simplify the data submission elements of the ICR, particularly the manufacturer-specific data elements.

CMS requires companies to submit a substantial amount of data, spanning decades of research and development, to capture manufacturers’ investment on a selected drug. If CMS’s primary objective is to determine if a manufacturer has recouped their costs on a selected product, we recommend CMS adopt a simplified “yes/no” checkbox in which manufacturers can attest to having recouped their R&D investment. Manufacturers that attest they have recouped their costs on a selected drug would not need to submit further information, whereas those that report they have not recouped their costs could be required to provide supplemental information. At a minimum, CMS should provide greater clarity on how collected data are used in establishing the MFP.

CMS should consider only clinically comparable therapeutic alternatives as comparators and improve transparency around comparator criteria and selection to enable a more robust and meaningful exchange with manufacturers.

As Novartis has urged in prior comments, CMS should clarify the processes and criteria used for the selection of therapeutic alternatives under sections 50.2 and 60.3, so that such criteria and processes are based solely on the scientific consensus around which products are truly therapeutically comparable in both clinical effectiveness and patient treatment burden. This will help to ensure that patients’ access to needed medications is driven by clinical considerations and not solely on cost differences between medications that are not clinically comparable. Moreover, patients with the same condition do not all benefit equally from a given treatment due to their varied needs. By mischaracterizing different drugs as therapeutic alternatives despite meaningful differences, CMS’s approach threatens to limit patients’ access to medications that meet their unique needs, a consideration expressly included in the IRA as a negotiation factor to be considered by CMS,[28] and to stifle the development of diverse treatment options.

Specifically, proposed therapeutic alternatives should have comparable real-world patient use to that of the comparator product. CMS should also consider whether a therapeutic alternative is a standard of care as defined by clinical guidelines and invite input from a broad range of stakeholders – including manufacturers, clinicians, and guideline authors – on the clinical appropriateness of proposed alternatives. These considerations are highly relevant to ensuring that the therapeutic alternatives that serve as comparators for purposes of the MFP negotiation are truly appropriate for price-setting purposes and reflect real-world clinical practice.

[28] *See* SSA § 1194(e)(2)(C) (providing for CMS to consider “the effects of [a selected] drug and therapeutic alternatives to such drug *on specific populations*” (emphasis added)).

In addition, the processes should include providing the manufacturer of the selected drug a written justification of the therapeutic alternatives that CMS proposes to select, including an explanation of the criteria used to develop such proposal and affording the manufacturer a meaningful opportunity to comment on the proposal. This should occur *prior* to the manufacturer data submission and public engagement events in order for manufacturers and other stakeholders to be best positioned to submit relevant data, provide informed feedback, and allow CMS time to reconsider its selected alternative(s).

CMS should not consider Coverage Gap Discount Program ("CGDP")/Manufacturer Discount Program ("MDP)" payments or previously negotiated MFPs when determining the prices of therapeutic alternatives for purposes of developing the starting point for an initial offer or other MFP-setting purposes.

CMS should reverse its proposal to consider CGDP/MDP discounts and MFPs, if applicable, when considering the prices of therapeutic alternatives as the starting point for the initial offer of a selected drug, where it determines that a therapeutic alternative is available.[29] CMS indicates that it intends to use the lower of (1) the negotiated price under Part D, net of CGDP/MDP discounts, or (2) the MFP for selected drugs negotiated for a prior IPAY, as the starting point.[30]

Congress was clear that selected drugs should not be subject to both the MFP and the discount that manufacturers offer on the negotiated price under Part D; the statute expressly excludes selected drugs from the MDP, which succeeded the CGDP in 2025, before any MFP is in effect under the DPNP in 2026.[31] To use the price of a therapeutic alternative net of the CGDP/MDP discount as a starting point for negotiations would be a backdoor way to subject a selected drug to both the MFP and the discount manufacturers offer on the Part D negotiated price, contrary to Congress's express intent.[32] Using the price of therapeutic alternatives, net of CGDP/MDP discounts, is an impermissible attempt to lower the MFP, and it is inconsistent with the statute.

We also ask CMS to reconsider using the MFP of a therapeutic alternative previously or concurrently selected for negotiation as the basis for an initial offer.[33] As with the CGDP/MDP, the MFP is not a price negotiated under market conditions. Instead, it is subject to a cap that results from a statutorily prescribed process, compliance with which is done at risk of significant CMPs and excise taxes. Moreover, if the MFP for a therapeutic alternative to a selected drug is already published and available, that MFP will have already exerted downward pressure on the pricing of the newly selected drug, with such pricing reported to CMS through the manufacturer data submission process, given that the newly selected drug will have had to compete with the MFP of the therapeutic alternative on the market. For these reasons, Novartis is concerned that the MFP of a therapeutic alternative is an inappropriate starting point for negotiations.

III. Negotiation Process

CMS should implement a consistent, transparent process to weighting factors in the MFP setting process, including more clarity on the role health economics and outcomes research (HEOR) data plays in establishing the MFP.

While the initial written offer from CMS provided some visibility into what factors influenced the initial MFP price offer during the IPAY 2026 process, CMS has opportunities to improve transparency into what factors drive price offers for selected drugs. Specifically, CMS should implement a rubric that is consistent across all selected products and provides clarity on CMS's weighting of factors for a selected product such as clinical value, clinical cost-offsets, extension of life, and therapeutic differentiation. CMS should also weight indications relative to patient utilization data in establishing an MFP for a selected drug. For example, if a given indication is only a small percentage of a selected drug's overall patient utilization, CMS should weight that indication accordingly with respect to how much that indication drives the MFP.

[29] *See* IPAY 2028 Draft Guidance at 129–32.
[30] *Id.* at 130.
[31] SSA § 1860D-14C(g)(2)(B).
[32] *See United States v. Jackson*, 143 F. 783, 786 (9th Cir. 1906) ("Courts should search out and follow the true intent of Congress and adopt 'the sense of the words which harmonizes best with the context, and promotes in the fullest manner the apparent policy and object of the legislation.").
[33] *See* IPAY 2028 Draft Guidance at 129–32.

Further, CMS provides very little clarity on the role HEOR data plays in its determination of the MFP for selected drugs. CMS should provide more specifics on the type of HEOR data that would make a meaningful difference in the establishment of an MFP, including clarity on how the agency values extending life, preventing death, or lowering the likelihood of future healthcare utilization in order to ensure appropriate evaluation of life saving medicines. Establishing a predictable framework for how CMS quantifies the value of HEOR data would help manufacturers develop appropriate evidence for the MFP process.

CMS should continue to refine the patient and caregiver engagement events so that they are structured to collect meaningful feedback.

We appreciate CMS's improvements to public engagement for IPAY 2026, particularly enabling discussion at patient-focused roundtables and hosting provider town halls. Patient and provider input is essential to helping CMS understand the real-world impact of selected drugs before making access decisions. To strengthen this process, we urge CMS to provide transparency into its process for selecting speakers for roundtable events to ensure that participants reflect a broad range of experiences, demographics, and perspectives. We also ask CMS to provide greater transparency and visibility into how patient and provider feedback is being used in actual drug reviews by incorporating this feedback into MFP explanations – an important step to encouraging continued engagement.

IV. Effectuation of MFP in 2026, 2027, and 2028

CMS should expedite its technology build for the Medicare Transaction Facilitator (MTF) Data Module (DM) and Payment Module (PM) and provide more clarity on the credit/debit leger system.

We appreciate CMS's continued progress on the technology build for the MTF components. However, several critical questions remain unresolved that are essential to achieving our shared goal of operationalizing the MFP by the January 1, 2026 "go live" date. Manufacturers urgently need clarity on operational requirements to build, test, and implement the necessary systems. We are particularly concerned about the limited visibility manufacturers currently have into the capabilities of the MTF PM, which is essential for receiving the payment data required to effectuate the MFP.

To support successful development and system integration, we urge CMS to share comprehensive, end-to-end technical specifications with manufacturers as soon as possible—ideally in advance of the September 1, 2025 deadline for submitting MFP effectuation plans. We are concerned that the adoption of any new technical requirements not currently accounted for in our technology build would present significant challenges to implementation and testing by the "go live" date. Additionally, delays in testing reduce the window manufacturers have to adapt and implement alternative solutions should the MTF not work properly or prove unviable. To support systems readiness, we strongly encourage CMS to provide prompt and clear visibility into the testing timelines for systems developed under the MTF DM and MTF PM. Early access to testing environments is critical for manufacturers to develop robust MFP effectuation plans and ensure smooth operationalization.

We also have significant concerns with the limited insight that manufacturers have into the design and functionality of the MTF's credit/debit ledger system. We urgently request detailed clarification on the credit/debit ledger capabilities, as these elements directly impact manufacturer payments and financial reconciliation. This clarity will be especially important for the Part B effectuation process, given the volume of Medicare providers and anticipated complexity. Similarly, we remain concerned about the lack of specificity and defined timelines for the complaints and disputes process and ask that CMS provide visibility into this process as soon as possible.

The MTF is currently the only solution with end-to-end capabilities to provide access to the MFP.

Novartis supports CMS's centralized approach to facilitating data and payment through the MTF DM and PM. This centralized structure promotes standardization, predictability, and reduces operational burden on stakeholders responsible for implementing these programs. While CMS is exploring private market alternatives to the MTF, we urge caution – currently there are no private market solutions that offer the MTF's end-to-end capabilities. Given that CMS can terminate the MTF DM with just 180 days' notice as

noted in the MTF Data Module User Agreement[34] between CMS and manufacturers, doing so without a viable replacement risks significant disruption and uncertainty for all stakeholders.

CMS should take a greater role in preventing 340B duplicate discounts.

By statute, a Primary Manufacturer of a selected drug has no obligation to offer both the MFP and the 340B ceiling price on the same unit.[35] The Primary Manufacturer is obligated only to offer the lower of the two prices. Specifically, the IRA specifies that, *where the drug is subject to 340B price and*:

- *The MFP is greater than the 340B ceiling price,* the manufacturer of the selected drug cannot be required to provide access to the MFP; or
- *The MFP is less than the 340B ceiling price,* the manufacturer of the selected drug can only be required to provide the MFP in a nonduplicated amount to the 340B ceiling price (which amount would be calculated as the 340B ceiling price less the MFP) as opposed to the full MFP rebate.

As we noted in our comments on CMS's IPAY 2027 Draft Guidance,[36] it is vital that CMS put in place robust mechanisms to identify 340B units and prevent 340B-MFP duplicate discounts as a necessary condition of any prompt MFP payment window. These mechanisms are critical to the successful implementation of the DPNP and necessary to avoid duplication of the Part B and Part D inflation rebates with drugs subject to the 340B ceiling price. The identification of 340B claims in a timely manner is crucial for manufacturers and CMS to prevent duplicate discounts, as mandated by statute described above. A lack of sufficient 340B data also threatens program integrity and will result in a high volume of future disputes. Therefore, we urge CMS to play a greater role in identifying 340B units and deduplicating the 340B ceiling price and MFP discounts.

The statutory guarantee against 340B-MFP duplicate discounts, described above, obligates CMS to establish meaningful mechanisms for identifying 340B units and otherwise enabling MFP-340B non-duplication, as a condition of its enforcement of the MFP payment obligation.[37] Such mechanisms are especially critical given the long and well-documented history of widespread 340B covered entity non-compliance with the separate 340B-MDRP duplicate discount prohibition.[38] And, unlike 340B-MDRP duplicate discounts, there is no statutory audit, dispute resolution, or penalty process to remediate 340B-MFP duplicate discounts.[39] Given that the risk of 340B-MFP duplicate discounts is even higher than that of 340B-MDRP duplicate discounts, we encourage CMS to recognize that it is much more vital to establish meaningful mechanisms to protect against such duplicate discounts.

Manufacturers alone lack the ability to identify and track 340B units dispensed to MFP individuals and typically have little insight into which units are subject to 340B pricing. Furthermore, manufacturers are unlikely to have willing partners in enforcing the statute among covered entities and their third-party administrators ("TPAs") and contract pharmacies—in fact, these stakeholders stand to derive substantial financial benefit from the payment of duplicate discounts.

While a manufacturer is obligated to provide only the lesser of the MFP and 340B discounts, MFP-340B deduplication cannot readily occur after the fact via a pricing true-up for drugs not directly dispensed or administered by the covered entity (e.g., through a contract pharmacy arrangement). That is because the discounts there are owed to different parties: the MFP is owed to the *pharmacy*, while the 340B ceiling price is owed to the *covered entity*. If a manufacturer has already provided the MFP to the pharmacy within the 14-day prompt MFP payment window and, then, under the 340B replenishment model, the covered entity places an order for a replenishment unit for the same prescription at a lower 340B ceiling price months later, that manufacturer would have no knowledge of that duplication and could not readily

[34] Medicare Transaction Facilitator Data Module User Agreement Between the Centers for Medicare & Medicaid Services And The Manufacturer, *available at* https://www.cms.gov/files/document/manufacturer-mtf-dm-user-agreement-final.pdf.
[35] SSA § 1193(d).
[36] IPAY 2027 Draft Guidance.
[37] *See United States v. Markgraf*, 736 F.2d 1179, 1183 (7th Cir. 1984) ("An administrative agency cannot abdicate its responsibility to implement statutory standards under the guise of determining that inaction is the best method of implementation.").
[38] *See, e.g.*, Government Accountability Office ("GAO"), Drug Discount Program: Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement, GAO-18-480 (2018), *available at* https://www.gao.gov/assets/gao-18-480.pdf. *See also* Public Health Service Act ("PHSA") § 340B(a)(5)(A).
[39] *Compare* SSA § 1193(d) *with* PHSA § 340B(a)(5)(C), (d)(2)(v), (3).

avoid the duplicate discount. Given the concerns and complexities outlined above, CMS should take the following steps that would better enable manufacturers to avoid duplicate discounts.

Permitting manufacturers to implement a 340B cash-rebate model is the best approach to prevent unlawful duplicate discounts.

As CMS takes on responsibility for administering the 340B program, the most effective and efficient way the agency can ensure non-duplication is to allow manufacturers to provide 340B pricing via retrospective cash-rebates to 340B covered entities, as already authorized under the statute. Under the product-replenishment model, currently the default approach in 340B, covered entities do not provide drug manufacturers with data showing why the purchases for which they claim a 340B price are actually 340B-eligible, and manufacturers have no way to readily find out on their own.

Under a cash-rebate system, however, covered entities would first buy medicines at commercial prices, as they do now. After identifying a prescription as 340B-eligible, a covered entity would submit a 340B rebate claim, which would include key payer information, to the manufacturer electronically. The manufacturer would then promptly pay the covered entity cash representing the difference between the commercial price and the 340B price. In this way, a cash-rebate system could generate sufficient data to allow manufacturers to adjust 340B discount payments to reflect MFP eligibility in a way that is fully transparent to both the manufacturer and covered entity and with adequate documentation to permit appropriate agency oversight.

If CMS declines to approve a cash-rebate model, the agency should require the use of 340B claims modifiers and should continue to explore establishing a centralized 340B claims data repository.

Alternatively, CMS could also ensure that non-duplication—and therefore eligibility for the MFP—can be validated by providing for two categories of data. As requested in previous comments, CMS should require the use of 340B or non-340B claims modifiers, as applicable, to identify whether a unit is 340B or non-340B, which should be supported by maintaining records showing that eligibility or ineligibility for the 340B ceiling price has been validated with the covered entity. These claims modifiers should be required data elements from dispensers billing the claim that are then passed to manufacturers through the MTF DM. This information would be helpful information to ascertain whether a single unit of a drug billed is identified as 340B or non-340B.

As noted above, under the widely-used product replenishment model, claimed 340B units are often not identified until well after they are dispensed and often are not identified by the pharmacy that dispensed the unit and received reimbursement. Therefore, 340B claims modifiers that are voluntary for pharmacies or not robustly monitored and audited by the agency are unlikely to be complete or accurate. Mandatory claims modifiers, however, are a useful tool to identify 340B units to protect against 340B – MFP duplicate discounts.

CMS has already taken welcome steps to require the use of a 340B claims modifier for drugs reimbursed under Part B that took effect on January 1, 2024. We reiterate our previous comments that no comparable steps have been taken for Part B drugs reimbursed under Medicare Advantage ("MA") or otherwise to protect against 340B-MFP duplicate discounts. Should CMS decline to require the use of a 340B or non-340B modifier for the purposes of deduplication with the MFP in both Part D and Part B, as requested above, given that CMS already collects this information from Part B providers today – in the form of the "TB" modifier – we request that CMS require the MTF DM transmit the 340B claims identifier on Part B claims via a new claims level data element sent to manufacturers to assist in preventing duplicate discounts on Part B MFP refund requests.

We are encouraged that CMS is exploring ways to incorporate asynchronous 340B data into future MTF processes to prevent duplicate 340B discounts. We strongly support CMS's consideration of a centralized claims data repository to facilitate accurate deduplication of 340B pricing and the MFP, similar to its current efforts related to Part D inflation rebates. Establishing a centralized database containing claims-level data on 340B units under Part D would significantly enhance the ability to identify and verify 340B claims. When paired with the mandatory use of 340B modifiers on all dispenser claims, as outlined above, such a repository would promote greater data transparency, strengthen program integrity, and

support compliance with statutory requirements.

Safe Harbors from CMPs are necessary to protect manufacturers in cases where the MTF is nonfunctional for reasons outside the manufacturers' control.

Considering the significant operational risks, Novartis asks that CMS provide adequate safe harbor provisions for manufacturers working in good faith to comply with their statutory obligations to provide access to the MFP. CMS should clarify that such good faith efforts are deemed to provide "access" in cases where lack of system workability and functionality are due to factors outside of a manufacturer's control. Taking this step will ensure that manufacturers acting in good faith are not subject to unjust CMPs, particularly in the program's first year.

CMS should clarify that it does not intend for large dispensing retailers to self-identify as anticipating material cash flow concerns.

Novartis supports CMS's goal of ensuring that Medicare beneficiaries maintain access to selected drugs and understands the financial strains that the DPNP may impose on certain dispensers. CMS notes in its Draft Guidance that it expects "sole proprietor rural and urban pharmacies with high volume of Medicare Part D prescriptions dispensed, pharmacies who predominantly rely on prescription revenue to maintain business operations, long-term care pharmacies, 340B covered entities with in-house pharmacies, and Indian Health Service, Tribal, and Urban Indian (I/T/U) pharmacies,"[40] to be most likely to self-identify as having a material cashflow concern. While we recognize the financial pressures some dispensing entities may face, we are concerned that dispensers beyond those the agency anticipates – such as large, national pharmacy chains – might claim material cashflow concerns.

While we appreciate the flexibility CMS has provided in allowing manufacturers to develop their own qualifying criteria for mitigation plans, we urge the agency to clarify that it does not intend for large pharmacy retailers, particularly those whose business operations are not materially dependent on prescription revenue, to self-identify as experiencing material cash flow challenges. It is also important to underscore that the IRA does not impose a statutory obligation on manufacturers to address such cashflow issues.

While CMS is clear in its Draft Guidance that it will not float funds to dispensing entities on behalf of manufacturers, we believe a more effective solution to addressing pharmacy cash flow challenges would be for CMS to adopt a model similar to the Part D CGDP. Specifically, CMS could facilitate the pass-through of CMS pre-funded MFP refund amounts to dispensers at the point of claims adjudication, with manufacturers invoiced afterward. We encourage CMS to consider implementing this approach for IPAY 2027 and beyond, combined with a robust mechanism to prevent 340B duplicate discounts.

CMS should ensure broad access to selected drugs for Medicare Part D beneficiaries through its formulary review process.

Novartis urges CMS to strengthen oversight of Part D plans to protect beneficiary access to selected drugs. Without further action, the DPNP could disrupt Part D competition and increase access barriers. While CMS acknowledges concerns about Part D plans restricting access to selected drugs, it stated that it "does not have sufficient information to determine whether changes to these formulary inclusion policies are warranted" and indicates it will maintain current policies for IPAY 2028. We appreciate CMS's monitoring efforts but are disappointed it will not adopt uniform tier placement or utilization management requirements for selected drugs in IPAY 2028.

While formulary coverage is essential for access to selected drugs, CMS must go beyond the IRA's minimum requirements to ensure meaningful beneficiary access. We urge CMS to clarify that Part D plans should not impose utilization management restrictions beyond a drug's FDA-approved label. Such restrictions hinder access and may incentivize plans and pharmacy benefit managers to favor higher-cost alternatives with greater rebates—undermining the intent of the DPNP. CMS should ensure selected drugs are not disadvantaged in formulary placement or subject to excessive cost-sharing, which could

[40] IPAY 2028 Draft Guidance at 73 – 74.

limit access and lead to unintended consequences.

V. Renegotiation process

CMS should articulate explicit criteria for identifying renegotiation-eligible drugs and selecting eligible drugs for renegotiation.

The SSA requires CMS to renegotiate the MFP for all selected drugs that subsequently change monopoly status to a long-monopoly or extended-monopoly drug; beyond this, CMS has significant discretion to select additional drugs for renegotiation. CMS may renegotiate the MFP for additional drugs for which "there has been a *material change* to any section 1194(e)(1) or (e)(2) factor. CMS may then select among those drugs those for which renegotiation is expected to "result in a significant change" in the MFP.[41]

CMS's proposal gives the agency extraordinary leeway when identifying and selecting renegotiation-eligible drugs. First, CMS proposes that it will evaluate whether there has been a "material change" based on a "holistic consideration" of the impact of the 1194(e)(1) and (2)(2) factors "collectively."[42] Second, CMS proposes that it will determine whether such a change would "result in a significant change" by considering "the likelihood that the new indication or material change would result in a renegotiated MFP that represents a 15 percent or greater change relative to the current MFP" and "whether such a change in the MFP for the renegotiation-eligible drug would have a significant impact on the Medicare Program."[43] CMS then proposes to determine the likelihood of 15 percent change and any "significant impact" on the Medicare program through a holistic inquiry based on "the totality of the information available and the circumstances of the renegotiation-eligible drug."[44]

CMS's "holistic" and "totality"-based standards are unworkably vague. First, CMS notes that "no criteria to select drugs for renegotiation can predict the actual outcome of a renegotiation" and that "the magnitude of the change in MFP could be higher or lower than 15 percent. This acknowledgement undercuts CMS's rationale for selection because it illustrates how imprecise CMS's "holistic" analysis is. Second, these proposed standards offer manufacturers no predictability as to when a previously selected drug may be subject to negotiation. Such predictability is essential when considering the massive amount of resources necessary to prepare for and engage in negotiation (and renegotiation). Such unclear, subjective standards do not give manufacturers an opportunity to predict and prepare for renegotiation and should not be finalized .

As an alternative, Novartis asks CMS to identify explicit criteria for the selection of a previously selected drug for renegotiation, in addition to the selection of drugs whose MFPs must be renegotiated by statute.

CMS should allow manufacturers to resubmit original data with material changes noted for renegotiation, instead of requiring an additional new data submission.

CMS proposes a new voluntary data collection from manufacturers to help the agency identify renegotiation-eligible drugs. The Draft Guidance states that CMS will collect new information on the section 1194(e)(1) manufacturer-specific data negotiation factors to support renegotiation and solicit new data on the section 1194(e)(2) therapeutic alternatives negotiation factors.

Rather than creating an entirely new submission of data to facilitate renegotiation, CMS should allow manufacturers to resubmit the initial set of data submitted with negotiation of the selected drug and identify any material changes in the data. This will greatly reduce the burden of renegotiation for both manufacturers and CMS, and it is a simple mechanism by which to streamline the complexity of simultaneous renegotiation and negotiation cycles.

VI. Providing Access to the MFP in Part B

[41] SSA §§ 1194(f)(2), (f)(3) (emphasis added).
[42] IPAY 2028 Draft Guidance at 190–93.
[43] *Id.* at 194.
[44] *Id.*

CMS should proceed with a centralized system to operationalize Part B effectuation.

CMS provided little guidance on how it plans to effectuate the MFP in Part B except that it intends to "align" Part B effectuation with the framework it established to effectuate the MFP in Part D. Novartis wishes to underscore the importance of centralized administration across the DPNP, including standardization, predictability, and mitigating the burden on stakeholders. For these reasons, Novartis recommends that CMS administer Part B effectuation similar to how CMS utilizes the MTF for Part D effectuation; through a standard, centralized approach with bilateral participation to facilitate MFP data exchange and payment for Part B drugs.

CMS should work with stakeholders to better understand the unique challenges that Medicare Part B presents to the effectuation of MFP compared to Medicare Part D.

Novartis appreciates CMS's solicitation of recommendations regarding the effectuation of MFP in Part B. While we generally agree with CMS's intent to align this process with the process in Part D to the extent possible, there are some unique considerations and challenges that CMS must consider when developing the process for effectuating the MFP in Part B. We urge CMS to work closely with all stakeholders, including manufacturers, to address these distinct challenges to MFP effectuation in Part B.

The Medicare program includes more than a million providers[45] who may need access to the MFP, whereas Part D includes a smaller network of around 60,000 dispensers. The vast difference in scale introduces significant challenges in implementing MFP uniformly across all Part B providers. For example, each Part B provider would need to be integrated into the MTF DM and PM to ensure efficient and timely effectuation of the MFP.

Additionally, Part B medical claims are less automated than Part D pharmacy claims, resulting in a data lag between claim processing and manufacturer receipt of such data needed to effectuate the MFP. CMS must also consider unique claim-level data fields for Part B, such as:

- Billing provider and service provider NPI;
- Medicare Advantage Plan ID (for MA only);
- HCPCS Code (J-Code/Q-Code);
- Claim Number;
- 340B Covered Entity ID/NPI;
- Place of Service code;
- 340B Claims Modifier Field ("TB" modifier);
- Vial Wastage Modifier Field ("JW" and "JZ" modifiers); and
- "UD" Modifier Field.

Under current policy, providers are reimbursed for physician-administered outpatient drugs at ASP + 6%. However, under the IRA, Medicare Part B reimbursement for selected drugs will shift to MFP + 6%, transferring financial risk to providers. This change is expected to significantly reduce Medicare reimbursement for provider-administered selected drugs[46] with research estimating a 47% - 63% reduction in add-on payments.[47] Specialties such as oncology and rheumatology – which heavily rely on the "buy and bill" reimbursement model – are likely to experience the most substantial financial impact. To preserve patient access to critical therapies, CMS must put careful consideration into the design of the effectuation process to ensure provider margins are not unduly eroded.

Finally, in Part D, the Wholesale Acquisition Cost ("WAC") serves as a natural pricing anchor, facilitating sufficient access of MFP across most dispensers. However, in Part B, there is no equivalent pricing

[45] Centers for Medicare & Medicaid Services. CMS Program Statistics – Medicare Providers, *available at* https://data.cms.gov/summary-statistics-on-provider-enrollment/medicare-provider-type-reports/cms-program-statistics-medicare-providers.
[46] Avalere. Commercial Spillover Impact of Part B Negotiations on Physicians. September 16, 2024, *available at* https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians.
[47] Avalere. IRA Medicare Part B Negotiation Shifts Financial Risk to Physicians. Nov 29, 2022, *available at* https://advisory.avalerehealth.com/insights/ira-medicare-part-b-negotiation-shifts-financial-risk-to-physicians.

benchmark that applies uniformly across the Medicare provider base. Provider acquisition costs can vary significantly, often below WAC, making it difficult to define a Standard Default Refund Amount (SDRA) that is sufficient for the majority of Medicare providers. We encourage CMS to continue to engage with stakeholders, including manufacturers, to define an SDRA for Part B.

CMS should explicitly exclude MFP from ASP calculations to align with the IRA's exclusion of MFP from AMP.

The IRA amends the Medicare Drug Rebate Program statute to require that the MFP be included in best price, but it is silent on whether MFP must be included in ASP calculations.[48] This ambiguity has triggered significant concern across the industry, because not only is ASP the benchmark for Medicare Part B reimbursement, it is widely used in commercial contracts. If a drug's MFP is included in the calculation of ASP, the ASP would drop significantly and no longer be adequate to cover the acquisition costs for drugs outside of the Medicare program, causing immediate and lasting negative impacts that threaten access to selected drugs. Additionally, manufacturers may face pressure to increase rebates to offset lost margins, further depressing ASP.

CMS should use its existing authority to exclude MFP units from ASP.

Section 1847A(b)(2)(B) defines a "unit" for purposes of payment under the ASP methodology as:

> . . . with respect to each National Drug Code (including package size) associated with a drug or biological, the lowest identifiable quantity (such as a capsule or tablet, milligram of molecules, or grams) of the drug or biological that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids. *For years after 2004, the Secretary may establish the unit for a manufacturer to report and methods for counting units as the Secretary determines appropriate to implement this section*.[49]

CMS's current definition of "unit" for calculating ASP is "the product represented by the 11-digit National Drug Code, unless otherwise specified by CMS to account for situations where labeling indicates that the amount of drug product represented by a National Drug Code varies. The method of counting units *excludes units of CAP drugs* … sold to an approved CAP vendor … for use under the CAP."[50]

As the regulatory text demonstrates, CMS has previously exercised its statutory authority to define "units" for ASP purposes to exclude certain units from the ASP calculation, namely: "units of [competitive acquisition program (CAP)] drugs . . . sold to an approved CAP vendor . . . for use under the CAP . . . ."[51] The CAP was established by Congress as an alternative payment methodology to ASP for certain drugs covered under Medicare Part B.[52]

CMS's rationale for excluding CAP units from ASP calculation is analogous to the current MFP situation; like the CAP, the MFP is an alternative to ASP and unit prices under the program are available only for units administered to Medicare beneficiaries. In excluding CAP units, CMS explained:

> [W]e recognize[] commenters' concerns about the effect of including CAP prices in the calculation of ASP and agree[] that the best outcome for both the ASP methodology and the CAP programs would be one in which prices under CAP did not affect payment amounts under the ASP methodology. In particular, we f[ind] compelling arguments from commenters about the separation of the ASP and CAP programs and that the two programs are intended to be alternatives to each other.[53]

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[48] SSA §1927(c)(1)(C)(ii)(V), (k)(1)(B)(i)(VI).
[49] d. at § 1847A(b)(2)(B) (emphasis added).
[50] 42 C.F.R. § 414.802.
[51] Id.
[52] *See generally* SSA § 1847. Although implemented as of July 1, 2006, CMS later postponed implementation of the program for 2009 after running into challenges with respect to its implementation, and it has not been implemented since then. CMS, Competitive Acquisition Program for Part B Drugs & Biologicals, *available at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/CompetitiveAcquisforBios (last accessed Jan. 29, 2023).
[53] 74 Fed. Reg. 61,738, 61,915-16 (Nov. 25, 2009)). CMS had initially only temporarily excluded CAP units from ASP, starting in 2006. 71 Fed. Reg. 47,870, 48,132 (Aug. 18, 2006).

CMS should exercise the same discretion to "establish the unit for a manufacturer to report" and exclude MFP units from a drug's ASP calculation. Novartis urges CMS to undertake rulemaking to exclude MFP units from ASP.

* * * * *

Novartis appreciates the opportunity to comment on CMS's Draft Guidance regarding the DPNP and MFP effectuation in 2026, 2027 and 2028. We welcome the opportunity to answer any questions you may have about the information provided above. Please contact me at courtney.piron@novartis.com.

Sincerely,

Courtney Piron
Head, US Public Affairs

June 26, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Drug Price Negotiation Program Draft Guidance

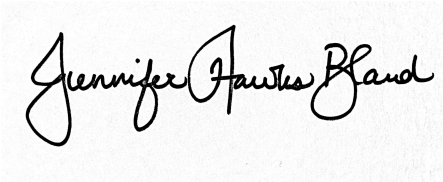
Dear Administrator Oz,
I am writing on behalf of NewYorkBIO, the leading trade association representing the life sciences industry in New York. NewYorkBIO members are deeply concerned about the potential impact of CMS's draft guidance for the Medicare Drug Price Negotiation Program, particularly the proposed interpretation of a Qualifying Single Source Drug (QSSD). This approach, as it currently stands, jeopardizes future innovation undertaken by New York bioscience companies and fails to meet the diverse and evolving needs of patients.

The proposed interpretation of a Qualifying Single Source Drug (QSSD)—treating products with the same active ingredient or moiety as the same drug—risks discouraging the development of new combination products, routes of administration, and indications that are essential for improving patient outcomes. These innovations are particularly important in fields like oncology and chronic disease, where treatment adherence, convenience, and personalization are critical to achieving better health outcomes. For example, in oncology, subcutaneous therapies have dramatically reduced infusion times and made treatment more accessible to rural and underserved populations. These delivery innovations aren't simply duplicative—they represent essential progress that enhances care and reduces barriers.

NewYorkBIO urges CMS to follow the statute and identify QSSDs by reference to a distinct New Drug Application (NDA) or Biologics License Application (BLA), consistent with the FDA's regulatory framework. This approach would ensure that meaningful innovations are appropriately recognized and preserved for patient access.

Thank you for your attention to this critical issue and the opportunity to submit this comment letter. We look forward to working with CMS to ensure that innovative bioscience companies can meet future patient needs and that their perspectives are adequately considered in policy decisions.

Sincerely,



Jennifer Hawks Bland
Chief Executive Officer
NewYorkBIO

The Honorable Chris Klomp
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

Submitted electronically to *IRARebateandNegotiation@cms.hhs.gov*

RE: Medicare Drug Price Negotiation Program Draft Guidance for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp,

On behalf of The ONCare Alliance, an Association Of 32 independent oncology practices with over 470 physicians and over 350 advanced practice clinicians, I submit comments on the Medicare drug price negotiation program draft guidance.

The mission of ONCare Alliance is to deliver state of the art cancer care in the communities we serve, while remaining independent of hospital, private equity, or other third-party ownership. The Alliance believes that the cost of healthcare provided by hospitals and vertically integrated entities is overly expensive and delivers too much profit to large corporations at the expense of the American people and the American taxpayers. We applaud the goal of lowering drug prices as we are working on the front lines of caring for patients with cancer and see their financial struggles and bankruptcies.

ONCare Alliance Member practices are committed to delivering the highest quality Cancer Care at an affordable price while working in a payment system we did not design.

THE PRACTICES OF ONCARE ALLIANCE ARE CONCERNED ABOUT THE UNINTENDED CONSEQUENCES OF THE INFLATION REDUCTION ACT WHICH WILL MAKE OUR PRACTICES UNSUSTAINABLE.

In 2003, average sales price, ASP, was created as part of MMA as the mechanism for practices to purchase chemotherapy, deliver it safely in OSHA regulated infusion suites and be paid at ASP +6%. During that time, I had the privilege of participating in the Practicing Physician's Advisory Council, a Congressionally delegated committee to advise the Secretary of HHS and the CMS Administrator on the effect CMS regulations would have on the independent practice of medicine.
During the ASP discussions, as the oncologist on the Council, I commented on the inadequacy of the payments by Medicare for all the work and services performed by oncologists and their practices. I was told at that time by CMS administrator Scully that the drug margin was designed to pay for the under reimbursed services.

For example, the payment for a first hour infusion was only $133 in 2014. [redacted] Now in 2024 the payment is $132/ hour, and we have the added expenses of Electronic Medical Records systems, USP 800 compliant pharmacies, and oncology trained nurses and pharmacists. ONCare Alliance practices did a time and

motion study in 2019, (presented to Oncology Circle, unpublished but available on request). [redacted]

Recently, my practice, New Mexico Oncology Hematology Consultants did a time and motion study to compare our costs of having a patient in an exam room [redacted]. Even with the newer management codes to allow payment for physicians to call family members, coordinate care with the rest of the Cancer Care treatment team, oversee infusion suite complications and handle patient toxicities, payments are not adequate.

The purpose of these examples is to show that oncology practices would not be solvent without the drug margin, particularly from commercial payers. ASP plus 6%, now 4.3% with sequestration, does not entirely cover the Medicare payment shortfall for the routine services we provide.

Now the Inflation Reduction Act is basically removing the margin on chemotherapy drugs, and no alternative payment system to cover our costs is offered.

Avalere published their evaluation of the effect of the inflation reduction act on practices in 2022 and calculated a 47% decrease in top line revenue to the practices because of the difference between a 4.3% margin on average sales price as compared to maximum fair price. Avalere Health Advisory. "IRA Medicare Part B Negotiation Shifts Financial Risk to Physicians." 29 November 2022. Available Here.

No small business can survive a cut of 47% in top line revenue.
After 20 years of lack of increases in the Physician fee schedule, compounded by an approximately 54% increase in practice expense, the practices are functioning at maximum efficiency and have limited Medicare margins, if any. Some practices of ONCare Alliance are willing to provide confidential unpublished data on the finances of our practices to demonstrate that with a 47% cut in top line revenue from the drug margin, we will not be able to stay in business.

PRESERVE THE ABILITY OF PRACTICES TO DELIVER CANCER CARE

Without an alternative source of revenue, remaining an independent physician fee schedule practice is not a viable option, even for the practices of ONCare Alliance, who are determined to remain independent.

During the early years of the IRA and until the hospitals figure out that they are also losing money delivering oncology services, we may be able to shift some patients to the hospital infusion centers for the drugs on the list.

When the list includes essential drugs and the hospitals will no longer accept those patients, physicians will be placed in the morally unacceptable position of deciding to treat the patient in front of them at a loss and risk having the practice collapse and not be available for future patients or deny some patients their best options to preserve the practice. No physician should be forced to make that decision.

By 2030 when the predicted decrease in top line revenue of 47% occurs, both freestanding oncology practices and hospital-based oncology practices will no longer survive. Access to care for millions of cancer patients will vanish.

The options available to ONCare Alliance practices include dissolution of the practice with retirement of the older partners, a sale to a hospital or to an insurance company such as Optum or to private equity. With a sale to a hospital system, the practices move from the Physician Fee Schedule to the Hospital Outpatient Perspective Payment System, where our prices to Medicare and Medicaid will double and drug prices will be marked up 160% on average. Sale to private equity or insurance companies has bee shown to result in significantly higher prices.

In all three scenarios, access to care, particularly for rural America will be diminished and costs will increase.

It was never the intent of the IRA to dismantle the Cancer Care delivery system in the United States.

CMS has the ability to preserve the delivery of Cancer Care by removing practices from the economic burden and administrative requirements of the IRA.
The Barasso (R WY) bill in the last Congress, HR 5391, would allow practices to continue to purchase drugs at ASP and be reimbursed at ASP +6%. This preserves the funds we use to keep our practices open.
The pharmaceutical manufacturers should deliver a rebate directly to CMS to make up the difference between ASP and maximum fair price, MFP.
MFP should not be factored into ASP calculations in order to preserve the working capital of the practices.

DELAYED PAYMENTS AND INCREASED OVERHEAD EXPENSES ARE A THREAT TO THE VIABILITY OF PRACTICES

Oncology practices are generally small privately owned businesses. Medical businesses are somewhat different as we cannot control our prices or pass on expenses to our customers as our prices are set by Medicare, Medicaid, and insurance companies. The increasing administrative burden placed on medical practices has significantly increased practice expense. [redacted]

Collecting payments through either the prospective or retrospective MTF-PM will add enormous and unsustainable administrative costs to practices and will create such a delay in payment that practices will have significant cash flow problems.

If the practices were required to purchase the drug and then wait for a rebate from the manufacturer, despite the proposed 14-day payment window, the delay would impact our ability to purchase chemotherapy for the next week's patients.

Currently when practices buy drugs, payment must occur between one week and 30 days. When we are paid for drugs by insurance companies, the delay is often 44 days. Medicare fee for service generally pays within 2 to 3 weeks and Medicare Advantage in 3-4 weeks. With either Medicare or commercial insurance then we must submit for secondary insurance or collect 20% from the patient. if there is a denial or a dispute in the amount, it is not considered a clean claim and payment can be delayed

further. Practices, therefore, are acting as the bank for insurance companies and for Medicare, purchasing the drugs and treating the patients and waiting for weeks to months for that money to re-enter the practice.

Despite the intent that the MTF payment module will pay within 14 days, we feel that is unlikely. A significant number of Medicare Advantage and nearly all commercial insurers have prolonged payment timelines. Without a consistent cash flow, practices will not be able to continue purchasing chemotherapy and treating patients. As soon as oncology practices are unable to deliver chemotherapy in a timely manner, they will go out of business.

The ONCare Alliance practices are very concerned that there will be different mechanisms and processes from every manufacturer making the administrative burden of collecting the money we are owed cost us most of the money we gain. On page 54 there is a comment that private payers may add additional requirements, which will make it even more onerous to simply deliver chemotherapy and be paid for it. Clarification as to when the claims can even be submitted are crucial. Do we submit for the MTF-PM when the first clean claim is submitted? Or when the secondary insurer has paid? How do we manage Medicare as a secondary payer? What is the process when a claim is denied and then paid on appeal? This is not uncommon with Medicare Advantage claims. How is drug waste managed when the single use vial size is 10 mg and the dose is 9 mg? What happens to dual eligible patients on Medicare and Medicaid? How does the Indian Health Service or TriCare factor into this system?

The MTF-PM should not be different for different manufacturers, Medicare advantage plans, Medicare contractors or Medicare Medicaid dual eligibles. Oncology practices do not have the administrative bandwidth to manage a system as complicated as is described in the proposed guidance. Many chemotherapy regimens include several drugs from several manufacturers and often oral chemotherapy covered under part D. Having to apply to multiple manufacturers to be made whole from one patient's care will exponentially increase our administrative costs and adversely impact cash flow.

The coverage gap discount program model would allow part B claims to be sent to the manufacturer through the MTF-DM and the refunds could be paid directly to CMS.

MFP should not be factored into ASP calculations. During the proposed Competitive Acquisition Program, CMS planned to not factor those prices into ASP calculations, so there is precedent for exclusion of values that would destabilize the delivery system.

A Standard Default Refund amount will not be accurate and will therefore create winners and losers among practices or require additional administrative work to challenge the payments. If the SDR is calculated from ASP, additional losses will occur as by definition of Average, half of the practices are purchasing drugs above ASP. Smaller rural practices unable to negotiate prices under ASP will see the decrease in their cash flow and fail first. Rural hospitals attempting to provide oncology or rheumatology infusions will fail shortly thereafter, as states will be only able to subsidize them for a short time. Using WAC will provide some cushion, but that may not be sufficient.

It is unclear how disputes would be handled in a sufficiently timely manner to preserve practice cash flow. Delay in resolving disputes works to the benefit of the manufacturers and the payers because the practices do not have either the legal abilities or the time to resolve the lengthy dispute. The track

record of resolving disputes with Medicare Advantage plans is dismal, which gives the practices great concern about whether or not any dispute would ever be resolved, much less in our favor.

PART B and PART D

Part B and part D are very different systems and will require different mechanisms for payment. Pharmacy Benefit Managers, PBM's, often require that we send prescriptions to their mail order or specialty pharmacies rather than filling them in the office. This adds increased expense and delay to the care of patients, but provides profit for the PBMs. ONCare Alliance was very disappointed that the IRA did not take the opportunity to remove the profiteering of the PBMs from the part D system. Removing the 50% of the cost of the oral chemotherapy which currently goes toward the profit of the PBM would go a long way to making drug prices cheaper for patients. Without the PBM's the practices would be able to use medically integrated dispensing to coordinate the oral and intravenous chemotherapy that is common in many regiments and avoid the delays that stress patients, families and practices.

PATIENT ACCESS TO PART B AND PART D DRUGS

We also have concerns that we will not be able to provide our patients with the appropriate drugs. If the optimal drug for a patient causes the practice to lose money the physician is placed in the morally difficult situation of choosing whether to treat the one patient in front of them and not be in business to treat future patients or to deny the patient in front of them and stay in business for the others. As new highly effective minimally, toxic, and very expensive drugs are placed on the IRA list our ability to purchase listed drugs and afford to deliver the drug will diminish or become nonexistent. We simply will not be able to offer those medications to the patients who need them. For a while we might be able to send those patients to a hospital where they are paid more by Medicare and commercial payers. That will work until the hospitals figure out they also are losing money on those drugs and will stop accepting the patients. Rural hospitals are already at risk of failing and cannot afford to lose money for a small number of patients. They are closing obstetrical services, which makes it unlikely they will retain cancer care.

Currently oncology practices pay staff to search for co-pay assistance for patients who are unable to afford either part D or part B drugs. Without this co-pay assistance, many patients would not be able to afford chemotherapy, even at maximum fair price. It is unclear in this system, whether or not the manufacturers would continue to provide patient assistance or whether we would be able to access it. It is also not clear how patient cost sharing factors into getting rebates from the manufacturers if that system were to be implemented.

REGISTRATION OF PRACTICES

The MTF-DM should not require more work on the side of the practices to register our in-house pharmacies. Medicare physician data should be up-to-date and accurate and used for this process as well.

ADDITIONAL SOLUTIONS

ONCare Alliance practices urge CMS to develop an alternative payment mechanism that removes dependence on the drug margin by shifting those dollars to direct and adequate payments for all the services and expenses provided by Oncology practices. The Oncology care model and the Enhancing Oncology Model do not shift money from the drug margin into other payments.

Revisiting MASON, Making Accountable Sustainable Oncology Networks was proposed to the Physician-facing Payment Technical Advisory Committee, PTAC, in 2018 and was unanimously approved on all 10 criteria but never funded. MASON proposed the use of AI to create accurate target prices for chemotherapy regimens, including drugs and the work required to get a cancer patient successfully treated with that regimen. Practices would then go at risk against the accurate target price. Drugs would be paid at invoice price. A separate fee for the cost of having a USP 800 compliant infusion facility, a pharmacy overhead payment, enhanced payments for work outside of the oncology consultation and an adequate payment to cover all the patient navigation services, the care coordination, in office response to toxicities would keep practices solvent while saving CMS and taxpayers money. An adequate payment for the indirect cost of maintaining a clinic would be paid separately.

As the original author of Mason, working with ONCare alliance practices, I propose to revise MASON 3.0 and offer it as a pilot project to CMMI. The goal of this pilot would be to prove that despite the lack of a robust drug margin with adequate transparent payments for other necessary services, Independent oncology practices can continue to serve the communities that need them.

CONCLUSION

We appreciate the opportunity to voice concerns and suggestions to CMS as you implement this important law. Our overarching goal is to be able to continue providing the appropriate chemotherapy and immunotherapy to our patients in the lower cost setting of a community based, physician managed oncology clinic. Achieving lower drug prices without dismantling the infrastructure of cancer care is an important goal we share.

Please allow us the opportunity to provide further information or answer questions by emailing me at mcaneny@nmohc.com [redacted].

Sincerely

Barbara McAneny MD MACP FASCO
Co-Chair ONCare Alliance
Former President American Medical Association
CEO New Mexico Oncology Hematology Consultants ltd
CEO Innovative Oncology Business Solutions and COME HOME CMMI award recipient, 2012
Author MASON

Oncology Nursing Society
Support. Synergy. Strength.

June 25, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Administrator Oz:

On behalf of the Oncology Nursing Society (ONS), a professional organization representing the interests of 100,000 registered nurses and other healthcare providers, we appreciate the opportunity to offer comments on the Medicare Drug Price Negotiation Program Draft Guidance for Initial Price Applicability Year 2028. Oncology nurses are privileged to support patients with cancer through their entire cancer experience, from diagnosis and treatment into survivorship or as they face their end-of-life journey.

We support and applaud the Inflation Reduction Act and Medicare Drug Price Negotiation Program's mission to address the growing cost of healthcare in this country. It is no secret that the cost of cancer care is prohibitively high. Given the high cost of these medications, we believe anti-cancer medications will continuously come before CMS for drug price negotiation. Indeed, these costs are so high that cancer care providers, including ONS members, began referring to the cumulative effects of these costs as "financial toxicity." Since oncology nurses are often the frontline providers helping patients navigate these concerns, we are keenly aware of the very real impact that financial toxicity can have on health outcomes.

ONS believes that CMS's current definition of Qualified Single Source Drugs (QSSDs) may be counterintuitive to the agency's overall goals within the Medicare Drug Price Negotiation Program as it may limit more cost-effective and accessible forms of anti-cancer medications from reaching patients. CMS's current definition of QSSDs includes New Drug Applications (NDAs) and Biological Licensing Agreements (BLAs) with the same active moiety or ingredient held by the same NDA or BLA holder. In other words, medications that become subsequently available in alternate forms, doses or strengths will still be considered part of the initially identified QSSD.

We are concerned that this definition could limit research and development that has a proven track record in bringing intravenous (IV) anti-cancer medications to patients through subcutaneous and even oral forms. While IV oncology medications are broadly available to patients and highly effective due to their direct and rapid absorption by the body, these medications require patients to spend extensive time at their infusion center or hospital while they receive their treatment. This is time spent away from work or family and can cause

financial strain on patients who are required to regularly leave daily life for routine infusions, sometimes lasting several hours per treatment. It also increases overall healthcare costs due to labor and facility utilization costs.

Several drugs that were initially available through IV were later launched through subcutaneous administration, which significantly reduces administration time, improves patient quality of life and even reduces costs. Subcutaneous administration of oncology medications has proven to reduce treatment time compared to IV administration,[i] sometimes from hours to minutes.[ii] This is beneficial for the patient as they are able to return to their regular routines quickly, but it is also immensely helpful in treating more patients on-site. This is critical as oncology infusion centers and hospitals manage occupancy limitations that may delay care or require patients to be transferred to alternative sites that are farther away from home. Subcutaneous administrations can also reduce staff and pharmacy time as they are simpler to prepare and administer.

Several oncology medications that were initially available through IV are also now available in oral form.[iii] Oral oncology medications have greatly improved patients' quality of life, allowing them to take their anti-cancer regime from the comfort of their home, without administration from a health care provider and without requiring extensive time at their oncologist's office. This allows patients to maintain their oncology treatment while spending more time engaging in everyday activities.

We also believe that FDA processes support a revised definition of QSSD that aligns with statute. Each time a pharmaceutical company seeks approval of a new indication for a previously approved medication, the FDA requires a supplemental NDA. The FDA then grants approvals for supplemental indications with their own NDA or BLA regardless of shared active ingredients, suggesting scientific rationale for treating each indication uniquely. In fact, from 2003 to 2021, the U.S. Food & Drug Administration approved 124 new drug applications in oncology, of which 374 unique indications were approved,[iv] demonstrating versatility and range in cancer research and discovery.

As cancer is the leading cause of death among Medicare beneficiaries ages 65-74, with 7 out of 10 cancer deaths occurring among Medicare beneficiaries,[v] it is imperative that CMS take action to ensure research and development, approval and continuous monitoring of oncology medications. ONS encourages CMS to redefine QSSD eligibility in line with statute so that supplemental approvals are classified as distinct new drug applications (NDA) or biologics license applications (BLA).

We thank you for your attention to this important matter and urge you to support research and development of essential cancer treatments. Should you require any further information or wish to discuss our concerns, please feel free to contact healthpolicy@ons.org.

Sincerely,

The Oncology Nursing Society

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ONS is a professional association that represents the over 100,000 oncology nurses in the United States and is the professional home to more than 35,000 members. ONS is committed to promoting excellence in oncology nursing and the transformation of cancer care. Since 1975, ONS has provided a professional community for oncology nurses, developed evidence-based

education programs and treatment information, and advocated for patient care, all in an effort to improve the quality of life and outcomes for patients with cancer and their families.

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[i] Oncologist. "Utilization of Immunotherapy in Patients with Cancer Treated in Routine Care Settings: A Population-Based Study Using Health Administrative Data." August 2022.
[ii] The ASCO Post. "FDA Helps Streamline Approval Process for Supplemental Drug Indications." December 2017.
[iii] Examples include, but are not limited to, Cyclophosphamide, Topotecan and Capecitabine.
[iv] Aging (Albany NY). "Advances in cancer therapy: clinical benefit of new cancer drugs." June 2023.
[v] American Cancer Society. "Cancer in Medicare: An American Cancer Society Cancer Action Network Chartbook." 2024.

PIPC Partnership to Improve Patient Care

June 26, 2025

Chris Klomp
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 212440-1850

Dear Deputy Administrator Klomp:

Thank you for this opportunity to comment on the draft guidance for the third cycle of the Medicare Drug Price Negotiation Program. Since passage of the Inflation Reduction Act, we have worked collaboratively as organizations representing patients and people with disabilities to amplify the perspectives of those with lived experience in the implementation of the Medicare Drug Price Negotiation Program. Our comments focus on the agency's approach to patient engagement — particularly in decisions related to clinical effectiveness, unmet medical need, therapeutic alternatives — as well as the agency's use of value assessments.

We appreciate CMS' ongoing efforts to build a public engagement strategy over the first two cycles and are encouraged that the process will continue to solicit input from patients and people with disabilities. However, we are concerned that the strategy outlined in the new guidance remains limited in scope. It lacks detail on how insights gathered from engagement events will be used and does not provide for the kind of continuous, substantive engagement necessary to ensure that patient voices are not only heard but meaningfully integrated into the process.

We are also concerned that the new guidance does not reflect statutory limitations on the use of quality-adjusted life years (QALYs) and similar measures under the Affordable Care Act — particularly given the revised approach proposed for IPAY 2028 that would no longer require submitters to clarify whether such measures are included in their evidence.

Therefore, we are pleased to share the following recommendations:

- CMS should avoid **one-size fits all value metrics.**
- CMS should develop a formalized process to ensure **continuous, robust engagement** of patients and people with disabilities at multiple levels.
- Using patient insights, CMS should **clearly communicate how it intends to use the input it receives,** and how that input is reflected in the final negotiated prices.
- CMS should solicit input from **a variety of patients who rely on the treatments in question, including those in rural areas** to ensure representation of the diversity of the patients and communities affected by the topic.
- CMS should ensure that opportunities for patient engagement are **accessible**.
- To gauge both successes and challenges, CMS should establish a structured process for **continuous review and assessment** of its engagement strategy.

CMS should avoid one-size-fits-all value metrics.

It is now widely recognized that traditional methods and metrics of value assessment such as the QALY have significant shortcomings. This has led to well-intentioned development of other measures and approaches that developers assert to be nondiscriminatory and more patient-centered. However, each approach comes with tradeoffs, need for improvement, and inherent methodological weaknesses. No patient is average, and no measure of value should assume so.

Prior law, including the Affordable Care Act, bars use of QALYs and similar measures
In this guidance, CMS reiterates its commitment to "learning from, collaborating with, and engaging the public, including patients, consumer advocates, health and data experts, and pharmaceutical supply chain entities in the policy-making process." The agency also expresses support for collecting real-world data and engaging patients related to its work to identify therapeutic alternatives.

However, we are concerned by the guidance's narrow framing of statutory limitations. CMS states that it 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." This reference to the IRA's statutory language bars CMS from using "information that treats extending the life of individuals in these populations as of lower value." However, it leaves out the broader protections established by the Affordable Care Act (ACA), which prohibits the use of the QALY and similar measures that "discount the value of a life because of an individual's disability."

Additionally, we are concerned by CMS' decision to remove a prior transparency requirement that asked those who submit evidence to disclose whether their studies used cost-effectiveness measures that could devalue the lives of specific populations, and to briefly explain how their data avoided such biases. CMS explains that it removed this requirement because not all respondents were familiar with cost-effectiveness methodology. However, the removal of this safeguard — without offering an alternative mechanism for transparency — undermines meaningful oversight. CMS' review of submitted measures is not a substitute for public accountability and does not ensure compliance with the anti-discrimination protections outlined in either the IRA or the ACA.

Recent regulatory developments further underscore these risks. While we appreciate the guidance's reaffirmed commitment to not using QALYs in the Negotiation Program, we remind the agency that value assessments can still be discriminatory even if they do not rely on QALYs. The final rules implementing Section 504 of the Rehabilitation Act[1] and Section 1557 of the ACA[2] both acknowledge the potential for value assessments to discriminate. In fact, the agency interpreted the Section 504 rule as "broader than Section 1182 of the Affordable Care Act, prohibits practices prohibited by section 1182 (where they are used to deny or afford an unequal opportunity to qualified individuals with disabilities

[1] HHS, "Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance," May 9, 2024, https://www.federalregister.gov/documents/2024/05/09/2024- 09237/nondiscrimination-on-the-basis-of-disability-in-programs-or-activities-receiving-federal-financial
[2] CMS, "Nondiscrimination in Health Programs and Activities," May 6, 2024, https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health- programs-and-activities

with respect to the eligibility or referral for, or provision or withdrawal of an aid, benefit, or service) and prohibits other instances of discriminatory value assessment."

The aim of these statutory and regulatory protections is not to encourage workarounds, but to ensure that measures used in federal programs do not disadvantage individuals based on age, disability, or health status. As discussed on the Senate floor, the spirit of these provisions was to protect vulnerable populations from policies that "set national practice standards or coverage restrictions" and to ensure that research used in such decisions is grounded in meaningful clinical outcomes.[3] Without transparency and clear limitations around value assessment methods, there is a heightened risk that discriminatory methodologies — like QALYs or similar tools — will enter the negotiation process without detection or accountability.

The data used to value health care may be discriminatory or fail to represent real-world experiences of patients and people with disabilities.

We urge CMS to not only comply with current law, but also to consider whether the evidence used in its decision-making was developed in a manner that reliably represents the population of patients and people with disabilities impacted. Value assessments are only as good as the data used in their development. Therefore, we urge the agency to consider the following factors:

- **Health utilities**: Also known as Health State Utility Value (HSUV), they mark the health-related quality of life (HrQOL) of a patient with a specific disease. A numeric valuation is applied to a health state based on preference of being in that state relative to perfect health, assigning a number between 0 and 1 to various conditions a person's health could be in (often called "health states" in which 0=death and 1=optimal health). They are typically derived from surveys asking how much, on average, someone prefers one health state compared to another. Health states typically represent degrees of impairment (not the disability or condition) such as active disease, response, remission, or mild, moderate and severe. Shortcomings include:
    - Survey data relies on average perspectives of quality of life in a health state, which are biased, inaccurate and almost never replicable. For example, there is significant research on the bias against disability among the public[4] and among providers[5].
    - The identified health states are typically not disease or condition specific, often surveying health from lens of mild, moderate or severe (such as the EQ- 5D6) and only accounting for health improvements that move between these broad states. Only large health improvements, i.e. HrQOL, count.
    - Health utilities typically give a lower value to people living below optimal health. For example, extending the life for person living at a .5 is worth half of a person at a 1.

[3] Colloquy by Senators Baucus, Enzi, Conrad, Hatch, Carper and Menendez. "Comparative Effectiveness Research Funds." Congressional Record 155:24 (February 6, 2009) p. S. 1796.
[4] Ari Ne'eman et. al., "Identifying And Exploring Bias In Public Opinion On Scarce Resource Allocation During The COVID-19 Pandemic," *Health Affairs* Vol. 41 No. 10 (October, 2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00504
[5] Lisa I. Iezzoni et. al., "Physicians' Perceptions of People With Disability and Their Health Care," *Health Affairs* Vol. 40 No. 2 (February, 2021), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01452

- **Disability weights**: Disability weights quantify health losses relating to non-fatal outcomes, expressed as years lived with disability (YLD). They typically have a value between 0 (equivalent to full health) and 1 (equivalent to death). For example, living 10 years with a 10 percent reduction in HRQoL is a disability weight of 0.10 – equal to losing one full year of good health (e.g., by dying one year before the life expectancy). Severity of condition (morbidity) and its death rate (mortality) are expressed as the number of healthy life years lost. Shortcomings include:
    - Disability weights are elicited by surveys, often of participants that do not have experience in the studied health state. Surveys are subject to bias against disability.
    - Disability weights from different studies are often not comparable, coming from different countries or populations with differing perceptions of disease and disability.
    - Assuming same weights to different aspects of quality of life as representative of all people risks being applicable to none.[6] Triathletes may highly weigh physical function. Academics may weigh mental acuity.
- **Health outcomes data**: Cost effectiveness analysis requires data on health outcomes to measure cost of gaining health. A product's "value" combines clinical effectiveness (impact of intervention on select health outcomes) and economic value (impact of intervention on healthcare resource use and costs). Shortcomings include:
    - Patient-centered outcomes and societal value are often ignored. For example, methods may not incorporate data on economic or social consequences such as loss of ability to work or caregiver effects.
    - Reliance on average estimates based on generic survey data obscures important differences in clinical needs and preferences, particularly complex diseases and those from underrepresented communities. [7]
- **Real-World Implications**: New methodologies for cost effectiveness analysis are abundant but untested. While recognition of flaws inherent in historic methods for assessing treatment value is driving innovation, literature on almost every method underscores need for extensive detailed data on patients' risk profiles, co-existing conditions, and other relevant factors currently lacking and challenging to obtain. Investment in data is needed.

Every value assessment measure has tradeoffs.

There has been longstanding protection against the use of discriminatory value assessment tools in statute. Therefore, we are concerned that CMS' draft guidance explicitly expressed interest in using alternative approaches as part of drug price negotiations. Every cost effectiveness measure has tradeoffs between conditions advantaged and disadvantaged:

[6] Anirban Basu & David Meltzer, "Value of Information on Preference Heterogeneity and Individualized Care," *Medical Decision Making* Vol. 27 No. 2 (March-April 2027), https://pubmed.ncbi.nlm.nih.gov/17409362/

[7] Michael J DiStefano et. al., "Alternative approaches to measuring value: an update on innovative methods in the context of the United States Medicare drug price negotiation program," *Expert Review of Pharmacoeconomics & Outcomes Research* Vol. 24 No. 2 (February 2024), https://pubmed.ncbi.nlm.nih.gov/37961908/

- **Quality-adjusted life year (QALY):** Less value to life-extending treatments among patients whose baseline health-related quality of life is low, particularly people living with disabilities. More value to treatments achieving maximum quality of life.
- **Equal value of life year gained (evLYG)**: Less value to treatments improving quality of life in extended life years. Same value as QALYs for treatments that do not extend life years regardless of quality-of-life improvements. More value to treatments extending life years.
- **Generalized Cost Effectiveness Analysis (GCEA):** Less value to treatments for common conditions to manage symptoms. More value to treatments for severe and disabling conditions.
- **Generalized risk-adjusted cost effectiveness (GRACE):** Less value to treatments for common conditions to manage symptoms. More value to treatments for severe and disabling conditions.
- **Disability adjusted life year (DALY):** Less value to treatments for people with disabilities due to focus on life years lost. More value to conditions leading to an early death without treatment.
- **Health years in total (HYT):** Less value to treatments that improve quality of life without increasing life expectancy. More value to treatments that extend life.
- **Life years gained (LYG):** Less value to treatments for patients with fewer years left to live (e.g., older adults or those with disabling conditions) and for largely non-fatal conditions (e.g., blindness, depression, rheumatoid arthritis. More value to treatments extending life.

Recommendation: We urge CMS to avoid use of one-size-fits-all value metrics, like the QALY or evLYG, as part of its decision-making, consistent with current Medicare law and regulations governing nondiscrimination. CMS should also identify and be transparent about the types and sources of research, data, and assessments considered in its decision-making process — including requiring disclosure of whether submitted evidence relies on cost-effectiveness measures such as QALYs, evLYG, or similar metrics. In addition, CMS should ensure it and other entities are exercising adequate oversight over the Medicare Drug Price Negotiation Program to ensure decisions do not rely on data from studies relying on one-size fits all metrics, like the QALY or evLYG.

Engage Patients and People with Disabilities.

We urge the Centers for Medicare & Medicaid Services (CMS) to strengthen and formalize its patient engagement process beyond written comment periods and one-time public events. Drawing on robust frameworks from leading organizations including PCORI, National Health Council (NHC), the PATIENTS Program at the University of Maryland, the Center for Innovation and Value Research (CIVR) (formerly known as the Innovation and Value Initiative (IVI)), and AcademyHealth, we want to reemphasize the following recommendations through which CMS would prioritize authentically involving patients and people with disabilities in agency decisions. We urge CMS to incorporate these best practices to foster meaningful dialogue with patients, caregivers, and people with disabilities across the agency. The insights from their lived experience will allow CMS to ensure advancement of policies and practices that improve health care value and patient outcomes.

Our recommendations for strengthening CMS' patient engagement strategies are grounded in the expertise of organizations dedicated to improving health care value through meaningful engagement

with patients and individuals with disabilities. These organizations have developed substantial recommendations to foster and guide patient engagement across the health care sector, emphasizing the crucial role of meaningful and authentic patient and caregiver engagement in research processes.

While we appreciate that CMS has outlined a public engagement strategy in the guidance, past experiences show room for improvement in execution and clarity. In response to CMS' 2023 listening sessions on the Medicare Drug Price Negotiation Program, NHC convened a roundtable discussion to provide a platform for the patient community to share their experience engaging with the agency.[8] Stakeholders outlined valuable insights gleaned from these sessions, which can contribute to shaping CMS' broader patient engagement strategies. The PATIENTS Program at the University of Maryland School of Pharmacy adopted a similar approach by hosting a Town Hall, bringing together stakeholders to gather insights and recommendations.[9] Their aim was to ensure that patient perspectives are being represented in the agency's decision-making. There is still room and appetite for CMS to incorporate some of these recommendations into its processes.

Furthermore, the PCORI-developed Foundational Expectations for Partnerships[10] and CIVR's Economic Impacts Framework[11] also informed our recommendations. PCORI's six expectations serve as a framework to guide meaningful, effective, and sustainable engagement to advance patient-centered comparative clinical effectiveness research (CER). Meanwhile, CIVR's framework, along with the principles used to develop it, encourages partnerships between patients, caregivers, and researchers to broaden the understanding and measurement of the six main economic impacts for patients.

CMS should work with an advisory group of experts from organizations representing people with chronic conditions and disabilities to enhance the existing engagement strategy and ensure continuous, robust engagement of patients and people with disabilities at multiple levels.

There is broad consensus among policymakers and leaders in the field of patient-centered outcomes research that robust engagement of people with lived experience is crucial. As part of NHC's vision for improving CMS' patient engagement over the next five years, one of three key improvements proposed is inclusion of patient perspectives at every stage of the decision-making process. To achieve this objective, both NHC and the PATIENTS Program urge CMS to establish partnerships with the patient community and formalize a process to create multiple touchpoints with people experiencing the disease or illness being studied. This aligns with PCORI's foundational expectations for partnerships, which emphasizes the importance of initiating touchpoints early, even during planning stages of a study.

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[8] NHC, "Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement," published March 2024, https://nationalhealthcouncil.org/wp-content/uploads/2024/03/Amplifying-the- Patient-Voice-Roundtable-and-Recommendations-on-CMS-Patient-Engagement.pdf

[9] The PATIENTS Program at the University of Maryland School of Pharmacy, "PATIENTS Professors Town Hall: Recommendations for the CMS Drug Price Negotiation Program Final Report," published July 12, 2023, https://www.pharmacy.umaryland.edu/media/SOP/wwwpharmacyumarylandedu/programs/PATIENTS/pdf/Patient-driven-recommendations-for-the-Medicare-Drug-Price-Negotiation-Program.pdf

[10] PCORI, "Engagement in Research: Foundational Expectations for Partnerships," updated February 2024, https://www.pcori.org/sites/default/files/PCORI-Engagement-in-Research-Foundational-Expectations-for- Partnerships.pdf

[11] IVI and AcademyHealth, "A Research Framework to Understand the Full Range of Economic Impacts on Patients and Caregivers," published May 2023, https://thevalueinitiative.org/wp- content/uploads/2023/06/05-2023-Economic-Impacts-Framework-Report_FINAL.pdf

Additionally, CIVR highlights that continuous partnerships provide valuable context from individuals' lived experiences to shape research priorities and NHC recommends CMS develop methods for incorporating this patient experience data into its program implementation. The experts participating in the advisory group should include those with experience engaging patients and people with disabilities throughout the life cycle of chronic conditions and disabilities to elicit information about the range of burdens and outcomes that matter most to them, as well as the differences among subpopulations.

Recommendation: Based on this strong consensus and alignment of goals, we recommend that CMS develop a formalized engagement process in consultation with engaged partners in the patient and disability communities that have expertise engaging people with lived experience related to their experiences with treatment. This process should not only ensure that the agency is actively engaging early and often with patient stakeholders but also guarantee ongoing engagement, fostering sustainable partnerships and building trustworthy relationships for future endeavors.

Using patient insights, CMS should clearly communicate how it intends to use the input it receives, and how that input is reflected in the final negotiated prices.

While CMS hosts public engagement events and asks stakeholders to submit data on selected drugs, the agency has not clearly explained how input will be used or how it will inform CMS' eventual conclusions. The process of collecting stakeholder input is critical, but equally important is ensuring that the information is meaningfully incorporated into decision-making.

This issue was highlighted during NHC's roundtable, where numerous stakeholders expressed feeling underprepared by CMS for the 2023 listening sessions, which limited their ability to meaningfully participate. They suggested that CMS could have better communicated the purpose of the information it is seeking, and how it is being used in determining prices for selected drugs. We appreciate that the agency provided more detailed guidance ahead of the 2025 roundtable events to help speakers prepare. However, we emphasize that this level of clarity should be applied more broadly to CMS's overall engagement strategy, with a clear articulation of how patient input is being incorporated into the agency's decision-making processes.

Recommendation: We encourage a cyclical approach, wherein patient engagement helps CMS communicate how it intends to use the information submitted by stakeholders on selected drugs and therapeutic alternatives. It is critical that this information is communicated to stakeholders to ensure they are prepared to provide appropriate feedback at public engagement events. CMS should be very explicit and transparent about the information it is seeking from patients and people with disabilities and how that input will influence decisions.

CMS should ensure that opportunities for patient engagement are accessible.

CIVR and PCORI emphasize the significance of allocating dedicated funds and resources to support and compensate patient engagement. We concur with this perspective and recommend CMS take responsibility for compensating patient participants to ensure that their patient engagement opportunities are accessible. Most of these individuals have to take time off from work and routine

caregiving duties to lend their expertise. They should be compensated as any expert would be for participating in such a process. Patient and disability advocates have echoed these sentiments, urging CMS to allocate resources such as financial assistance, accessible materials, disability-friendly meeting arrangements, and extended input and comment periods.

It will also be critical that CMS provide accessible materials, emphasizing the use of plain language and health literacy principles to ensure patient understanding and inclusivity. They also advocate for diverse engagement approaches, recognizing that online-only methods may not be accessible to everyone. Notably, NHC recommends that Congress provide this support, along with funding and oversight, to strengthen CMS' engagement efforts.

Additionally, NHC recommends that CMS enhance its own accessibility. Communication with executive branch agencies can often be challenging due to bureaucracy and the need for institutional knowledge to communicate effectively. Streamlining the process for initiating dialogue, such as by creating an ombudsman or a clearly identified point of contact, is essential for effective engagement.

Recommendation: While CMS has outlined virtual engagement events, further action is needed to ensure true accessibility and inclusion for all patient and disability communities. CMS should create an ombudsman for engagement of stakeholders from the patient and disability communities, dedicate funds and resources to support and compensate patient engagement, and ensure accessibility through use of plain language materials and by providing opportunities for engagement through written comments, in- person meetings and online events.

To gauge both successes and challenges, CMS should establish a structured process for continuous review and assessment of its stakeholder engagement strategy.

PCORI's final expectation for patient engagement underscores the importance of gathering input and feedback throughout projects to pinpoint areas of success and areas for improvement, enabling adjustments in future engagement strategies. PCORI emphasizes that continuous learning is essential for enhancing engagement strategies, allowing researchers to assess whether engagement is effective, equitable, and as intended. The PATIENTS Program echoes PCORI's expectation, advocating for a third-party evaluation of patient and stakeholder engagement to ensure transparency and accountability.

Recommendation: CMS should commit to continuous learning, refining its patient engagement strategy and promoting health equity as part of a structured assessment of what works and what does not work, in collaboration with engaged patients and people with disabilities.

Conclusion

We urge CMS to continue refining its implementation of the Medicare Drug Price Negotiation Program to ensure alignment with existing law governing the use of value assessments and to strengthen meaningful, continuous engagement with patients and people with disabilities. While we appreciate the steps CMS has taken to formalize an engagement strategy, further action is needed to ensure that patient voices are not only heard but integrated into decision-making, and that the agency relies on high-quality, representative sources of evidence. We appreciate CMS' consideration of our

recommendations, offering a holistic approach to improving patient engagement across the agency. Embracing these recommendations will not only strengthen CMS' relationship with stakeholders but also pave the way for more effective delivery of quality health care, ultimately benefiting patients and the health care system.

Sincerely,

Alliance for Aging Research
Alliance for Patient Access
ALS Association
American Association of Kidney Patients
American Association on Health and Disability
Axis Advocates
Blue Ridge Independent Living Center
Caring Ambassadors Program, Inc.
Color of Gastrointestinal Illnesses
Cystic Fibrosis Research Institute
Depression and Bipolar Support Alliance
Diabetes Leadership Council
Diabetes Patient Advocacy Coalition
Disability Policy Consortium
Disability Rights Education and Defense Fund (DREDF)
Epilepsy Foundation of America
GO2 for Lung Cancer
Headache & Migraine Policy Forum
Health Hats
HealthHIV
Healthy Men Inc.
Infusion Access Foundation
Lakeshore Foundation
Lupus and Allied Diseases Association, Inc.
National Hispanic Medical Association (NHMA)
National Infusion Center Association
National Minority Quality Forum
Not Dead Yet
Partnership to Improve Patient Care
Sickle Cell Foundation of Georgia, Inc.
Statewide Independent Living Council of IL
The Bonnell Foundation: Living with cystic fibrosis
United Cerebral Palsy
WeMatter Organization

PATIENTS FOR AFFORDABLE DRUGS™

June 26, 2025

The Honorable Mehmet Oz
Administrator
Center for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Medicare Program; Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program Draft Guidance; Comment Request

Dear Administrator Oz:

Patients For Affordable Drugs (P4AD) appreciates the opportunity to offer comments on the newest draft guidance for the Medicare Drug Price Negotiation Program.

P4AD is the only national patient advocacy organization focused exclusively on system-changing policies that lower prescription drug prices. We are bipartisan and do not accept funding from any entities that profit from the development or distribution of prescription drugs. Since we launched eight years ago, we have collected over 38,000 stories from patients from all 50 states who are struggling to afford their prescription drugs because of high prices.[1] Recent polling shows that nearly nine in ten voters — across party lines — say prescription drugs are priced too high.[2] Voters overwhelmingly believe drug companies prioritize profits over patients and are the actors driving the unaffordable prices.

The United States is experiencing a drug affordability crisis. One in three people in the U.S. cannot afford to pay for their prescription drugs. Americans unfairly pay between four and eight times more for brand-name drugs than people in other wealthy nations.[3] Older Americans are particularly vulnerable and are more likely to skip doses or forgo prescription refills due to cost, at more than double the rate in other countries.[4] About one in five adults ages 65 and older either skipped, delayed, or rationed their prescribed medicines in 2022 due to cost.[5] In that same year, 20 percent of adults 65 and older were concerned about being able to afford their needed prescriptions.[6] Studies have estimated that over 1.1 million people on Medicare could die in the next decade because they are unable to afford their prescriptions.[7]

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[1](2024, June 20). *Patients For Affordable Drugs Map*. Patients For Affordable Drugs. https://map.patientsforaffordabledrugs.org/
[2](2025, April 22). *Majority of Americans Support Lower Drug Prices, Demand Congress Act*, Fabrizio Ward. https://www.arnoldventures.org/newsroom/new-poll-majority-of-americans-support-lower-drug-prices-demand-congress-act
[3](2024, February 1) *International Prescription Drug Price Comparisons*. RAND Corporation. https://www.rand.org/pubs/research_reports/RRA788-3.html
[4](2024, December 5). *Healthcare Affordability for Older Adults: How the U.S. Compares to Other Countries*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2024/dec/health-care-affordability-older-adults-how-us-compares-other-countries
[5](2023, May 18). *Cost-Related Medication Nonadherence and Desire for Medication Cost Information Among Adults Aged 65 Years and Older in the US in 2022*. Journal of the American Medical Association. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2805012
[6](2022). *Healthcare in America Report*. Gallup. https://www.gallup.com/analytics/401972/healthcare-in-america-2022.aspx
[7](2020, November 18). *High Drug Prices and Patient Costs: Millions of Lives and Billions of Dollars Lost*. Council for Informed Drug Spending Analysis. https://www.cidsa.org/publications/xcenda-summary

We applaud the Trump administration's commitment to addressing this national crisis, including the administration's support of the Medicare Drug Price Negotiation Program, which is set to deliver savings to 9 million people on Medicare and taxpayers in 2026, with millions more expected to benefit in the second round of negotiations. We urge the administration to negotiate a better deal for Americans through Medicare negotiation and prevent pharma lobbyists from rigging the system in their favor.

Identifying Potential Qualifying Single-Source Drugs

P4AD applauds CMS for its rigorous standards in compiling dosage forms and strengths for identifying qualifying single-source drugs. We urge CMS to continue to hold pharmaceutical companies accountable by preventing gamesmanship of the negotiation program and by aggregating all combinations of active moieties into one qualifying single-source drug for purposes of negotiation. This is especially important when considering the already well-known tactics pharmaceutical manufacturers use to extend their monopolies for decades past their initial patent expiration, helping to keep Americans paying the highest prices in the world.

Separately, the current draft guidance solicits comments on a loophole for combination products. Currently, pharmaceutical manufacturers can combine the active moiety eligible for negotiation with another ingredient that does not provide a clinically significant benefit and is not biologically active against the disease state in order to escape negotiation for an extended period. We believe that if this loophole is allowed to continue, then manufacturers will create combination drugs without any clinically significant benefit to extend their artificial monopolies, evade negotiations, and keep prices high for patients and taxpayers.

These "new" combination products are not lifesaving innovations; they are Big Pharma's attempt at using product hopping to dodge negotiations. We urge CMS to close this loophole and push pharmaceutical manufacturers to instead focus on the lifesaving innovation Americans are depending on.

Part B Expenditures

P4AD is excited to see the negotiation program expand to include Part B covered drugs in 2028, as Part B spending has grown similarly to Part D spending in the past decade, largely driven by the rise in drug prices.[8] Many high-cost products such as drugs that treat cancer or autoimmune conditions are more frequently covered by Part B. While we are pleased to see the inclusion of Part B drugs, we have concerns that under the current draft guidance CMS would not be using all of the applicable expenditure data available to calculate drug expenditures for negotiation eligibility.

In draft guidance for previous negotiation cycles, CMS utilized prescription drug expenditure data that included expenditure data from standalone Prescription Drug Plans as well as Medicare Advantage Prescription Drug Plans. Under the current draft guidance, CMS intends to use "Part B claims data" to identify high-spend drugs for negotiation, which may or may not include expenditure data from Medicare Advantage. Medicare Advantage enrollees have similar access to Part B-covered products as those enrolled in traditional Medicare plans, but may be exposed to much higher coinsurance rates depending

[8](2021, October 7). *Addressing high prices of pharmaceutical products (and other technologies) covered under Medicare*. MedPAC. https://www.medpac.gov/document/addressing-high-prices-of-pharmaceutical-products-and-other-technologies-covered-under-medicare/

on their plan coverage.[9] As Medicare Advantage has grown to cover more than half of the Medicare enrollee population, neglecting to include this data would prevent the administration from negotiating the best deal possible for the largest population of patients possible.[10]

We urge CMS to include Medicare Advantage Prescription Drug Plan expenditure data when identifying high-spend drugs for negotiation eligibility.

Public Engagement

P4AD applauds the administration's continued dedication to lowering prices for patients and maintaining transparency throughout the negotiation process. We appreciate CMS's dedication to providing patient listening sessions that allowed patient advocates to share their stories about the high cost of the drugs selected for the second round of negotiations. These listening sessions ensure patients like Janet from South Carolina, whose husband can't afford the over $600 monthly co-pay for Janumet, are heard. Patient voices and perspectives should be centered whenever possible in the negotiation process to ensure the best possible outcomes for those whose lives and livelihoods depend on the outcomes of the negotiation program.

The process of renegotiation is new to this upcoming negotiation cycle and we encourage CMS to continue to center patient experiences living with high drug prices. The current guidance does not explicitly commit to providing opportunities for patients to share their experiences with selected renegotiation drugs. We propose CMS hold public engagement events and evidence submission periods for patients to share their stories.

Thank you again for the opportunity to provide comments. We would be happy to collaborate further to lower drug prices for American patients.

Sincerely,

Merith Basey MSc
Executive Director
Patients For Affordable Drugs

[9](2022, March 15). *Medicare Part B Drugs: Cost Implications for Beneficiaries in Traditional Medicare and Medicare Advantage*. KFF. https://www.kff.org/medicare/issue-brief/medicare-part-b-drugs-cost-implications-for-beneficiaries-in-traditional-medicare-and-medicare-advantage/

[10](2024, August 8). *Medicare Advantage in 2024: Enrollment Update and Key Trends*. KFF. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/

PERSONALIZED MEDICINE COALITION

June 26, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Sent electronically to IRARebateandNegotiation@cms.hhs.gov

Re: Draft Guidance for the Medicare Drug Price Negotiation Program: Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028

Dear Administrator Oz:

The Personalized Medicine Coalition (PMC), a multi-stakeholder group comprising nearly 200 institutions from across the health care spectrum, thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to submit comments on CMS' draft guidance for implementation of the Medicare Drug Price Negotiation Program for the initial price applicability year (IPAY) 2028.[i] We believe the procedures and methodologies in the draft guidance proposed for use in negotiations during the third cycle of the program could negatively impact the current and future availability of personalized medicine treatment approaches. PMC's comments build upon those previously shared on IPAY 2026 and IPAY 2027 and urge CMS to ensure that the negotiation process and renegotiation of previously selected drugs genuinely aligns with patient needs and preferences, ultimately leading to better health outcomes.[ii]

Personalized medicine is an evolving field in which physicians use diagnostic tests to determine which medical treatments will work best for each patient or use medical interventions to alter molecular mechanisms that impact health. By combining data from diagnostic tests with an individual's medical history, circumstances, and values, health care providers can develop targeted treatment and prevention plans with their patients. Personalized medicine is playing an important role in transforming care and patient outcomes for a range of serious and life-threatening diseases and conditions, helping to shift patient and provider experiences away from trial-and-error medicine and toward a more streamlined process for making clinical decisions.

PMC and CMS share the goal of achieving better health outcomes and lowering costs for patients. We urge CMS to refine its negotiation process so that it does not disrupt the innovation ecosystem and patient access to personalized medicine by ensuring that:

- Patients do not face additional barriers accessing negotiated medicines and their treatment alternatives, including Medicare Part B drugs;
- CMS maintains processes to prevent, monitor, and correct for any unintended, downstream impacts of the Medicare Drug Price Negotiation Program on patient access to personalized medicine and on pipelines for new personalized medicine treatments and expanded indications;
- CMS recognizes the clinical and societal benefits of personalized medicine and incorporates patients' perspectives on care value;
- CMS' methodology, negotiation process, and renegotiation establish consistency and transparency by communicating how factors considered are weighed and how external data are factored into its decisions; and
- CMS refines procedures that allow a robust exchange of information with manufacturers, patient organizations, and other stakeholders in determining the MFP throughout the negotiation process and renegotiation of previously selected drugs.

Statement of Neutrality

Many of PMC's members will present their own responses to the *Medicare Drug Price Negotiation Program Draft Guidance for IPAY 2028 and Manufacturer Effectuation of the MFP in 2026, 2027 and 2028* and will actively advocate for those positions. PMC's comments are designed to provide feedback so that the general concept of personalized medicine can advance, and are not intended to impact adversely the ability of individual PMC members, alone or in combination, to pursue separate comments with respect to the draft guidance and/or any that follows.

Considering and Monitoring Unintended Impacts on Personalized Medicine

Medicare's drug price negotiation program could narrow patients' access to existing treatment options in personalized medicine. PMC has previously submitted comments to CMS on the difficulties utilization management practices, such as prior authorization and step therapy, can create for patients in accessing the latest treatments and standards of care informed by personalized medicine.[iii,iv,v] We are concerned that plans may be incentivized to disadvantage selected drugs with utilization management that is not based on medical appropriateness, potentially exacerbating an already growing trend in the use of step therapy and its embedding in prior authorization requirements.[vi,vii,viii]

Because negotiated drugs are being offered to plans at a lower price, PMC believes negotiated drugs should not face additional cost-control practices that could limit eligible Medicare beneficiaries' access to them. While PMC thanks CMS for identifying several criteria the agency will use to assess whether plans meet requirements for covering negotiated drugs through its existing formulary review process, CMS' proposal should not defer on implementing explicit policy requirements. **We request CMS further clarify specifically the extent to which any utilization management will be permitted for negotiated drugs in traditional Medicare and Medicare Advantage. PMC also encourages CMS to address**

how it plans to monitor and address the real-world impacts of any utilization management changes, while ensuring that any changes do not impede patient access to negotiated drugs and competitors within their class.

The inclusion of drugs reimbursed under Medicare Part B in the IPAY 2028 cycle represents a significant evolution in the Medicare Drug Price Negotiation Program. Infused therapies, biologics, and other physician-administered treatments commonly used by individuals with cancer, autoimmune conditions, neurologic diseases, and rare disorders are now in scope of the program.[ix] This expansion introduces a distinct set of challenges for Part B drugs including personalized medicines.

Medicare Part B drugs are generally administered in clinical settings where providers purchase the drug upfront and are later reimbursed at the drug's Average Sales Price (ASP) plus 6 percent.[x] Applying the Maximum Fair Price (MFP) to these therapies requires detailed implementation guidance specific to the operational realities of Part B. Because these therapies will no longer be reimbursed based on ASP + 6%, **CMS must clarify how providers should submit claims for drugs subject to the MFP; updated coding protocols, reconciliation pathways, and integration requirements for Medicare Administrative Contractors (MACs); and release a dedicated billing guidance document that includes FAQ's for use cases, edge scenarios, and transition instructions for off-cycle or multi-dose claims.[xi] Absent clarification and additional guidance, providers may encounter billing challenges that could affect timely reimbursement and patient access to Part B drugs.**

Furthermore, if reimbursement under the MFP falls below the acquisition cost for a drug, or introduces new uncertainties providers may opt not to stock or offer these therapies to their patients.[xii] Past CMS experiences have demonstrated that even modest shortfalls between ASP and acquisition costs have resulted in reduced provider uptake.[xiii] **CMS should consider whether temporary transition payments from the agency or acquisition cost safeguards are needed to preserve meaningful access for all patients, particularly during the early phases of implementation.**

Personalized medicines have accounted for at least a quarter of new drug approvals for each of the past 10 years.[xiv] PMC previously expressed that the Medicare Drug Price Negotiation Program could have an outsized effect in discouraging the pharmaceutical industry from bringing additional personalized medicines and expanded indications to the market. Multiple analyses, including those from the Congressional Budget Office (CBO), have called attention to the potential consequences of the Medicare drug price negotiation program, such as canceled research and development and disincentives to invest in small-molecule medicines and therapeutic areas that require incremental innovation.[xv,xvi,xvii,xviii] **CMS should take every step possible to maintain processes to prevent, monitor, and correct for any unintended, downstream impacts of the Medicare Drug Price Negotiation Program on patient access to personalized medicine and on pipelines for personalized medicine treatments approaches.**

Orphan drug products and additional rare designations

Currently under the IRA, only orphan drugs that treat a single rare disease are excluded from the Medicare Drug Price Negotiation Program. If an orphan product is indicated for multiple diseases, even if these are also orphan indications, it loses its exclusion from negotiation, in effect, disincentivizing further

research and development of additional indications and expanded uses of existing drugs for rare diseases. PMC is concerned that this narrow exclusion could stifle post-approval research into additional orphan indications for rare diseases. Only about one quarter of all orphan drugs approved in the last two decades have a single indication.[xix] Continued research and development after an orphan drug's initial approval is crucial and often results in expanded indications within that rare disease or for entirely separate rare diseases for which there is no existing therapy. In fact a recent analysis found that after the *IRA* was passed, the percentage of drugs with an initial orphan designation that went on to receive a second designation decreased by 48 percent despite a steady increase observed before the *IRA*.[xx] PMC believes the well-intended but narrow orphan drug exclusion contradicts the goals of the *Orphan Drug Act* to foster the development of new treatments for rare diseases. PMC continues to support legislation to broaden the orphan drug exclusion in statute to ensure that investment decisions among multiple potential orphan indications can still prioritize indications for very rare diseases. **CMS should also monitor the impact of the Medicare Drug Price Negotiation Program on the research and development of orphan products and additional orphan designations that benefit patients with rare diseases.**

Small-molecule drugs

Many targeted cancer therapies that deliver personalized medicine to patients are small-molecule drugs.[xxi] According to *IRA* statute, small-molecule drugs are eligible for negotiation nine years after approval versus 13 years for biological, or large-molecule, products. PMC remains concerned that implementation of these differential timelines will disincentivize investment in small-molecule over large-molecule drugs. These dynamics may impact the growing pipelines of personalized medicines available to patients, including patients from communities already experiencing disproportionately high incidence and mortality rates of certain diseases like cancer. One analysis estimates 79 fewer small-molecule drugs and 188 fewer indications coming to market over the next 20 years.[xxii] A cross-sectional analysis comparing the number of subsequent indications between personalized medicines as defined by the PMC and non-personalized medicines found that the *IRA's* Medicare Drug Price Negotiation Program may be three times more likely to disincentivize subsequent indications for small-molecule personalized medicines than non-personalized medicines.[xxiii] **To reduce the impact of differential timelines for drugs and biologics on clinical development for small molecules and patients who need these critical therapies, PMC supports the administration's directive to work with Congress to amend the *IRA* to establish equal timelines for the negotiation of both drugs and biologics at 13 years. We also believe CMS should monitor impacts of the negotiation program on the development of small-molecule personalized medicines.[xxiv]**

Post-approval research and expanded indications

In identifying drug products for negotiation, CMS broadly interprets the *IRA* statute in Sec. 30.1 of the draft guidance to aggregate drugs for selection based on a single active moiety, or ingredient, across multiple New Drug Applications (NDAs) or Biologics License Applications (BLAs). As drug products age and approach eligibility for price negotiation, companies may be disincentivized to pursue additional indications, which can require additional approvals after the original NDA or BLA approval. PMC is concerned that the negotiation program will deter incremental innovation supported by post-approval research, including the development of expanded indications that provide patients with personalized

medicine treatment options.

Research conducted after approval of a new drug is important for advancing personalized medicine. After initial approval of a targeted therapy by FDA, further research provides greater understanding of patients' responses to treatment based on results from molecular diagnostics. This research leads to new or improved treatment indications that contribute to progress in personalized medicine. But smaller patient subpopulations can make it difficult to recoup investment in this research, which can require additional clinical trials and NDAs or BLAs. One white paper examining six products in chronic diseases, rare diseases, and cancer found that over half (seven out of 15) of the applications for expanded indications were approved at about the same time or after the product could have been selected to begin negotiation (at seven or 11 years).[xxv] Over the past decade, PMC has identified more than 150 expanded indications significant to advancing personalized medicine.[xxvi] Notably, these expanded indications have had an upward trend in the average time since a drug's initial approval. Since these expanded indications can increase the product's aggregated utilization and risk for earlier selection, the drug price negotiation program can alter manufacturers' decision-making for investing in researching new uses for a drug post approval, potentially affecting patients with serious conditions or unmet needs.

PMC is 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 leading to new indications, forms of administration, and combination products. **CMS should require that, for a drug or biological product to be included in a Qualified Single Source Drug (QSSD), it should be limited to drug products/biological products that are approved/licensed under a single NDA/BLA. In addition, each product within a QSSD should independently meet the age requirement of 7 years for a small drug product or 11 years for a biological product.**

The IPAY 2028 draft guidance proposes to take fixed-dose combinations that include multiple active ingredients and treat them as the same drug. CMS should apply a consistent approach to fixed-combination products for the purposes of identifying QSSDs but should not adopt this proposal. If implemented a new or improved formulation of a drug, including drugs for a completely different patient population or disease, approved under a separate NDA or BLA, could face price setting immediately after FDA approval. **PMC is very concerned with this broad definition of drugs eligible for negotiation and that it may discourage the types of innovation that improve patient adherence and outcomes.**

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. 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. CMS should consider using patient engagement to determine whether/how a drug, including fixed-combination products, provide therapeutic advances as experienced by patients and publicly explain how the agency factored in patient input into price setting.

Recognizing the Clinical and Societal Value of Personalized Medicine

Drugs with personalized medicine treatment strategies create considerable benefits for patients and society since they are used in a manner that directs them toward patients who are most likely to benefit and away from those who are not. Economic worth of a particular treatment is typically based on analysis of its safety and effectiveness at a population level. In many cases, value assessment methodologies fail to adequately account for the safety and effectiveness benefits that may be realized by individual patients or patient subpopulations. When assessing value, it is important to consider the holistic benefits of a treatment at the patient, subpopulation, and societal levels.

PMC appreciates CMS' reference to patient experiences in its discussion of the clinical benefits of selected drugs and their therapeutic alternatives in Sec 50.2 of the draft guidance. Although CMS has broadened its consideration of patient experiences, based on the methodology outlined in guidance and the released MFP explanations for IPAY 2026, it is still unclear how input from patients, caregivers, and providers will influence CMS' analysis of clinical benefit and whether CMS may consider the benefit of personalized medicine. **In general, PMC urges CMS to consider the following aspects of clinical and societal value related to personalized medicine that advance patient-centered care,** [xxvii] **ensuring that the value of personalized medicine to direct patients toward or away from treatments based on their likelihood to benefit from them is factored into determining the MFP for a selected drug:**

- **Diagnostic testing strategies:** Diagnostic tests can help guide treatment decisions and determine which treatments will be most effective and safest for any given patient. Such testing is a crucial element of the personalized treatment regimen. For example, the use of companion diagnostics can help define subpopulations of patients who may benefit from a treatment, and those who will not. The availability of diagnostic tests and consideration of test results that help inform treatment decision-making for drugs with biomarker implications must be figured into the value assessment methodology for personalized medicines. **PMC encourages CMS to consider the value of applicable diagnostic strategies in its evaluation of unmet medical need and clinical effectiveness.**

- **Heterogeneity of treatment effects:** Some patients will experience more or less benefit from a treatment than suggested by the averages reported within clinical trials and population-based data. Health care policies based on averages can misjudge and undervalue personalized medicines simply because the data required for value-based decision-making do not account for patient subpopulations or because long-term efficacy data is not yet available. **PMC encourages CMS to consider the full range of patient outcomes and benefits that may not be represented in population average-based data.**

- **Patient values and circumstances:** Personalized medicine depends not only on the consideration of a patient's molecular and biological characteristics but also on individual values, clinical and economic circumstances, and the potential impact of a therapy for that patient over the long term. Fundamental patient values and preferences, including the impact of treatment on quality of life, quantity vs. quality of time, functional ability related to illness or

treatments, cost of supportive care, and other patient costs of treatment are weighed by patients and their caregivers when deciding on a treatment in consultation with health care providers. Although CMS has attempted to broaden its definition for unmet medical need in past guidance, we believe CMS' definition continues to be too narrow to appropriately assess the value personalized medicines provide to patients with unmet medical needs. **PMC encourages CMS to further expand its definition of unmet medical need to formally consider a broad range of patient outcomes and impacts, including unmet medical needs unique to individual patients and patient subpopulations.**

- **Treatment efficiency:** Although value assessments generally focus on improvements in effectiveness, they do not generally consider avoiding ineffective or harmful treatment options and reducing the downstream expenses associated with rapid disease progression and/or adverse events. In order to capture economic as well as clinical value, value assessments need to consider costs and outcomes across health care. **As CMS evaluates the costs and benefits of personalized medicines to society, PMC encourages the agency to formally consider a broad range of economic impacts beyond just the proposed consideration of changes to a patient's productivity, including broader cost offsets and societal benefits, like treatment efficiency.**

PMC appreciates that CMS will not directly rely on the quality-adjusted life year (QALY), there are still significant concerns that studies relying on the QALY or other similar metrics could impact the determination of MFP The QALY does not sufficiently account for the broad heterogeneity of clinically relevant characteristics and preferences across patients and diseases, nor does it consider aspects of value defined by patients and their families. The measure relies on population averages that do not consider the heterogeneity of patient populations, even within the same condition.

While CMS states it will follow statute, the draft IPAY 2028 guidance indicates in Sec. 50.2 that CMS still plans to separate and exclude QALY metrics from evaluations of research that otherwise factor in QALYs when such content is "relevant and allowable." This approach may not effectively separate QALYs from CMS' analysis because CMS may continue to rely on studies that employ QALY-related data from secondary sources, or that CMS may exclude analyses that are otherwise helpful in establishing the value of a drug for a patient. Regarding CMS' *Negotiation Data Elements Information Collection Request* that asks the public to submit information on a selected drug, we are concerned that CMS plans to remove the requirement for submitters to indicate whether their submission contains information from studies that use QALYs. Citations referenced in CMS' IPAY 2026 MFP already explain that studies relying on the QALY and similar metrics have the potential to discriminate or assign a lower value to the elderly, patients with disabilities, and the chronically ill. PMC believes the agency would be better served by focusing on factors related to comparative clinical outcomes and unmet need that are described in statute, which can better capture the benefits of personalized medicine. There is not one measure of value that holistically captures the value and benefits of any medical treatment. **We continue to encourage CMS to consider a wide variety of measures consistent with CMS' statutory focus on comparative effectiveness research and unmet need, especially those driven by patient experience data, patient input, and patient-centeredness.**

Facilitating Meaningful Stakeholder Engagement

To help build public trust in the negotiation process and ensure predictability informs stakeholder participation in patient-focused listening sessions, provider town halls, and data submission during future years of the negotiation program, CMS must be transparent about how it considers information provided. We thank CMS for intending to publish an explanation of the factors that had the greatest influence in determining a drug's MFP, but CMS must also improve transparency regarding how stakeholder input is used. **The current process is insufficient to assure stakeholders that their contributions have influenced policy outcomes or to hear a rationale for why any of their feedback was ultimately not acted upon. CMS should develop a centralized, publicly accessible archive of all listening session and town hall materials—including agendas, guidance prompts, anonymized summaries, and recordings. This will allow other stakeholders (e.g., academic researchers, patient organizations, and clinicians) to review patterns in patient-reported data and understand how those perspectives inform Medicare drug pricing decisions.**

Organizations like the National Health Council have published recommendations for how CMS can further improve patients' experiences in these listening sessions and their overall engagement in the negotiation program.[xxviii] PMC recommends CMS consider how to foster robust, bi-directional communication between public stakeholders and the agency, and we encourage the agency to adopt recommendations from patient advocacy organizations. **In an effort to yield more actionable insights for the third cycle of the negotiation process, CMS should consider the burden of data collection and submission on stakeholders and offer flexibility that facilitates the inclusion of a broad range of perspectives. We ask CMS to allow patients, caregivers, clinicians, and organizations representing these groups additional time to submit data; be provided with at least 30 days advance notice to arrange for participation in all listening sessions; and have advance thematic guidance to prepare relevant input. CMS should also publish preliminary thinking on therapeutic alternatives at the time a drug is selected for negotiation so that stakeholders can react and advise CMS on suitability of the alternatives proposed.**

Renegotiation of Previously Selected Drugs

The *IRA* anticipated that the clinical and economic value of a drug could evolve over time—due to factors such as new FDA-approved indications, biosimilar entry, or shifts in real-world utilization. The IPAY 2028 draft guidance outlines four circumstances under which a drug may become eligible for renegotiation: the approval of a new FDA indication; a shift in exclusivity status; a "material change" in a statutory factor such as clinical benefit or unmet need; or a discretionary determination by CMS based on new evidence. While these are aligned with the statute's intent, **the process by which CMS will determine that a drug qualifies for renegotiation should be more transparent. CMS should commit to issuing public notices of intent to renegotiate, followed by a defined comment period to allow patients, clinicians, and other affected parties to submit updated clinical data, real-world outcomes, and patient perspectives**.[xxix]

The phrase "material change" appears throughout the IPAY 2028 guidance but is never defined. PMC is concerned that this could lead to confusion or inconsistent application. **CMS should develop and**

publish examples to clarify the types of clinical, economic or operational changes that would trigger renegotiation. The timing of renegotiation reviews is also unclear. The guidance references future IPAY cycles but does not specify whether CMS will review eligibility for renegotiation on a set schedule or only on an ad hoc basis. A regular review timeline should be considered to promote consistency and allow stakeholders to anticipate upcoming changes.

Conclusion

As the agency continues to implement the drug price negotiation program, we urge CMS to carefully consider these comments for this and future guidance. PMC looks forward to working with you and your colleagues to ensure the program maintains the ecosystem for innovation in personalized medicine and fosters patient access to needed personalized medicine treatments. If you have any questions about the contents of this letter, please contact me at 202-499-0986 or cbens@personalizedmedicinecoalition.org.

Sincerely,

Cynthia A. Bens
Senior Vice President, Public Policy

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66 Hudson Boulevard East
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June 26, 2025

VIA Electronic Filing – *IRARebateandNegotiation@cms.hhs.gov*

Chris Klomp
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
PO Box 8016
Baltimore, MD 21244-8016

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for the Initial Price Applicability Year 2028, and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027 and 2028

Dear Deputy Administrator Klomp:

Pfizer Inc. appreciates the opportunity to submit comments on the Centers for Medicare and Medicaid Services' (CMS) Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 (henceforth referred to as the "Guidance"). Pfizer Inc. is a research-based, global biopharmaceutical company. We apply science and our global resources to bring therapies to people that extend and significantly improve their lives through the discovery, development and manufacture of medicines and vaccines.

The Inflation Reduction Act (IRA) established the so-called "Medicare Drug Price Negotiation Program", which in fact, is not a true "negotiation" framework, but a dangerous price setting policy that will significantly harm patient access to medicines and threaten U.S. leadership in biopharmaceutical research and development. We refer to this new program as government price setting rather that a true "negotiation" because manufacturers who do not enter into the process are subject to per-day excise taxes starting at almost twice the sales of the selected drug and increasing to 1,900 percent of a drug's total revenues.

The Trump Administration has inherited a flawed process for government price setting of pharmaceuticals. Under President Trump's leadership CMS now has the opportunity, through thoughtful, detailed, and careful rulemaking and guidance, to mitigate some of the negative consequences that can result when governments set prices for medicines. We were encouraged by the President's Executive Order on *Lowering Drug Prices By Once Again Putting Americans First*, and its directives to improve the IRA so as to improve transparency and minimize any negative impacts of the maximum fair price on pharmaceutical innovation.[1] However, we are concerned that the policies outlined in the Draft Guidance are a continuation of flawed Biden-era policies that will threaten the ability of manufacturers to develop the pharmacological innovations that save and improve Americans' lives. The time to course-correct and abandon the prior administration's errors is now.

[1] White House. (April 2025). Presidential Actions, Lowering Drug Prices by Once Again Putting Americans First. Available at: https://www.whitehouse.gov/presidential-actions/2025/04/lowering-drug-prices-by-once-again-putting-americans-first/.

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We provided comments in response to the Guidance for IPAY 2026 and 2027, and articulated concrete, actionable recommendations for CMS that were largely disregarded. We strongly recommend CMS revisit and adopt these recommendations in implementing the Program for IPAY 2028. As members of the Pharmaceutical Research and Manufacturers of America (PhRMA), we endorse their comments and write separately to highlight key points.

Our comments on specific sections of the Draft Guidance are summarized below.

####

Section 30.1 Identification of Selected Drugs for Initial Price Applicability Year 2028

Identifying potential qualifying single source drugs

Pfizer continues to oppose the broad interpretation of the qualifying single source drug (QSSD) definition used by CMS for IPAYs 2026-27 and the proposed continuation of this interpretation for IPAY 2028. We further oppose CMS's proposed exception to its fixed-combination drug policy. The *Loper Bright Enterprises v. Raimondo* decision states that an agency is required to apply the "single, best meaning" of a statute.[2] The President also issued a memorandum on April 9, 2025, prioritizing the review and repeal pursuant to Executive Order 14219 of existing regulations that are unlawful under *Loper Bright*.[3] CMS's current definition of a QSSD is inconsistent with principles articulated by the Supreme Court in *Loper Bright,* is untethered from the statute and would continue to stifle the development of innovative and life-saving drug and biological products.

Our previous comments have described how CMS's general definition of a QSSD, which aggregates all dosage forms and strengths of a product with the same active ingredient/moiety and the same holder of a BLA/NDA, is inconsistent with the statute.[4] Pfizer continues to urge CMS to conform its definition of a QSSD with the statutory requirements. Therefore, CMS should require that to be included in a QSSD, each individual drug product or biological product must be approved or licensed (1) under the same NDA or BLA, either as part of the original application or under a supplement to such application, and (2) at least seven years or eleven years (as applicable) before the selected drug publication date. Any other approach would violate the statute, *Loper Bright* principles and stifles innovation.

Even if CMS retains its general definition of a QSSD, the Agency should not adopt their proposal to aggregate certain fixed-combination products. The proposal to exclude products not "biologically active against the disease state" and as such do "not result in a clinically meaningful difference" misstates the value of products working in combination and is generally vague and unworkable. In the Draft Guidance CMS outlines an approach in line with its IPAY 2027 guidance, where a distinct combination of active moieties/active ingredients is treated as one active moiety/active ingredient for the purpose of identifying potential QSSDs. In the Draft Guidance, CMS indicates that while this approach "is generally appropriate," it might not be appropriate for certain fixed-combination products for which one of the active moieties or active ingredients is not "therapeutically" or "biologically active" against "the disease state(s) the drug is indicated for and thus

[2] 1144 S. Ct. 2244, 2266 (2024).
[3] White House. (April 2025). Presidential Actions, Directing the Repeal of Unlawful Regulations. Available at: https://www.whitehouse.gov/presidential-actions/2025/04/directing-the-repeal-of-unlawful-regulations/.
[4] Medicare Drug Price Negotiation Program: Public Submissions.

does not result in a clinically meaningful difference" and provides an example where one active moiety or active ingredient in the fixed-combination product "affects the bioavailability" of the other active moiety or active ingredient "but is not therapeutically active" against the indicated disease state. In this example, CMS concludes that the addition of such component "does not result in a clinically meaningful difference."

Pfizer disagrees with this interpretation.

As CMS evaluates this proposed policy and considers subsequent comments, understanding the value and benefits offered by fixed combination products is essential. Fixed combination products offer: 1) optimized pharmacokinetics, allowing for better therapeutic effects and fewer patient side effects, 2) reduced patient burden including enhanced convenience and medication adherence and 3) maximized synergistic outcomes and improved efficacy, because the combined effect of the drugs is greater than the sum of their individual effects.

According to the FDA, fixed combination products have emerged "as the standard of care in certain disease settings," that "play an important role in optimizing adherence to dosing regimens and improving patient outcomes."[5] The FDA "has encouraged the development of these therapies through various policies and initiatives." Reflecting this importance, many commonly-used and life-saving products are in fact fixed-dose combinations. Suboxone, a widely used tool for treatment of opioid dependence, is a fixed combination of buprenorphine and naloxone. And some antiretrovirals used for the treatment of HIV are in fact combinations of *three* active ingredients: BIKTARVY® is a fixed combination of bictegravir, emtricitabine, and tenofovir alafenamide. CMS's proposal seemingly fails to recognize this, discounting the value of fixed combination products based on arbitrary judgments of a product's clinical value, and disincentivizing their new development, contrary to the FDA's own position.

In addition, fixed-dose combination products might be developed as collaborations between different manufacturers. For example, fixed-dose Combination STEGLUJAN™ (ertugliflozin and sitagliptin) was launched as a collaboration between Pfizer and Merck.[6] Continuing to treat fixed-dose combinations of products as their own product will allow CMS to sidestep any complicated questions of assigning primary manufacturer status to such collaborations when only one of the included ingredients/moieties is selected.

Finally, the standards proposed by CMS give little insight into how CMS will actually determine which fixed combination products are and are not eligible for treatment as a separate QSSD. For example, how would CMS determine QSSD eligibility for a novel combination that has been granted a new chemical entity (NCE) for its small and/or large molecule components? The term "clinically meaningful difference," is not defined in the draft guidance and does not appear in the text of the IRA, suggesting that Congress did not grant CMS the authority to define such terms. Nor do "therapeutically active" or "biologically active" have any grounding in the statute or explanation in the guidance. The lack of meaning gives CMS a free hand to pick and choose from amongst fixed combination products without limit on its discretion. Meanwhile, manufacturers would be left guessing as to their product's status for years to come because there is currently no mechanism by which a manufacturer could have an official judgment from CMS as to whether a particular combination would be separately treated for QSSD

[5] FDA, "New Chemical Entity Exclusivity Determinations for Certain Fixed Combination Drug Products" (Oct. 2014) (available at: https://www.fda.gov/media/87932/download).

[6] Pfizer, "FDA Approves SGLT2 Inhibitor STEGLATRO™ (ertugliflozin) and Fixed-Dose Combination STEGLUJAN™ (ertugliflozin and sitagliptin) for Adults with Type 2 Diabetes" (Dec. 2017) (available at: https://www.pfizer.com/news/press-release/press-release detail/fda_approves_sglt2_inhibitor_steglatro_ertugliflozin_and_fixed_dose_combination_steglujan_ertugliflozin_and_sitagliptin_for_adults_with_type_2_diabetes)

purposes. Only when CMS releases its lists of selected drugs, years after a fixed combination product's approval, would a manufacturer finally know how CMS has implemented this nebulous decision.

Applying statutory criteria for qualifying single source drugs

CMS's continued insistence on requiring "bona fide" marketing of a selected drug's generic or biosimilar before that product will no longer be considered a single source drug has no support in the plain text of the IRA statue. This concept is entirely invented by CMS in excess of its statutory authority and should be abandoned. CMS should recognize the term "marketed" in the IRA as it appears in the statute and as it is well understood in the context of pharmaceutical products —as the introduction or delivery for introduction of a product into interstate commerce.

As an executive agency, CMS is bound to follow Congress's statutes as written.[7] The Supreme Court has recently explained, in its *Loper Bright* decision, that in every instance, the courts will judge an agency's interpretation by "the question that matters: Does the statute authorize the challenged agency action?"[8]

Here, it does not. The plain text of IRA requires that a selected drug remain a selected drug only until its generic form is "approved and marketed under section 505(j)" of the Food, Drug, and Cosmetic Act (FDCA), or a biosimilar is "licensed and marketed under section 351(k)" of the Public Health Service Act (PHSA).[9] The only permissible interpretation of this language is that Congress intended CMS to refer to the concepts of "approval" and "marketing" as used by the Food and Drug Administration, the agency tasked with implementing these sections of the FDCA and PHSA. Applying this standard, CMS would simply look to whether a generic or biosimilar has been "approved" or "licensed" (as it does now), and whether the product has in turn been "introduced into interstate commerce" such that it is being "commercially marketed" as defined by the FDA.[10]

CMS's concept of requiring "bona fide" marketing, above and beyond the requirement that a drug be "marketed" appears nowhere in this construction. It is a contrivance adopted by CMS in contravention of the plain meaning of the statute to address a hypothetical concern about the *availability* of generics and biosimilars in the face of "token or de minimis" sales by manufacturers.[11] The steps proposed by CMS in the Draft Guidance to determine a product's "bona fide" generic or biosimilar competition further demonstrate how far CMS has strayed from the statute. CMS proposes to engage in a "holistic inquiry" based on the "totality of the circumstances," to determine whether a "generic drug or biosimilar is regularly and consistently available for purchase through the pharmaceutical supply chain." The opaque "holistic inquiry" the agency proposes to undertake with respect to continued biosimilar marketing leaves biosimilar sponsors with no certainty as to how, or even whether, they can meet this subjective standard. Pfizer acknowledges CMS's inclusion of examples of "bona fide marketing" in the IPAY 2028 Draft Guidance. However, these examples do not offer clear criteria for determining when marketing will be considered "bona fide," leaving manufacturers with no certainty as to how, or if, they can meet this arbitrary and ambiguous standard.

Nothing in the actual text of IRA contemplates CMS monitoring the supply chain of drugs to determine whether a

[7] *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 391 (2024) (internal citations and quotations omitted).
[8] *Id.*
[9] SSA 1192(e).
[10] 21 C.F.R. § 314.3.
[11] CMS, Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026 at p. 72 (June 30, 2023).

product's availability meets an ill-defined subjective standard of availability.

CMS should hew to the text of IRA and abandon its "bona fide" marketing standard.

30.3.1.3 Delay in the Selection and Negotiation of Certain Biologics with High Likelihood of Biosimilar Market Entry; High Likelihood

We continue to urge CMS to implement the biosimilars "pause" provision in section 1192(f) in a way that serves its intended purpose: to promote the entry of biosimilars to the market by ensuring that the establishment of an MFP for a reference biologic does not quash market incentives for biosimilar entry and the true market competition that entry will bring.

Biosimilar competition has been very successful in providing cost savings to healthcare systems and are estimated to save the U.S. healthcare system anywhere between $40 billion[12] and $180 billion over the next 5 years.[13] Because of the potential biosimilars have to lower the cost of biologics, it is critical that the 2-year pause be implemented in a manner that supports continued investment in development of these important products. We therefore urge CMS to not impose insurmountable evidentiary burden on applicants for a biosimilars "pause" in demonstrating a "high likelihood" that that the biosimilar will be licensed and marketed before the "High Likelihood Deadline." Given the potential biosimilars have to lower the cost of biologics, it is critical that the 2-year pause be implemented in a manner that supports continued investment in development of these important products. We therefore urge CMS to not impose insurmountable evidentiary burden on applicants for a biosimilars "pause" in demonstrating a "high likelihood" that that the biosimilar will be licensed and marketed before the "High Likelihood Deadline."

We appreciate CMS's solicitation of comments on additional evidence applicants might submit to demonstrate that patents are unlikely to prevent the biosimilar from being marketed before the deadline. In this regard, CMS should consult with and make this determination in conjunction with the FDA, which is best positioned to gauge likelihood of licensure. And applicants should be welcome to submit evidence of any kind, be it public statements or otherwise, to demonstrate high likelihood. In particular, evidence of the applicant's own efforts to prepare for the licensure of a biosimilar is itself strong evidence of a high likelihood of marketing: a manufacturer would not invest substantial sums in preparing to launch a biosimilar product without confidence that product could reach the market in a timely manner.

As in our past comments, we urge CMS to consider these factors including:

- A copy of a notice of first commercial marketing pursuant to 42 U.S.C. § 262(l)(8), which the biosimilar applicant must provide to the reference product sponsor no later than 180 days before the date of first commercial marketing.

- Public statements from the biosimilar manufacturer that it is planning for biosimilar launch before the date that is two years after the selected drug publication date (*e.g.*, press statements, excerpts from investor relations reports or meetings, and public statements from a corporate director). These statements could also be accompanied by an attestation signed by the General Counsel and/or Chief

[12] RAND Corporation. *Biosimilar Drugs Could Generate $28.4 Billion in Savings over Five Years*. January 10, 2022. Available at: https://www.rand.org/news/press/2022/01/10.html .
[13] IQVIA Institute for Human Data Science. *Biosimilars in the United States 2023-2027*. January 2023. https://www.iqvia.com/insights/the-iqvia- institute/reports/biosimilars-in-the-united-states-2023-2027.

Executive Officer. The fiduciary obligations biosimilar companies owe to their shareholders ensure accountability, providing a preexisting check against self-serving statements.

- Public statements from the reference product sponsor that it is planning for biosimilar launch before the date that is two years after the selected drug publication date (*e.g.*, in disclosures to the Securities and Exchange Commission).

30.1.1 Orphan Drug Exclusion from Qualifying Single Source Drugs

CMS' interpretation of the orphan-drug exclusion is another example of the agency's misaligned interpretation of the statue that will devastate rare disease research and drug discovery. Section 1192(e)(3)(A) provides for a wholesale exclusion from the IRA for "a drug that is designated as a drug for only one rare disease or condition under section 526 of the [FDCA] and for which the only approved indication (or indications) is for such disease or condition."[14] Congress intended for orphan-drugs to be excluded from the QSSD definition and CMS should honor that intent.

When Congress passed the Orphan Drug Act more than forty years ago, they incentivized the development and approval of drugs to treat rare diseases. The framework the ODA created works. Since then, more than 650 orphan drugs have been approved, including 28 new approvals in 2023 alone.[6] Despite these advancements, approximately 95% of rare diseases still do not have FDA-approved treatment. This staggering statistic is unlikely to change if CMS's current interpretation of the orphan-drug exclusion remains in place.

Further, the statutory exclusion from the definition of a QSSD for eligible orphan drugs indicates that the 7- or 11-year clock should begin once a product loses eligibility for the exclusion, not retroactively to the data of initial approval or licensure, as CMS currently proposes.

CMS's current policy is to apply the orphan-drug exclusion based on the active moiety or ingredient, rather than on a product-by-product basis. Pfizer urges CMS to better preserve the incentives for orphan disease research and limit the definition of a QSSD to those products approved by FDA in a single NDA or BLA. Since the orphan drug exclusion is defined as an exception from the definition of a QSSD it should also be applied on an NDA/BLA basis.

Section 40.4 Providing Access to the MFP in 2026, 2027 and 2028

Pfizer is grateful for the opportunity to provide advance suggestions on the implementation of the Maximum Fair Price (MFP) for 2028. This being the first year of Part B drug eligibility for price setting, there are several complications and considerations that are unique to drugs payable under Part B that CMS must take into account as it contemplates an effectuation process.

As CMS creates its effectuation plans for 2028 for Part B and Part D drugs, we wish to flag several areas of concern for CMS's attention: the non-duplication of 340B units; the impact of MFP sales on Average Sales Price (ASP), defining a Standard Default Rebate Amount (SDRA) for Part B drugs, claim-level data elements for Part B effectuation, timing of manufacturer MFP refund payments, providing access to the MFP for provider-administered drugs and potential private market solutions for MFP effectuation.

[14] SSA § 1192(e)(3)(A).

Part B Effectuation

Pfizer appreciates the opportunity to provide comments on providing access to the MFP for drugs covered under Medicare Part B. In general, we support allowing Primary Manufacturers to provide access to the MFP via a retrospective approach using the MTF Data Module and Payment Module. However, unique challenges exist for Part B drugs that the Part B effectuation process must account for. These include the large number of providers dispensing Part B drugs and the delays in submission of encounter data for MA plan beneficiaries.

Section 40.4.5 – Nonduplication with 340B Ceiling Price

The IRA statue protects manufacturers of selected drugs from being subject to "double discounts" by 340B covered entities – the MFP and the 340B discount. Enforcing this rule will take on special challenges with the introduction of Part B drugs, particularly in light of the number of Part B-covered drugs in the Medicare Drug "Negotiation" Program that will be dispensed to beneficiaries enrolled in Medicare Advantage plans.

In order to appropriately track and eliminate duplicate discounts for 340B-covered entities, we ask CMS to establish a neutral claims clearinghouse responsible for identifying and removing 340B duplicate claims from the universe of Part B drug claims for which manufacturers must make payment to effectuate MFP. This is an important and necessary step since claims will necessarily flow through any MTF from multiple sources: there will be traditional Medicare claims processed by Medicare Administrative Contractors, and Medicare Advantage claims processed through Medicare Advantage plans and appearing in encounter data. Manufacturers will face challenges identifying potential 340B units in these multiple data streams. We ask CMS to centralize and economize this task.

The lack of uniformity in claims identifiers that covered entities may use for Part B drug claims further underscores the need for a centralized clearinghouse. CMS currently requires all entities that submit claims for separately payable drugs under Part B in traditional Medicare to utilize either the "JG" or "TB" modifiers to identify claims subject to 340B agreements. We applaud this step but note that it is not uniformly followed. A recent report by IQVIA found that only 61 percent of treatments for Part B separately payable drugs originating at rural referral centers and sole community hospitals used a relevant 340B modifier.[15] This is a highly concerning result given that CMS requires these entities, who presumably acquire the bulk of their drugs through the 340B program, to use the "JG" and "TB" modifiers on claims seeking Medicare payment for a 340B-acquired drug. We therefore ask that CMS increase enforcement of the "JG" and "TB" modifier requirement.

Even if this modifier were uniformly adopted in the traditional Medicare program, it would not facilitate the identification of claims for Part B drugs covered through Medicare Advantage because the JG/TB modifiers are not required to be reported in that program. CMS should therefore extend the requirement for use of the modifiers to claims for Part B drugs that Medicare Advantage plans pay.

Impact on Average Sales Price

Pfizer urges CMS to confirm that the Maximum Fair Price (MFP) is excluded from the calculation of Average Sales Price (ASP) for selected drugs. Including MFP in ASP would not only distort the benchmark Congress designed to reflect provider acquisition costs but also exceed CMS's statutory authority. The IRA explicitly

[15] IQVIA. (February 2023). Can 340B Modifiers Avoid Duplicate Discounts in the IRA? Available at: https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2023/can-340b-modifiers-avoid-duplicate-discounts-in-the-ira.pdf.

excludes MFP from Average Manufacturer Price (AMP) and is silent on ASP[16]—however, this silence cannot be construed as authorization under the Major Questions Doctrine[17]. Moreover, including MFP in ASP would have far-reaching consequences, including reduced provider reimbursement,[18] diminished patient access, and destabilization of commercial and Medicare Advantage markets.[19] CMS has both the authority[20] and precedent to exclude MFP-priced units from ASP, as it did under the Competitive Acquisition Program.[21]

ASP was created by Congress to accurately reflect health care providers' acquisition costs. In time, the ASP has become an industry standard used across many different insurance programs to identify providers' costs and set payment rates accordingly. Including the discounts paid by manufacturers of selected drugs to effectuate the MFP would falsely skew the ASP to reflect not the actual acquisition cost of drugs, but instead an artificially subsidized cost that applies only to selected patients. This would undermine the ASP's very purpose as a standard pricing benchmark, curtailing its meaning and utility.

We therefore ask CMS to confirm that MFP is excluded from the ASP calculation to preserve the integrity of ASP and protect the healthcare ecosystem.

Defining a Standard Default Refund Amount for Part B Drugs

Pfizer believes that CMS should maintain consistency with prior policy and allow effectuation of the MFP for Part B drugs through payment of a standard default refund amount (SDRA).

As CMS considers proposals for how to define the Part B SDRA, we urge CMS to consider that the wholesale acquisition environment for drugs and biologicals administered by providers is more complex and varied than those obtained and dispensed by pharmacies. While CMS finalized that the SDRA for Part D will be WAC minus MFP, Part B provider acquisition costs may not be so closely tied to WAC, or uniform from provider to provider, making it a poor choice as a standard SDRA for Part B because provider acquisition cost may be significantly further below WAC than pharmacy acquisition cost.

Claim-level Data Elements Needed for Part B Effectuation

In order to accurately and timely process refunds for Part B selected drugs, manufacturers must have timely access to accurate data. Pfizer therefore respectfully requests that the following claim-level fields for original Medicare and Medicare Advantage claims are provided to manufacturers:

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[16] SSA §1927(c)(1)(C)(ii)(V), (k)(1)(B)(i)(VI).
[17] Util. Air Regul. Group v. EPA, 573 U.S. 302, 324 (2014). Under the major questions doctrine, statutes are not interpreted as authorizing federal agencies to make decisions with "vast economic and political significance" unless the statute does that explicitly.
[18] A recent survey of commercial insurers showed that they reimburse for 72 percent of covered lives in the physician office based on a medicine's ASP. ASP is also the basis of Medicaid reimbursement for provider-administered medicines in many states. *See*, Avalere Health. (September 2024). Commercial Spillover Impact of Part B Negotiations on Physicians. Available at: https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians
[19] Including MFP in ASP would substantially reduce ASP, which would likely erode (1) MA and commercial plan payments for selected drugs, both during and after the drug is selected; and (2) Medicare FFS payments, for up to an 18-month period after deselection, due to the two quarter lag in ASP reporting and the 12-month average of lagged price concessions.
[20] SSA § 1847A(b)(2)(B); after 2004, "[t]he Secretary may establish the unit for a manufacturer to report and methods for counting units as the Secretary determines appropriate to implement this section."
[21] 70 Fed. Reg. 70,478, 70,481 (Nov. 21, 2005) (amending 42 C.F.R. § 414.802).

- Medicare Advantage Plan ID (for MA only);
- HCPCS Code (J-Code/Q-Code) and the NDC-11;
- Claim Number (would replace the Prescription/Service Reference Number field);
- Unit of Measure;
- Date of Administration (would replace Date of Service);
- 340B Covered Entity ID/NPI;
- Place of Service Code;
- 340B Claims Modifier Field ("TB" modifier);
- Vial Wastage Modifier Field ("JW" and "JZ" modifiers); and
- "UD" Modifier Field.

As noted above, we once again urge CMS to establish a claims repository that manufacturers may use to examine claims data, particularly to identify potentially duplicate 340B claims.

Timing of Manufacturer MFP Refund Payments

Pfizer urges CMS to give manufacturers 30 days to remit payment to providers from the time claim information is received. This 30-day window is consistent with the current timing required for CMS to reimburse providers under Part B. For Part D selected drugs, CMS imposed a 14-day payment obligation on manufacturers for refunds which is intended to mirror the 14-day timely claims payment deadlines already in place in the Part D program.[22] While such a short window might be appropriate given the real-time claims adjudication common for covered outpatient drugs, the medical claims associated with Part B are typically paid in 30 days given their complexity.[23] CMS should therefore maintain consistent logic and adopt a 30-day payment window for Part B refund payments.

Providing Access to the MFP in Medicare Advantage for Selected Provider-Administered Drugs

As discussed in our comments in Section 40.4.5 above, providers administering Part B selected drugs to Medicare Advantage (MA) beneficiaries may face delays and difficulty in receiving refunds unless CMS takes steps to improve and expand on data reporting by MA plans.

While CMS has made significant strides in improving MA plan submission of encounter data, those data might lag significantly and are not necessarily reported with the same regularity as Part B original Medicare claims. We suggest that CMS consider imposing a direct obligation on MA plans to regularly transmit actual claims data to the Part B MTF, and attest to its accuracy.

Part D Effectuation

Pfizer welcomes the Agency's solicitation of comments on providing access to the MFP for drugs under Medicare Part D. We offer the following comments.

Potential Private Market Solutions

Pfizer appreciates CMS' solicitation of comments on potential private market solutions that could offer an

[22] 42 C.F.R. § 423.520.
[23] 42 C.F.R. § 422.520(a).

alternative to the MTF. While we believe that this solicitation is premature given that the IPAY 2026 effectuation cycle has yet to begin, Pfizer continues to believe that the best, least burdensome, and most efficient way to effectuate the MFP would be for CMS to utilize an approach similar to the Part D Coverage Gap Discount Program (CGDP), including pass-through of CMS pre-funded MFP refund amounts to dispensers on behalf of Primary Manufacturers at the time of claim adjudication, with manufacturers invoiced at a later date. While we acknowledge that implementing a CGDP-like approach is likely not possible for IPAY 2026 at this point, we continue to urge CMS to consider this approach for IPAY 2027 and subsequent years.

Section 40.4.1 – Retrospective Refund Amount to Effectuate the MFP and the Standard Default Refund Amount

Making the SDRA a True Default

Pfizer urges CMS to take steps to reduce the burden on Primary Manufacturers and dispensing entities by solidifying the use of the SDRA as a *true* default. CMS continues to propose that the SDRA would be a default amount only for manufacturers and dispensing entities that "agree to use such standardized pricing." Efficient administration of the negotiation program and reliable effectuation of MFP should not be dependent on the agreement of each individual dispenser in the United States or require thousands of negotiations and agreement. We urge CMS to adopt the SDRA as the true default payment option even absent the agreement of an individual dispenser.

Dispenser Acquisition Costs that Exceed WAC

The creation of the SDRA is a valuable innovation that will allow manufacturers to efficiently satisfy their effectuation obligation under IRA while promptly reimbursing excess acquisition costs to dispensing entities. CMS should not undermine this innovation by adopting exceptions for the rare case when the SDRA might not fully make whole a particular dispensing entity that did not acquire its products at WAC. Deviating from the SDRA may create adverse incentives for dispensers and others in the pharmaceutical supply chain to increase their profits through improper arrangements that artificially increase MFP amounts.

Section 40.4.2.1 – Primary Manufacturer Participation in the MTF DM

Clarification of Timing for MFP Refund Payments

CMS should specify how the 14-day prompt MFP payment deadline will be enforced when due date falls on a weekend or holiday. As is common practice in nearly all other circumstances, such payments should be due on the first following business day. Otherwise, manufacturers will have no way to timely effectuate payments on the due date, since processors and financial institutions are closed on weekends and holidays.

Section 40.4.2.2 – Dispensing Entity Enrollment in the MTF DM

Dispensing Entities with Material Cashflow Concerns

Pfizer continues to object to the requirement to develop mitigation plans for pharmacies self-identifying as having material cashflow concerns. We recognize CMS's concern that some small dispensing entities may be required to float the acquisition cost of products for a short additional period while awaiting payment of a SDRA refund from manufacturers. But the simplest resolution for this issue would be for CMS to pass-

through refund amounts, prefunded by CMS, at the time of claim adjudication.

If CMS will require manufacturers to develop mitigation plans, we ask that the agency acknowledge manufacturer's ability to request documentation to support dispensing entities' claim of cashflow concerns.

Section 40.4.3.1 – Required Primary Manufacturer Reporting of Claim-Level Payment Elements for MFP Refund Payments When a Primary Manufacturer Passes Payment through the MTF PM

Transaction Codes for Manufacturer Claim-level Payment Elements

Under current CMS guidance, Payment Code 4 only addresses scenarios where a selected drug's 340B ceiling price is lower than the MFP. However, a drug's 340B ceiling price can also be equal to the MFP or, under certain circumstances, higher than the MFP. Pfizer urges CMS to:

- Expand the existing Code 4 to include scenarios where the 340B ceiling price is equal to the MFP. Currently, Code 4 only addresses situations where the 340B ceiling price is lower than the MFP. However, the 340B ceiling price can also be equal to the MFP, and manufacturers need a clear mechanism to address these situations and avoid duplicate discounts. If a manufacturer can utilize Code 4 both where the 340B ceiling price is equal to or lower than the MFP refund, the manufacturer can continue to provide access to the 340B price while avoiding a duplicate 340B/MFP discount. We believe the expansion of Code 4 to include the scenario of the 340B ceiling price being equal to the MFP would be consistent with the combined meaning of sections 1193(d)(1) and 1193(d)(2) of the Social Security Act (the Act).

- Add a new payment element code to address the scenario where the 340B ceiling price is higher than the MFP by allowing manufacturers to calculate the MFP refund as the difference between the higher 340B ceiling price and the MFP. Section 1193(d)(2) of the Act states that a manufacturer of a selected drug "shall be required to provide access to the maximum fair price to such covered entity with respect to maximum fair price eligible individuals… at such ceiling price in a nonduplicated amount to the ceiling price if such maximum fair price is below the ceiling price for such selected drug" (emphasis added). But the existing payment element codes established by CMS do not seem to contemplate this scenario. In such cases, we believe manufacturers should be able to pay the difference between the higher 340B ceiling price and the lower MFP as the MFP refund amount. If manufacturers can provide access to the MFP by paying the difference between the higher 340B ceiling price and a lower MFP, while still providing the 340B covered entity with access to the 340B price, this will prevent a duplicate discount (discussed below).

- Clarify that manufacturers utilizing the MTF PM should also be able to use the credit/debit ledger system to make these adjustments for claims identified as 340B outside of the 14-day prompt MFP payment window.

Pfizer remains highly concerned about CMS' position not to assume any responsibility for deduplicating discounts between the 340B ceiling price and MFP.[24] Under the current 340B replenishment model used by

[24] Medicare Drug Price Negotiation Program: Final 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. *See* https://www.cms.gov/files/document/medicare-drug-price-negotiation-final-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf.

covered entities, manufacturers in many cases have very limited insight into which Part D units are subject to 340B pricing, which creates a significant risk of duplicate 340B and MFP discounts despite the IRA's statutory prohibition. Given these overarching concerns about the risk of duplicate discounts at a minimum we ask that CMS allow manufacturers to have a clear way to address 340B/MFP duplicate discounts by taking steps outlined above.

Section 40.4.3.2 – Primary Manufacturer and MTF PM MFP Refund Payment Adjustments due to Claim Amendments Through the MTF PM

Credit/Debit Ledger and Manufacturer Termination of Participation in the MTF PM

Pfizer recommends that manufacturers terminating participation in the MTF PM maintain access to the credit/debit ledger, including accruals of credits and debits, during the run-out period for claims initiated while the manufacturer was still participating in the MTF PM.

Pfizer also urges CMS to develop a process for manufacturer reimbursement in situations where there are insufficient MFP refund claims against which to apply accrued credits. This scenario may occur, for example, when a generic or biosimilar competitor has entered the market, but due to timing, the brand is still a selected drug.

Furthermore, Pfizer encourages CMS to provide manufacturers that utilize alternative arrangements outside the MTF PM access to the credit/debit ledger system to provide access to the MFP. Since manufacturers using alternative arrangements will still report claims-level payment information to the MTF DM, this information can be used to populate a simple, non-dynamic credit/debit record system. Although this ledger system will not alter the actual payments from manufacturers utilizing alternative arrangements, it will still be useful to have a central record of payments within the MTF system.

Section 40.4.5 – Nonduplication with 340B Ceiling Price

Pfizer has significant concerns with the Agency's current intention not to play a role in deduplicating MFP and 340B discounts. As discussed earlier, in regards to the Part B selected drugs, we urge CMS to establish a claims repository and utilize mandatory claim modifiers with accountability for 340B covered entities who file claims for refunds for Part D selected drugs.

Section 50.1 Manufacturer-Specific Data

Pfizer cautions CMS that its proposal to collect "forward looking" market data for a selected drug is unworkable and imposes undue complexity and burden on publicly-traded companies such as Pfizer.

Collecting forward-looking projections is inconsistent with the data submission requirements otherwise imposed on manufacturers. CMS requires that manufacturers submit accurate information in connection with the price setting process. In fact, "omission or inaccuracy of manufacturer-submitted information" can serve as a violation of a manufacturer's agreement with CMS, which in turn could be cause for imposition of Civil Monetary Penalties.[25] As such, manufacturers take great pains to verify the accuracy of information submitted to CMS. While companies endeavor to accurately forecast future information, forward-looking projections result from a complex series of judgments about future events and uncertainties, are based on estimates and assumptions that may prove to be

[25] Guidance at p. 177.

incomplete or inaccurate, and unanticipated events and circumstances may occur that might cause companies to change those estimates and assumptions. Therefore, due to their inherent uncertainties, it would not be possible for companies to ensure that forecasts will be accurate.

Further, publicly traded companies such as Pfizer must carefully parse when and how they share forward-looking information and projections with outside stakeholders.[26] Manufacturers obliged to generate projections and submit them to CMS may in turn be obliged to share similar data with other stakeholders, bringing the price setting process into public view.

CMS should not adopt a requirement that manufacturers of selected drugs submit "forward looking" projections.

60.1 Establishment of a Single MFP for Negotiation and Renegotiation Purposes

Pfizer believes CMS's current approach of calculating a single MFP on the basis of a 30-day supply is and has been unworkable since its adoption. With the introduction of Part B drugs to the price setting program, CMS should take this opportunity to re-calibrate the approach. CMS should ideally work with manufacturers of selected drugs to identify the best approach for the specific selected drug in question. Alternatively, CMS can adopt a standard methodology that determines MFP on a per-unit basis.

A 30-day supply methodology has significant drawbacks, and fails to recognize the complexity of how different therapies are used in different ways. For example, when comparing two products where the treatment duration varies (e.g., an oncology medicine that is administered on an ongoing basis vs. a single-dose therapy), comparing the cost of a 30-day equivalent supply would not accurately capture the total cost of comparable outcomes. It also fails to address the problem of starting dosages of medicines, where a patient's dosage increases over a period of time upon first starting a medication before reaching a steady, long-term dosage amount (i.e., titration), dosage that varies by body weight, patient non-adherence. Products with non-repetitive uses like vaccines, or occasional use like emergency inhalers, are especially ill-suited to this approach.

Now, with the introduction of price setting in Part B, these problems with the 30-day supply are compounded. Physician-administered drugs may have even more varied dosage regimens than self-administered Part D therapies. As CMS acknowledges, some of these products are "indicated for administration once in a course of treatment," making the 30-day supply metric inapposite.

CMS should leave room for flexibility to accommodate unique Part B dosing situations, and work with manufacturers at the outset of negotiations to identify the right approach. For example, there may be Part B drugs whose vial size does not correspond to the actual amount dosed in all cases, as reflected in Medicare's policies for refunds for certain discarded single-dose containers.[27] CMS should take care to apply the MFP in a manner that accounts for additional product sold in a given vial, and not accidentally reduce the MFP to reflect amounts not dispensed.

Alternatively, Pfizer urges CMS to resolve these issues and move to a "per unit" approach that is more carefully tailored to the real usage of selected drugs. In this approach, the particular unit selected for each drug could, and should vary, based on the actual indications and usage of that drug. We suggest that CMS be transparent in its files of established MFPs and concise explanations, regarding how it selected such a unit, and how the MFP was translated to the unit price. CMS should also work with Primary Manufacturers of selected drugs to determine

[26] 15 U.S.C. § 78u-5.
[27] SSA 1847(h).

which approach is most appropriate on a drug-by-drug basis.

In cases where CMS will ultimately use the day equivalent supply approach, we join in PhRMA's comments suggesting refinements to the methodology.

60.3.1 Identifying Indications for the Selected Drug and Therapeutic Alternatives for Each Indication

Pfizer opposes CMS's potential proposal to consider non-pharmaceutical health care services payable under Medicare Part A or Part B as potential therapeutic alternatives to the selected drug.

For IPAY 2026 and 2027, CMS correctly adopted the position to take account only of pharmaceutical therapeutic alternatives, since these are the "most analogous alternatives to the selected drug."[28] Taking account of health care services and other non-pharmaceutical alternatives would invite methodological complexity that is simply too great for the price setting process to contend with. For example, the prices of health care services are not readily determinable in a way that is analogous to a 30-day or per-unit supply of a drug or biological.

For example, counseling, unlike pharmaceutical treatment, can't be easily quantified into a "30-days supply" due to varying schedules and treatment durations. The costs of surgical episodes (and in fact, the cost of most Medicare-covered health care services) can vary significantly depending on the location of care and the complexity of the case.

There is also a lack of visibility into the Agency's selection of therapeutic alternatives which creates no pathways for stakeholders to provide input on CMS' selection even when they believe CMS' selection may be incorrect. There are strong regulatory considerations that would counsel CMS to be more transparent in explaining how it has selected therapeutic alternatives. Under basic principles of administrative law, CMS must not act arbitrarily or capriciously or fail to consider an important aspect of a problem before it. Without visibility into how therapeutic alternatives were selected, neither manufacturers nor the public can know if CMS has honored its duties and met this standard, by selecting therapeutic alternatives appropriately.

Because of these unaddressed issues, it would be premature for the Agency to broaden the consideration of potential therapeutic alternatives to non-drug alternatives. Therefore, CMS should retain its current policy of looking only at pharmaceutical therapeutic alternatives, rather than introduce these intractable issues into the price setting process.

60.3.2 Developing a Starting Point for the Initial Offer

Pfizer opposes CMS's proposal to use alternative methodologies such as domestic reference pricing or unit cost of production and distribution for establishing a starting point for price setting for selected drugs with one or more therapeutic alternatives.[29] These approaches only exacerbates the harmful effects of the IRA, further devaluing treatment advances and discouraging continued progress against unmet medical needs.

60.3.4 Adjusting the Preliminary Price Based on Consideration of Section 1194(e)(1) Factors

For IPAY 2028, CMS seeks comments on whether to emphasize certain section 1194(e)(1) factors when adjusting

[28] CMS, "Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026" at 145 (June 30, 2023).
[29] IPAY 2028 Draft Guidance at p. 131, § 60.3.2

the preliminary price or consider data on pending and approved patent applications and exclusively independently.

CMS should assign greater importance to (e)(2) factors over (e)(1) factors, particularly those reflecting the drug's benefits to patients, caregivers, and society. This approach would encourage additional evidence on the comparative health benefits of different treatments. Conversely, placing too much emphasis on (e)(1) factors could hinder innovation. Pricing should reflect the value and benefits of innovations rather than just manufacturers' costs. CMS needs to provide transparency on the evidence types it will use to evaluate data, such as the extent a drug represents a therapeutic advance or addresses an unmet need, and its effects on specific populations.

Concerning the data on pending and approved patent applications and exclusivities, if CMS will consider this independently, we believe this would be best understood as markers of a product's innovative nature, the investment that the manufacturer made in developing the product, and the lack of therapeutic alternatives, all of which are factors that weigh in favor of increasing the preliminary price.

60.4.1 Engagement with Primary Manufacturers and Interested Parties Prior to Initial Offers

Pfizer maintains that patient and clinician input is an important factor in the price setting process. Their first-hand experience, including access and adherence challenges and quality of life impacts, is critical for the Agency to understand as part of the Medicare price setting process.

Pfizer commends CMS for the improvements to the public engagement events for IPAY 2027. However, we urge the agency to continue to work towards better ways to obtain the valuable insights of patients, caregivers, and clinicians. First, the opaque nature of the price setting process and lack of transparency into if and how the agency uses the information from the public engagement events it hosts deters patients, caregivers, and clinicians from seeing the value of their participation in these events. CMS should consider making public, via the MFP justifications or otherwise, how the information obtained from the public engagement events informs the price setting process. Second, further simplifying and streamlining the time commitment to engage – particularly for health care providers who are engaged in direct patient care, is critical. Absent a significant change in the approach to these public engagement events, CMS runs the risk of declining participation from these important stakeholders. Third, CMS should provide the public with ample notice about the dates of public engagement events, including providing a registration window of at least 30 days. As part of this advance notice, CMS should provide prospective participants with more thematic guidance about the types of information they seek so that participant testimony is actionable and relevant to the Agency. Finally, CMS should consider additional modes of patient, caregiver, and clinician engagement, such as through written testimony.

80. MFP-Eligible Individuals in 2026, 2027, and 2028

Pfizer is pleased that CMS is requesting comment on how to monitor Medicare Advantage plans' use of Part B step therapy practices for selected drugs. We encourage CMS to revisit its current rules for Medicare Advantage step therapy and carefully scrutinize any effort by a Medicare Advantage plan to inappropriately limit access to a selected drug.

Though CMS has taken steps to limit Medicare Advantage plan denials of medically-necessary physician services

such as inpatient admissions and post-acute care,[30]and placed guardrails on plan medical policies,[31] for Part D drugs and continued to allow plans to adopt programs of step therapy under regulations that predate CMS's recent efforts to protect beneficiaries.

With Part B drugs now eligible for price setting, it is time for CMS to reassess its Medicare Advantage step therapy regulations with respect to selected drugs, if not all drugs and biologicals. CMS has stated that the purpose of step therapy in Part B is to "provide the means for Medicare Advantage plans to better manage and negotiate the costs of providing Part B drugs."[32] Yet selected drugs will have a CMS-established MFP that should diminish any cost-related justification for a Medicare Advantage plan to use step therapy. Further, permitting step therapy on selected drugs will hinder enrollees' access to MFPs, which is contrary to the purported goals of the Medicare price setting program.

While there are improvements to be made in the Part D formulary review process to ensure that patients do not face unnecessary barriers to their needed medications, CMS should consider instituting a similar utilization management review process for Part B drugs covered by Medicare Advantage plans.

90. Manufacturer Compliance and Oversight & 100. Civil Monetary Penalties

CMS reserves the right in the Draft Guidance to impose stiff penalties on manufacturers for violations of their obligations under the program. Yet as CMS would surely agree, implementation of the program and effectuation of the MFP, particularly in the early years, will be a daunting task for all parties. Accordingly, Pfizer suggests that CMS exercise discretion in imposition of CMPs and use them sparingly. In particular, CMS should recognize when manufacturers are taking good faith efforts to comply with CMS directives, and limit imposition of CMPs to blatant or wanton disregard of the IRA statute and obligations.

Moreover, there are myriad circumstances that fall beyond a manufacturer's control for which a manufacturer should not be punished. For example, manufacturers can bear little responsibility for data and technology problems originating from CMS or the MTF's own systems. And covered entities may refuse to share data, limiting manufacturers' capabilities in de-duplicating claims. CMS should take special care in examining the availability of 340B-related data and determining whether the 340B de-duplication exception should apply before assessing a CMP.

110. Part D Formulary Inclusion of Selected Drugs

The IRA brings the most significant changes to the Medicare Part D program since the program's creation. These changes have the potential to restrict Part D beneficiaries' access to their medicines, the exact opposite of what the IRA claims to do, if steps are not taken to ensure beneficiary access.

Pfizer is particularly concerned about the likelihood of increased utilization management (UM) tactics plans will impose onto beneficiaries to manage costs given the dramatic increase in plans' liability as a result of Part D redesign and the introduction of Part D drugs with MFPs. Research has already demonstrated that nine in 10 Part D plans say they intend to increase access restrictions on drugs in the coming years because of the IRA

[30] 42 C.F.R. 422.101(b)(2).
[31] 42 C.F.R. 422.101(b)(6).
[32] 84 Fed. Reg. 23832

and CMS should take these threats seriously.[33]

While CMS states that "CMS does not have sufficient information to determine whether changes to [its] formulary inclusion policies are warranted," Pfizer and others have observed that the changes brought by IRA to the Part D benefit are already influencing formularies. One research team has observed that of the 25 drugs already selected for negotiation, in 2025 there is a "a high degree of prior authorization for the specialty drugs,"[34] suggesting that CMS must proactively review existing prior authorizations for these products to confirm it conforms to CMS policies. They also found that tiers were designed in such a way that "the MFP is unlikely to meaningfully reduce beneficiary out-of-pocket costs."

Pfizer believes there are concrete actions CMS can take to ensure Part D beneficiaries have access to their needed medications and realize the promise of IRA's Part D benefit design changes:

- Strengthened formulary guidelines to protect patient and physician choice
- Enhanced CMS formulary reviews and transparency to consider the potential impact of the IRA
- Improved plan reporting and accountability
- Create mechanisms for more meaningful stakeholder feedback

Preserving Patient/Physician Choice

Protecting patients who change plans

When it comes to prescribing medications, preserving patient and physician choice is essential. As discussed earlier, plans are increasing the number of drugs subject to UM, a trend that is sure to continue as their liability increases as a result of Part D redesign. Utilization management tools such as clinically inappropriate prior authorization and step therapy directly undermines patient and physician choice of medicines and often delays access to needed medications. This problem is exacerbated for patients who change plans, mid-year or during open enrollment because they must go through the UM process again, even if they were previously approved for the medicine. CMS should establish a policy that enables patients to avoid repeat UM for the same medicine once they change plans, at minimum in the case where a beneficiary changes to a plan within the same parent organization. Ultimately, CMS should strive to adopt a policy where UM approval spans across plans and parent organizations. A beneficiary's approval for a medication should span plans and plan years, for the duration of their therapy.

Enhanced CMS Formulary Reviews and Transparency

The dramatic changes to the Part D program in 2025 and the introduction of Part D drugs at MFP in 2026 present an opportunity for CMS to reassess its existing formulary review processes to ensure Part D beneficiaries continue to have robust access to Part D drugs. While CMS has acknowledged and expressed

[33] Magnolia Market Access. (2024). IRA Payer Insights Report Chartbook Summary of Key Findings. Available at: https://www.magnoliamarketaccess.com/wp-content/uploads/MMA_IRA-Payer-Insights-Survey-4.0_Chartbook_2024.07.31.pdf

[34] Axelsen, K. et al, "Medicare Drug Price Negotiation: Saving money for Medicare, but what about patients?" (March 2025)(available at: https://www.dlapiper.com/en-us/insights/publications/2025/03/medicare-drug-price-negotiation-saving-money-for-medicare-but-what-about-patients)

concern about the tightening of formularies, increased use of coinsurance tiers and increased UM in Part D as well as publicly stated its commitment to continue robust formulary reviews, going so far as developing a "Selected Drug Sub-Review" process to ensure MFP products are on formulary, CMS can do more to ensure Medicare beneficiaries can access their medications without obstacles.[35]

Ensuring Adequate Formularies

CMS should review its current formulary review standards, including the impact of the "Selected Drug Formulary Sub-Review," through transparent reporting and consider enhancing standards to ensure adequate Part D drug coverage in light of Part D redesign and MFPs going into effect. Pfizer is concerned that the current formulary standards, including the outlier test, may not adequately capture instances where selected drugs are subject to UM, especially in classes where one or more price-set drugs are present. CMS could also consider conducting a retrospective analysis of UM trends in Part D over time and use the findings to inform where increased CMS oversight is needed.

Additional Transparency of Annual Formulary Review

CMS should consider making the results of its formulary review process, including the "Selected Drug Formulary Sub-Review" process publicly available, particularly in cases where CMS does not approve a formulary design or utilization management practice.[36] This could discourage similar behavior from other plans and improve patient access to medicine overall.

Improved Plan Reporting and Accountability

Transparency for Patients via Medicare Plan Finder

Medicare Part D beneficiaries use the Medicare Plan Finder (MPF) to choose the Medicare coverage that best suits their needs. CMS should consider enhancing MPF to include information about a plan's UM requirements for certain drugs. For example, when a Part D beneficiary visits the MPF during open enrollment and inputs their medications, the MPF should include a flag, or description of the UM requirements for that drug(s). This will help beneficiaries make truly meaningful plan choices and ensure their timely access to needed medications.

Develop meaningful beneficiary-centered UM-related quality measures as part of the Star Ratings Program

New Star Ratings focused on UM will improve quality and prevent administrative UM barriers to clinically appropriate medicines within clinically appropriate formulary designs. CMS could develop additional Star Ratings measures based on the enhanced CAHPS survey questions Pfizer recommended in its IPAY 2027 letter to CMS.

Create Mechanisms for More Meaningful Engagement of Stakeholders on Modernizing Part D Formulary Standards and Oversight, and Ongoing Input on Formulary and UM Policies

[35] HPMS (April 2025) CY 2026 Part D Formulary Submission Information. Available at: HPMS Memos for WK 3 April 14-18 | CMS

[36] HPMS (April 2025) CY 2026 Part D Formulary Submission Information. Available at: HPMS Memos for WK 3 April 14-18 | CMS

As discussed earlier in this letter, CMS Part D formulary oversight standards are due for a comprehensive review and update to reflect the impact of IRA. CMS should take steps to ensure formularies are designed to provide beneficiary access to their needed medications without unnecessary burden.

Soliciting Stakeholder Input on Formulary Review Methods

CMS should engage in a formal rulemaking process, such as through the CY 2027 MA/Part D proposed rule, to ensure that all stakeholders, including patients, caregivers and clinicians may participate. In advance of the rulemaking process, CMS should launch an open, transparent, and inclusive process to solicit stakeholder input including convening an expert panel, and/or group roundtables to obtain in-depth insights and recommendations.

Additionally, CMS could utilize the stakeholder engagement events it holds as part of the annual price-setting process to obtain feedback and real-world access experience from patients, caregivers and clinicians of selected drugs. In fact, during the IPAY 2027 public engagement events, concerns about utilization management and other access challenges were raised.[37]

Enhancing Existing Survey Mechanisms

CMS currently develops and administers patient experience surveys to assess patient, provider, and caregiver experiences with the health care system. CMS should consider leveraging the existing surveys to include questions about beneficiary experiences with UM and their Part D formulary designs. Ease of access to needed medications is an important part of a patient's health care experience. In light of the changes to Part D due to the IRA, having a direct engagement with impacted beneficiaries in the early years of the law's implementation is a worthy endeavor for the Agency as part of its oversight responsibilities. CMS should also consider developing a companion clinician survey, with particular emphasis on specialties that are impacted by the selected drugs.

130. Renegotiation of a Maximum Fair Price for Initial Price Applicability Year 2028

The renegotiation process is an important component of the IRA that allows CMS and manufacturers of selected drugs to adjust the MFP once established to reflect subsequent developments that would warrant significant changes in a selected drug's MFP. However, without firm guardrails around when specifically, a selected drug will be picked for renegotiation, manufacturers and CMS face a risk of being trapped, again and again, in endless cycles of annual renegotiation meetings over the same selected drug.

We therefore ask that CMS hew closely to the statutory requirements for selection of products for renegotiation. The statute requires renegotiation of products experiencing certain changes in monopoly status.[38] But as to the remaining renegotiation-eligible products, those with new indications or "material changes" in negotiation factors, CMS may only select such products for renegotiation if it expects renegotiation is likely to result in a "significant change" in the MFP.[39]

Pfizer urges the Agency to consider not just whether a change in the MFP is a "significant change" based on the narrow consideration of whether the numerical value change is large or small, but rather whether the change is

[37] Public Engagement Events | CMS
[38] SSA 1194(f)(3)(A-B).
[39] SSA 1194(f)(3)(C).

66 Hudson Boulevard East
New York, NY 10001-2192

more broadly “significant” or in other terms, important or impactful to the Medicare program and its beneficiaries beyond the simple change in price. For example, CMS should consider whether the change would lead to greater value for patients, how the change would affect providers and pharmacies dispensing the product, or how it would impact the marketplace and development of new therapies.

CMS should also work to ensure that there is as much transparency as possible in its determination of renegotiation eligibility— especially for drugs that meet eligibility criteria through a “material change” in the negotiation factors that CMS determines would cause a “significant change” in the MFP. To ensure price stability for manufacturers and the public, and to minimize renegotiation burdens, CMS should define what qualifies as a “significant change” requiring renegotiation. We believe an anticipated 35% change or more in the negotiated MFP would constitute a reasonable approach, as that mirrors the change in non-FAMP ceiling when a selected drug changes monopoly status.

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Thank you for considering these comments. If you have questions or need additional information, please feel free to contact me at margaret.davis@pfizer.com or 917-678-1316.

Sincerely,

Margaret Davis

Head of U.S. Federal Policy

Corporate Affairs

Submitted via email to: IRARebateandNegotiation@cms.hhs.gov

June 26, 2025

Chris Klomp, Deputy Administrator and Director of the Center for Medicare
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Drug Price Negotiation Program Draft Guidance

Dear Director Klomp:

The Pharmaceutical Care Management Association (PCMA) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS's) Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028 issued on May 12, 2025.[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 289 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.

PCMA's comments are informed by two overarching policy priorities that should govern CMS's implementation of the Medicare Drug Price Negotiation Program (Negotiation Program).

1. **Pharmacies should be shielded from the financial risks associated with delays or failures in receiving the maximum fair price (MFP)**.

[1] Available at https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf

The current approach, as reflected in the Draft Guidance and prior guidance, is to facilitate retrospective effectuation of the MFP, which exposes pharmacies to risks of delayed or failed payments. Pharmacies are already concerned about delays in retrospective MFP payments made by manufacturers within the required 14-day prompt payment time frame. There is legitimate concern that the current Medicare Transaction Facilitator (MTF) forms and submission guidance will shift the financial risk from primary manufacturers to dispensing entities.

For example, our members have reported that while the majority of prescription drug event (PDE) records are submitted within seven days, a not insignificant portion of these PDEs are reversed for multiple reasons, including when an enrollee does not pick up their medication from the pharmacy within 14 days. These post-seven-day PDE reversals represent a real financial risk to dispensing pharmacies for retroactive repayment and adjudication requests by manufacturers. Only with a prospective effectuation of MFP would pharmacies be protected from serious financial risks, especially when they are already operating on small margins.

PCMA instead advocates for a shift toward a system in which the MFP is effectuated prospectively only. While retrospective methods may be used as interim solutions, the ultimate goal should be to establish a permanent approach that makes the MFP available to dispensing entities prospectively and ensures their long-term financial viability.

2. **CMS has an obligation to minimize the administrative responsibilities of Part D plans in the implementation of the MFP**.

CMS's current approach for MFP effectuation, which relies on PDE records for MFP reimbursement, inappropriately burdens Part D plans with the operationalization of effectuating the MFP, which is clearly the sole province of manufacturers under the Inflation Reduction Act (IRA). In addition, the proposed approach to direct member reimbursement (DMR) requests would require Part D plans to assume the responsibility of manufacturers by making the MFP available to beneficiaries who submit DMR requests. We do not believe it is appropriate to overhaul existing processes that Part D plans and pharmacies use for processing and paying claims, especially for the purpose of integrating a sub-process that affects only a handful of selected drugs. PCMA urges CMS to explore alternative methods that would instead assign the responsibility for MFP effectuation solely to the drug manufacturer, including effectuation of the MFP to beneficiaries who submit DMR requests, consistent with the plain language of the IRA.

Our specific comments on the Draft Guidance are laid out below.

Section 30. Identification of Selected Drugs for Initial Price Applicability Year 2028

Background. For Part D drugs, consistent with its IPAY 2026 and 2027 Revised Guidance, CMS intends to define "total expenditures," for purposes of identifying "negotiation-eligible" drugs under Part D, by using its revised regulatory definition of "gross covered prescription drug costs" (GCPDC) — a definition that was not in effect at the time the Negotiation Program was established under the IRA. This revised definition, as reinterpreted by the agency, excludes rebates and other price concessions.[2] In other words, CMS proposes to continue to identify and rank negotiation-eligible drugs without regard to the discounts that Part D plans currently secure on these same products.

For Part B, which will be included in the Negotiation Program beginning with IPAY 2028, CMS states that it will use "Part B claims data" to calculate total expenditures for purposes of identifying negotiation-eligible Part B drugs. CMS does not define "Part B claims data," nor does it discuss or shed light anywhere on what the term means, but the term appears to be limited to Medicare fee-for-service (FFS) claims, thus excluding Medicare Advantage (MA) payment data.[3] CMS states that, as required by the IRA, expenditures for a drug or biological product that are bundled or packaged into the payment for another service will be excluded from the calculation of total expenditures under Part B.

Comment. PCMA has previously objected to CMS's revision of the regulatory definition of GCPDC for purposes of identifying negotiation-eligible Part D drugs under the Negotiation Program.[4] When Congress enacted the Negotiation Program and employed the GCPDC term, it did so with an understanding that CMS's long-standing interpretation of the term would also govern the implementation of the Negotiation Program. Congress did not provide any sign that it expected CMS to revise this interpretation, either in the plain statutory language enacting the Negotiation Program or in any legislative history.

Congress's expectation that the long-standing GCPDC definition, *being net of price concessions*, would govern the Negotiation Program also makes sense from a public policy perspective. It is counterintuitive that in implementing a Negotiation Program

[2] See Draft Guidance, footnote 5, p.8.
[3] For purposes of our comments below, we presume that "Part B claims data" means the Average Sales Price (ASP) or Wholesale Acquisition Cost (WAC), as appropriate under the statute, paid to the billing provider but not the plus 6 percent portion of the reimbursement rate.
[4] See 88 Fed. Reg. 22120, 22261 (April 12, 2023) (amending GCPDC definition at 42 C.F.R. § 423.308).

intended to reduce drug costs and improve access, CMS would rank negotiation-eligible drugs without regard to how effectively Part D plans are negotiating prices for these same drugs. Instructing CMS to negotiate prices for drugs that are already subject to substantial rebates through Part D plans is redundant and could potentially disrupt the market-driven structure that is foundational to the Part D program. Further, such a decision clearly decreases the potential actual savings the program would realize under the Negotiation Program. Given the President's clear directive to CMS to increase the government's savings with respect to the Negotiation Program, and to "prioritize the selection of prescription drugs with high costs to the Medicare program," CMS should reconsider its current definition of GCPDC.[5]

With respect to Part B, if only Part B claims data (e.g. payments based on ASP) is used for drug selection, this will represent *net* market pricing, taking into account all discounts and price concessions on these drugs, whereas Part D drugs will be chosen based on *gross* costs if CMS does not reverse course. It is egregiously inconsistent and arbitrary for Part B drugs to be selected based on a methodology opposite to the one used for Part D drugs, exacerbating the problem caused by the failure to include complete Part B utilization data and further decreasing the likelihood that a Part B drug will be selected.

In addition, CMS should consider how to incorporate MA encounter data into total expenditures for purposes of identifying negotiation-eligible Part B drugs. More than half of Medicare beneficiaries are in MA plans, and thus CMS will fail to consider the majority of Part B drug utilization if it does not include this encounter data. The effect of this omission will be to make Part D drugs more likely to be selected than Part B drugs and thus overweight Part D drugs in the Negotiation Program. There is no indication that Congress intended this, and it runs counter to the clear congressional objective of selecting the drugs representing the greatest cost to the Medicare program for negotiation. Leaving out more than half of Part B expenditures not only skews the choice of drugs to Part D drugs but means that some of the drugs that are most expensive to the Medicare program may not be selected, disadvantaging the program and beneficiaries alike.

In addition, while we understand that CMS is required by statute to exclude drugs bundled or packaged into payment for another service, we note that while hospital outpatient bundled drugs are mostly high-volume, lower-cost drugs, they also include high-cost drugs used in end-stage renal disease dialysis services. These services are billed separately but are not currently paid separately. CMS should consider, within the existing statutory framework, how it might include bundled drugs that are billed

[5] Executive Order 14273, Lowering Drug Prices by Once Again Putting Americans First, April 15, 2025.

separately as negotiation-eligible Part B drugs, since doing so could present opportunities for significant program savings.

PCMA Recommendations. CMS should:

- ***Reconsider use of its revised GCPDC definition for identifying negotiation-eligible Part D drugs and instead revert to the long-standing definition that was in effect when the Negotiation Program was enacted.***
- ***Consider ways to include Part B utilization data from MA plans in the selection process, whether directly or by extrapolation, to ensure that the 15 drugs chosen in IPAY 2028 do in fact represent the 15 drugs most costly to the Medicare program.***

Section 30.1. Identification of Qualifying Single Source Drugs for Initial Price Applicability Year 2028

Background. Under the Draft Guidance, if a drug is a fixed combination drug with two or more active moieties / active ingredients, the distinct combination of active moieties / active ingredients will be considered as one active moiety / active ingredient for the purpose of identifying potential qualifying single source drugs. CMS states that while it believes this policy is generally appropriate, it acknowledges that there may exist fixed combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) for which the drug is indicated, thus not resulting in a clinically meaningful difference. CMS thus solicits comments on whether the addition of Part B drugs may impact this policy. Specifically, it asks how it might consider grouping fixed combination drug products with products containing at least one but not all of the active moieties / active ingredients into the same potential qualifying single source drug for Part B and/or Part D drugs.

In this draft guidance, CMS is introducing a nuanced and potentially far-reaching policy regarding fixed combination drug products. Specifically, CMS proposes that combinations of multiple active moieties / active ingredients be treated as a single active moiety for the purposes of drug identification in the Negotiation Program while acknowledging exceptions when one ingredient is not clinically relevant to the drug's therapeutic purpose.

This policy has important implications in how plans and PBMs assess formulary inclusion, negotiate rebates, and manage drug utilization. Grouping drugs with partially overlapping ingredients could limit plans' abilities to differentiate clinically distinct formulations, even when such differences are relevant to safety, adherence, or patient-specific dosing. For example, a plan may prefer a single-agent drug over a fixed

combination due to formulary tiering, cost-efficiency, or rebate structure. CMS's proposed grouping policy could undermine this strategy by treating clinically distinct options as the same qualifying single source drug, reducing leverage in formulary design and potentially increasing patient costs.

There is serious potential for misalignment with clinical or regulatory realities. Not all fixed combination drugs are interchangeable with single-agent therapies. A fixed-dose combination may contain a non-therapeutic stabilizer or a complementary, not primary, agent. Also, grouping based on shared ingredients without evaluating clinical contribution could produce non-equivalent groupings, affecting both formulary coverage decisions and patient outcomes. CMS's suggestion that non-active moieties might warrant exclusion is appropriate, but PCMA cautions that this gray zone could result in uncertain implementation, requiring greater clarity in clinical criteria.

Additionally, PBMs managing Part D formularies could face administrative challenges if CMS applies different logic for Part B drugs (e.g., oncology combinations administered in-office) versus Part D drugs (e.g., oral cardiovascular combinations). Cross-setting inconsistencies could increase processing complexity, especially for dual-eligible patients or those transitioning from medical to pharmacy benefit settings.

PCMA recommends that CMS:

- **Apply a clinical relevance filter:** Define clinical contribution thresholds and require evidence of therapeutic activity from each ingredient in a fixed combination before aggregating drugs.
- **Allow distinct formulary treatment design:** Maintain formulary flexibility for plans to treat drugs with partial ingredient overlap as separate formulary entities when clinically justified.
- **Coordinate across benefit types:** Align policies across Part B and Part D, and engage stakeholders to ensure operational consistency in coding, classification, and pricing models.
- **Engage plans and PBMs in technical implementation guidance:** Coordinate with plans and PBMs in defining how MFPs will be applied across fixed and partial combinations, including whether manufacturers must harmonize list and net prices across product lines.

CMS's proposed approach to grouping fixed combination products under the IPAY 2028 framework represents a well-intentioned effort to simplify drug identification but risks significant downstream effects on PBM functionality, especially in formulary management, rebate negotiations, and benefit design. PCMA urges CMS to proceed cautiously, with clinical specificity and operational alignment, and to preserve the tools necessary to ensure cost-effective and patient-centered drug management.

Section 30.3. Selection of Drugs for Negotiation for Initial Price Applicability Year 2028

Background. To identify negotiation-eligible drugs for IPAY 2028, CMS states that it will identify the 50 qualifying single source drugs that have the highest Total Expenditures under Part D during the applicable 12-month period and separately identify the 50 qualifying single source drugs that have the highest Total Expenditures under Part B during the same period. It will then select up to 15 negotiation-eligible drugs for negotiation for IPAY 2028 by combined Total Expenditures under both Part B and Part D and rank the drugs in descending order: The negotiation-eligible drug with the highest Total Expenditures under Part B and Part D will be listed first, and the negotiation-eligible drug with the lowest Total Expenditures under Part B and Part D will be listed last. CMS clarifies that if a negotiation-eligible drug appears on both high-spend lists, it will receive only one ranking for purposes of selection, according to its combined Total Expenditures under both Part B and Part D.

Comment. As discussed in our comments on Section 30 above, CMS is inconsistent in its methodologies for determining Total Expenditures under Parts B and D, including leaving out more than half of the Part B expenditures from the combined total expenditures used to choose the top 15 drugs eligible for IPAY 2028 negotiation. This flawed approach will result in a significant overweighting of Part D drugs in the list of selected drugs, contrary to the intent of Congress and to the ultimate detriment of beneficiaries and the Medicare program. If CMS is unable to obtain claims data for Part B utilization under the MA program, it should at a minimum extrapolate from the FFS data to determine a proxy for Total Expenditures for Part B drugs under the MA program and include this in the Total Expenditures for Part B.

PCMA Recommendations. CMS should:

- ***Include expenditures on Part B drugs in the MA program, either directly or by extrapolation, in Part B Total Expenditures so that (1) these expenditures properly capture the Part B drugs most expensive to the Medicare program, and (2) over-representation of Part D drugs in the list of selected drugs is avoided.***
- ***Calculate Total Expenditures for Part D drugs net of rebates and other price concessions to ensure that like costs are included for Part B and D drugs and that the true costs of a drug to the Medicare program are considered in identifying negotiation-eligible drugs.***

Section 30.3.1. Delay in the Selection and Negotiation of Certain Biological Products with High Likelihood of Biosimilar Market Entry

Background. CMS updates the process for a biosimilar manufacturer to request a biosimilar delay by establishing a detailed process for requesting an additional year of delay. After confirming that the biosimilar was not licensed and marketed during the initial delay period, CMS will review the same statutory requirements as for the initial delay request but will also require clear and convincing evidence that the biosimilar manufacturer has made significant progress toward licensure and marketing since the initial request.

Comment. We continue to believe that the optimal strategy for reducing drug prices for high-priced biologics lies in fostering competition between reference products and biosimilars. In the initial cycle of the Negotiation Program, we understand that at least for a biosimilar that would have qualified as achieving a delay in its reference product's negotiation status; however, it appears the companies were not aware of the arcane process CMS instituted to identify such products.

Instead, CMS should directly share information with biosimilar manufacturers for the reference products that are likely to be eligible for negotiation. The agency has direct relationships with drug manufacturers through the several government price reporting programs it administers. Most biosimilars launched in the US are already approved for use outside the US, so CMS would know exactly *which* manufacturers to contact. For example, CMS could publish, well in advance of the Initial Delay Request deadline, the full list of Part B and D drugs eligible for selection by Total Expenditure before considering any exclusions. The agency could push this out through the average manufacturer price, average sales price, Manufacturer Discount Program via the Health Plan Management System, and other venues to ensure that all manufacturers are aware of these drugs' potential statuses. This is especially important because CMS uses a different time period than is otherwise publicly available when calculating Total Expenditures spending, creating uncertainty that biosimilar manufacturers are left to manage. The process of submitting an Initial Delay Request demands considerable effort and coordination within a biosimilar manufacturer's organization. Uncertainty surrounding the selection of reference biological products for the Negotiation Program adds to this complexity and creates an unnecessary burden on biosimilar manufacturers. This lack of predictability also leads to inefficiencies in the Negotiation Program's execution.

PCMA Recommendation: CMS should either publish a preliminary list of the 50 drugs eligible for selection well before the official publication date, giving

biosimilar manufacturers more time to evaluate whether to submit an Initial Delay Request, or otherwise engage in targeted communications with biosimilar manufacturers. This outreach would inform these manufacturers in advance if their reference products were being considered for negotiation, thus aiding in their planning and decision-making processes.

Section 40. Requirements for Manufacturers of Selected Drugs

Background. In the CY 2026 Final Part D Policy & Technical Rule,[6] CMS shortened the general 30-day window for plans to submit initial PDE records to seven days for selected drugs to facilitate more timely payment of MFP refunds to dispensing entities.[7]

CMS retains the 14-day prompt pay window for manufacturers to reimburse dispensing entities. In other words, CMS requires that the Primary Manufacturer transmit payment of an amount that provides access to the MFP within 14 calendar days of when the MTF sends data to the Primary Manufacturer that verifies the selected drug was dispensed to an MFP-eligible individual.

CMS retains the same guidance regarding 340B claims to avoid deduplication of discounts between the MFP and 340B ceiling price.

CMS states that it expects and encourages interested parties to work together as necessary to develop mechanisms to ensure timely effectuation of MFP refund payments. It also gives examples of ways in which manufacturers could make the MTF available on a prospective basis, such as by leveraging virtual inventory management systems and pharmaceutical wholesaler chargebacks or by establishing pre-funded MFP refund payment accounts directly with dispensing entities.

Comment. We urge CMS to rescind the change in the CY 2026 Final Rule requiring Part D plans to submit PDEs for selected drugs within seven days of receipt of a claim for a selected drug. As stated in our comments to the CY 2026 Proposed Rule, this shorter time frame imposes significant operational and administrative burdens on Part D plans, especially for claims requiring coordination of benefits, prior authorization, or other complex processing. This shortened time frame also does not accommodate post-seven-day PDE reversals, which are not uncommon (i.e., when beneficiaries fail to pick up their medications at the pharmacy within 14 days). We recommend that CMS assess PDE submission timelines after at least one year of implementation of the Negotiation

[6] 90 Fed. Reg. 15792 (April 15, 2025) ("CY 2026 Final Rule").
[7] See 42 C.F.R. § 423.325(b) ("A Part D sponsor must submit initial PDE records for selected drugs (as described at section 1192(c) of the Act) within 7 calendar days from the date the Part D sponsor (or its contracted first tier, downstream, or related entity) receives the claim").

Program or, at a minimum, extend the PDE submission window for selected drugs to 14 days, which will accommodate the majority of reversals.

For 340B drugs, we again urge CMS to more closely consider a standardized 340B deduplication method or an extension to the 14-day prompt payment standard to account for challenges in the deduplication of discounts between the MFP and 340B ceiling price. We are concerned that the 14-day prompt payment period for manufacturers may not be sufficient time to deduplicate 340B-eligible claims, especially in the context of contract pharmacy 340B-eligible claims. CMS has opted not to consolidate the deduplication process within the MTF, which may lead to a proliferation of deduplication methods by manufacturers, potentially affecting 340B covered entities in various ways. There is a risk that manufacturers might not complete the deduplication process within the 14-day window, which could result in the issuance of duplicate discounts, in contravention of the statute. Again, under a retrospective reimbursement to pharmacy model, it is pharmacies who are most harmed by CMS's decision not to take an active role in deduplication. Rather, manufacturers who can operationalize MFP at the point of acquisition will have better data from dispensers and can more effectively reduce their 340B duplicate discount risks.

Finally, we continue to emphasize that the current retrospective reimbursement process places the financial risk associated with the difference between the pharmacy acquisition cost and the MFP on the pharmacies as opposed to the manufacturer. Pharmacies should not be exposed to potential financial shortfalls because of a manufacturer's preference on how to implement a statutory obligation that rests solely on the manufacturer. Moreover, any friction that pharmacies encounter in accessing the MFP will necessarily be felt by beneficiaries, as pharmacies may adjust their drug purchasing and inventory policies, thereby affecting beneficiaries' access. Further, many PBMs operate mail and specialty pharmacies that will also be subject to these financial considerations. Thus, while we agree that the MTF stands to act as an essential and wholly independent intermediary for bridging the gap between manufacturers and dispensing entities, thereby smoothing the implementation process of the MFP within a retrospective model, it remains the case that the most effective and error-resistant approach for ensuring that dispensing entities have access to the MFP would be for manufacturers to prospectively provide the MFP to these entities.

We therefore recommend that CMS prioritize the development of a prospective MFP implementation strategy and consider the retrospective approach as a secondary alternative. While we appreciate CMS providing suggestions for a timelier effectuation of the MFP, these suggestions are unlikely to progress beyond mere ideas without the same full support and involvement that CMS has provided for the retrospective

effectuation method through the Medicare Transaction Facilitator Data Module (MTF-DM).

PCMA Recommendations:

- ***We strongly urge CMS to rescind the seven-day submission window for PDEs for selected drugs and either wait until at least one year after implementation of the Negotiation Program to reevaluate the PDE submission window or otherwise change the seven-day time frame for PDE submissions for selected drugs to a minimum of 14 days.***
- ***For 340B drugs, CMS should more closely consider a standardized 340B deduplication method or an extension to the 14-day prompt payment standard to account for challenges in the deduplication of discounts between the MFP and 340B ceiling price.***
- ***CMS should work with all stakeholders to prioritize and facilitate the establishment of a prospective MFP effectuation process.***

Section 40.4. Providing Access to the MFP in 2026, 2027, and 2028

Background. CMS states that it is not including at this time a detailed policy on providing access to the MFP for selected drugs payable under Part B. It adds that to the extent appropriate and feasible, it intends to align the policies and operations for providing access to the MFP for selected drugs payable under Part B with those for selected drugs covered under Part D.

Comment. We believe many health care providers have mechanisms in place to receive discounts retrospectively as credits toward purchases. For instance, many manufacturers offer volume-based discounts to hospitals or group practices executed through wholesaler contracts, with the differences charged back as credits toward future purchases. Providers and manufacturers could utilize these mechanisms for effectuation of the MFP. This is different in the case of pharmacies, which generally do not have relationships with manufacturers through wholesalers.

PCMA Recommendation: Manufacturers should, whenever possible, utilize existing mechanisms in place with providers, such as through wholesaler chargebacks, to provide access to the MFP to providers for Part B drugs.

Section 70. Removal from the Selected Drug List Before or During Negotiation, or After an MFP Is in Effect

Background. A selected drug will no longer be subject to the negotiation process and will cease to be a selected drug when a generic or biosimilar, as applicable, is marketed "on a bona fide basis." CMS states that the determination as to whether a generic drug or biosimilar is being marketed on a bona fide basis is a totality-of-the-circumstances inquiry that will not necessarily turn on any one source of data. CMS states that relevant factors may include whether the generic drug or biosimilar is regularly and consistently available for purchase through the pharmaceutical supply chain and whether any licenses or other agreements between a Primary Manufacturer and a generic drug or biosimilar manufacturer limit the availability or distribution of the generic drug or biosimilar.

Comment. We would like to emphasize again the critical importance of CMS's prompt public notification when it determines that a generic or biosimilar is being marketed on a bona fide basis. This information is pivotal for Part D plans, as it directly influences their ability to negotiate drug prices and manage formulary coverage for the selected drug and its competitors. The expectation is that the MFP's implementation will likely deter manufacturers from offering additional discounts. Therefore, if a selected drug is exempt from the MFP due to a bona fide marketing determination, it is imperative that Part D plans are informed promptly. This will enable them to engage in timely negotiations with the drug's manufacturer, who will no longer be bound by the MFP obligations.

We also ask CMS to provide clear guidance regarding the mandatory coverage requirement outlined in section 1860D-4(b)(3)(I)(i) of the statute. This requirement should not be applicable to a selected drug for which CMS has determined that the MFP does not apply due to the identification of bona fide marketing within the specified time frame. The statute is clear that the mandatory formulary coverage requirement applies only to a selected drug "for which a maximum price…is in effect with respect to the year."[8] In instances for which CMS makes a bona fide marketing determination for a selected drug between the publication date of the selected drug list and the end of the negotiation period, the drug remains a selected drug for the initial year without the MFP being in effect for that year. Consequently, the mandatory coverage requirement should not be enforced for that drug. For other selected drugs for which an MFP is in effect and the generic or biosimilar becomes available in the market, CMS should, at a minimum, allow Part D plans the flexibility to immediately change the formulary placement of the drug or impose utilization management (UM) requirements on the selected drugs.

PCMA Recommendations. CMS should:

- ***Provide prompt notice to Part D plans once it determines that there is "bona fide marketing" of a generic or biosimilar drug to the selected drug.***

[8] Social Security Act § 1860D-4(b)(3)(I)(i).

- ***Make clear in the final guidance that Part D plans are not required to include on their formularies selected drugs for which CMS has determined a generic or biosimilar is being marketed on a bona fide basis between the selected drug publication date and the end of the negotiation period.***
- ***Allow plans to immediately change the formulary placement or impose UM requirements on selected drugs required to be included on a plan's formulary but for which a generic or biosimilar is available in the market.***

Section 80.1 Direct Member Reimbursements and Access to the MFP for Selected Drugs in 2026, 2027, and 2028

Background. CMS states that access to the MFP for an MFP-eligible individual who submits a covered direct member reimbursement (DMR) request for a selected drug will be facilitated by the Part D plan sponsor. MFP-eligible individuals who submit a covered DMR request for a selected drug must not pay more than the MFP plus any dispensing fees. Specifically, whether the claim is in-network or out-of-network, MFP-eligible individuals who submit a covered DMR request for a selected drug must not pay more than the MFP plus any dispensing fees if the individual is in the deductible phase of the benefit or more than the copayment or coinsurance if they are in other phases of the benefit. This means that the Part D plan will be responsible for reimbursing the individual at least the difference between the cash price paid by the enrollee to the dispensing entity and the negotiated price (for in-network claims) or between the cash price and the MFP plus dispensing fee (for out-of-network claims). CMS adds that Primary Manufacturers and Part D plan sponsors may establish a reimbursement process related to DMR requests for MFP-eligible claims as necessary to ensure MFP effectuation for these MFP-eligible individuals.

Comment. We strongly object to Part D plan sponsors being held responsible for the reimbursement to members. This is not only contrary to the IRA, which imposes this responsibility solely on manufacturers, but also unnecessary, in that most pharmacies are likely enrolled in the MTF-DM even if they are not in a specific Part D plan's network. Manufacturers should instead be required to provide access to the MFP to beneficiaries in DMR situations through MTF-DM enrolled pharmacies. This is another reason why direct submission of claims by pharmacies to the MTF-DM is preferable to the current approach that puts Part D plans in the middle. Moreover, while CMS states that manufacturers and Part D plans may establish a reimbursement process for DMR claims, it is not clear on what basis CMS believes manufacturers would agree to this unless required to do so by CMS. Even then, there is no existing mechanism by which this could be effectuated.

We also note that, as with vaccines subject to no cost sharing under Part D and insulin with capped cost sharing, beneficiaries who go out-of-network are reimbursed as if they obtained the drug in-network, with the plan having to pick up the difference between the pharmacy or provider's cash price and the amount, if any, required to be covered by the member. This eliminates any disincentive to beneficiaries for going out-of-network, which is contrary to the long-standing policy of the Part D program. Per the Medicare Modernization Act, out-of-network utilization must be limited to emergency situations, with beneficiaries, in most cases, bearing the excess costs charged by the pharmacy in these situations. In addition, CMS's proposed policy provides a strong and dangerous incentive for pharmacies and other providers to not run the claim through the beneficiary's Part D plan, since in this situation, the pharmacy can charge any amount it wishes. While pharmacy contracts include language requiring in-network pharmacies to process claims through the Part D benefit when they have the beneficiary's Part D insurance information, it will be much more challenging for Part D plans to enforce this when the financial incentives are so heavily stacked in opposition.

CMS should also discuss in the final guidance how the president's Executive Order on Delivering Most-Favored-Nation Prescription Drug Pricing to American Patients. [9] interacts with the MFP and DMR claims. Specifically, actions taken by CMS under the Executive Order may include requiring manufacturers to sell drugs directly to consumers at or below target prices set by the secretary of Health and Human Services. There is a complicated set of interactions that will arise if drugs sold direct to consumer (DTC) are also negotiated drugs for IPAY 2026 and beyond. For example, CMS should address whether the target prices will be equal to or less than the MFP, as well as whether DTC claims will be treated as DMR per the draft guidance. Further, CMS should ensure that if the manufacturer makes selected drugs available to consumers at target prices below the MFP, those same prices should be made available to consumers who pay cash for these drugs at pharmacies.

PCMA Recommendation:

- ***Part D plans should not be responsible, financially or administratively, for providing access to the MFP on behalf of manufacturers for DMR claims. Instead, manufacturers should utilize the existing process through the MTF-DM to provide access to the MFP through the pharmacies, most of which will already be enrolled with the MTF-DM.***

[9] See Executive Order on Most Favored Nation Prescription Drug Pricing to American Patients, May 12, 2025.

- ***CMS needs to define a standard "dispensing fee" as used in "MFP-eligible individuals who submit a covered DMR request for a selected drug must not pay more than the MFP plus any dispensing fees."***

Section 90.2.2. Centralized Intake System for Complaints and Disputes Related to MFP Availability and MTF Functionality

Background. The complaint and dispute process will be set up with two "tracks" within one overall system. The first track is a dispute functionality within the MTF for qualifying disputes from Primary Manufacturers or dispensing entities and, beginning in 2028, Part B providers regarding a technical aspect of the MTF process. The second track is a complaint process that will intake complaints and will be available to the public as well as Primary Manufacturers and dispensing entities and, beginning in 2028, Part B providers, regardless of their degree of participation in any aspect of the MTF. This will encompass any issues that do not qualify as disputes under the definition set forth below.

Comment. We support the establishment of a centralized intake system for receiving reports related to access to the MFP, as proposed by CMS. We believe this system will help ensure that MFP-eligible individuals and dispensing entities can obtain the MFP as required by the program, and that any issues or disputes can be resolved in a timely and efficient manner. We also appreciate that CMS will provide dispute functionality within the MTF for qualifying disputes and a complaint process for issues that do not qualify as disputes. However, we are concerned that the IPAY 2028 Draft Guidance does not explicitly allow Part D plan sponsors to use the complaint process to report any problems they encounter that relate to the MFP under the "first track," such as the mandatory formulary coverage requirements. Part D plan sponsors are key stakeholders in the program and have a direct interest in ensuring that the MFP is available and accessible to their enrollees. We recommend that CMS clarify that Part D plan sponsors can also submit complaints through the centralized intake system and that CMS will respond to and address their concerns.

PCMA Recommendation: CMS should clarify that Part D plans may avail themselves of the "first track" of the proposed complaint and dispute system.

Section 110. Part D Formulary Inclusion of Selected Drugs

Background. CMS states that, for CY 2028, it will continue the formulary inclusion policies described in prior guidance and that it does not have sufficient information at this time to determine whether changes to these formulary inclusion policies are

warranted. Thus, CMS will use its formulary review process to assess the following: (1) any instances in which Part D sponsors place selected drugs on non-preferred tiers; (2) any instances in which a selected drug is placed on a higher cost-sharing tier than non-selected brand drugs in the same class; (3) any instances in which Part D sponsors require utilization of an alternative brand drug prior to a selected drug (i.e., step therapy); or (4) any instances in which Part D sponsors impose more restrictive utilization management (e.g., step therapy and/or prior authorization) for a selected drug compared to a non-selected brand drug in the same class.

CMS also states that it will continue to require formularies to include all dosage forms and strengths of the selected drug that constitute a covered Part D drug and for which the MFP is in effect.

Comment. Consistent with previous PCMA comments, CMS should only require the formulary inclusion of dosage forms and strengths of selected drugs that are necessary to meet the needs of the Part D plan's patient population. CMS should also clarify that for selected drug dosage forms and strengths that are included on formulary, their default formulary placement should be as a non-preferred brand. We are concerned that, as currently stated in the draft guidance, CMS is creating a presumption that selected drugs get preferential formulary treatment. This is contrary to the intent of Congress, which provided for no such preferential treatment for selected drugs in the IRA and required only that selected drugs be included on formularies. Since Part D plans are compelled to include these drugs on their formularies, they should be allowed more, not less, flexibility in their formulary placement and in the imposition of UM edits. Plans would use this flexibility to help negotiate *lower* pricing than MFP when possible, reducing cost-sharing and premiums as a result. Thus, the default for these drugs should be that they are placed on the non-preferred brand tier.

Further, CMS should provide guidance on the application of transition policies, formulary exceptions, and tiering exception requests to selected drugs.

PCMA Recommendations:

- ***CMS should only require the formulary inclusion of dosage forms and strengths of selected drugs that are necessary to meet the needs of the Part D plan's patient population.***
- ***Part D plans should be allowed maximum formulary flexibility with respect to both formulary placement and the imposition of UM edits on selected drugs.***

Section 110.1. Formulary Inclusion Exception Successor Regulation for 2027 and 2028

Background. CMS incorporates its guidance from the Final CY 2026 Part D Redesign Program Instructions into the successor regulation allowing removal of a selected drug from a Part D plan's formulary. Accordingly, during a selected drug's price-applicability period, Part D plan sponsors may immediately substitute a selected drug that is a brand-name drug with a generic of the brand-name drug and substitute a selected drug that is a reference product with an interchangeable biological product of the reference product, provided the notice and timing requirements in 42 C.F.R. § 423.120(e)(2)(i), and the associated notice requirements of § 423.120(f)(2)-(4), are met. CMS also stated in the Final Part D Redesign Program Instructions that although the statute gives CMS the authority to identify maintenance changes as part of the successor regulation, it declined to do so at that time but may in the future identify new regulations that constitute the successor regulation (e.g., as the biosimilar market matures or as additional changes are made to the underlying regulations).

Comment: PCMA is concerned that CMS's proposed approach is likely to limit generic and biosimilar uptake, as well as raise barriers to access to lower-cost drug options, potentially leading to misalignment between formulary coverage in multiple plan years in cases in which new generics or biosimilars come to market later within the calendar year. CMS seems to be taking an overly narrow interpretation of the underlying statute and regulations, which restricts Part D plans from managing their formularies by covering less expensive, therapeutically equivalent medications and unnecessarily places even greater pressure on Part D plans that are already in a financially difficult situation due to the IRA's changes. CMS's proposal will ultimately restrict access to lower-cost drugs and is in conflict with the agency's overarching goals of promoting access to and uptake of lower-cost generic and biosimilar options and of lowering costs in the Part D program.

We also note that in some instances, the timing factors related to Part D formulary substitution policies in the recently finalized CY2026 MA & Part D redesign final rule limit these policies' application. The specific time periods finalized do not provide sufficient time for full evaluation and completion of activities prior to making and implementing decisions regarding the current formulary product, including activities such as evaluation of the new product's attributes (e.g., formulation, interchangeability, pricing), confirmation of sufficient availability in the marketplace, communication of changes, and updating of systems. Because of these proposed changes, we urge CMS to uphold current IRA guidance allowing formulary flexibilities related to tiering and UM

strategies for selected drugs, preserving the ability of plan sponsors to adopt tiering and UM strategies that allow driving toward the lowest net-cost product.

Finally, we strongly recommend that CMS interpret the successor regulation to include maintenance changes. This will give Part D plans much-needed flexibility to remove a selected drug when there is a generic or biosimilar being marketed on a bona fide basis, but because of the timing of formulary submissions, the immediate substitution conditions for removal could not be met.

PCMA Recommendation: CMS should allow Part D sponsors to maintain the flexibility to replace a selected drug from its formulary via immediate substitution, regardless of when the relevant generic or interchangeable biological product came to market in the calendar year. Furthermore, CMS should take all steps within its authority to preserve formulary flexibility for plan sponsors, including utilization management, placement, tiering, and cost sharing of selected drugs.

Conclusion

We thank CMS for letting us comment on this year's edition of the draft IPAY 2028 guidance. If you have any questions, please contact Emilia Clements at eclements@pcmanet.org.

Sincerely,

Tim Dube

Tim Dube, Senior Vice President, Policy & Regulatory Insights, PCMA

cc: Emilia Clements, Associate Vice President, Federal Regulatory Affairs, PCMA

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June 26, 2025

VIA Electronic Filing – *IRARebateandNegotiation@cms.hhs.gov*

Chris Klomp
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
Attn: PO Box 8016

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp,

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 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028* (Guidance or the Guidance), which CMS released on May 12, 2025.[1] PhRMA represents the country's leading innovative biopharmaceutical research companies, which are laser focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat and cure disease. Over the last decade, PhRMA member companies have invested more than $800 billion in the search for new treatments and cures, and they support nearly five million jobs in the United States.[2]

PhRMA has longstanding concerns about the impact of government price setting on patients, and our country's position as a leader in biopharmaceutical innovation. As it stands today, the U.S. leads the world in biopharmaceutical innovation, but middlemen and government intervention create inefficiency and threaten our leadership – risking American jobs, access to critical treatments and cures, and future innovation.

[1] Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028. Available at: https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf
[2] PhRMA. (July 16, 2024). 2024 PhRMA Annual Membership Survey. Available at: https://phrma.org/resources/2024-phrma-annual-membership-survey

- Three out of every four new medicines are approved in the U.S. before anywhere else in the world.[3]
- Prescription drugs represent a small and stable share (14 percent) of total US health care spending[4] because of the U.S.' unique intellectual property framework that balances innovation with robust generic and biosimilar competition.
- Yet, 50 percent of medicine spending goes to someone who did not make the medicines, and people pay more than they should.[5] Growth in patient out-of-pocket costs for medicines has outpaced growth in the prices paid by insurers[6] – price setting does not address these challenges and instead creates significantly *more* bureaucracy.

Not only does the Inflation Reduction Act (IRA) fail to address these issues, but it has been a disaster for patients. Research has shown that nine in 10 Part D plans say they intend to increase access restrictions on – and limit access to – medicines in the coming years because of the IRA.[7] Further, patients may pay *more* out-of-pocket costs as a result of the IRA – 3.5 million patients taking medicines subject to price setting may see higher out-of-pocket (OOP) costs in 2026, with OOP costs climbing 12 percent on average.[8]

This Administration has inherited the unfortunate responsibility of implementing an irreparably flawed price setting program. While it is impossible to fully erase the disruption that has been and will be caused by the IRA's price setting program, this Administration has an opportunity to take steps to mitigate that harm. This is further reinforced in the Executive Order signed by President Trump on April 15, 2025, entitled "Lowering Drug Prices by Once Again Putting Americans First," which instructed the Secretary of Health and Human Services to "propose and seek comment on" guidance implementing the Medicare Drug Price Negotiation Program. The Executive Order also specifically stated that "The guidance shall improve the transparency of the Medicare Drug Price Negotiation Program, prioritize the selection of prescription drugs with high costs to the Medicare program, and minimize any negative impacts of the maximum fair price on pharmaceutical innovation within the United States."

While the Executive Order appeared to signal a willingness to rethink implementation of the Program, the Draft Guidance not only retains the policy framework set forth by the Biden Administration, but *doubles down on certain inefficient, wasteful, and harmful aspects of the Program,* including the last Administration's position that it can create rules with the force and effect of law, solely through

[3] PhRMA analysis of Novel Drug Approvals at FDA. (2023). Available at: https://www.fda.gov/drugs/development-approval-process-drugs/novel-drug-approvals-fda
[4] The Altarum Institute. (July 2022). Projections of the Non-Retail Prescription Drug Share of National Health Expenditures. Available at: https://drugchannelsinstitute.com/files/Projections-of-Non-Retail-Drug-Share-of-NHE-2022.pdf
[5] BRG. (January 2022). The Pharmaceutical Supply Chain, 2013 – 2020. Available at: https://www.thinkbrg.com/insights/publications/pharmaceutical-supply-chain-2013-2020/
[6] Mallatt J., Dunn A., Fernando L. (September 2024). Consumer Out-Of-Pocket Drug Prices Grew Faster Than Prices Faced By Insurers After Accounting for Rebates, 2007 – 2020. *HealthAffairs.* Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01344
[7] Magnolia Market Access. (2024). IRA Payer Insights Report Chartbook Summary of Key Findings. Available at: https://www.magnoliamarketaccess.com/wp-content/uploads/MMA_IRA-Payer-Insights-Survey-4.0_Chartbook_2024.07.31.pdf
[8] Milliman. (June 2024). Expected Impact of the IRA Medicare Drug Price Negotiation Program on Medicare Part D Beneficiary Out-of-Pocket Costs. Available at: https://www.milliman.com/en/insight/ira-mdpnp-impact-on-beneficiary-oop

guidance.[9] Rather than dismantling bureaucracy, this Draft Guidance creates additional bureaucracy within the Agency. Rather than streamlining and alleviating burden to stakeholders, this Draft Guidance adds to their burden. And rather than providing relief to Americans who struggle to afford their medicines at the pharmacy counter, the Draft Guidance fails to offer Americans sufficient protection from health insurance plans, who have publicly stated they intend to *worsen* access to drugs selected for price setting. Any meaningful changes exist merely in the margins of this Draft Guidance.

Further, the so-called "negotiation" as defined in the IRA and detailed further in Draft Guidance documents released by both the current and prior Administration is fundamentally misaligned and incompatible with a true negotiation process. Unfortunately, the framework set forth in both the IRA and the Draft Guidance diverge significantly from the principles and practices of genuine negotiation as seen in the private market. Instead, the structure and implementation of the IRA's pricing provisions raise serious concerns about fairness, transparency, and legality.

- **The IRA's "negotiation" process bears no resemblance to private market negotiations.** Under the IRA, CMS wields unilateral authority to set drug prices with minimal input from manufacturers, who face severe penalties—including market exclusion, exorbitant excise taxes, or civil monetary penalties—if they do not comply. Unlike private negotiations, where both parties engage in mutual exchange and can walk away, CMS dictates terms through a rigid, non-negotiable framework. Manufacturers are required to sign contracts before knowing the final price, cannot revise terms, and are denied legal recourse or transparency into CMS' decision-making process. This coercive structure lacks the flexibility, reciprocity, and balance that define genuine negotiation.
- **CMS' methodology for setting prices lacks transparency and objective standards.** Rather than following a consistent, replicable process, CMS relies on a vague "qualitative approach" that allows it to weigh and combine factors arbitrarily. The Agency provides no clarity on how evidence is evaluated, how factors are prioritized, or how final prices are determined. Moreover, CMS seeks input on potential changes to the starting point that would make the process even less transparent and more subjective. This opacity makes it nearly impossible for manufacturers to understand or influence the outcome, and raises concerns about bias, inconsistency, and the potential for flawed or incomplete analysis. Without a transparent framework, CMS can attempt to justify virtually any price below the statutory ceiling, undermining predictability and fairness. Where CMS does provide a measure of clarity, such as CMS' apparent interest in new approaches to establish a starting point for MFPs (e.g., domestic reference pricing and "unit cost of

[9] *See e.g., Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019). *See also* HHS Office of the General Counsel, Advisory Opinion 20-05 on Implementing Allina (December 2020), available at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2101111604-mh-advisory-opinion-20-05-on-implementing-allina_12.03.2020_signed.pdf. CMS again cites to Congress' direction to implement through program instruction or other forms of guidance, and claims it is authorized to follow "policymaking procedures that differ from the notice-and-comment procedures that would otherwise apply under the APA or the Medicare statute." But such direction does not explicitly supersede section 1871 or APA requirements. The provision requiring program guidance is not prefaced with a "notwithstanding" clause, a phrasing that would have clarified the IRA's preemptive intent. "Repeals by implication are not favored, and are a rarity." Maine Cmty. Health Options v. United States, 140 S. Ct. 1308, 1323 (2020) (cleaned up).

production and distribution"), those approaches are deeply flawed (See Appendix D for additional detail on PhRMA's concerns with these proposals).

- **The IRA unconstitutionally delegates legislative power to CMS.** As interpreted by CMS, the statute grants it broad, unchecked authority to define key terms, impose penalties, and interpret statutory language without oversight. CMS has already expanded its reach by redefining what constitutes a "manufacturer" and by asserting control over entities not directly named in FDA applications. The Biden Administration even went so far as claiming that the IRA authorized it to contradict the plain language of laws written by Congress.[10] This sweeping assertion of legislative power, combined with the continuation of Biden Administration's expansive interpretations and lack of accountability, raises serious constitutional questions about separation of powers and the limits of agency authority.

The impact of the IRA's unilateral price setting is widespread, causing harm to patients, key stakeholders such as pharmacies and providers, as well as innovation and market competition. In this letter, we articulate our core concerns with the IRA, as well as with CMS' Draft Guidance for IPAY 2028, which have been further exacerbated by an implementation strategy crafted by the Biden Administration that repeatedly overreaches and fails to protect patients. We also discuss implementation issues we believe the Administration should take the opportunity to address immediately. Areas for concern addressed in this letter include:

I. Harms to Biopharmaceutical Innovation and Investment in Research & Development

II. Undermines Competitive Market Dynamics

III. Disruptive to Stakeholders

IV. Puts Patient Access at Risk

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 MFP Calculation;

[10] *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.").

Appendix C: Access and Coverage;

Appendix D: Information Collection and Negotiation Process; and

Appendix E: Renegotiation

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I. Harm to Biopharmaceutical Innovation and Investment in Research & Development

The IRA and CMS' implementation of the Program fundamentally alter existing R&D incentives and jeopardize the future development of medicines with very real consequences for patients and the broader health care system. Although impacts may vary by company, the IRA and CMS' interpretation of the statute are already discouraging:

- **Post-Approval Innovation.** CMS' broad definition of QSSD, as well as when drugs become eligible for negotiation within their lifecycle, discourages R&D that improves patient outcomes and occurs after a drug or biological is initially FDA approved.
- **Development of Small Molecule Medicines.** By giving small molecule drugs four fewer years than biologics before price negotiations begin, the IRA discourages 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 and the companies that are focused on providing treatment options for these populations.
- **Development of Treatments for Chronic Diseases.** CMS' continued selection of chronic disease medicines – which are comparatively low-cost, but widely used – for price setting signals that the IRA makes investing in these medicines uncertain and risky.

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 Qualifying Single Source Drug (QSSD) under the IRA is untethered from the statute and will stifle the development of innovative and lifesaving treatments by treating new dosage forms and formulations with the same active ingredient or moiety as the same drug - even if they are approved under separate applications for different diseases or patient populations. This means that distinct new treatments could face immediate price setting upon approval, eroding the value of critical post-approval innovation and disincentivizing the development of new forms of medicines. A recent study showed that if CMS had applied this approach retroactively to novel drugs approved between 2006 and 2013, 110 unique drugs and biologics products could have been swept into price setting – more than double the intended 50.[11] The consequences are already evident: for IPAY 2026 and 2027, CMS selected

[11] Stratevi. (2025). Combining Apples and Oranges: An Examination of CMS' Methods for Defining a Qualifying Single Source Drug. Available at: https://static1.squarespace.com/static/621e5edfadb9950783f45d9a/t/67cf3ba77613db2190dfb3a6/1741634472366/Multiple+Forms+Policy+Brief.pdf

16 and 26 distinct NDAs and BLAs, respectively, many with different brand names and some approved within three years – far exceeding the statutory limits on the age of the selected drug.

CMS' implementation of the Program will disincentivize post-approval R&D and the development of small molecule medicines, which are critical for driving treatment advances in certain disease areas.

Under the flawed IRA statute, small molecule medicines face price setting four years before biologic medicines. This so-called "pill penalty" discourages the development of treatments that are often the most accessible and critical for conditions like cancer, mental illness, and chronic diseases. Since the IRA was introduced, early-stage investment in small molecules has plummeted by nearly 70 percent among smaller, early-stage biopharma companies.[12] Because post-approval trials can take years to complete and require significant investment, biopharmaceutical companies are also shifting away from pursuing new indications for already FDA-approved treatment in disease areas where post-approval R&D has been indispensable. Since the IRA's enactment, monthly starts of industry-funded post-approval trials for small molecules have dropped 47.3 percent, a much steeper decline than for other drug types.[13] 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.[14] 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.[15] Unfortunately, many of these indications may be forgone moving forward.

CMS' interpretation of the orphan drug exclusion threatens the development of new medicines to meet unmet needs for patients with rare diseases.

The Orphan Drug Act of 1983 successfully spurred development of treatments for rare diseases by addressing the limited investment incentives caused by small patient populations, high R&D costs, and low success rates – leading to more than 750 orphan drug approvals since its enactment, compared to just 10 in the decade before passage.[16] However, the IRA threatens this progress by narrowly exempting only single-indication orphan drugs from price setting, and CMS' restrictive interpretation of this exemption further undermines incentives for post-approval research that expands access to additional rare disease indications. Historically, 35 percent of orphan drugs have been approved for more than one disease, and 15 percent for more than one rare disease,[17] but under the IRA, additional designations or approvals outside a single orphan designation disqualifies a drug from exemption, discouraging such efforts. Compounding this, broader IRA disincentives compress the time companies have to recoup investments,

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[12] Schulthess, D.G., O'Loughlin, G., Askeland, M. et al. (2025). The Inflation Reduction Act's Impact Upon Early-Stage Venture Capital Investments. *Ther Innov Regul Sci*. Available at: https://doi.org/10.1007/s43441-025-00773-3

[13] Zheng H., Patterson J., Campbell J. (2025). The Inflation Act and Drug Development: Potential Early Signals of Impact on Post-approval Clinical Trials. *Therapeutic Innovation & Regulatory Science*, 1-9.

[14] 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

[15] Grabowski H., Long G. (March 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

[16] PhRMA analysis of FDA Orphan Drug Product designation database. Available at: https://www.accessdata.fda.gov/scripts/opdlisting/oopd/

[17] 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.

even though more than 80 percent of revenue for orphan-designated products historically came 10 or more years after initial approval. As a result, the IRA creates financial incentives to prioritize larger indications earlier, which could lead to delayed or fewer treatments for rare disease populations,[18] despite the fact that post-approval uses have historically accounted for 30 percent of all new treatment options for patients with rare diseases.[19]

The IRA and CMS' implementation of the Program will jeopardize our ability to treat and prevent chronic disease and bend the cost curve in the years ahead.

Chronic conditions - including mental illness - are the largest drivers of health care costs, accounting for 90 percent of the $4.5 trillion spent on health care annually,[20] and their impact is set to worsen as the number of individuals with three or more chronic conditions is projected to nearly double by 2030. [21,22,23] With eighty percent of chronic disease considered preventable,[24] bending the cost curve will require a comprehensive strategy centered on prevention, early intervention and continued innovation – especially for the Medicare population. Medicines play a critical role in this effort, helping patients prevent and manage disease, avoid complications, and reduce costly health care services as evidenced by Medicare's spending slowdown between 1999 and 2012, where one quarter of the reduction was attributed to greater use of cardiovascular drugs.[25] Yet, implementation of the Program is undermining these gains by discouraging investment in medicines for common illnesses such as heart disease, diabetes, cancer and autoimmune diseases.[26] The Medicare spending that renders medicines eligible for price setting is a factor not of high price, but wide use. By targeting these treatments for price setting, the IRA is weakening one of our most essential tools for combating chronic illness and controlling long-term costs. Economists at the University of Chicago estimate that IRA's price setting policies could raise overall health care spending by $50.8 billion over a 20-year period due to forgone savings from reduced in medical care utilization that medicines would have otherwise delivered.[27]

Key Concerns and Recommendations

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[18] 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

[19] IQVIA. (February 2025). Proliferation of Innovation Over Time: Frequency, Timing and Clinical Value of Expansions Post-Initial Approval. Available at: https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/proliferation-of-innovation-over-time

[20] 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.

[21] 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

[22] 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

[23] 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.

[24] Katz D.L., Frates E.P., Bonnet J.P., et al. (July 2018). Lifestyle as Medicine: The Case for a True Health Initiative. *Am J Health Promot.* Available at: https://pubmed.ncbi.nlm.nih.gov/28523941/

[25] 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/.

[26] HHS. (August 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

[27] 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/

Orphan Drug Exemption. A drug is disqualified from eligibility for the Orphan Drug Exemption (ODE) immediately after a medicine receives a second orphan designation or a new indication outside of its first orphan designation, whether for a different rare disease or another type of disease. Instead of running the 7- or 11-year eligibility clock from when the product loses the exclusion, CMS chose to instead look back to the original FDA approval date to determine eligibility for price setting. Instead, CMS should begin the clock for eligibility for price setting after the product loses its ODE eligibility, not when the product was originally approved. In addition, CMS should evaluate each drug product or biological product individually, such that the approval of a new drug product or biological product could trigger application of the exclusion and a new seven- or 11-year clock to begin upon loss of that exclusion.

Definition of QSSD. A qualifying single source drug (QSSD) is a drug eligible for price setting under the IRA. CMS has interpreted QSSD as all dosage forms and strengths of a drug from the same manufacturer with the same active moiety (for a small molecule) or active ingredient (for a biologic), even if approved under different applications (NDAs or BLAs). For QSSDs that will be selected for price setting in 2028, CMS is proposing to potentially take this misguided approach even further by grouping fixed-dose combinations together with separately approved drugs with just one active ingredient into a single QSSD. Sweeping drugs approved under different applications into one QSSD for price setting is inconsistent with the statute and ignores the significant time and investment manufacturers make in pursuing approval for improved versions of a drug, or fixed dose combinations. Rather, CMS should revise the guidance and treat products approved under different NDAs or BLAs as distinct QSSDs.

For more detailed legal and policy considerations for how CMS can improve the definition of QSSD and the Orphan Drug Exemption, see Appendix A (Drug Selection) to this letter.

II. Undermines Competitive Market Dynamics

The U.S. market-based system is designed to balance innovation, access, and cost containment by promoting robust competition among brand medicines, generics, and biosimilars—driving down prices, and often reducing costs by 60 percent or more.[28] Competition among brand drugs alone has generated billions in savings, with one study showing that launches of new brand medicines between 2013 and 2017 led to over $10 billion in price reductions across 12 therapeutic classes. [29] Over time, this system delivers long-term savings as branded medicines are followed by generics and biosimilars, which now account for 90 percent of prescriptions and have saved $3.1 trillion over the past decade. [30] Despite this success, the IRA and CMS' implementation of its price setting program threaten to dismantle these incentives by allowing the government to impose prices so low that generic and biosimilar manufacturers may no longer find it viable to enter the market. The IRA undermines the statutory framework that rewards first-to-market generics, weakening their ability to compete and recoup investments. For biosimilars, the misalignment between IRA timelines and the 12-year exclusivity period under the Biologics Price Competition and Innovation Act, coupled with CMS' vague and extra-statutory "bona fide marketing" standard, creates profound uncertainty. With biosimilar development already requiring 7 to 8 years and up

[28] Hernandez, I., et al. (2024). Price benchmarks of drugs selected for Medicare price negotiation and their therapeutic alternatives. *Journal of Managed Care & Specialty Pharmacy.* Available at: https://doi.org/10.18553/jmcp.2024.24153
[29] 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
[30] AAM. (2024). The U.S. Generic & Biosimilar Medicines Savings Report, 2024. Available at: https://accessiblemeds.org/resources/reports/2024-savings-report/

to $250 million in investment,[31] this lack of predictability may make future development financially infeasible, leading to fewer products on the market and potential drug shortages while limiting competition. Though the IRA includes a "Special Rule" to potentially delay selection and price setting of eligible biologics facing biosimilar competition, the IRA's statutory language and CMS' interpretation of the law ultimately fail to provide biosimilar manufacturers with the assurances needed to invest resources for biosimilar development. Ultimately, by substituting price setting for competition, the IRA risks unraveling the very system that has delivered both innovation and affordability to patients.

Key Concerns and Recommendations

Biosimilar Pause. The conditions CMS established for qualifying for the pause fail to provide manufacturers with sufficient certainty to invest in biosimilar development. CMS should provide a "pause" if a biosimilar manufacturer can demonstrate that filed agreements do not bar the manufacturer from marketing or the investor disclosures indicate that the product will be ready for marketing before the end of the relevant period. CMS should apply similar approaches when evaluating requests for the second one-year pause and only deny requests with definitive evidence of an inability to come to market.

Bona Fide Marketing. CMS should clarify that "marketing" of a generic drug or biosimilar biological product means its introduction or delivery for introduction into interstate commerce, not the "bona fide marketing" concept invented by CMS.

For more detailed legal and policy considerations for how CMS can improve the biosimilar pause and its interpretation of "marketed," see Appendix A (Drug Selection).

III. Disruptive to Stakeholders

The IRA requires manufacturers to "provide access" to the government-set MFP when a drug is prescribed to a beneficiary (also known as "effectuating the MFP"). However, the IRA is silent on *how* manufacturers should provide access to the MFP. In implementing the Program thus far, CMS has failed to mitigate the potential harm to stakeholders, particularly pharmacies and health care providers, who dispense and administer price-set drugs. A National Community Pharmacists Association (NCPA) survey of its membership revealed that 93.2 percent of independent pharmacists are considering not stocking, or have already decided not to stock, one or more of the first 10 Part D drugs selected for price setting.[32] If pharmacies and health care providers decline to stock or administer selected drugs, it could lead to significant access issues for patients, particularly given that selected drugs are inherently among the most utilized drugs in the Medicare program.

Key Concerns and Recommendations

Part D Effectuation. For IPAY 2027 and beyond, PhRMA continues to believe that the best, most efficient way to ensure prompt pharmacy payment and reduced stakeholder burden would be for, CMS to rely on a model similar to the Part D Coverage Gap Discount Program, where MFP refunds would be paid to pharmacies at or close to the time pharmacies are reimbursed by Part D plans. CMS would provide funds to cover these payments in advance, with manufacturers later invoiced. While we share CMS' goal

[31] Blackstone E.A., Joseph P.F. (2013). The economics of biosimilars. *Am Health Drug Benefits*, 6(8):469-478. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC4031732/

[32] NCPA. (January 2025). Report for January 2025 Survey of Independent Pharmacy Owners/Managers. Available at: https://ncpa.org/sites/default/files/2025-01/1.27.2025-FinalExecSummary.NCPA_.MemberSurvey.pdf

of prompt pharmacy payment, we continue to have significant concerns with the requirement to develop mitigation plans for pharmacies self-identifying as having material cashflow concerns.

In addition, to improve program integrity and avoid forcing manufacturers to make an MFP effectuation payment before a drug's 340B status is known, potentially violating the nonduplication provision, CMS must ensure that manufacturers receive timely and accurate information about 340B units in order to deduplicate 340B and MFP discounts. For this reason, CMS should establish a claims repository (along the lines of the one it is exploring to fulfill its obligation to exclude 340B units from Part D inflation rebates) and share this critical data with manufacturers.

CMS should also make clear that the agency will not impose penalties on manufacturers should the MTF DM or PM systems encounter technical issues affecting payment.

Inclusion of MFP in ASP for Selected Drugs. Under the IRA, providers face billions of dollars in cuts in Medicare Part B reimbursement for provider-administered drugs and potentially face similar reductions in the commercial market. PhRMA firmly believes that CMS lacks the legal authority to include MFP in the calculation of Average Sales Price (ASP). Instead, CMS should exercise its existing authority to exclude the MFP from ASP reporting requirements.

Research suggests that including MFP in ASP would further erode reimbursement, with providers projected to face decreases to add-on payments of up to $37 billion for Part B selected drugs.[33] And because ASP serves as a payment benchmark for a wide swath of commercial market health plans and Medicare Advantage (MA) plans,[34] the decrease in provider payments includes an up to 18 percent reduction in add-on payments for provider-administered selected drugs in the commercial and MA markets.[35] Beyond cuts to provider reimbursement, including MFP in ASP for selected medicines will have broadly negative effects on patient access to selected Part B medicines—especially for patients that receive the medicines at rural, community-based, and independent practices—and is likely to distort the competitive marketplace for Part B medicines.

Given the above, PhRMA requests that CMS clearly state that price-set drug units sold at the MFP are excluded from the calculation of ASP and keep providers whole through the definition of the MFP refund amount.

For more detailed legal and policy considerations on this issue, as well as recommendations for how CMS can improve effectuation of the MFP for Part D selected drugs and exclude MFP from the calculation of ASP, see Appendix B (Effectuation) to this letter.

IV. Puts Patient Access at Risk

Price setting in the Part D program undermines the ability of plans to negotiate with manufacturers, which is foundational to the competitive structure and success of Part D. At the same time, it does little to address plan and PBM abuses that harm patient access and increase out-of-pocket costs. In 2025,

[33] Avalere Health. (September 2024). Commercial Spillover Impact of Part B Negotiations on Physicians. Available at: https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians

[34] A recent survey of commercial insurers showed that they reimburse for 72 percent of covered lives in the physician office based on a medicine's ASP. ASP is also the basis of Medicaid reimbursement for provider-administered medicines in many states. *See*, Avalere Health. (September 2024). Commercial Spillover Impact of Part B Negotiations on Physicians. Available at: https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians

[35] Ibid.

beneficiaries in Part D experienced significant reductions in plan choices, higher premiums, and more restrictive plan designs that threaten access to affordable care for more than 50 million seniors and individuals with disabilities. Unless CMS acts, these harms will worsen in 2026 and beyond. As Part B medicines become eligible for price setting beginning in IPAY 2028, we have increased concerns regarding MA plan use of step therapy to limit access to selected Part B drugs or their competitor (a policy PhRMA opposes).

Government price setting and other provisions in the IRA are reshaping formulary dynamics, and plan responses threaten beneficiary access.

Even before government price setting takes effect, various studies have found that plans and PBMs have begun to employ increasingly stringent practices to restrict access to care.[36] One recent analysis found a substantial increase in plans shifting coverage of price-set drugs away from fixed copayments to coinsurance, leading to an increase in beneficiary cost sharing of up to nearly 76 percent.[37] As a result of the IRA, 83 percent of payers expect to increase formulary exclusions in Part D and the vast majority payers expect to increase some type of utilization management.[38] The use of inappropriate utilization management by plans as a blunt instrument to contain costs in response to increases in plan liability will lead to further barriers to patient access by exacerbating already high provider burden, contributing to provider burnout, altering providers' clinical decision-making, and driving patients to treatments that are not aligned with clinical guidelines or not suited for the individual patient when accounting for their unique characteristics.[39,40,41,42]

In addition to worsening access, the IRA is undermining the Part D program, triggering higher premiums and fewer plan choices for beneficiaries.

The number of stand-alone Part D drug plans fell by 26 percent in 2025, to the lowest number of plans available since the program began.[43] At the same time, premiums for beneficiaries who pay monthly premiums for standalone Part D plans rose by an average of 19 percent in 2025 compared to 2023, before the IRA took effect, despite the IRA's premium stabilization program and CMS' additional premium stabilization demonstration.[44] The independent Medicare Payment Advisory Commission also examined these trends in its most recent Report to Congress, describing concerns about the continued availability of

[36] 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
[37] CAHC/Magnolia Market Access. (February 2025). Rotten to the Core: IRA Undermines Medicare Part D. Available at: https://cahc.net/wp-content/uploads/2025/02/CAHC-Part-D-Penalty-Brief-2025.pdf
[38] Magnolia Market Access. (2024). Inflation Reduction Act Payer Insights Report. Available at: www.magnoliamarketaccess.com/wp-content/uploads/MMA_IRA-Payer-Insights-Survey4.0_Chartbook_2024.07.31.pdf
[39] American Medical Association. (2024). 2024 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[40] Salzbrenner S.G. et al. (July 2023). Influence of prior authorization requirements on provider clinical decision-making. *Am J Manag Care*. Available at: https://pubmed.ncbi.nlm.nih.gov/37523751/
[41] Gracie J., Jimenez R., Winkfield K.M. (October 2024). The Burden of Insurance Prior Authorization on Cancer Care: A Review of Evidence From Radiation Oncology. *Adv Radiat Oncol*. Available at: https://pubmed.ncbi.nlm.nih.gov/39758976/
[42] Struthers A. et al. (November 2024). Utilization management and physician burnout. *Am J Manag Care*. Available at: https://pubmed.ncbi.nlm.nih.gov/39546758/
[43] Avalere Health. (October 2024). Number of Part D Plan Choices Declines for 2025. Available at: https://avalere.com/insights/number-of-part-d-plan-choices-decline-for-2025
[44] Internal PhRMA analysis of 2023 and 2025 Part D enrollment and premium data.

a sufficient number of plans in the standalone market, and noting that IRA's changes may further amplify trends that contribute to enrollment shifts towards MA-PDs.[45]

Key Concerns and Recommendations

As described above, price setting in Medicare Part D (as well as other IRA provisions) has caused significant harm to patients and consumers through reduced access to medicines, higher premiums and out-of-pocket costs for price-set medicines, and reduced plan options. We appreciate CMS' recent recognition of the importance of monitoring for potential access disruptions for price-set medicines.[46] However, PhRMA is concerned that CMS' existing formulary review and appeals processes are insufficient to protect patient access, not only for MFP-selected medicines but more generally as well. CMS should adopt stronger oversight and safeguards to protect beneficiary access to price-set medicines, including through improving transparency, enhancing patient utilization management and other access safeguards, and strengthening formulary review reporting.

For more detailed legal and policy considerations on this issue, as well as recommendations for how CMS can improve protect patient access to medicines, see Appendix C (Access and Coverage) to this letter.

* * *

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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[45] MedPAC. June 2025 Report to Congress: Medicare and the Health Care Delivery System. Available at: https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/
[46] HPMS. (April 2025). CY 2026 Part D Formulary Submission Information. Available at: https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-3-april-14-18

Appendix A: Drug Selection

I. Identification of Qualifying Single Source Drugs for IPAY 2028

PhRMA opposes the overbroad interpretation of a qualifying single source drug (QSSD) that CMS used for initial price applicability year (IPAY) 2026 and 2027 and proposes to maintain for IPAY 2028. Under *Loper Bright Enterprises v. Raimondo*, an agency is required to apply the "single, best meaning" of a statute.[47] The President issued a memorandum on April 9, 2025, prioritizing the review and repeal pursuant to Executive Order 14219 of existing regulations that are unlawful under *Loper Bright.*[48] The definition of QSSD is untethered from the statute and would continue to stifle the development of innovative and life-saving drug and biological products in contravention of *Loper Bright*. Additionally, for IPAY 2028, CMS suggests that it may take a new approach for identifying potential QSSDs for certain fixed-combination products that raises additional legal and policy concerns. For IPAY 2028 and future years, we urge CMS to carefully consider comments on the QSSD definition – and to choose a definition that aligns with the statute and its focus on the Food and Drug Administration's (FDA's) approval under section 505(c) of the Federal Food, Drug, and Cosmetic Act (FDCA) or section 351(a) of the Public Health Service Act (PHSA). We also urge CMS not to adopt its new proposed approach to aggregation of certain fixed-combination products, which is divorced from FDA's definition of a fixed combination and which depends on CMS' own determination of whether the combination results in a clinically meaningful difference.

The IRA defines a QSSD, in relevant part, as follows:

> (A) DRUG PRODUCTS.—A drug—
>
> > (i) that is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act and is marketed pursuant to such approval;
> >
> > (ii) for which, as of the selected drug publication date with respect to such initial price applicability year, at least 7 years will have elapsed since the date of such approval; and
> >
> > (iii) that is not the listed drug for any drug that is approved and marketed under section 505(j) of such Act.
>
> (B) BIOLOGICAL PRODUCTS.—A biological product—
>
> > (i) that is licensed under section 351(a) of the Public Health Service Act and is marketed under section 351 of such Act;
> >
> > (ii) for which, as of the selected drug publication date with respect to such initial price applicability year, at least 11 years will have elapsed since the date of such licensure;

[47] 603 U.S. 369 (2024).
[48] White House. (April 2025). Presidential Actions, Directing the Repeal of Unlawful Regulations. Available at: https://www.whitehouse.gov/presidential-actions/2025/04/directing-the-repeal-of-unlawful-regulations/.

(iii) that is not the reference product for any biological product that is licensed and marketed under section 351(k) of such Act.[49]

Thus, the statute establishes two key requirements for each QSSD:

(1) **Approval under an NDA or BLA.** A QSSD must be "approved under section 505(c)" of the FDCA or "licensed under section 351(a)" of the PHSA. At least 7 years (for a drug) or 11 years (for a biological) must have elapsed since the date of "such approval," or "such licensure" – both in the singular, referencing a single new drug application (NDA) or biologics license application (BLA). Therefore, each QSSD is limited to drug products or biological products approved under the same NDA or licensed under the same BLA. The terms "drug product" or "biological product" refer to the finished product, including the unique dosage form, strength, and route of administration.[50]

(2) **Age Requirement.** For a drug product, the statute requires "at least 7 years" to have elapsed from the date of approval to the selected drug publication date. For a biological product, the statute requires "at least 11 years" to have elapsed from the date of approval to the selected drug publication date. Because a drug product or biological product cannot be marketed until it is approved or licensed,[51] the 7 or 11 year "age requirement" must be applied to each particular drug product or biological product, whether it was approved under the original NDA/BLA or a supplement to a given NDA or BLA.

Despite these clear Congressional directives, CMS proposes to continue using an overly broad interpretation of a QSSD that impermissibly aggregates drug products and biological products based on their active moiety or active ingredient—neither of which is mentioned in the IRA. The Guidance specifies that "all dosage forms and strengths of the drug with the same active moiety and the same holder of a [NDA], inclusive of products that are marketed pursuant to different NDAs," constitute the same QSSD.[52] For biological products, the Guidance describes a QSSD as "all dosage forms and strengths of the biological product with the same active ingredient and the same holder of a [BLA], inclusive of products that are marketed pursuant to different BLAs."[53] Additionally, CMS misapplies the age requirement. CMS states that "the earliest date of approval" or "the earliest date of licensure" of the initial FDA application number assigned to the respective NDA / BLA holder for the active moiety / active ingredient (or in the case of fixed combination drugs, for the distinct combination of active moieties / active ingredients) would determine whether the respective 7 or 11 year period for QSSD status had elapsed.[54] The statute, however, requires each individual drug product or biological product to meet the age requirement.

PhRMA urges CMS to align its definition of a QSSD with the statutory requirements. ***Specifically, CMS should require that, for a drug or biological product to be included in a QSSD, it must be approved or licensed under the same NDA or BLA, either as part of the original application or under a supplement***

[49] Social Security Act (SSA) § 1192(e)(1) (emphasis added).
[50] *See* e.g., 21 C.F.R. § 314.3, defining "drug product" as "a finished dosage form, e.g., tablet, capsule, or solution, that contains a drug substance, generally, but not necessarily, in association with one or more other ingredients."
[51] *See* FDCA §§ 505(a), 506A(a), (c); PHSA § 351(a)(1); 21 C.F.R. §§ 314.70, 601.12.
[52] IPAY 2028 Draft Guidance, at 11.
[53] *Ibid*.
[54] *Ibid.* at 14 (emphasis added).

to such application. Further, the approval or licensure of any drug product or biological product must have occurred at least 7 or 11 years (as applicable) prior to the selected drug publication date (i.e., ., the relevant supplement must be at least 7 or 11 years old).[55] Any other approach would violate the statute and stifle innovation. These two principles are briefly addressed further below.

A QSSD must be limited to drug products/biological products that are approved/licensed under a single NDA/BLA.

The terms "active moiety" and "active ingredient" appear nowhere in the QSSD statutory definition (or anywhere in the IRA). Rather, as explained above, the statute unambiguously defines the scope of a QSSD based on an individual NDA or BLA.

The statute's anchor to an NDA or BLA aligns with the fact that Congress authorized FDA to "approve" and "license" drug products and biological products, not their active moieties and active ingredients alone.[56] Moreover, both prongs of the QSSD definition refer to finished products: the subparagraph header for drugs is "[d]rug products," not drug substance or active moiety, and the subparagraph header for biological products similarly refers to "[b]iological products," not active ingredients.

Had Congress intended to define QSSD at the active moiety or active ingredient level, it would have said so in the statute.[57] As demonstrated in a recent amendment to the FDCA's new chemical entity exclusivity provisions that replaced the term "active ingredient" with "active moiety," [58] Congress is familiar with both of these terms and knows how to use them when they are intended.

Additionally, CMS' assertion that its "approach to identifying a potential [QSSD] aligns with the requirement in section 1192(d)(3)(B) of the Act,"[59] (the "Use of Data" provision) is incorrect. The Use of Data provision states:

> In determining whether a qualifying single source drug satisfies any of the criteria [related to a negotiation-eligible drug and the small biotech exception] the Secretary shall use data that is aggregated across dosage forms and strengths of the drug, including new formulations of the drug, such as an extended release formulation, and not based on the specific formulation or package size or package type of the drug.[60]

The reference to "a qualifying single source drug" and "of the drug" – both in the singular – demonstrate that the Use of Data provision directs CMS to aggregate data on certain eligible drug products or

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[55] Under CMS' current position, "a selected drug will no longer be subject to the negotiation process and will cease to be a selected drug . . . if CMS determines (1) the FDA has approved a generic drug under section 505(j) of the FD&C Act that identifies as its reference-listed drug a product that is included in the selected drug, or the FDA has licensed a biosimilar biological product under section 351(k) of the PHS Act that identifies as its reference product a product that is included in the selected drug; and, (2) the generic drug or biosimilar biological product, as applicable, is marketed pursuant to such approval or licensure." IPAY 2026 Initial Guidance, at p. 164. Given CMS' current approach to QSSD, PhRMA supports this position.
[56] FDCA § 505(c); PHSA § 351(a).
[57] *Conn. Nat'l Bank v. Germain*, 503 U.S. 249, 253-254 (1992) ("We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there. *See, e. g., United States v. Ron Pair Enterprises, Inc.*, 489 U. S. 235, 241–242 (1989); *United States v. Goldenberg*, 168 U. S. 95, 102–103 (1897); *Oneale v. Thornton*, 6 Cranch 53, 68 (1810). When the words of a statute are unambiguous, then, this first canon is also the last: 'judicial inquiry is complete.' *Rubin v. United States*, 449 U. S. 424, 430 (1981); *see also* Ron Pair Enterprises, supra, at 241.").
[58] *See* Ensuring Innovation Act, Pub. L. No.. 117-9, 135 Stat. 255 (2021).
[59] IPAY 2028 Draft Guidance, at 12.
[60] SSA § 1192(d)(3)(B) (emphasis added).

biological products within the same QSSD. Nothing in the Use of Data provision permits or requires CMS to expand the scope of a QSSD to encompass drug products or biological products approved under "different NDAs or BLAs." Rather, the statute is clear that each QSSD constitutes eligible drug products or biological products approved under a single NDA/BLA (including supplements to such application).

Each drug product or biological product in a QSSD must independently meet the age requirement.

PhRMA opposes CMS' proposal to base the age requirement off "the earliest date" of approval or licensure of the initial FDA application number assigned to the NDA / BLA holder for the active moiety / active ingredient (or in the case of fixed combination drugs, for the distinct combination of active moieties / active ingredients).[61] Under this approach, even a new drug product or biological product (e.g., a new dosage form, strength, or route of administration) approved under a supplemental application after an MFP has been set would be part of the existing QSSD and saddled with its pre-existing MFP. This approach directly conflicts with the statute, which requires that each drug product or biological product independently meet the age requirement. CMS lacks the authority to extend MFPs to drugs and biologics that have not been approved or licensed for the statutorily-specified number of years.

As explained above, the statutory QSSD definition refers back to the number of years (i.e., 7 or 11 years) since "such approval" under section 505(c) of the FDCA or section 351(a) of the PHSA. By law, a new drug product or biological product must be approved before it can be marketed.[62] Thus, for each drug product or biological product, the relevant approval date is the date of FDA approval of the original or supplemental NDA/BLA for that drug product or biological product – not the approval date of an older drug product or biological product that happens to have the same active moiety or active ingredient.

Maintaining CMS' current approach will further stifle medical innovation.

Not only is CMS' current QSSD definition inconsistent with the statute, if carried over to future years it would hurt patients by continuing to curb incentives for innovation. Under CMS' approach, once a product containing a novel active ingredient or active moiety has been approved or licensed, incentives for ongoing or new research on drug or biological products with that active ingredient or moiety would sharply decline. No matter how clinically significant the innovation is, the same manufacturer's novel product with a previously approved active moiety or ingredient would be subject to selection for price setting if approved after the seven- or 11-year period for the initial product. Therefore, this approach can broadly cut incentives to invest in a variety of medical advances. For example, the National Pharmaceutical Council has concluded that the price setting program will lead to delays in single-indication drug launches, reduce investments in post-approval research for new indications, and have a negative impact on long-term health outcomes.[63] Another study observed, since passage of the IRA, a "35% decline in clinical trial launches for the Medicare-aged population and a 70% decline in funding for early-stage developments in small molecules [that] indicates significant negative impacts on the population the IRA legislation is allegedly designed to aid."[64] Even if a product with a previously

[61] IPAY 2028 Draft Guidance, at 14 (emphasis added).
[62] *See* FDCA §§ 505(a), 506A(a), (c); PHSA § 351(a)(1); 21 C.F.R. §§ 314.70, 601.12.
[63] O'Brien J.M., Motyka J., Patterson J. (November 2023). How the IRA Could Delay Pharmaceutical Launches, Reduce Indications, and Chill Evidence Generation. *Health Affairs.* Available at: https://www.healthaffairs.org/content/forefront/ira-could-delay-pharmaceutical-launches-reduce-indications-and-chill-evidence.
[64] Schulthess D.G., O'Loughlin G., Askeland M., Gassull D., Bowen H.P. (April 2025). The Inflation Reduction Act's Impact Upon Early-Stage Venture Capital Investments. *Ther Innov Regul Sci.* Available at: https://pubmed.ncbi.nlm.nih.gov/40223014/

approved active moiety or active ingredient were improved in a way that provides a different and meaningful benefit to patients, the improved product would not receive its own seven- or 11-year period (for drugs or biologics, respectively) before potential identification as a QSSD. For example, products with wholly novel delivery systems for previously approved active ingredients that allow much safer, more effective, and more accessible treatment, such as in the home, would be discouraged. As noted earlier, such a product could even have an MFP from day one – which suggests that the research to fuel development of the advanced product may never occur. To avoid these disincentives for pharmaceutical innovation that will harm public health, CMS should revise its aggregation methodology to conform to the statute.

CMS should apply a consistent approach to fixed-combination products for the purposes of identifying QSSDs and should not adopt the proposed new approach.

For IPAY 2028, CMS suggests that it is contemplating a new and different approach to aggregating certain fixed-combination products. CMS describes a general approach consistent with its IPAY 2027 guidance where a distinct combination of active moieties / active ingredients is considered to be one active moiety / active ingredient for the purpose of identifying potential QSSDs.[65] However, CMS indicates that while this approach "is generally appropriate," it might not be appropriate for certain fixed-combination products for which one of the active moieties or active ingredients is not "therapeutically" or "biologically active" against "the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference."[66] CMS provides an example where one active moiety or active ingredient in the fixed-combination product "affects the bioavailability" of the other active moiety or active ingredient "but is not therapeutically active" against the indicated disease state, and CMS concludes that the addition of such component "does not result in a clinically meaningful difference."[67] We have a number of concerns with this proposal:

First, there is no statutory basis for CMS' proposed approach. The IRA does not include any language authorizing CMS to parse the internal composition of FDA-approved drug products. The terms "therapeutically active," "biologically active," and "clinically meaningful difference" do not appear in the statute, and Congress did not delegate to CMS the authority to make judgements about the contribution of individual components to a drug's therapeutic or biological effect or clinical meaningfulness for purposes of the QSSD definition. These are scientific determinations that lie squarely within FDA's jurisdiction and expertise. While CMS' recognition that a fixed-combination product may constitute a distinct QSSD aligns with the statute and FDA practice, CMS' attempt to disaggregate such products based on undefined criteria raises significant concerns.

Second, there is no legal or scientific basis for CMS treating different fixed-combination products differently for the purposes of identifying QSSDs. The described approach is inconsistent with FDA's own longstanding regulations. FDA's fixed-combination regulation states that "[t]wo or more drugs may be combined in a single dosage form when *each component makes a contribution to the claimed effects* and the dosage of each component (amount, frequency, duration) is such that the combination is safe and effective for a significant patient population[.]"[68] This regulation explicitly recognizes special cases

[65] IPAY 2028 Draft Guidance, at 13.
[66] *Ibid*.
[67] *Ibid*.
[68] 21 C.F.R. § 300.50(a).

where components are added "to enhance the safety or effectiveness of the principal active component" or "to minimize the potential for abuse of the principal active component."[69] Because each active moiety or active ingredient in a fixed-combination product *must* contribute to the claimed effects in order for FDA to approve a fixed-combination product, all such components necessarily are "therapeutically active" and "biologically active," and "result in a clinically meaningful difference." CMS' proposed requirement that each ingredient be "biologically active against the disease state(s)" directly contradicts this established FDA framework.

Moreover, under FDA regulations, an "active moiety" is defined as the molecule or ion (excluding certain appendages) "*responsible for the physiological or pharmacological action of the drug substance*,"[70] and "active ingredient" to mean "any component that is intended to furnish *pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease*."[71] A component cannot be classified by FDA as an active moiety or active ingredient and simultaneously be considered therapeutically or biologically inactive. FDA's recognition of a component as such confirms that it is therapeutically and biologically active, not an excipient or inactive ingredient.[72] Thus, there is no legal or scientific basis for adopting an approach in which CMS' treatment of a fixed-combination product would depend on CMS' determination of whether a component is therapeutically or biologically active or results in a clinically meaningful difference.

Third, in deciding which fixed-combination products to develop for patients, pharmaceutical manufacturers have relied upon CMS' existing consistent approach to all fixed-combination products. Having established this approach and induced industry reliance upon it, CMS cannot now arbitrarily abandon it without compelling justification, especially not through the scientifically baseless distinctions proposed here. CMS has provided no adequate justification for abandoning its established approach, and any such departure would require CMS to demonstrate both statutory authority and scientific expertise it does not possess to override FDA's determinations regarding active ingredients under 21 C.F.R. § 300.50. Moreover, CMS lacks both statutory authority and scientific expertise to second-guess FDA's determinations regarding active ingredients under 21 C.F.R. § 300.50, and any attempt to do so would create an impermissible conflict between federal agencies with overlapping jurisdiction over the same products.

Fourth, the proposal creates a situation where products approved per FDA regulations could be penalized under federal reimbursement regulations. This regulatory conflict undermines regulatory predictability, as manufacturers have relied on FDA's 21 C.F.R. § 300.50 standard when developing fixed combination products. The CMS proposal retroactively changes this standard, potentially subjecting compliant products to accelerated selection timelines. Furthermore, it creates dual standards where a product could simultaneously meet FDA's standards for an approvable fixed-combination drug while failing CMS' narrower interpretation for QSSD classification purposes. The lack of harmonization between FDA and CMS standards raises serious concerns about federal health care policy coherence.

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[69] 21 C.F.R. § 300.50(a)(1) and (2).
[70] 21 C.F.R. § 314.3(b).
[71] 21 C.F.R. § 210.3(b)(7).
[72] *See, e.g.,* FDA Final Guidance, *Using the Inactive Ingredient Database* at 1 n. 2 (July 2019) (defining "excipients" to mean any *inactive ingredients* that are added intentionally to therapeutic and diagnostic products, *but that are not intended to exert therapeutic effects at the intended dosage, although they may act to improve product delivery* (e.g., enhance absorption or control release of the drug substance).").

Fifth, PhRMA is concerned that the draft guidance does not provide a clear definition, criteria, or standards for determining what constitutes being "biologically active against the disease state(s)." This ambiguity leads to numerous unanswered questions regarding the scope of activity required, as well as whether components must have a direct therapeutic effect on the primary pathophysiology or if indirect effects such as improving drug delivery or enhancing bioavailability would qualify. The level of evidence CMS would require to demonstrate biological activity remains undefined, as does how broadly or narrowly "the disease state(s)" would be defined. As an example, for cancer drugs, it is unclear whether "biologically active against the disease state(s)" means activity specifically against tumor cells or if enhancing immune function or reducing treatment toxicity would qualify. The term "clinically meaningful difference" is equally problematic due to its vagueness. Will this be assessed based on primary clinical endpoints from pivotal trials, secondary endpoints or exploratory analyses, real-world evidence of improved adherence or quality of life, health care resource utilization metrics, or patient-reported outcomes? What constitutes "meaningful" remains unclear—is a 20 percent improvement in bioavailability meaningful? A 50 percent reduction in infusion time? A change from IV to subcutaneous administration? The stakeholder perspective for determining meaningfulness—whether patients, providers, payers, or CMS specifically—is never clarified. Patients should play a large role in dictating what types of innovation would bring value and fulfill unmet needs, not CMS. Introducing terms like "clinically meaningful difference" at this QSSD determination stage risks conflating identification with a premature value assessment.

Sixth, PhRMA has concerns that the proposed policy would breed uncertainty about when and whether a particular product can be selected for price setting, as determination of whether a component is therapeutically or biologically active or results in a clinically meaningful difference may be difficult to predict, particularly in the absence of clear definitions of these terms. The resulting uncertainty would disincentivize future investment in novel fixed combination products for diseases such as cancer to the detriment of patients.

II. Biosimilars "Pause"

PhRMA urges CMS to implement the biosimilars "pause" provision in section 1192(f) in a way that promotes predictability for biologic and biosimilar manufacturers in the marketplace. Congress has enacted a "Special Rule"[73] enabling certain biosimilar manufacturers to obtain a "pause" before the reference product is selected for MFP price setting to allow time for the biosimilar product to secure approval and begin marketing.[74] The statute provides for an initial 1-year "pause" if CMS determines there is a "high likelihood" that a biosimilar will be "licensed and marketed" before the date that is two years after the selected drug publication date with respect to the IPAY.[75] Further, the statute requires CMS to "delay the inclusion of" a reference product on the list of selected drugs for a second 1-year period if the biosimilar product has not been licensed and marketed during the initial 1-year period and, in response to a request timely made by a biosimilar manufacturer, CMS determines that:

> (1) there remains a "high likelihood . . . that such biosimilar biological product . . . will be licensed and marketed . . . before the date that is

[73] Pub. L. 117-169 § 1102, 136 Stat. 1818, 1854. (August 2022). Available at: https://www.congress.gov/117/plaws/publ169/PLAW-117publ169.pdf.
[74] SSA § 1192(f)(1)(A).
[75] SSA § 1192(f)(2)(A).

> two years after the selected drug publication date for which such biological product" would have been a selected drug, and
>
> (2) "on the basis of clear and convincing evidence," the biosimilar manufacturer "has made a significant amount of progress. . . towards both such licensure and the marketing of such biosimilar biological product . . . since the receipt by the Secretary" of the request for an initial 1-year pause.[76]

Predictable and flexible implementation of the "pause" is required to maintain a robust and competitive U.S. market through biosimilar competition. Congress created a carefully balanced system through the Biologics Price Competition and Innovation Act (BPCIA) to encourage competition in the marketplace between reference biologics and biosimilars, while maintaining incentives for continued innovation. Since the introduction of the first biosimilar in 2015, a total of 44 biosimilars have launched to compete against 13 brand biologic products leading to a total of $36 billion in savings.[77] [78] The introduction of biosimilar competition into the biologics market has led to dramatically lower prices not only for biosimilars, but also for reference products.[79] One recent study examining average sales prices in Medicare since 2015 found brand biologic prices dropped 10-13 percent for *each* additional biosimilar competitor, with some brand biologic competing with as many as six biosimilars.[80] [81] Annualized savings from biosimilars reached $12.4 billion in 2023.[82] The success of the biosimilars market is largely due to the regulatory predictability and efficiencies that have been provided by the FDA's successful implementation of the abbreviated approval pathway for biosimilars and the resources provided through the Biosimilar User Fee Act.

The IRA jeopardizes this carefully constructed balance that has significantly benefited patients and reduced health care spending. The timeframes for MFP price setting are in many cases well before it is feasible for a biosimilar to come to market, creating a significant disincentive for manufacturers to invest in these cost-saving alternatives. The processes necessary to market a biosimilar product can be complex, and there are many steps that are not solely in control of the biosimilar sponsor, including FDA review or timelines for patent litigation under the BPCIA's "patent dance" framework. Despite this complexity, the statutory "pause" provisions set rigid time requirements for completion of these activities. The fact that reference biologics may be selected for MFP price setting before the biosimilar may even be eligible for

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[76] SSA § 1192(f)(2)(B).
[77] Amerisource Bergen. (January 2025). U.S. Biosimilars Landscape. Available at: https://www.amerisourcebergen.com/-/media/assets/corporate/global/resource-pages/cencora-biosimilars-usmarketlandscape-jan25.pdf
[78] Association for Accessible Medicines. (September 2024). 2024 U.S. Generic & Biosimilar Medicines Savings Report. Available at: https://accessiblemeds.org/resources/reports/2024-savings-report/#:~:text=Savings%20from%20biosimilar%20medicines%20alone,of%20these%20lower%2Dcost%20medicines.
[79] Xcenda. (July 2022). Biosimilars are Lowering Costs in the Medicare Part B and Across the Healthcare System Overall. Available at: https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/xcenda_biosimilar_trends_issue_one_july2022.pdf.
[80] Jofre-Bonet M. et al. (May 2025) The Price Effects of Biosimilars in the United States. *Value in Health*. Available at: https://www.valueinhealthjournal.com/article/S1098-3015(25)00086-5/abstract?_returnURL=https%3A%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS1098301525000865%3Fshowall%3Dtrue
[81] PhRMA. (October 2021). The U.S. Market for Biosimilars and Biologics Medicines. Available at: https://www.phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Org/PDF/A-C/PhRMA---Biosimilars-Market-Multi-Pager_v11.pdf.
[82] IQVIA. (January 2023). Biosimilars in the United States 2023-2027 Competition, Savings, and Sustainability. Available at: https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/biosimilars-in-the-united-states-2023-2027.

licensure only exacerbates the timing issues. Even though biosimilars may not be approved until 12 years after the first licensure of a reference product,[83] the IRA would allow selection of the reference product for MFP-setting after only 11 years.

In this context, it is critical that CMS implements the "pause" provision in as predictable and flexible a manner as possible. In this regard, we are concerned by the brief and inflexible 30-day window CMS anticipates for submission on initial delay requests. We also urge CMS to revise its approach to determining whether there is a "high likelihood" that a biosimilar product will be licensed and marketed during the relevant time period by adhering more closely to the statute and providing additional clarity and flexibility. While we acknowledge that for IPAY 2028, CMS has described in more detail what information it proposes to consider as "clear and convincing evidence" of a "significant amount of progress" in support of an additional delay request,[84] we urge CMS to provide greater clarity on such information. We provide factors that should guide CMS' determination that there is "clear and convincing evidence" of a "significant amount of progress" towards licensure and marketing of the biosimilar product.

CMS should provide a longer window of time for submitting initial delay requests.

For IPAY 2028, CMS explains that it intends to provide the opening date for submissions of initial delay requests after approval of the Drug Selection Information Collection Request (ICR) by the Office of Management and Budget (OMB).[85] Consistent with IPAY 2027, CMS explains that it anticipates a 30-day window for submission of initial delay requests.[86] We are concerned that biosimilar manufacturers cannot predict when OMB may approve the ICR and that 30 days is an inadequate time period to prepare and submit such requests. The lack of notice and brevity of the submission window offer neither the predictability nor flexibility needed to implement the biosimilar pause effectively.

CMS' interpretation of the "high likelihood" requirement is untethered from the statute, unworkably vague, and overly rigid.

The statute directs CMS to determine that there is a "high likelihood" the biosimilar product will be licensed and marketed if it finds that FDA has accepted for review or has approved a biosimilar application, and information submitted by the biosimilar manufacturer "provides clear and convincing evidence that such biosimilar biological product will," within the specified time period, "be marketed."[87] Specifically, the statute provides that CMS will consider the following information in determining whether there is such a "high likelihood":

> All agreements related to the biosimilar product filed with the Federal Trade Commission (FTC) or Assistant Attorney General (DOJ) pursuant to section 1112(a) and (c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA);
>
> To the extent available, the manufacturing schedule for the biosimilar product submitted to FDA during its review of the BLA; and

[83] PHSA § 351(k)(7)(A).
[84] IPAY 2028 Draft Guidance, at 38-39. See also IPAY 2027 Final Guidance, at 177, fn. 84.
[85] IPAY 2028 Draft Guidance, at 28, fn 38.
[86] *Ibid*. at 28-29.
[87] SSA § 1192(f)(3).

To the extent available, certain disclosures by the biosimilar manufacturer that pertain to the marketing of the biosimilar product and that are made in certain filings with the Securities and Exchange Commission (SEC) or in comparable documentation distributed to the shareholders of privately held companies.[88]

As explained above, under *Loper Bright Enterprises v. Raimondo*, an agency is required to apply the "single, best meaning" of a statute.[89] Also as noted above, the President issued a memorandum on April 9, 2025, prioritizing the review and repeal pursuant to Executive Order 14219 of existing regulations that are unlawful under *Loper Bright.*[90] CMS has not implemented the statutory provisions governing the information to be used to make a "high likelihood" determination in a manner that represents the single, best meaning of the statute. The approach described in the draft guidance is inconsistent with the statute and is burdensome.

First, CMS maintains that for CMS to determine that there is a "high likelihood" for purposes of qualifying for a "pause" with respect to IPAY 2028, the biosimilar's application for licensure must be approved or accepted for review by the FDA no later than January 15, 2026.[91] Given the rigid timelines associated with the statutory "pause" and the fact that biologics may be selected for MFP price setting before the biosimilar may even be eligible for licensure, PhRMA urges CMS to allow the biosimilar manufacturer to submit information indicating that its application for licensure will be accepted for review or approved by FDA by the date of selection, i.e., February 1, 2026. CMS could also consider providing at least one quarter of advance notice to manufacturers of drugs anticipated for selection and providing biosimilar manufacturers the opportunity to inquire if a particular reference biologic is among the drugs anticipated for selection.

Second, with respect to CMS' evaluation of the "high likelihood" of marketing, PhRMA has significant concerns with CMS expectations that the above information submitted by the biosimilar manufacturer "demonstrates both (1) that patents *related to* the Reference Drug are unlikely to prevent the Biosimilar from being marketed; and (2) that the Biosimilar Manufacturer will be operationally ready to market the Biosimilar."[92] CMS proposes that it will consider the first requirement met if (A) "there are no unexpired patents relating to the reference product . . . that are applicable to the Biosimilar"; (B) "one or more court decisions or decisions by the United States Patent and Trademark Office (USPTO)'s Patent Trial and Appeal Board (PTAB) establish the invalidity, unenforceability, or non-infringement of any potentially applicable unexpired patent relating to the reference product included in the Reference Drug that the patent holder asserted was applicable to the Biosimilar"; or (C) "the Biosimilar Manufacturer has a signed legal agreement with the Reference Manufacturer that permits the Biosimilar Manufacturer to market the Biosimilar before the High Likelihood Deadline, without imposing improper constraints on the Biosimilar Manufacturer."[93,94]

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[88] SSA § 1192(f)(3)(B).
[89] 144 S. Ct. 2244, 2266 (2024).
[90] White House. (April 2025). Presidential Actions, Directing the Repeal of Unlawful Regulations. Available at: https://www.whitehouse.gov/presidential-actions/2025/04/directing-the-repeal-of-unlawful-regulations/.
[91] IPAY 2028 Draft Guidance, at 30.
[92] *Ibid*. at 36 (emphasis added).
[93] *Ibid*. at 36-37.
[94] CMS should clarify that "improper constraints" in this context is meant to refer to the agreements described in section 1192(f)(2)(D)(iv)(II)(aa) or (bb).

With respect to the first requirement (i.e., "that patents *related to* the Reference Drug are unlikely to prevent the Biosimilar from being marketed"), it is unclear which patents CMS considers to be "related to" the reference product. For IPAY 2028, CMS is soliciting comments "regarding whether there is additional or alternative evidence that may demonstrate that patents related to the Reference Drug are unlikely to prevent the Biosimilar from being marketed before the High Likelihood Deadline."[95] We urge CMS to clarify or eliminate the first requirement, as it unnecessarily limits the availability of the "pause." If this factor is retained for IPAY 2028, we support CMS' consideration of additional or alternative evidence in determining whether patents related to the reference product are unlikely to prevent the biosimilar from being marketed before the "High Likelihood" deadline and suggest that this should be at the discretion of the biosimilar manufacturer on a case-by-case basis.

Second, we agree that "CMS should consider public-facing statements in which the Biosimilar Manufacturer asserts that ongoing patent disputes will be resolved within the relevant time period for the High Likelihood Deadline."[96] We urge CMS to consider such public-facing statements, including publicly disclosed biosimilar entry dates, as doing so would represent a less onerous and more efficient way of making such a determination.

Third, CMS is soliciting "comments on whether investments in operationalization efforts, or other Biosimilar Manufacturer activity, may be evidence that demonstrates a patent dispute will be resolved or not prevent marketing of the Biosimilar by the High Likelihood Deadline."[97] Below, PhRMA identifies the types of Biosimilar Manufacturer activities that should be considered in high likelihood determinations.

Related to this issue, PhRMA also requests that CMS clarify that if a Biosimilar Manufacturer has carved out a patent-protected indication or method of use from the Biosimilar's labeling, then such patents would not be considered "applicable to the Biosimilar," and, therefore, will not be considered in this analysis consistent with the approach set forth in the summary of public comments in the Revised IPAY 2026 Guidance. There, CMS noted that "if a Biosimilar Manufacturer has carved out a patent-protected indication or method of use from the Biosimilar's labeling, then such patents would not be considered to be 'applicable to the Biosimilar.'"[98]

With respect to the second requirement (i.e., "that the Biosimilar Manufacturer will be operationally ready to market the Biosimilar"), the term "operationally ready" is vague, and we are concerned that CMS will implement this language narrowly, to the detriment of biosimilar development. CMS rigid requirement that the biosimilar demonstrate both showings also undermines the flexibility necessary to avoid undermining the delicate balance Congress established through the BPCIA.

To give the statute its single, best meaning and to implement an approach that is least burdensome, PhRMA urges CMS to permit submission of additional information and documents by any person or obtained by CMS from any other source for CMS to consider in making a "high likelihood" determination. This approach enables CMS to base its determination on the most comprehensive body of evidence and thus give the statute its single, best meaning. CMS should also acknowledge that public

[95] IPAY 2028 Draft Guidance, at 40.
[96] *Ibid.*
[97] *Ibid.*
[98] *See* Revised IPAY 2026 Guidance, at 26.

disclosures such as press releases or other communications may suffice as evidence that the biosimilar was accepted for review or approved by FDA, of the status of the biosimilar's clinical studies, and of the expected time to market. Much of the information necessary to make a "high likelihood" determination is available in readily accessible public sources and should not necessitate a burdensome submission by the biosimilar manufacturer.

In addition, we recommend that CMS find a "high likelihood" of marketing if, absent definitive evidence of an inability to come to market based on the manufacturing schedule, the biosimilar manufacturer meets either of the following criteria:

1. Agreements filed with the FTC/DOJ do not bar the biosimilar manufacturer from marketing the biosimilar product before the end of the relevant period; or
2. The investor disclosures indicate plans to market, or the manufacturing schedule submitted to FDA for the biosimilar product indicates that commercial lots of the biosimilar product are expected to be produced, before the end of the relevant period.

These criteria are directly tied to the information that the biosimilar manufacturer is required to submit under section 1192(f)(1)(B)(ii). Moreover, allowing the biosimilar manufacturer to satisfy *either* showing provides necessary flexibility to prevent the IRA from jeopardizing biosimilar development.

If CMS has remaining questions about the likelihood of marketing, CMS could also consider the following additional criteria:

- The biosimilar manufacturer has not stated in its disclosures to investors or in filings to the SEC, such as Forms 10-K or 10-Q, that it will not market the biosimilar product before the end of the relevant period;
- The biosimilar manufacturer has not withdrawn its BLA;
- The biosimilar manufacturer is not in arrears for any user fees due under section 744H of the FDCA for the biosimilar application;
- No manufacturing facility where the biosimilar is made, processed, etc., has a classification of Official Action Indicated;
- No clinical trial protocol amendments have been filed that would delay enrollment completion dates and subsequent biosimilar marketing beyond the pause period.

CMS should undertake a predictable and flexible approach toward evaluating requests for the second 1-year pause.

If an initial "pause" is granted, then for purposes of assessing whether the requirements for a second 1-year pause have been met, the statute requires CMS to determine, on the basis of "clear and convincing evidence," whether a biosimilar manufacturer has made a "significant amount of progress" toward "licensure" and "marketing." This re-evaluation is to be based on the following sources of information:

All agreements related to the biosimilar product filed with the FTC/DOJ pursuant to section 1112(a) and (c) of the MMA; and

Any additional information and documents submitted by the biosimilar manufacturer in response to a request from CMS.[99]

PhRMA appreciates that for IPAY 2027, CMS solicited comment regarding the types of documentation and information that may constitute "clear and convincing evidence" of a "significant amount of progress." For IPAY 2028, CMS describes procedures for submission of additional delay requests and the requirements for granting them in its draft guidance that largely mirror those described for an initial delay request. CMS has provided a high-level description of the information it will use to determine whether a "significant amount of progress has been made" based on a "holistic review."[100] CMS explains that it will "consider if the Biosimilar Manufacturer can demonstrate affirmative progress towards being operationally ready to market the Biosimilar" and will "consider the Biosimilar Manufacturer's progress on the actions, activities, and milestones that are typical of the normal course of business leading up to the marketing of a drug since the successful Initial Delay Request submission for the Biosimilar evidenced in both any updates or supplements to the documents" specified above.[101] These general descriptions lack specificity and thus do not provide sufficient notice of the types of evidence CMS may consider in making a "significant amount of progress" determination.[102] It is not clear what CMS considers to be "operationally ready" or "actions, activities, and milestones that are typical of the normal course of business leading up to the marketing of a drug."[103] These vagueness of these evidentiary standards will not lead to predictable implementation of the biosimilar pause. We recommend clarifying these points.

We maintain that CMS' analysis of an additional delay request should be both predictable and flexible. To that end, CMS should simply seek attestation by the biosimilar manufacturer that it has made progress toward marketing in order to determine whether to grant a second-year pause. To the extent CMS makes a further inquiry, it should be limited to definitive evidence of an inability to come to market and absent such definitive evidence of an inability to come to market, CMS should find a "significant amount of progress" if any of the criteria below are met:

1. If the biosimilar application was pending upon review during the first year of the pause:
    a. FDA has since approved the application;
    b. The first cycle of review remains ongoing, i.e., FDA's user fee goal date for action on the application has not yet occurred; or
    c. FDA has issued a complete response letter to the biosimilar manufacturer for the BLA and, as of the time that CMS is assessing eligibility for the second 1-year pause, the biosimilar manufacturer has resubmitted the BLA; or
2. The biosimilar manufacturer's investor disclosures indicate plans to market before the end of the relevant period;

[99] SSA § 1192(f)(2)(B)(i)(II).
[100] IPAY 2028 Draft Guidance, at 38.
[101] IPAY 2028 Draft Guidance, 38-39.
[102] *Ibid*. at 38-39.
[103] "Rule of law principles require that parties have fair notice and an opportunity to conform their behavior to legal rules." *Circus Circus Casinos, Inc. v. NLRB*, 961 F.3d 469, 476 (D.C. Cir. 2020). *See also supra* note **Error! Bookmark not defined.**.

3. The manufacturing schedule submitted to FDA for the biosimilar product indicates that commercial lots of the biosimilar product are expected to be produced before the end of the relevant period; or

4. Agreements filed with the FTC/DOJ do not bar the biosimilar manufacturer from marketing the biosimilar product before the end of the relevant period.

If CMS has remaining questions about the likelihood of marketing, CMS could also consider the following additional criteria:

- The biosimilar manufacturer has not stated in its disclosures to investors that it will not market the biosimilar product before the end of the relevant period;
- The biosimilar manufacturer has not withdrawn its BLA;
- The biosimilar manufacturer is not in arrears for any user fees due under section 744H of the FDCA for the biosimilar application; and
- No manufacturing facility where the biosimilar is made, processed, etc., has a classification of Official Action Indicated.

III. "Bona Fide Marketing"

PhRMA opposes CMS' extra-statutory concept of "bona fide marketing." In relevant part, section 1192(e)(1) of the SSA defines a qualifying single source drug (QSSD) as a drug product "that is not the listed drug for any [generic] drug that is approved and marketed under section 505(j)" of the FDCA and a biological product "that is not the reference product for any [biosimilar] biological product that is licensed and marketed under section 351(k)" of the PHSA.[104] Similarly, section 1192(c) provides that a product ceases to be a "selected drug" beginning before the first year that begins at least nine months after the date on which the Secretary determines at least one generic drug or biosimilar biological product "is approved or licensed (as applicable)" and "is marketed pursuant to such approval or licensure."[105]

Nonetheless, the Draft Guidance refers to "bona fide marketing," stating that CMS "will consider a generic drug or biosimilar to be marketed when the totality of the circumstances, including the data specified below, reveals that the manufacturer of that approved generic drug or licensed biosimilar is engaging in bona fide marketing of that drug or biosimilar."[106] The Draft Guidance also states that "[t]he determination whether a selected drug should not be subject to the negotiation process and ultimately removed from the selected drug list" will depend upon evidence that "reveals that the manufacturer of the generic drug or biosimilar is engaging in bona fide marketing of that drug or product."[107] Furthermore, even after CMS determines that a potential QSSD will not be considered a QSSD or that a selected drug has ceased to be a selected drug, CMS "will monitor . . . whether meaningful competition continues to exist in the market by ongoing assessments of whether the manufacturer of the generic drug or biosimilar is engaging in bona fide marketing."[108]

[104] SSA § 1192(e)(1)(A)(iii) & (B)(iii).
[105] SSA § 1192(c)(1).
[106] IPAY 2028 Draft Guidance, at 14.
[107] IPAY 2028 Draft Guidance, at 156 (emphasis added).
[108] IPAY 2028 Draft Guidance, at 176.

The addition of the term "bona fide" adds an extra-statutory limitation and is at odds with the ordinary meaning of "marketed." CMS' approach also is inconsistent with other provisions of the IRA, where Congress expressly imposed volume-based requirements for marketing purposes. Finally, the statute does not permit CMS to monitor for "bona fide marketing" after it determines that a product is not a QSSD or has ceased to be a selected drug or even vaguely contemplate such a monitoring program.

The statute does not allow for imposition of CMS' "bona fide" qualifier.

As noted, CMS is obligated under *Loper Bright*[109] and the President's April 9, 2025 memorandum[110] to adopt the single, best meaning of the IRA and withdraw any interpretation that conflicts with that single, best meaning. PhRMA urges CMS to withdraw the bona fide qualifier because it is inconsistent with the single, best meaning of the statute.

The ordinary meaning of "marketing," which is also the way "marketing" is used in the pharmaceutical sector specifically, does not support CMS' narrowly-focused approach that departs from the best meaning of the relevant statutory text. For example, Merriam-Webster's dictionary defines marketing as "to expose for sale in a market."[111] In a Supreme Court case interpreting the meaning of "marketing" when the term was undefined in a statute, the Court looked to the "ordinary meaning" of the term and concluded that "[m]arketing ordinarily refers to the act of holding forth property for sale, together with the activities preparatory thereto … The word does not require that the promotional or merchandising activities connected with the selling be extensive."[112] Thus, when "marketing" is undefined, the Court simply requires the product to be "for sale."[113]

These definitions also reflect the generally accepted, ordinary meaning of "marketed" in the context of a pharmaceutical product, and, consequently, the meaning of "marketed" that Congress intended in the context of the IRA. For instance, the ordinary meaning of "marketing" is consistent with FDA's conception of marketing under section 505(j) of the FDCA, which is relevant given that the IRA's statutory QSSD and selected drug definitions reference a generic drug "marketed under section 505(j)."[114] In the context of 180-day exclusivity for first generic applicants, the FDCA provides that FDA shall not make effective a subsequent generic application until "180 days after the date of the first commercial marketing of the drug . . . by any first applicant."[115] In regulations, FDA defines the term "commercial marketing" (a term that is narrower than "marketing") as "the introduction or delivery for introduction into interstate commerce of a drug product described in an ANDA, outside the control of the ANDA applicant, except . . . for investigational use . . . or transfer of the drug product to parties identified in the ANDA for reasons other than sale."[116] Similarly, for purposes of implementing section 506I of the

[109] *Loper Bright*, 144 S. Ct. 2244, 2266 (2024).
[110] White House. (April 2025). Presidential Actions, Directing the Repeal of Unlawful Regulations. Available at: https://www.whitehouse.gov/presidential-actions/2025/04/directing-the-repeal-of-unlawful-regulations/.
[111] Merriam-Webster.com. "Market." Available at: https://www.merriam-webster.com.
[112] *Asgrow Seed Co. v. Winterboer*, 513 U.S. 179, 187 (1995)
[113] *Ibid.* ("One can market apples by simply displaying them on a cart with a price tag; or market a stock by simply listing it on a stock exchange; or market a house (we would normally say 'place it on the market') by simply setting a 'for sale' sign on the front lawn. Indeed, some dictionaries give as one meaning of 'market' simply 'to sell. ' See, *e.g.,* Oxford Universal Dictionary 1208 (3d ed. 1955); Webster's New International Dictionary 1504 (2d ed. 1950).").
[114] SSA § 1192(e)(1)(A)(iii); *see also id.* SSA § 1192(c)(1)(A)(i).
[115] FDCA § 505(j)(5)(B)(iv)(I).
[116] 21 C.F.R. § 314.3.

FDCA concerning required notifications to FDA about the marketing status of a product,[117] FDA considers a product's marketing status to depend on whether a product is distributed by the application holder, i.e., whether the product is available for sale.[118]

In contrast, the Draft Guidance imposes an extra-statutory limitation on what qualifies as marketing of a generic or biosimilar biological product for purposes of the QSSD definition and for determining whether a product ceases to be a selected drug or otherwise is no longer subject to the price setting process or to an MFP. Indeed, in the IPAY 2026 Initial Guidance's "Appendix C: Definitions for Purposes of Collecting Manufacturer-Specific Data," CMS defined "marketing" as "the introduction or delivery for introduction into interstate commerce of a drug product."[119] Perhaps recognizing the tension between this definition and its extra-statutory "bona fide marketing" concept, CMS deleted this definition from the IPAY 2026 and 2027 Guidances, both of which instead refer to "[m]arketing 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."[120] For IPAY 2028, CMS has maintained this definition but has proposed to add after "health professionals" "including providing free products to health professionals or patients."[121] While these expenditures may not be relevant to either generics or biosimilars, the introduction into interstate commerce of a drug product applies equally to define marketing in the generic and biosimilar context.

In this Draft Guidance for IPAY 2028, CMS has provided three examples to illustrate its analysis of "bona fide" marketing:

1. If a potential QSSD has at least one approved generic drug or licensed biosimilar that has "high and consistent PDE utilization, AMP sales, and/or ASP sales," then CMS indicates that it will consider the generic(s) or biosimilar(s) of the potential QSSD "bona fide" marketed.
2. If a potential QSSD might "have a newly or recently approved generic or licensed biosimilar and the product has relatively low PDE utilization, AMP sales, and/or ASP sales,"[122] CMS explains that where it finds "in additional review of public information that the generic or biosimilar manufacturer has successfully launched their product, and there is no evidence of agreements limiting distribution of the generic or biosimilar product," then CMS will consider the generic or biosimilar product of the potential QSSD as "bona fide" marketed.[123]

3. If a potential QSSD might have an approved generic or licensed biosimilar product "with no PDE utilization, AMP sales, and/or ASP sales," if CMS finds "in additional review of public information that there are ongoing patent disputes and no generic or biosimilar manufacturer has

[117] Section 506I requires NDA and ANDA holders to provide written notification prior to withdrawing an approved product from sale and if the drug will not be available for sale within 180 days of the date of approval.
[118] FDA. (August 2020). Guidance for Industry: Marketing Status Notifications Under Section 506I of the Federal Food, Drug, and Cosmetic Act; Content and Format. Available at: https://www.fda.gov/media/120095/download
[119] IPAY 2027 Draft Guidance, at 82.
[120] Revised IPAY 2026 Guidance, at 194; Draft IPAY 2027 Guidance, at 131.
[121] Draft IPAY 2028 Guidance, at 209.
[122] *Ibid*.
[123] *Ibid.*

successfully launched their product," then CMS will consider the generic or biosimilar product of the potential QSSD as not "bona fide" marketed.[124]

We appreciate that CMS has provided these examples and has clarified certain types of data sources that it intends to consult for determining if "bona fide" marketing exists. These examples, however, do not resolve the unlawful and extra-statutory nature of the "bona fide" qualifier. Moreover, the third example should be deleted, as it would result in a determination that the generic drug or biosimilar is not "marketed" even where it is. For instance, this example would result in the wrong outcome where a particular biosimilar has recently launched, e.g., at risk or based on a settlement without any patent litigation proceedings as to its biosimilar (notwithstanding the existence of other patent disputes as to biosimilars of the same reference product), but PDE, AMP, and ASP sales do not yet reflect the launch.

CMS' approach conflicts with other provisions of the IRA.

CMS' imposition of the "bona fide" qualifier conflicts with other provisions of the IRA addressing the biosimilar "pause" and the treatment of authorized generics. Although Congress made no reference to "bona fide" marketing or any similar gloss in the QSSD or selected drug definitions, in other provisions of the same section of the statute, CMS expressly imposes limitations on what qualifies as marketing. When "Congress includes particular language in one section of a statute but omits it in another section of the same Act," it is "generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion."[125] Congress's decision not to qualify the term "marketed" in the QSSD or selected drug definitions demonstrates that CMS' additional "bona fide" limitation conflicts with the statute.

The IRA expressly prohibits manufacturers from receiving the biosimilars-based selection "pause" based on volume-limited arrangements. Specifically, section 1192(f)(2)(D)(iv) states that "[i]n no case shall the Secretary delay the inclusion of a biological product as a selected drug" if "the manufacturer of the biosimilar . . . entered into any agreement . . . with the manufacturer of the reference product . . . that . . . restricts the quantity (either directly or indirectly) of the biosimilar biological product that may be sold in the United States over a specified period of time."[126] Volume-limited arrangements were also known in the industry at the time Congress enacted the IRA. Clearly, then, Congress knew how to impose volume-based requirements or limitations and did so in the very same section of the statute but elected not to do so in the definitions of QSSD and selected drug.

The statute does not permit CMS to continually evaluate "bona fide marketing".

Furthermore, there is no statutory mechanism that permits CMS to monitor "whether the manufacturer of the generic drug or biosimilar is engaging in bona fide marketing" *after* it determines that a potential QSSD will not be considered a QSSD or that a selected drug should be removed from the Program.[127] Nonetheless, CMS states that it "will monitor, after such . . . determination is made, whether meaningful competition continues to exist in the market by ongoing assessments of whether the manufacturer of the generic drug or biosimilar is engaging in bona fide marketing."[128] CMS seems to imply that it can *revisit*

[124] *Ibid.*
[125] *Russello v. United States,* 464 U.S. 16, 23 (1983) (citations omitted).
[126] SSA § 1192(f)(2)(D)(iv) (emphasis added).
[127] IPAY 2028 Draft Guidance, at 176.
[128] IPAY 2028 Draft Guidance, at 176.

such determinations and potentially restore a product to "selected drug" status, even though this is not contemplated by the statute. The statute is clear that once a product is determined not to meet the definition of a QSSD or ceases to be a selected drug, it is no longer eligible for price setting. Instead, the statute provides explicitly that once a selected drug ceases to be a selected drug, CMS' agreement with the manufacturer "shall no longer be effective" and the drug "is no longer considered a selected drug."[129]

There is no statutory basis for CMS to restore selected drug status to a product that is no longer a selected drug or to enter into a new section 1193 agreement with a manufacturer after the parties' section 1193 agreement has terminated due to the approval and marketing of a generic or biosimilar. Further, the product's MFP and the manufacturer's agreement to provide access to that MFP to entities that dispense or administer the drug to Medicare beneficiaries are set forth in the agreement—which would have terminated.[130] Accordingly, a whole new process of price setting procedures and setting an MFP for the drug would be needed for the Program to apply, but the statute never mentions or even hints at this extended series of events or any of its parts. Congress would not have authorized this approach of CMS ending a product's selected drug status, terminating the CMS-manufacturer agreement, and then reinstating the drug's selected drug status and requiring the manufacturer to enter into a new agreement, without saying so expressly. Nor would Congress have silently delegated to CMS the unilateral authority to develop and carry out this far-fetched re-selected drug process. CMS' approach has no statutory foundation and conflicts with the statute's express terms. Moreover, to the extent CMS is suggesting it has jurisdiction to police competition, and the expertise necessary to do so, that suggestion is incorrect.[131] Instead, that authority rests with the agencies charged with enforcement of the antitrust laws.

IV. Orphan Drug Exclusion from Qualifying Single Source Drugs

CMS' interpretation of the orphan drug exclusion is overly narrow. Section 1192(e)(3)(A) provides for a wholesale exclusion from the IRA for "a drug that is designated as a drug for only one rare disease or condition under section 526 of the [FDCA] and for which the only approved indication (or indications) is for such disease or condition."[132] CMS' careless implementation of the exclusion itself as laid out in the IPAY 2028 Draft Guidance also represents serious flaws. In fact, the process that CMS notes it will follow to determine whether a drug will qualify for the orphan drug exclusion relies on databases that may not accurately reflect whether a drug's indication falls within the scope of the orphan drug designation.

Like the Guidance for IPAY 2026 and 2027, the proposed Guidance for IPAY 2028 continues to constrain the exclusion in ways that are not supported by the statute and that would undermine research and development in the rare disease space. As addressed further below, the Guidance has this effect in two ways. First, for orphan drugs that lose eligibility for the exclusion, CMS proposes to apply the seven- or 11-year age requirement *retroactively* from the date of initial approval or licensure. Second, per CMS'

[129] SSA § 1193(b) (emphasis added).
[130] SSA § 1193(a)(3); CMS, Medicare Drug Price Negotiation Program Template Agreement, Addendum 1 (Negotiated Maximum Fair Price).
[131] Courts are unlikely to find that Congress implicitly granted an agency certain important powers (and instead will require an express grant of authority) where the agency "has no expertise in crafting …policy [in the area in question]." *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015). *See also, e.g.*, *Gonzales v. Oregon*, 546 U.S. 243, 266–67 (2006) (Congress would not be presumed to delegate interpretive authority to the Attorney General on an issue where he lacked expertise); *City & Cnty. of San Francisco v. Trump*, 897 F.3d 1225, 1242 (9th Cir. 2018) (an agency interpretation of an important economic and political question may not be entitled to deference and "[t]his is particularly true where the agency lacks expertise").
[132] SSA § 1192(e)(3)(A).

overly broad interpretation of a QSSD, CMS proposes to evaluate applicability of the orphan drug exclusion on an active moiety or active ingredient basis, rather than for each individual drug product or biological product.

In each case, the best reading of the statute compels the opposite result. The fact that the IRA provides for an exclusion from the definition of a QSSD for eligible orphan drugs indicates that the seven- or 11-year clock should only begin running once a product loses eligibility for the exclusion. It also supports evaluating each drug product or biological product individually, such that the approval of a new drug product or biological product could trigger application of the exclusion and a new seven- or 11-year clock to begin upon loss of that exclusion.

Our proposed interpretation also preserves incentives for orphan drug research and development, consistent with Congress's mandate. More than forty years ago, Congress incentivized the development and approval of drugs to treat rare diseases and conditions by enacting the Orphan Drug Act, and FDA has approved hundreds of drugs under that framework. The orphan drug exclusion in the IRA reflects Congress's intent to promote continued orphan drug development to meet the needs of patients with rare diseases. PhRMA urges CMS to interpret the exclusion with this policy goal in mind, i.e., to encourage continued drug development for patients with rare diseases or conditions.

The seven- or 11-year clock should begin upon loss of eligibility for the orphan drug exclusion.

When a product initially qualifies for the orphan drug exclusion but subsequently loses its eligibility, CMS should interpret the statute in a manner that initiates the drug's selection timeline from the date on when the exclusion was lost. In other words, the seven- or 11-year clock should begin when the previously excluded drug receives a designation for a second orphan disease or gains approval for a use outside a single orphan designation—not from the date of the earliest approval or licensure of the active moiety or active ingredient, as CMS proposes.[133]

CMS' contrary interpretation fails to give the orphan drug exclusion the full and meaningful effect intended by Congress. Under CMS' proposed approach, the clock would be considered to have run *retroactively* from an approval that initially qualified for the exclusion. This reading is inconsistent with the scope and purpose of the exclusion, which exempts orphan drugs from the definition of a QSSD altogether if conditions are met. By disregarding the exclusion's intent and applying the timeline retroactively, CMS' interpretation undermines the very protection that the orphan drug exclusion aims to provide.

Policy reasons also compel CMS to interpret the law in this manner: If selection timing is retrospectively linked to an orphan drug's previously-exempt approvals once the exemption is lost, then companies may be incentivized to delay or altogether forgo seeking orphan approval. Instead, manufacturers may be driven to prioritize initial approval for indications with a larger potential patient population in order to maximize the potential value of the product before it becomes subject to price setting. CMS' interpretation therefore undermines Congress' steadfast commitment to encouraging the development of orphan drugs, a policy that has been in place for over four decades and was explicitly extended to the IRA through the orphan drug exclusion in section 1192(e)(3)(A). CMS must recognize the far-reaching

[133] IPAY 2028 Draft Guidance, at 16-17.

implications of its interpretation and align its approach with the long-standing legislative intent to promote the development of orphan drugs to meet the significant unmet need of patients.

CMS' approach disincentivizes companies from following the science and effectively undermines the existing incentives in the Orphan Drug Act designed to bring new treatments for rare and orphan diseases as quickly as possible. Consider, for instance, a company researching a new drug for an orphan indication that could be brought to market as its initial FDA approval, potentially offering a curative therapy to a small population of patients with limited or no other treatment options. Consider as well that this drug may have other promising applications that will take significantly more time and resources to bring to market but would serve a much larger patient population. Under CMS' current interpretation the company is incentivized to prioritize seeking the first approval for the larger population to allow it to have the full seven- or 11-year period to earn sufficient revenues to earn a return on its investment and continue investing in post-approval R&D. By contrast, if the company chooses to launch the orphan indication first, the manufacturer could face a much shorter—or even nonexistent—period to market the larger indication before price setting. If, for example, five years after the initial approval, FDA approves a new, non-orphan indication, the product would have as few as two years to be marketed for the non-orphan indication before potential selection for price setting. The consequences are even more perverse if a company obtains a second orphan designation. In such a scenario, the drug might never receive marketing approval for a second orphan use, but any subsequent uses would be subject to a retroactively truncated timeline before selection.

The above scenarios clearly illustrate how CMS' interpretation unjustly penalizes drugs that were initially subject to the orphan drug exclusion compared to other, non-orphan products. By contrast, if CMS interprets the statute to link eligibility for price setting to the date of the approval for an indication outside the first orphan designation or receipt of a new designation, CMS would preserve the incentives for a manufacturer to seek an orphan indication early and make the medicine available quickly to an underserved group of patients, as well as incentives for seeking orphan drug designation. By aligning its interpretation with the legislative intent and the needs of rare disease patients, CMS can foster an environment that encourages innovation, accelerates access to orphan drugs, and upholds the spirit of the Orphan Drug Act.

The orphan drug exclusion should be applied to the drug or biological products approved in a single NDA/BLA.

PhRMA maintains that CMS should determine the applicability of the orphan drug exclusion based on the specific drug or biological products approved in a single NDA or BLA, consistent with our proposed interpretation of the QSSD definition described above. Currently, the Draft Guidance states that "[t]o determine whether a potential qualifying single source drug qualifies for the Orphan Drug Exclusion, CMS will consider *all* dosage forms and strengths of the potential qualifying single source drug, as described in section 30.1 of this draft guidance."[134] This interpretation indicates that CMS will aggregate multiple drug or biological products based on their active moiety or active ingredient and then subsequently evaluate each aggregated grouping to determine whether it meets the conditions of the orphan drug exclusion. Further, if any single drug product or biological product loses the exclusion, other products with the same active moiety or active ingredient would also lose the exclusion regardless of their

[134] IPAY 2028 Draft Guidance, at 16 (emphasis added).

individual orphan drug status. This blanket application of the exclusion criteria extends the problems with the QSSD definition, potentially penalizing drugs that have successfully met the requirements for orphan drug designation.

The shared active moiety and ingredient approach suffers from the same inherent flaws as CMS' proposed definition of a QSSD.

PhRMA believes a QSSD must be strictly limited to those drug or biological products approved by FDA in a single NDA or BLA. Since the orphan drug exclusion is explicitly defined as an exception from the definition of a QSSD, it logically follows that it should be applied on an NDA/BLA basis as well. Furthermore, each drug or biological product approved under an individual NDA or BLA must independently meet the age requirement, which should be calculated from the date the exclusion is lost, as discussed above.

In addition to aligning with the statute, this approach better preserves incentives for orphan drug research and development. Under CMS' interpretation, once the orphan drug exclusion is lost for a single drug product or biological product (e.g., due to its approval for a non-rare disease), there would be severely diminished incentives to pursue new orphan drug approvals for the same active moiety or active ingredient. This would have a chilling effect on the development of new therapies for rare diseases, as manufacturers would be discouraged from investing in additional orphan indications once the exclusion is lost for any product sharing the same active moiety or ingredient. By adopting a product-specific approach, CMS can ensure that the incentives for orphan drug development remain robust, encouraging manufacturers to continue pursuing new treatments for rare diseases even if the exclusion is lost for a particular product.

V. Interpretation of Section 1192(c)(1) Regarding Timing of Generic or Biosimilar Entry

PhRMA disagrees with CMS' interpretation of section 1192(c)(1) to require that a generic drug or biosimilar is approved and marketed by November 1, 2026—over a year before IPAY 2028 begins—in order for a drug selected by February 2026 not to be subject to an MFP in IPAY 2028. So long as CMS makes a determination of generic or biosimilar approval and marketing by March 31, 2027 (i.e., at least nine months prior to January 1, 2028), the selected drug should not be subject to an MFP for IPAY 2028.

Consider a drug selected in February 2026 for IPAY 2028 for which CMS determines on March 1, 2027, that a generic drug has been approved and marketed. Section 1192(c)(1) states that "each negotiation-eligible drug included on the list published . . . *with respect to an initial price applicability year* . . . shall be *referred to* as a 'selected drug' with respect to *such year* and *each subsequent year* beginning before the first year that begins at least 9 months after the date on which the Secretary determines at least one drug or biological product" has been approved or licensed and marketed pursuant to such approval or licensure.[135]

The provision should be read such that if the generic or biosimilar launches by March 31, 2027, the drug would no longer be "referred to" as a selected drug with respect to the year beginning on January 1, 2028, either because "such year" begins at least nine months after CMS' determination of generic approval and marketing; or because such year is a subsequent year that begins at least nine months after CMS'

[135] SSA § 1192(c)(1) (emphasis added).

determination. Accordingly, the MFP would not go into effect in IPAY 2028. Before CMS made its determination of generic approval and marketing, the drug was "referred to as a 'selected drug' with respect [to IPAY 2028]"—consistent with the statutory language—as the manufacturer was required to submit data to CMS, engage in the price setting process, sign an MFP agreement, and have its MFP published.

The above approach helps promote competition by incentivizing market entry of generics and biosimilars, while also giving CMS a nine-month lead time to terminate selection of a branded drug after generic or biosimilar entry. By contrast, if CMS continues with its proposed interpretation, a generic or biosimilar launched more than a year before the IPAY begins (e.g., on November 2, 2026) would still have to compete against a price-set brand name drug beginning on January 1, 2028.

Appendix B: Effectuation of the Maximum Fair Price and MFP Calculation

PhRMA appreciates the opportunity to provide technical comments on the portions of the *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028* (Draft Guidance) governing effectuation of the Maximum Fair Price (MFP) in Part B and Part D (sections 40.4 and 90), the determination of a single MFP and ceiling price as part of the negotiation and renegotiation process (section 60), and the imposition of civil monetary penalties for manufacturers that fail to ensure access to the MFP (section 100).

In general, PhRMA notes that the Draft Guidance will likely be finalized after manufacturer MFP effectuation plans for Initial Price Applicability Year (IPAY) 2026 are due on September 1, 2025. Because of this, we urge the Centers for Medicare & Medicaid Services (CMS, the Agency) to:

- Clearly denote that any significant changes made between the draft and final versions of the guidance are not in effect for IPAY 2026; and
- Publicly report metrics on pharmacy enrollment and other aspects of the MTF DM and PM roll-out as we approach the start of IPAY 2026, as well as to publish more detailed information on the MTF testing scope and timeline process. Specifically, we request that CMS publish a detailed test plan covering scenarios, file formats, and timelines as soon as possible. Early visibility will allow manufacturers to prepare data, workflows, and staffing for a robust pilot cycle.

In the sections below, PhRMA provides more specific recommendations that CMS should make in final guidance. A selection of key recommendations and requests include:

- **MFP Effectuation in Part B.** CMS needs to take steps in future rulemaking or guidance to require Medicare Advantage (MA) plans to report claims data on a more frequent basis for selected provider-administered medicines and to require MA plans to mandate 340B covered entities to identify 340B-eligible claims through the use of mandatory modifiers.
- **MFP Effectuation in Part D.** CMS should clarify that manufacturers using the standard default refund amount (SDRA) may use it as a true default (i.e., are presumed to have provided access to the MFP). CMS should also broaden the approach to claims edits related to MFP eligibility to include claims identified as outliers by the Drug Data Processing System (DDPS) with regards to fields listed in Appendix B of the Draft Guidance
- **Establishing a Single Ceiling Price and MFP.** Starting with Part B and Part D drugs selected for IPAY 2028, we urge CMS to work with Primary Manufacturers at the start of the negotiation process to align on the best analytical approach to calculating a single ceiling price and MFP for each selected drug, along with therapeutic alternatives. If CMS continues with a 30-day equivalent supply approach (or for drugs where CMS and the Primary Manufacturer agree that a 30-day equivalent supply approach is best), we urge CMS to make a number of changes to its current methodology. And regardless of the approach, CMS should ensure that it provides needed detail on its calculation of MFPs to allow for understanding and replication.
- **Civil Monetary Penalties.** CMS should affirmatively commit to not imposing civil monetary penalties (CMPs) on manufacturers that do not provide access to the MFP as a result of technical

issues with the Medicare Transaction Facilitator Data Module (MTF DM) or Payment Module (MTF PM), or for any other issue that is outside the manufacturer's control. CMS should also ensure that CMPs are not imposed based on new technical requirements imposed close to the start of (or during) the IPAY.

I. Sections 40.4 and 90 – Effectuation and Compliance Oversight for Drugs Covered under Medicare Part B

PhRMA appreciates the Agency's solicitation of recommendations on a variety of topics related to how manufacturers can provide access to the MFP for selected drugs covered under Medicare Part B. We agree with CMS' proposed intention to align, as much as possible, the MFP effectuation approach for Part B and Part D selected drugs, including by continuing to offer Primary Manufacturers the ability to provide access to the MFP through a retrospective approach facilitated by the MTF Data Module (DM) and Payment Module (PM) that is data driven and transparent. However, there are some unique considerations for selected drugs covered under Part B, including a much greater number of providers and a current lack of timely receipt of claims data for beneficiaries enrolled in MA plans.

Excluding MFP from the Calculation of ASP

PhRMA firmly believes that CMS lacks the legal authority to include MFP in the calculation of Average Sales Price (ASP) but has the legal authority to exclude the MFP from ASP reporting requirements. Given the significant policy and legal rationales detailed below, ***we urge CMS to explicitly confirm MFP's exclusion from ASP in order to provide critical certainty for manufacturer reporting and stability to provider payments and to protect patient access.***

Beginning in IPAY 2028 for selected Part B drugs, the IRA requires provider reimbursement for such drugs to be based on the MFP as opposed to the ASP, which serves as the basis of reimbursement for the majority of separately payable Part B drugs today. This will drastically reduce Medicare reimbursement for provider-administered selected medicines even while costs necessary to administer products in-office remain the same. Indeed, research suggests that if CMS were to include MFP in ASP it would further erode reimbursement, with providers projected to face decreases to add-on payments of up to $37 billion for Part B selected drugs.[136] And because ASP serves as a payment benchmark for a wide swath of commercial market health plans and MA plans,[137] the decrease in provider payments includes an up to 18 percent reduction in add-on payments for provider-administered selected drugs in the commercial market and MA.[138] The inclusion of MFP in the calculation of ASP would most significantly impact oncology practices.[139] Equally concerning, small and rural providers, which typically operate on slimmer margins than large health systems, would be least able to absorb the reimbursement cuts triggered by the inclusion of MFP in the calculation of ASP. As a result, more practices could close or consolidate with hospital systems, reducing patient access to community providers and increasing Medicare program costs.

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[136] Avalere Health. (September 2024). Commercial Spillover Impact of Part B Negotiations on Physicians. Available at: https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians.
[137] A recent survey of commercial insurers showed that they reimburse for 72 percent of covered lives in the physician office based on a medicine's ASP. ASP is also the basis of Medicaid reimbursement for provider-administered medicines in many states. *See*, Avalere Health. (September 2024). Commercial Spillover Impact of Part B Negotiations on Physicians. Available at: https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians.
[138] *Ibid.*
[139] *Ibid.*

Given the significant negative impact expected, and the fact that CMS lacks the legal authority to include MFP in the calculation of ASP, selected drug sales at MFP should be excluded from ASP reporting. Below, we outline the numerous policy and legal arguments for this critical exclusion:

Under the Major Questions Doctrine, CMS Cannot Construe the IRA's Silence on ASP as Delegating Authority to Include MFP in ASP

The IRA explicitly includes MFP in Best Price and excludes MFP from Average Manufacturer Price (AMP),[140] but is silent on whether MFP is included in ASP. Under the major questions doctrine, statutes are not interpreted as authorizing federal agencies to make decisions with "vast economic and political significance" unless the statute does that explicitly.[141] In *West Virginia v. EPA,* a seminal case on the major questions doctrine, the Court held that the EPA could not lawfully regulate certain emissions because it lacked "clear congressional authorization" to do so.[142] Specifically, the Court said that "[t]his view of EPA's authority [advocated by EPA] was not only unprecedented; it also effected a 'fundamental revision of the statute, changing it from [one sort of] scheme of . . . regulation' into an entirely different kind."[143] Hence, the Court doubted that Congress would grant EPA the discretion to regulate in this manner without a clear delegation.[144]

In enacting the IRA, Congress was well aware of the significance and unprecedented nature of the Drug Price Negotiation Program (the "Program"): HHS said, "[f]or the first time, thanks to President Biden's [IRA] – the historic law lowering health care costs – Medicare is able to negotiate the prices of prescription drugs."[145] And any CMS decision to require that manufacturers include MFP pricing in their ASP calculations would change ASP from a market-based metric—what Congress intentionally created in the 2003 Medicare Modernization Act—to a metric largely dominated by a single CMS-set price, which is likely to cause major repercussions for providers and patients who rely on physician-administered drugs. In addition, the IRA excludes Part B drugs for the Program's first two years—inclusion of MFP in ASP for selected IPAY 2026 and IPAY 2027 drugs with Part B utilization would eliminate this two-year timeline by injecting MFP into ASP before IPAY 2028.

As discussed above, including MFP in ASP could have dramatic and sustained adverse effects on health care providers and patients. Such a policy could sharply reduce payments to providers for physician-administered drugs – across the Medicare Fee-for-Service (FFS), MA, and commercial markets, and over a long period of time – thus jeopardizing the ability of physicians and other

[140] SSA §1927(c)(1)(C)(ii)(V), (k)(1)(B)(i)(VI).
[141] *Util. Air Regul. Group v. EPA,* 573 U.S. 302, 324 (2014) (internal quotations omitted).
[142] *West Virginia v. Env't Prot. Agency*, 597 U.S 697, 732, 734 (2022).
[143] *Ibid.* at 728.
[144] *Ibid*. at 729. See also, *e.g.*, *ibid.* at 723 (Even where an agency's regulatory assertion "had a colorable textual basis, . . . [e]xtraordinary grants of regulatory authority are rarely accomplished through modest words, vague terms, or subtle device[s]. Nor does Congress typically use oblique or elliptical language to empower an agency to make a "radical or fundamental change" to a statutory scheme.") (internal quotations and citations omitted).
[145] HHS. (August 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.

providers to furnish these important medicines to their patients. Including MFP in ASP would substantially reduce ASP, which would likely erode (1) MA and commercial plan payments for selected drugs, both during and after the drug is selected; and (2) Medicare FFS payments, for up to an 18-month period after deselection, due to the two quarter lag in ASP reporting and the 12-month average of lagged price concessions.

Moreover, selected and deselected drugs may seem like a rarity today, but their number will quickly mount, as CMS will choose 20 new selected drugs every year from 2029 forward.[146] Eventually, selected and deselected drugs could account for the vast majority of covered Medicare drugs. Congress would not have silently permitted CMS to decide whether to trigger such a major, across-the-board, and potentially long-lasting deterioration of price in the marketplace for physician-administered drugs, impacting provider payment rates, patients' access to critical medicines, and with implications for clinical decision making. Accordingly, CMS lacks authority to require that manufacturers include MFP in their ASP calculations.

CMS Should Align the Treatment of ASP with the IRA's Exclusion of MFP from AMP

Under the IRA, MFP is explicitly excluded from the calculation of AMP, and sales data captured in AMP are a subset of data included in ASP. Specifically, AMP represents the average price paid to the manufacturer by wholesalers for drugs distributed to retail community pharmacies and retail community pharmacy purchases directly from the manufacturer, while ASP represents manufacturer sales of a drug to all eligible purchasers, inclusive of sales in retail settings. Since the IRA explicitly excludes MFP from AMP reporting, it is necessary to exclude MFP from ASP reporting as well, since it would create a distortion across these comparable pricing benchmarks to exclude MFP from retail sales reported under AMP but not require such exclusion of MFP under ASP.

Moreover, when Congress established ASP as the basis for Medicare Part B drug reimbursement, it also provided a mechanism for monitoring market prices and adjusting ASP-based payments in certain situations. Specifically, the Social Security Act (SSA, the Act) states that if the Office of Inspector General (OIG) finds that the ASP for a drug exceeds its AMP by more than a certain threshold, AMP is substituted as the basis of provider reimbursement for that drug. As Congress envisioned comparability between ASP and AMP as outlined above, we believe it is critical, and logically consistent, to maintain similar exclusions from ASP and AMP to ensure such comparisons are done on an "apples to apples" basis.

Furthermore, since MFP is expressly excluded from AMP, Part D rebatable drugs continue to have inflation rebates calculated on a metric that excludes MFP while they are selected under the Program. By excluding MFP from ASP, CMS would be aligning the treatment for Part B rebatable drugs, whose inflation rebate obligations remain based on ASP while they are selected,[147] as well as once they are deselected.

CMS Has Existing Authority to Exclude MFP from ASP

[146] SSA § 1192(a).
[147] SSA §1847A(i)(3)(A)(ii).

Under the SSA, the Secretary may establish ASP "units" for manufacturers to report and methods for "counting units" included in ASP for years after 2004.[148] Indeed, CMS previously relied on this authority to exclude units sold to vendors through the Part B Competitive Acquisition Program (CAP) from the calculation of ASP.

Congress established the CAP as an alternative payment methodology to ASP for Part B drugs. A physician could acquire certain Part B drugs either under the traditional buy and bill model or from CAP vendors under contract with CMS. In a 2005 interim final rule, CMS revised the definition of "unit" to state that "the method of counting units excludes units of CAP drugs … administered to a beneficiary by a participating CAP physician."[149]

CMS could thus invoke this same "counting units" authority to exclude MFP units from ASP to avert the impact of reduced reimbursement rates on providers and patient access. CMS could then amend the definition of a "unit" in 42 C.F.R. § 414.802 to specify that for selected drugs, "units" also excludes units priced at MFP (or for which the manufacturer provided a refund to reduce the provider's net price to MFP) to meet the MFP access requirements under the IRA.

Defining a Standard Default Refund Amount for Medicare Part B Drugs

PhRMA appreciates CMS' solicitation of comments in section 40 regarding whether the MTF DM should include a standard default refund amount (SDRA) among the claim-level data elements shared with manufacturers and how such SDRA could be calculated.

As PhRMA has previously discussed with CMS, we continue to believe that deciding on a formula to define the SDRA is more complicated for Part B covered drugs than under Part D. In Part D, Wholesale Acquisition Cost (WAC) provides a natural anchor that ensures sufficient access to the MFP for the vast majority of pharmacies and other dispensers.[150] By contrast, there is not as clear of a pricing metric that would work for the vast majority of providers for Part B drugs. From our conversations with members, we believe that provider acquisition cost can be significantly further below WAC than pharmacy acquisition cost, making WAC a poor choice for a Part B SDRA.

PhRMA continues to discuss with our membership a number of options for how to define a Part B SDRA and we will provide separate, additional comments on this topic to CMS as soon as possible.

Claim-level Data Elements Needed for Medicare Part B Effectuation

PhRMA appreciates CMS' solicitation of comments regarding considerations for claim-level data elements pertaining to selected drugs payable under Medicare Part B.

We believe that the claim-level data fields that will already be provided from the MTF DM for selected drugs covered under Part D should also be provided for selected drugs covered under Part B (including NDC codes, as we discuss in more detail later in this appendix). However, given differences in claims

[148] SSA § 1847A(b)(2)(B); after 2004, "[t]he Secretary may establish the unit for a manufacturer to report and methods for counting units as the Secretary determines appropriate to implement this section."
[149] 70 Fed. Reg. 70,478, 70,481 (Nov. 21, 2005) (amending 42 C.F.R. § 414.802).
[150] Based on NADAC surveys, on average, pharmacies purchase brand single-source drugs for about 4 percent below WAC. *See* https://www.medicaid.gov/medicaid/prescription-drugs/downloads/retail-price-survey/nadac-equiv-metrics.pdf.

and reimbursement between the two programs, some additional data fields will be required for Part B drugs. Specifically, at a minimum, ***PhRMA strongly encourages CMS to provide the following additional fields to manufacturers on a detailed claim-level basis for provider-administered drugs covered under both the Part B FFS program and MA:***

- Medicare Advantage Plan ID (for MA only);
- HCPCS Code (J-Code/Q-Code) and the NDC-11;
- Claim Number (would replace the Prescription/Service Reference Number field);
- Unit of Measure;
- Date of Administration (would replace Date of Service);
- 340B Covered Entity ID/NPI;
- Place of Service code;
- 340B Claims Modifier Field ("TB" modifier);
- Vial Wastage Modifier Field ("JW" and "JZ" modifiers); and
- "UD" Modifier Field.

One distinction for drugs payable under Part B is that CMS already requires the use of the "TB" modifier to identify 340B eligible units in the Part B FFS program. Given the statutory prohibition in the Act for duplicate 340B and MFP discounts, the "TB" modifier field should be provided to manufacturers to assist in deduplication. PhRMA continues to have significant concerns, however, that all prescriptions subject to a 340B agreement may not be appropriately captured. As noted in prior comments to the Agency, PhRMA requests that CMS also add a non-340B modifier (similar to the addition of the "JZ" modifier to indicate no discarded units), such that Part B claims cannot be silent on whether a 340B determination was made. CMS also should require the use of the "TB" modifier and a non-340B modifier by providers seeking reimbursement under MA, which we discuss in more detail below.

Finally, ***we continue to urge CMS to establish a claims-data repository or clearinghouse to identify 340B prescriptions dispensed or administrated to beneficiaries*** and to share this critical identification data with Primary Manufacturers. This is particularly crucial for Part D given the lack of a mandatory claims modifier but would also be useful for Part B drugs.

Providing Access to the MFP in Medicare Advantage for Provider-Administered Selected Drugs

Effectuating the MFP for provider-administered selected drugs furnished to MA enrollees will present some unique considerations that CMS will need to address. First, a critical component of MFP effectuation in both Part B and Part D is the provision of claims data to verify a selected drug has been administered or dispensed to a Medicare beneficiary. Under Part D, claims data are already being reported to CMS by Part D plan sponsors in the form of Prescription Drug Event (PDE) data, and under Part B FFS, the Medicare Administrative Contractors (MACs) likewise already receive claims data from providers and could provide these data to the MTF DM. However, CMS currently has limited visibility into MA claims. CMS does receive MA Encounter Data, but these data can be reported with a significant timing lag (over a year).[151] This significant lag would prevent prompt payment of MFP refunds to providers serving MA patients. ***We thus strongly recommend that CMS require MA plans to submit***

[151] See 42 CFR 422.310(g) and CMS. Encounter Data Submission and Processing Guide. (May 2025). Version 5.2. Available at: https://www.csscoperations.com/internet/csscw3_files.nsf/F2/ED_Submission_Processing_Guide_20221130_v5.2.0.pdf/$FILE/ED_Submission_Processing_Guide_20221130_v5.2.0.pdf.

claims data to the MTF DM on a more frequent basis for purposes of MFP effectuation, and PhRMA believes CMS can rely on various authorities to do so.[152]

Second, CMS must address how it will identify and handle claims for 340B drugs administered to Part B MA beneficiaries. The "TB" 340B claims modifier is not currently required on provider claims to MA plans. ***PhRMA strongly encourages CMS through future guidance or rulemaking to require MA plans to require 340B covered entities participating in their networks to utilize the "TB" modifier,*** and we believe CMS has the authority to do so effective for IPAY 2028.[153] As we have noted to CMS previously (and discuss in more detail below in the Part D effectuation section of this technical appendix), under the existing 340B replenishment model, chargeback requests are made at the package level, not at the individual claim level. As such, manufacturers have, at best, very limited insight into whether 340B replenishment requests contain underlying Medicare administrations. Thus, in the absence of a claims modifier or other method for identifying individual 340B claims (such as a claims repository), manufacturers will be unable to avoid 340B/MFP duplicate discounts in MA. ***CMS should also require the use of a non-340B modifier, as well, such that a clear 340B determination is made for each MA and FFS claim.***

Other Part B Effectuation Recommendations

Timing of Manufacturer MFP Refund Payments

PhRMA recommends that manufacturers have 30 days from the receipt of claims data to make the MFP available to providers for selected Part B drugs. This would align with the current timing required for CMS to reimburse providers under Part B and would thus mirror CMS' determination of the reimbursement timeline in Part D (Part D plans have 14 days to pay pharmacies from the receipt of a clean claim, which CMS pointed to in establishing the 14-day prompt MFP payment window for manufacturers).

Manufacturer Compliance and Oversight

PhRMA appreciates CMS' solicitation of comments in section 90 of the Draft Guidance on the types of information that should be included in the MFP Effectuation Plans for drugs payable under Part B, and how the requirements may need to differ from what is outlined for selected Part D drugs. PhRMA generally recommends that the MFP Effectuation Plan process remain highly similar across Part B and Part D selected drugs. However, PhRMA will require more detailed information about the effectuation process for drugs payable under Part B in order to provide meaningful comment.

Moreover, PhRMA would note a similar response to the comment solicitation regarding the complaints and dispute process for Part B selected drugs and how it may (or may not) need to differ from the process for Part D selected drugs. Again, while we generally believe that the process should be as similar as possible for Part B drugs as Part D drugs, PhRMA reiterates that we will require more information regarding the effectuation process for drugs payable under Part B in order to provide meaningful comment on this issue.

[152] *See, e.g.,* SSA §§ 1853(a)(3)(B), 1857(e); 42 C.F.R. §422.310.
[153] *Ibid.*

II. Sections 40.4 and 90 – Effectuation for Drugs Covered under Part D

Potential Private Market Solutions

PhRMA appreciates CMS' solicitation of comments on potential private market solutions that could offer an alternative to the MTF. However, ***we continue to believe that the best, least burdensome, and most efficient way to effectuate the MFP would be for CMS to utilize an approach similar to the Part D Coverage Gap Discount Program (CGDP), including pass-through of CMS pre-funded MFP refund amounts to dispensers on behalf of Primary Manufacturers at the time of claim adjudication with manufacturers invoiced at a later date.*** We urge CMS to consider this approach for IPAY 2027 and subsequent years. Because of the risk of 340B/MFP duplicate discounts under any approach to effectuation***, we continue to note that effectuation models must include a solution on identifying 340B claims to be consistent with the statute***.

While we are aware of several entities that are working to develop private market solutions, our understanding is that none of these solutions will be able to transmit MFP refund payments from manufacturers to dispensers before mid-2026 at the earliest and none currently offer an "end-to-end" solution that could replace the capabilities of the MTF DM and PM. In addition, with the start of IPAY 2026 still six months away, neither CMS nor any supply chain stakeholders have any experience to draw upon with regards to MFP effectuation or the functioning of the MTF DM or PM, let alone how the MTF DM and PM will work for Part B covered selected drugs for IPAY 2028. Thus, we believe the Agency's solicitation on private market solutions is premature. We would recommend that the Agency wait until at least after IPAY 2028 concludes before seeking feedback on whether private market alternatives could provide a meaningful option for MFP effectuation.

More broadly, PhRMA again stresses that CMS should also build in substantial lead-time if it intends to impose significant new requirements or expectations on manufacturers with respect to MFP effectuation.

PhRMA also remains concerned with the Agency's continued interpretation of the IRA as placing "sole responsibility" to provide access to the MFP on manufacturers, yet at the same time, placing strict requirements on manufacturers if they choose to use an approach outside the MTF PM. For example, CMS is maintaining the requirement for manufacturers to transmit payment to dispensers within 14 days from receipt of MTF DM claim data even if a pharmacy and manufacturer have agreed to a different timeline under an alternative arrangement. Given the Agency's repeated statements that it is "sole responsibility" of manufacturers to provide access, then for arrangements outside of the MTF PM, CMS should defer to terms governing pharmacy and manufacturer agreements.

Section 40.4.1 – Retrospective Refund Amount to Effectuate the MFP and the Standard Default Refund Amount

Making the SDRA a True Default

PhRMA appreciates the Agency's continued support on defining an SDRA for Part D covered drugs as the difference between the wholesale acquisition cost (WAC) and the MFP for a selected drug. We believe the ability to utilize an SDRA will bring significant efficiencies to both Primary Manufacturers and dispensers in effectuating the MFP.

However, ***we continue to urge CMS to further solidify use of the SDRA by making it a true default.*** While CMS notes that the Agency believes "using WAC to calculate an SDRA generally *best approximates* the acquisition costs of dispensing entities and offers a *reliable refund amount* for both manufacturers and dispensing entities,"[154] (emphasis added) the Agency in the very same sentence indicates that the SDRA is for manufacturers and dispensing entities that "agree to use such standardized pricing."

A key goal of establishing an SDRA is to reduce stakeholder burden by allowing the MFP refund to be easily defined by a method that results in a sufficient MFP refund and that does not require entity-by-entity negotiation or agreement. Otherwise, the SDRA (which has "default" in its name) is hardly a default under either the dictionary definition or common understanding of the word. ***CMS should explicitly allow Primary Manufacturers to assume the SDRA is sufficient to provide the dispenser access to the MFP for the selected drug.*** This would reduce burden on both Primary Manufacturers and dispensers by lessening the situations where dispensers would need to engage in the process of coming to an agreement with Primary Manufacturers. Further, because CMS acknowledges that the SDRA best approximates acquisition costs, dispensing entities claiming acquisition costs beyond the SDRA could be required to provide documentation and explanation for such claims.

Dispenser Acquisition Costs that Exceed WAC

PhRMA continues to have significant concerns with the Agency's implication that the SDRA may not be sufficient to provide access to the MFP. We note that the Draft Guidance includes new language specifying that when CMS is determining whether a manufacturer has provided access to the MFP, the Agency "will undertake a fact-specific assessment that will consider…. whether the retrospective refund amount… is sufficient to account for commercially reasonable costs the dispensing entity is likely to encounter in the supply chain…."[155] While we recognize the Agency's concern that not all dispensers are able to acquire drugs at or below WAC, we continue to believe this is a small minority of dispensers. Further, the Draft Guidance could undermine the integrity of the program by creating adverse incentives for dispensers and others in the pharmaceutical supply chain to improperly increase profits through arrangements that artificially increase MFP refund amounts.[156]

Concerns with potential manipulation of prices and profits are not hypothetical, as instances of stakeholders artificially increasing costs to others in the supply chain are abundant. For example, until CMS prohibited the practice beginning in January 2024, Part D plan sponsors could enter into arrangements with pharmacies that resulted in the Part D negotiated price being higher than the final

[154] Draft Guidance at 58.
[155] Draft Guidance at 165.
[156] For example, consider an illustrative selected drug with a WAC of $100 and an MFP of $40. Wholesaler A typically purchases the selected drug from the Primary Manufacturer at a price of $96, and Dispenser B typically purchases the selected drug from Wholesaler A at a price of $98. Utilizing the SDRA, the Primary Manufacturer would owe an MFP refund of $60, giving Dispenser B a margin of $2 on the transaction (excluding dispensing fees) and Wholesaler A likewise a margin of $2. However, consider that Dispenser B could enter into an arrangement with Wholesaler A to acquire the selected drug at a cost of $120. The Primary Manufacturer would then owe an MFP refund of $80. If Wholesaler A agrees to retrospectively refund $10 of the acquisition price to Dispenser B, Wholesaler A would earn a margin of $14 and Dispenser B could earn a margin of $10 (excluding dispensing fees), substantially higher than before.

payment from the Part D plan sponsor to the pharmacy.[157] The resulting inflated negotiated price increased costs to the federal government in the form of higher low-income subsidies, to manufacturers in the form of higher Part D coverage gap discounts, and to beneficiaries with coinsurance in the form of higher cost sharing, as all of these figures are calculated based on the Part D "negotiated price."

Thus, PhRMA remains concerned, based on past precedent, about exposing Primary Manufacturers to significant risk of having to pay artificially inflated MFP refund amounts (and of the program integrity spillover effects for CMS if the Program becomes a vehicle for inflating revenues in the supply chain). We therefore recommend that CMS take the following actions in final guidance:

- ***Specify the type of documentation that a dispenser must provide to a Primary Manufacturer if the dispenser is seeking an MFP refund calculated on a basis other than the SDRA.*** Specifically, this documentation should cover not only the acquisition cost to the dispenser (net of all price concessions) but should also disclose any business arrangements or ownership arrangements between the dispenser and the entity they are purchasing the selected drug from.
- ***Track which dispensers or types of dispensers are claiming acquisition costs above WAC.*** If CMS notices an increasing trend in these arrangements, the Agency should publicly report it to increase awareness among policymakers and stakeholders and engage in dispenser audits to ensure dispensers or other supply chain entities are not inappropriately profiting by inflating MFP refund amounts.

Section 40.4.2.1 – Primary Manufacturer Participation in the MTF DM

Treatment of Claims with DDPS Edits

PhRMA supports the Agency's proposed approach to handling claims with DDPS edits and agrees with the proposed listing of DDPS edits impacting MFP eligibility included in Appendix B of the Draft Guidance. We believe CMS' proposed approach fairly balances the interests of both dispensers and manufacturers.

However, PhRMA is concerned that the definition of "Invalid" for certain fields listed in Appendix B of the Draft Guidance may be too narrow for the purposes of appropriately calculating the correct MFP refund payment amount. For example, a quantity of 1,200 tablets for one prescription of a selected drug that is more commonly dispensed as a quantity of 120 is clearly an error. But, the quantity of 1,200 tablets is greater than 0.001, which means it would seem to be considered valid for the purposes of the DDPS transmitting the claim to the MTF DM under CMS' proposed approach. In this situation, the manufacturer would be responsible for a very large MFP refund outlay and would then have to wait for the error to be resolved by the Part D plan and pharmacy before receiving an adjustment. ***Given this, we ask that CMS broaden the interpretation of edits related to MFP eligibility to also include outliers identified by DDPS that impact payment by the Part D plan.*** In other words, claims identified as having an outlier value for a field listed in Appendix B would also not be transmitted to the MTF DM until the outlier value is resolved.

[157] CMS. Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency. Final Rule. May 9, 2022. Available at: https://public-inspection.federalregister.gov/2022-09375.pdf.

We also encourage CMS, through coordination between the DDPS and MTF DM, to allow dispensing entities to track when claims have been transmitted from the DDPS to the MTF DM and to Primary Manufacturers. Until a Primary Manufacturer receives claims data from the MTF DM, they will be unable to respond to any dispensing entity inquiries on a given claim. By sharing the status of claims transmission, CMS can improve transparency, reduce premature inquiries, and reduce stakeholder burden.

Clarification on Timing for MFP Refund Payments

PhRMA strongly urges CMS to modify its current technical guidance that the 14-day prompt MFP payment deadline remains unchanged even if the due date falls on a weekend or holiday.[158] Specifically, we ask that CMS instead specify that if the 14-day prompt MFP payment window deadline falls on a Saturday, Sunday, or holiday, the payment deadline is extended to the first business day thereafter. This would align with manufacturer payment requirements under the Part D Manufacturer Discount Program,[159] as well as with other federal standards governing prompt pay terms.[160] Wire transfers for electronic payments cannot be processed on weekends or holidays given that the US Automated Clearing House (ACH) Network only operates on business days,[161] creating the need for CMS to establish appropriate deadlines.

Section 40.4.2.2 – Dispensing Entity Enrollment in the MTF DM

Dispensing Entities with Material Cashflow Concerns

While PhRMA shares the Agency's goal of ensuring dispensers are paid promptly, we continue to believe that the best way to alleviate pharmacy cashflow concerns would be for CMS to utilize an approach similar to the Part D CGDP, including pass-through of CMS pre-funded MFP refund amounts to dispensers on behalf of Primary Manufacturers at the time of claim adjudication with manufacturers invoiced at a later date. As noted above, we continue to urge CMS to consider this approach for IPAY 2027 and subsequent years.

PhRMA continues to have concerns with the requirement to develop mitigation plans for pharmacies self-identifying as having material cashflow concerns. Again, while we share the Agency's goal of prompt pharmacy payment, there is no statutory basis for the requirement, and the lack of quantifiable standards for which pharmacies can self-identify creates significant difficulty for manufacturers in making determinations about which dispensers are most in need of assistance.

To allow manufacturers to better target mitigation plans, CMS should affirmatively acknowledge that Primary Manufacturers are permitted to require that any pharmacies claiming material cashflow concerns provide documentation to Primary Manufacturers to support such claims.

Section 40.4.3.1 – Required Primary Manufacturer Reporting of Claim-Level Payment Elements for MFP Refund Payments When a Primary Manufacturer Passes Payment through the MTF PM

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[158] CMS. (May 2025). Medicare Transaction Facilitator: Manufacturer Frequently Asked Questions. Available at: https://www.cms.gov/files/document/manufacturer-technical-faqs.pdf.
[159] CMS. (December 2024). Revised Medicare Part D Manufacturer Discount Program Final Guidance. Available at: https://www.cms.gov/files/document/manufacturer-discount-program-final-guidance.pdf.
[160] *See e.g.* Code of Federal Regulations. Title 5, Chapter III, Subchapter B, Part 1315. Available at: https://www.ecfr.gov/current/title-5/chapter-III/subchapter-B/part-1315.
[161] Nacha. The ABCs of ACH. Available at: https://www.nacha.org/content/abcs-ach.

Transaction Codes for Manufacturer Claim-level Payment Elements

In the Draft Guidance, CMS notes that a manufacturer should use Payment Code "4" to indicate that no MFP refund is being transmitted on a given claim because the claim is 340B-eligible and the 340B ceiling price is below the MFP. However, a drug's 340B ceiling price can also be equal to the MFP or, under certain circumstances, higher than the MFP. PhRMA is concerned that the Draft Guidance fails to account for the combined requirements across section 1193(d)(1) *and* section 1193(d)(2) of the Act. Thus, we strongly urge CMS to:

- Expand Payment Code "4" to include the scenario where the 340B ceiling price is equal to the MFP; and
- Add an additional Payment Code to address the scenario where the 340B ceiling price is higher than the MFP to indicate that a manufacturer is transmitting less than a full MFP refund amount. Specifically, the manufacturer's MFP refund amount in this scenario should be the difference between the 340B ceiling price and the MFP.

More detail is provided on these recommendations below.

PhRMA also remains highly concerned about CMS' refusal to play a role in identifying and deduplicating 340B claims, with CMS stating in the Draft Guidance that the Agency "will not, at this time, assume responsibility for deduplicating discounts between the 340B ceiling price and MFP."[162] Under the current 340B replenishment model used by the majority of covered entities, manufacturers have, at best, very limited insight into whether 340B replenishment requests contain underlying Medicare dispenses, which creates a significant risk of duplicate 340B and MFP discounts despite the IRA's statutory prohibition.[163]

Under the 340B replenishment model, the pharmacy or provider will track, typically with a computerized system, units of medicines dispensed or administered to individuals who the covered entity or its third-party administrator classifies as 340B-eligible patients. When a certain threshold of units is reached, the pharmacy or provider places an order to replenish that stock at the discounted price.[164] A manufacturer will provide access to the 340B price on the replenishment order through a wholesaler chargeback. However, requests for chargebacks are at the package level, and typically do not contain information about the individual prescriptions underlying the replenishment request. As an example, a 340B covered entity could seek to replenish a 900-tablet bottle of a selected drug at the 340B price. Underlying that request are prescriptions filled for 340B patients with a variety of insurance coverage, but the manufacturer will not know which, if any, of those prescriptions were filled by Part D beneficiaries. Indeed, laws in at least eight states[165] include express provisions prohibiting manufacturers from requiring claims data from 340B covered entities as a condition of providing access to the 340B price. This makes it extremely difficult, if not impossible, for manufacturers to avoid the risk of 340B/MFP duplicate discounts.

[162] Draft Guidance at 96.
[163] By discussing the replenishment model used by covered entities, we do not mean to imply that that the model is consistent with the 340B statute.
[164] For an overview of the replenishment model, as utilized by contract pharmacies in the 340B program, please see: OIG. (February 2014). Memorandum Report: Contract Pharmacy Arrangements in the 340B Program. Available at: https://oig.hhs.gov/oei/reports/oei-05-13-00431.pdf.
[165] Colorado, Nebraska, New Mexico, North Dakota, South Dakota, Tennessee, Utah, and West Virginia.

While we continue to urge CMS to facilitate deduplication of statutorily prohibited 340B/MFP claims, such as through a claims repository with mandatory reporting or through HHS not blocking manufacturers from offering the 340B price as a rebate, in the interim, we recommend CMS adopt a clear way for manufacturers to address the 340B/MFP duplicate discounts they can identify, such as by expanding the Payment Codes to cover situations where the 340B ceiling price is equal to or higher than the MFP.

Specifically, as noted above, we ask that CMS expand Payment Code "4" to include the scenario where the 340B ceiling price is equal to the MFP. If a manufacturer can utilize Code "4" both where the 340B ceiling price is equal to or lower than the MFP refund, the manufacturer can continue to provide access to the 340B price while avoiding a duplicate 340B/MFP discount. We believe the expansion of Code "4" to include the scenario of the 340B ceiling price equaling the MFP is consistent with the requirements of sections 1193(d)(1) and 1193(d)(2) of the Act.

PhRMA also recommends that CMS expand the existing list of Payment Codes to address the scenario where the 340B ceiling price is higher than the MFP. The new code would recognize that manufacturers have calculated the MFP refund as the difference between the higher 340B ceiling price and the MFP.[166] Section 1193(d)(2) of the Act states that a manufacturer of a selected drug "shall be required to provide access to the maximum fair price to such covered entity with respect to maximum fair price eligible individuals… at such [340B] ceiling price in a *nonduplicated amount to the [340B] ceiling price* if such maximum fair price is below the ceiling price for such selected drug" (emphasis added). But the existing Payment Element Codes established by CMS do not seem to contemplate this scenario. And again, because manufacturers typically lack the information necessary to exclude individual prescriptions from a replenishment chargeback request, there is a high likelihood that, without further due diligence by CMS in designing the MTF system, a manufacturer will pay both an MFP refund and provide access to the 340B ceiling price on the same claim. If manufacturers can provide access to the MFP in this scenario by paying the difference between the higher 340B ceiling price and a lower MFP, while still providing the 340B covered entity with access to the 340B price, this could assist in preventing a duplicate discount.

MTF DM Receipt File

In the Draft Guidance, CMS notes that, for informational purposes, the MTF DM will issue a receipt file to Primary Manufacturers that elect to participate in the MTF PM. We appreciate CMS' solicitation of comments on content for the receipt file that would be informative for Primary Manufacturers.

PhRMA believes the following data elements would be crucial to include in such a receipt file:

- Record ID;
- Whether payment was made via ERA or remittance (paper check);
- Method for determining MFP refund amount;
- Amount of payment sent as the MFP refund:
    - Amount exclusive of any credits;
    - Amount of any credits applied; and
    - Net amount of payment sent as the MFP refund.
- Transaction code;

[166] This could also be addressed by amending the existing Payment Code "2".

- Date of service (date prescription was dispensed); and
- Date and timestamp of MFP refund payment initiation by the MTF PM.

Section 40.4.3.2 – Primary Manufacturer and MTF PM MFP Refund Payment Adjustments due to Claim Amendments Through the MTF PM

Claim Adjustments and Reversals

PhRMA requests that the MTF not automatically apply credits and debits, as this could create difficulties with manufacturers' ability to reconcile to MFP refund payments. Instead, notification of credits and debits should first be shared with Primary Manufacturers, as manufacturers must have the opportunity to validate pricing and payment values prior to credit/debit application. Or at a minimum, if the MTF is automatically applying credits and debits, Primary Manufacturers must have full transparency into the underlying original MFP refund claim. This approach will improve data integrity and reduce reconciliation discrepancies between CMS and manufacturers.

Credit/Debit Ledger and Manufacturer Termination of Participation in the MTF PM

Given the potentially long run-out period on claims, PhRMA recommends that manufacturers terminating participation in the MTF PM maintain access to the credit/debit ledger, including to accruals of credits and debits, during the run-out period for claims initiated while the manufacturer was still participating in the MTF PM.

In addition, PhRMA urges CMS to develop a process for manufacturer reimbursement in situations where there are insufficient MFP refund claims against which to apply accrued credits. This scenario may occur, for example, when a generic or biosimilar competitor has come to market, but due to timing, the brand is still a selected drug. We would be happy to engage with CMS on how best to address this issue.

Finally, PhRMA again encourages CMS to provide access to the credit/debit ledger system to manufacturers that choose to utilize alternative arrangements outside the MTF PM to provide access to the MFP. Because manufacturers using alternative arrangements will still be reporting claims-level payment information to the MTF DM, this information can be used to populate a simple, non-dynamic credit/debit record system. While we understand the credit/debit ledger system could not be used to alter the actual payments from manufacturers utilizing alternative arrangements, it will still be useful to manufacturers in having a central record of payments within the MTF system.

Section 40.4.5 – Nonduplication with 340B Ceiling Price

As discussed above, PhRMA has significant concerns with the Agency's current intention not to play a role in deduplicating MFP and 340B discounts. Duplicate MFP and 340B discounts are clearly prohibited under the IRA, yet under the current 340B replenishment model used by the majority of covered entities, manufacturers have, at best, very limited insight into whether 340B replenishment requests contain underlying Medicare dispenses. To improve program integrity and avoid forcing manufacturers to make an MFP effectuation payment prior to knowing a drug's 340B status, potentially violating the IRA's nonduplication provision, CMS must ensure that manufacturers receive timely and accurate information about 340B units in order to deduplicate 340B and MFP discounts. For this reason, CMS should establish a claims repository and utilize mandatory and enforceable claim modifiers for 340B covered entities (CEs). Or alternatively, we continue to maintain that HHS should not block manufacturers from offering

the 340B price as a rebate, which would ensure manufacturers have crucial claims data to prevent duplication of MFP/340B discounts in the absence of HHS action. If CMS fails to prevent prohibited duplicate 340B/MFP discounts, this could create an unsustainable burden on manufacturers, as well as undermine program integrity and add to the already ongoing waste, fraud, and abuse that has plagued the 340B program.

Requiring 340B CEs (or entities acting on their behalf, such as third-party administrators, or TPAs) to submit claim-level data[167] to a neutral claims repository could provide CMS with the information necessary to efficiently identify duplicate 340B and MFP discount requests. CMS could also utilize this data to remove identified 340B-eligible units from the Part D inflation rebate, which the IRA also requires, effective January 1, 2026.

Mandatory 340B claim modifiers, appended at or soon after drug dispense or administration, could also be an effective methodology for identifying 340B-eligible units in Part D if CMS enforces compliance with such a requirement. However, PhRMA maintains significant concern that modifiers, even when mandatory, do not identify all 340B-eligible units, because available evidence suggests CEs may fail to comply with existing 340B modifier requirements under Medicare Part B and manufacturers are ill-equipped to police this type of CE non-compliance. For example, a 2023 report by IQVIA found that only 61 percent of administrations of Part B separately payable drugs originating at rural referral centers and sole community hospitals used a relevant 340B modifier,[168] a highly concerning result given that CMS required these entities at the time of the study to use the "JG" and "TB" modifiers[169] on claims seeking Medicare Part B payment for a 340B-acquired drug. While there are situations where it is appropriate for CEs not to use the relevant 340B claims modifiers,[170] a finding of 61 percent modifier usage seems outside the bounds of expected utilization when by comparison, IQVIA found that 89 percent of administrations of Part B separately payable drugs originating at 340B disproportionate share hospitals used a relevant modifier.[171] Since the requirement to use either the "JG" or "TB" modifiers applies equally to disproportionate share hospitals, rural referral centers, and sole community hospitals, PhRMA would have expected more similar modifier utilization.

Department of Health and Human Services (HHS) Enforcement

In recognition of CMS' position that it "will not, at this time, assume responsibility for deduplicating discounts between the 340B ceiling price and MFP"[172] and will not require dispensers to indicate to Primary Manufacturers which selected drug claims are for 340B-eligible units,[173] ***PhRMA urges HHS to exercise enforcement discretion with respect to Primary Manufacturers' deduplication efforts.***

[167] For example, claim-level data could include the prescription reference number or claim number, prescribed date, date of service, NDC, quantity dispensed, the BIN/PCN of the beneficiary' prescription drug insurance, National Provider Identifier (NPI) of the dispensing pharmacy, 340B number and name of the CE, wholesaler invoice number, and any utilized 340B claim modifier.
[168] IQVIA. (February 2023). Can 340B Modifiers Avoid Duplicate Discounts in the IRA? Available at: https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2023/can-340b-modifiers-avoid-duplicate-discounts-in-the-ira.pdf.
[169] Per the CY 2024 OPPS/ASC final rule, effective January 1, 2025, CMS will require all 340B CEs to use the "TB" modifier.
[170] For example, if the CE is able to purchase the drug at a lower price than the 340B price, or if the state is claiming a Medicaid rebate on the drug, the CE would not claim the 340B discount and not utilize the relevant modifier on the Part B claim.
[171] IQVIA. (February 2023). Can 340B Modifiers Avoid Duplicate Discounts in the IRA? Available at: https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2023/can-340b-modifiers-avoid-duplicate-discounts-in-the-ira.pdf.
[172] Draft Guidance at 96.
[173] Draft Guidance at 66.

Specifically, HHS should not pursue enforcement against a Primary Manufacturer under the agencies' respective IRA and section 340B authorities if the Primary Manufacturer can demonstrate it has engaged in reasonable, good faith efforts with a covered entity to fulfill the manufacturer's obligations under section 1193 of the SSA and section 340B(a)(1) of the PHS Act, as applicable. As noted above, the prevailing 340B replenishment model presents significant challenges to appropriately identifying individual prescription claims that are the basis for CE replenishment requests at the applicable 340B price. If 340B CEs and other prescription drug supply chain stakeholders do not work in good faith with a Primary Manufacturer to identify which selected drug claims are for 340B-eligible units, then a Primary Manufacturer should not be subject to an HHS enforcement action if the manufacturer, despite its reasonable, good faith efforts, is unable to provide access to the 340B ceiling price or MFP.

In addition, PhRMA strongly recommends that ***HHS promote program integrity by taking steps to ensure 340B CEs do not claim duplicate 340B and MFP discounts.***

Finally, we continue to urge that CMS should consider whether the claim is subject to the 340B de-duplication exception under Section 1193(d)(1) of the Act, which could appropriately exempt it from an MFP refund obligation, when assessing whether the MFP was made available.

III. Section 60 – Establishment of a Single MFP and Ceiling Price under the Negotiation and Renegotiation Process

Calculating a Single Ceiling Price and MFP

PhRMA appreciates the Agency's solicitation for comment in section 60 of the Draft Guidance regarding the calculation of a single MFP and ceiling price.

PhRMA has numerous significant concerns with CMS' current approach to the calculation of a single ceiling price and MFP based on a 30-day equivalent supply for drugs covered under Part D and the Agency's proposed approach for drugs covered under Part B. As detailed below, the reliance on claims data to establish the 30-day equivalent supply can lead to undervaluing of drugs, particularly those with more frequent recurring administrations. The 30-day equivalent supply approach is also ill-suited to drugs with variable dosing, for example with dosing that varies based on a patient's body weight or with dosing that varies based on the treatment phase of the condition. Given this, PhRMA strongly recommends that for both Part B and Part D drugs selected for IPAY 2028 and beyond CMS should:

- ***Maintain flexibility and work with Primary Manufacturers at the start of the negotiation process to align on the best analytical approach to calculating a single ceiling price and MFP for each selected drug, along with therapeutic alternatives.***
- ***Consider a per unit approach as a default methodology.*** A per unit approach could be the best method for many drugs, although does present challenges in certain circumstances.

If CMS continues with a 30-day equivalent supply approach (or for drugs where CMS and the Primary Manufacturer agree that a 30-day equivalent supply approach is best), we urge CMS to make a number of changes to its current methodology, including ***utilizing labeled dosing regimens as opposed to claims data, dividing all days supplied and days-in-between values by 30, and to work with Primary Manufacturers to appropriately adjust the MFP for drugs with non-linear pricing per unit.***

A number of PhRMA's concerns with the Agency's current 30-day equivalent supply approach could be well addressed by the Agency moving to a per unit approach for drugs selected for IPAY 2028 and beyond, where a single ceiling price and MFP would be calculated per unit of a drug.[174] For example, we believe a per unit approach could be the best methodology for drugs with variable dosing, as a price per unit easily accommodates dosing that needs to change in strength or frequency. However, a per unit approach can also be inappropriate in certain scenarios. For example, a per unit approach may not be well-suited to Part B covered drugs reimbursed under multiple HCPCS codes where pricing per unit varies across codes. A per unit approach may also present challenges in comparing pricing for a selected drug with a therapeutic alternative if the therapeutic alternative is delivered as a different formulation, has different billable units, or requires different strengths. In these situations, using a 30-day equivalent supply approach to compare pricing between a selected drugs and its therapeutic alternative may be superior.[175]

Given the relative strengths and weaknesses of both approaches, as noted above, ***we urge CMS to be flexible and work with Primary Manufacturers to agree on the best approach to calculating a single ceiling price and single MFP for each selected drug starting with Part B and Part D covered drugs selected for IPAY 2028***. However, we believe that a per unit approach is likely the best method for many of the drugs the Agency will consider under the Program, and as such, could be established as a default.

More detail on our reasoning and recommendations is provided below.

There are several reasons why we believe a single ceiling price and single MFP per unit would be superior to calculating a single MFP per 30-day equivalent supply in most circumstances, and as such, should be the default methodology used by CMS. First, because CMS has relied on quantities dispensed (and proposes to rely on a similar approach for provider-administered drugs by calculating the average days between administrations) as opposed to FDA-approved dosing regimens, it is difficult for stakeholders to understand how CMS arrived at the publicly reported single MFP values. The majority of stakeholders lack access to the claim-level data necessary to replicate CMS' estimate of a 30-day equivalent supply, creating a lack of transparency for stakeholders and raising questions about program integrity.

Second, variations in quantities dispensed (such as starter packs, prescriptions filled at less than a typical supply due to unique patient treatment considerations, breaks in medication treatment due to surgical care, etc.) result in CMS establishing 30-day equivalent supplies that no patients actually take. For example, a selected drug meant to be taken as one tablet per day on an ongoing basis would typically be considered to have a 30-day equivalent supply of 30 tablets. But dispenses of lesser quantities of this same drug could lead to CMS estimating an average 30-day equivalent supply of, for hypothetical example, 28.3 tablets. No patient is actually prescribed 28.3 tablets, and as such, the single MFP reported by CMS

[174] We believe the unit could vary across selected drugs. For example, for a selected drug solely available as an oral solid, a single MFP per tablet/capsule could work well. By contrast, for a selected drug available as both an oral solid and oral liquid, a single MFP per milligram would be more appropriate. For drugs administered as reconstituted powders, a per unit of active ingredient approach may be best. But in varying the unit across drugs, it would then be crucial for CMS to include the definition of a unit for each selected drug in the publicly released MFP files to ensure program transparency.

[175] For selected drugs with therapeutic alternatives administered in the same form, a per unit approach can still be appropriate. However, CMS would need to be sure to then appropriately compare the therapeutic alternative to the selected drug, as dosages needed for clinical effectiveness can differ across therapies. For example, if a selected drug is administered as 5ml per week and its therapeutic alternative is administered as 10 ml per week, CMS would need to compare the price per ml for the selected drug against the price per 2ml of the therapeutic alternative to ensure an appropriate comparison.

carries very little value for patients or other stakeholders. If CMS believes that reporting a single MFP at the per unit level will not be meaningful for patients or other public stakeholders, the Agency could highlight the MFP for the most commonly dispensed package size or administered amount as part of its release of public MFP files.

Third, because the dosing and package size of medicines varies, CMS is already calculating a per unit MFP in addition to the single MFP per 30-day equivalent supply. This creates extra work for CMS staff that could be avoided by going straight to a per unit MFP calculation.

Fourth, the 30-day equivalent supply approach presents unique challenges for medicines with dosages that change based on body weight, indication, or the progression of treatment. For example, patients with different body weights will require different amounts of insulin over a period of 30 days for the treatment of Type I diabetes. Insulin dosing also varies depending on if a patient is using insulin to treat either Type I or Type II diabetes. And many cancer medicines and treatments for autoimmune diseases require more frequent administrations early on in the course of treatment versus less frequent administrations once a condition has been stabilized or reached a maintenance phase. Using a 30-day equivalent approach like CMS has been using for covered Part D selected drugs, and is proposing for covered Part B selected drugs, obscures these important differences in dosing and can lead to the undervaluing of medicines. By contrast, establishing a single ceiling price and MFP per unit preserves this variation in dosing much more accurately.

Fifth, the 30-day equivalent supply approach is particularly ill-suited to medications taken on an as-needed basis (such as rescue inhalers) or taken on an infrequent basis (such as long-acting injectables). Utilization of medicines taken on an as-needed basis can vary substantially between patients, and long-acting injectable administration can occur bi-annually or on an alternative frequency per year. Both of these situations lead to logically suspect results of 30-day equivalent supplies established based on average dispenses or the average of time in between administrations.

Given all of the reasons above, we believe CMS calculating a single ceiling price and MFP per unit would be a superior approach, and as such, should be the default methodology. However, we again note that because a per unit approach can present challenges in certain situations, CMS should maintain flexibility and should work with Primary Manufacturers to assess whether a per unit approach or 30-day equivalent supply approach would be best for a particular selected drug.

For selected Part B and Part D covered drugs where the Agency and Primary Manufacturer agree that a 30-day equivalent supply approach is more appropriate (or if CMS continues with a 30-day equivalent supply approach across all selected drugs), we strongly recommend the following changes for both Part D and Part B covered drugs:

- ***CMS should use FDA-approved dosage regimens to set 30-day equivalent supplies for Part B and Part D covered drugs.*** If CMS does not use approved dosage regimens, then CMS should ensure that the Agency's calculations of 30-day equivalent supplies do not exceed FDA-approved dosage regimens for selected drugs.
- ***CMS should always divide the days supplied (or days-between-service for Part B covered drugs) by 30 to establish a 30-day equivalent supply.*** Treating all drugs with a days supplied of less than or equal to 34 as one 30-day supply, as CMS does currently for Part D covered drugs

and is proposing for Part B covered drugs, can result in significantly undervaluing drugs with more frequent administrations. For example, consider an oncology drug that is infused once every 14 days. CMS is proposing to treat each administration of this drug as one 30-day supply, when in reality, a patient taking this drug will receive on average 2.14 administrations each 30 days. If CMS instead were to divide the 14 days by 30, it would give CMS the much more accurate result that each administration of this drug represents 0.467 30-day equivalent supplies. This approach would also align with CMS' existing methodology for drugs with a days supplied that exceeds 34.[176]

- ***Prior to the start of the negotiation process for a given selected drug, CMS should speak with the Primary Manufacturer and other stakeholders about existing approaches to calculating 30-day equivalent supplies.*** Manufacturers have significant experience with calculating 30-day equivalent supplies under certain state drug price transparency reporting requirements, and there are certain vendors that assist manufacturers with these calculations. We suggest that CMS speak with manufacturers and these vendors to better understand how 30-day equivalent supplies are calculated for medicines, particularly medicines falling into one of the more complicated situations described above, such as medicines with dosages that vary by indication or during the course of treatment. For example, for drugs with dosages that vary by the patient's weight, manufacturers today can calculate 30-day equivalent supplies by relying on the average weight of patients.

- ***CMS should provide greater transparency into how it calculates the single MFP for each selected drug and how it calculates the starting point for negotiation.*** This is particularly the case if CMS utilizes different approaches for different selected drugs. But even if CMS maintains the 30-day equivalent supply approach, CMS should report the estimated 30-day equivalent supply as part of the publicly released MFP files, along with the underlying calculation inputs to show how the MFP per package (and per HCPCS code for Part B covered drugs) was calculated.

Requiring Reporting of NDC Codes for Part B Covered Drugs

PhRMA strongly encourages CMS to require the submission of NDC codes for reimbursement for selected drugs under Part B FFS and on MA claims effective for IPAY 2028.

Currently under Part B FFS, reimbursement of Part B covered drugs is handled at the HCPCS code level. For reimbursement, CMS publishes an ASP-based payment rate per HCPCS-code unit representing a potentially blended price across different strengths and package sizes. A provider then indicates on the claim the HCPCS code and number of billing units administered. A drug's NDC is not a required field for Medicare reimbursement for most covered Part B drugs.

However, MFP effectuation based on HCPCS codes may not produce a refund that provides reasonably accurate access to the MFP to the provider. For example, in some cases, a HCPCS code may include multiple single-source drugs (e.g. J9217, or all insulins which are grouped together under J1817). Only one of these drugs may be a selected drug, or the drugs may be separate selected drugs. In this situation,

[176] *See* 42 C.F.R. § 423.104(d)(2)(iv)(A)(2*)*; CMS. (June 2023). Medicare Drug Price Negotiation Program: Revised Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2026. Available at: https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf; Draft Guidance at 113.

the specific drug administered to the MFP-eligible individual could not be identified by the HCPCS code alone, so it would not be possible to determine if the individual received a selected drug (or which selected drug the individual received). To address this problem and establish the MFP refund amount, and indeed to ensure appropriate provider reimbursement, it will be crucial for CMS and manufacturers to know the underlying NDC of the medicine administered to the MFP-eligible beneficiary.

In addition, if CMS proceeds with calculating an MFP per 30-day equivalent supply, requiring reporting of NDCs would then avoid the agency having to estimate allocation of the HCPCS code 30-days supply to underlying NDCs.

Providers are already required to report the NDC for reimbursement under Medicare in certain circumstances (see the Medicare Claims Processing Manual, Chapter 26) and for other federal programs, such as Medicaid. As such, requiring providers to report the NDC more broadly on Medicare claims would not be a unique or unprecedented burden.

For these reasons, CMS should require the submission of NDC codes for reimbursement under Part B FFS and on MA claims through guidance and rulemaking effective for IPAY 2028.

IV. Section 100 – Civil Monetary Penalties and Failure of Manufacturer to Ensure Access to a Price Less than or Equal to the MFP in 2026, 2027, and 2028

PhRMA notes that CMS appears to have added a new example for "Violations of the Agreement" in Table 10, specifically the "[f]ailure to submit data requested by CMS in accordance with its oversight responsibilities under section 1196(b) of the Act." This open-ended language creates considerable uncertainty for primary manufacturers and should be struck or specified further so that manufacturers can anticipate the information that might lead to CMPs.

We also continue to urge CMS to ensure that no civil money penalties will accrue on manufacturers should CMS delays or technical difficulties cause the MTF DM or PM systems to encounter technical issues at the outset of IPAY 2026. As CMS acknowledges in section 40.4.3.2 of the draft guidance: "The precise process of authorization surrounding payment transfer continues to be developed." Given the uncertainty regarding payment transfer, CMS should affirmatively commit to hold harmless policies where payments are not transmitted, received, or logged due to events outside the control of the Primary Manufacturer. This would include delays in CMS notifying manufacturers of key systems requirements that must be met without sufficient time for manufacturers to build systems capabilities for those requirements. CMS could ensure that manufacturers are held harmless through specifying that the "additional context, evidence refuting the violation, proof of mitigation of noncompliance, and/or other factors for CMS' consideration," as specified in section 90.2 of the draft guidance will automatically include evidence, such as of MTF PM or MTF DM malfunction/delay and/or CMS introduction of new technical or substantive requirements.[177]

[177] In section 40.4.3.1 of the Draft Guidance, CMS recognizes that technical errors may cause delay, stating: "If the Primary Manufacturer is unable to transmit the claim-level payment elements, for example, if there is a technical breakdown in the transmission process, the Primary Manufacturer must continue to attempt to transmit the claim-level payment elements in good faith until successful transmission of the claim-level payment elements and must maintain documentation of the Primary Manufacturer's good faith effort in case there is a related complaint or dispute."

Appendix C: Access and Coverage

The Inflation Reduction Act (IRA) threatens the success of the Medicare Part D program's market-based prescription drug benefit through its introduction of government price setting. Along with broader IRA provisions, price setting is expected to erode the incentive structure that enables private sector negotiation, while doing little to address plan and pharmacy benefit manager (PBM) abuses that hinder patient access and raise out of pocket costs.[178,179] Thought leaders, clinicians, patients, and other stakeholders have raised serious concerns about increasingly restrictive trends in Medicare Part D formulary design and utilization management (UM)[180,181,182], and these concerns materialized in 2025 plan designs, from copayments to coinsurance trends,[183] combined with significant reductions in plan choices and higher premiums,[184] threaten affordable access to care for millions of beneficiaries.

This summer, CMS will review 2026 plan bids that reflect government price setting for the first time. As the Part D program approaches its 20-year anniversary, CMS must ensure it continues delivering affordable access to innovative, life-saving treatments for more than 50 million seniors and individuals with disabilities.

Although CMS has expressed concerns that Part D sponsors "may be incentivized in certain circumstances to disadvantage selected drugs" we remain concerned that CMS' existing formulary review process may not be sufficient to protect patient access.[185] As initial price applicability year (IPAY) 2028 will also see Part B drugs eligible for selection for the first time, PhRMA also has concerns about access for patients covered by Medicare Advantage, where plans are using step therapy to limit access to physician-administered therapies. Patients shouldn't pay more or face more difficult barriers to accessing their medicines than they did before CMS set prices for those medicines. We recommend CMS adopt stronger oversight and safeguards to protect beneficiary access in three key areas:

- **Improving transparency and data collection**. CMS should require Part D sponsors to report data that will provide critical transparency into the true impact of coverage denials on Part D beneficiaries, and develop meaningful, patient-centered measures of medication access in the Star Ratings program.
- **Enhancing patient access safeguards.** CMS should ensure all prior authorization (PA) requirements are accessible to all stakeholders, require plan sponsors to allow utilization

[178] Council for Affordable Health Coverage. (February 2025). Rotten to the Core: The Inflation Reduction Act Pill Penalty. Available at: https://cahc.net/rotten-to-the-core-the-inflation-reduction-act-pill-penalty/
[179] Pioneer Institute. The Inflation Reduction Act (IRA): Impact on Medication Pricing, Spending, Affordability, and Access. Available at: https://pioneerinstitute.org/the-inflation-reduction-act-ira-overview/
[180] Westrich K., Buelt L., Motyka J., Campbell J.D. (June 2025). Tracing the Arc of Medication Utilization Management Over Time. *Health Affairs Forefront.* Available at: https://www.healthaffairs.org/content/forefront/tracing-arc-medication-utilization-management-over-time
[181] Fendrick A.M., Axelsen K. (January 2025). Medicare Reforms Necessitate More Formulary Oversight. *Health Affairs Forefront.* Available at: https://www.healthaffairs.org/content/forefront/medicare-reforms-necessitate-more-formulary-oversight
[182] Fendrick, A.M. (August 2024). CMS Should Do More to Fulfill the IRA's Promise to Lower Drug Costs for Patients. *Health Affairs Forefront.* Available at: https://www.healthaffairs.org/content/forefront/cms-should-do-more-fulfill-ira-s-promise-lower-drug-costs-patients
[183] Avalere Health. (October 2024). 2025 Part D Formularies Shift to More Coinsurance and UM. Available at: https://advisory.avalerehealth.com/insights/2025-part-d-formularies-shift-to-more-coinsurance-and-um
[184] Avalere Health. (October 2023). Part D Premiums Increasing Despite Stabilization Program. Available at: https://advisory.avalerehealth.com/insights/part-d-premiums-increasing-despite-stabilization-program
[185] Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191-1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028", §110.

management (UM) to "follow" the patient, update Medicare Plan Finder (MPF) to require plans to clearly display specific UM requirements, and require plans to allow beneficiaries to obtain initial coverage determinations directly at the pharmacy counter. Further, CMS should ensure appropriate oversight of MA plans' use of step therapy for Part B drugs, given the inclusion of Part B drugs in IPAY 2028.

- **Strengthening formulary review reporting.** CMS should monitor and publicly report on formulary trends across all Part D plans and ensure the average number of medicines covered per class does not decrease.

The recommendations below represent key improvements CMS should consider.

I. Improve Transparency and Data Collection

Government price setting and other Part D provisions in the IRA are reshaping formulary dynamics, leading to increased risk of access disruptions due to plan financial pressure. While Part D plan dynamics are facing unprecedented changes, the ultimate impact of Part D sponsors' implementation of formulary UM and the appeals processes are opaque and currently are not available to either CMS or the public for review.

Moreover, recent analysis suggests that these processes are not adequate to prevent Part D beneficiaries from facing excessive barriers to timely access. For example, a recent IQVIA white paper that followed patients from 2020 to 2024 across five chronic therapeutic areas found that:

- Over 70 percent of Medicare Part D patients were initially denied coverage when trying to fill a new prescription for pulmonary arterial hypertension (PAH), multiple sclerosis (MS), immunology, and migraine medications.
- 10 to 19 percent of patients faced delays of five weeks or longer.
- On average, patients encountered two to three rejections before receiving approval, though some had to go through eleven or more.[186]

A survey of Medicare beneficiaries by the organization No Patient Left Behind (NPLB) revealed a similar concerning trend, finding that, among beneficiaries reporting their Part D plan initially rejected a medicine prescribed by their doctor, 40 percent had to use a medication that was not their physician's first choice, and 17 percent were unable to access any prescribed treatment at all.[187]

These findings underscore the importance of CMS collecting, and making transparent, additional data on the real-world effects of formulary design and plan UM policies, including the Part D appeals process.

CMS has traditionally depended on the appeals process to ensure access to medically necessary treatments. However, this approach places the burden on beneficiaries, often during urgent health situations, and offers little transparency into downstream impacts, patient outcomes, or broader system patterns. These data gaps hinder CMS' ability to evaluate beneficiary access to medications and to assess the fairness and consistency of plan decision-making processes and formulary design.

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[186] IQVIA. (June 2025). The Impact of Formulary Controls on Medicare Patients in Five Chronic Therapeutic Areas. Available at: https://www.iqvia.com/locations/united-states/library/white-papers/the-impact-of-formulary-controls-on-medicare-patients-in-five-chronic-therapeutic-areas

[187] No Patient Left Behind (March 2024). Price Controls Hinder Treatment Access in Medicare Part D. Available at: https://www.nopatientleftbehind.org/resource-materials/price-controls-hinder-treatment-access-in-medicare-part-d

These findings highlight the significant time, effort, and administrative burden Medicare patients face when starting a new prescribed therapy after an initial denial from their Part D plan. For patients with chronic conditions or those newly diagnosed and just beginning treatment, these barriers can be overwhelming, delaying care at a critical moment. These problems could be further exacerbated by the IRA's disruption to Medicare Part D. To safeguard patient access, CMS should take the steps outlined below.

CMS should require Part D sponsors to report data that will provide critical transparency into the true impact of coverage denials on Part D beneficiaries who rely on Medicare Part D. While UM may sometimes be an appropriate tool for Part D sponsors, it is essential that CMS, and the public, understand the real-world effects of these tools on beneficiary access to needed medications to ensure that UM is used in ways that are clinically appropriate and not as a cost-driven procedural barrier.

To ensure meaningful oversight, CMS should collect and publicly report both plan and beneficiary-level data that capture the true patient experience enabling CMS, researchers, advocates, and the public to assess the efficacy and impact of current coverage policies. These measures could include efforts to understand the experience when beneficiaries are denied coverage for their medicine at a pharmacy, such as:

- How often are beneficiaries denied coverage at the point of sale?
- Of those denied coverage, how many pursue an appeal? How many abandon therapy entirely?
- How long does it take between the first point of sale rejection until a beneficiary ultimately receives the medicine they were prescribed or a therapeutic alternative?

Furthermore, when beneficiaries attempt to appeal their plan's denial, CMS should collect more granular, contract level data on how often beneficiaries are successful in reversing plans' rejections.

These measures will provide CMS with critical insight to strengthen Part D plan oversight and review.

CMS should develop meaningful, beneficiary-centered measures of real-world beneficiary access to Part D medicines, reflective of plan UM practices, within the Star Ratings Program. Currently, the only Star measure that holds plans accountable for their coverage decisions evaluates how quickly a Medicare Advantage (MA) plan sends information for an independent review, and the rate at which an independent review (the "IRE") upholds the plans' appeals.[188] To more accurately measure beneficiary access, CMS should consider developing measures for the Star Ratings program that track the overall or therapeutic-area specific denial rate relative to an acceptable standard or average, or the rate at which plan sponsors fully or partially overturn coverage denials upon initial beneficiary appeal. This would serve as a proxy for potentially inappropriate rejections or insufficient plan transparency to prescribers. This enhanced data will provide CMS with critical insights into beneficiary experiences, enabling more effective oversight and targeted reforms to protect patient access and improve health outcomes.

II. Improve Patient Access Safeguards

The IRA introduced unprecedented changes to the structure of the Medicare Part D – disruption which builds on nearly a decade of increased UM restrictions in Part D.[189] Recent data show that plans are

[188] CMS. Medicare 2025 Part C & D Star Ratings Technical Notes. Available at: https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf

[189] 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

employing even more stringent practices to restrict access. For example, a recent analysis of 2023 coverage found that:

- Five out of ten standalone prescription drug plan (PDP) beneficiaries and six out of ten Medicare Advantage prescription drug plan (MA-PD) beneficiaries are in plans where they may face step therapy requirements embedded within prior authorization for psoriatic arthritis medicines. [190]
- In PDPs, psoriatic arthritis medicines are subject to step therapy 93 percent of the time and multiple sclerosis medicines are subject to step therapy 51 percent of the time.[191]

While UM strategies can play a useful role in ensuring that patients receive clinically appropriate medicines 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. Without strong oversight and guardrails, the very tools intended to manage costs may ultimately undermine the goals of the Part D program. The following recommendations outline targeted actions to protect beneficiary access, improve transparency, and ensure clinically appropriate care.

CMS should ensure that all prior authorization requirements, including prerequisite therapy protocols, are fully transparent, accessible, and understandable to both patients and providers. We commend CMS for its recent step in requiring plans to include a new field – *'Prerequisite Therapy Required'*– as part of prior authorization criteria,[192] and urge CMS to take further action to promote transparency and accessibility.

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.

CMS should update the Medicare Plan Finder to include specific types of UM requirements for covered medicines, and this information should be more prominently displayed. Currently, MPF indicates that a medicine is subject to prior authorization or step therapy restrictions, but it does not include information on exactly what medicines must be tried prior to receiving the originally prescribed medication. After using MPF, a beneficiary today would have to call the plan or find the information on the plan's website. Making this information easily accessible and understandable on MPF, particularly for medicines selected for price setting, will ensure beneficiaries can make well-informed decisions when selecting a plan that best meets their health care needs. Without clear visibility into these restrictions, beneficiaries may enroll in plans without fully understanding what will be required to access necessary medications. This additional transparency may be particularly helpful for beneficiaries taking selected medicines, given the risk of additional access challenges for those medicines.

CMS should require Part D plan sponsors to honor previously satisfied UM requirements when beneficiaries switch plans within the same parent organization. CMS should aim to create a seamless system where UM "follows the patient" during any plan changes – that is, once a beneficiary has met a

[190] "Embedded" step therapy refers to instances when the formulary lists the drug as having PA and does not note ST, but the PA criteria require a patient to step through at least one drug
[191] Avalere Health. (March 2025). Part D Prior Authorization Policies May Include Step Therapy. Available at: https://advisory.avalerehealth.com/insights/part-d-prior-authorization-policies-may-include-step-therapy
[192] HPMS. (April 2025). CY 2026 Part D Formulary Submission Information. Available at: https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-3-april-14-18

UM requirement for a specific medication, that approval should be transferable across plans. As a first step, CMS should require Part D sponsors to honor existing UM approvals and not impose new or repeated UM requirements on beneficiaries undergoing ongoing treatment who switch plans within the same parent organization. For patients with chronic or complex conditions, having to repeatedly "re-prove" delays care, burdens providers, and puts patients at risk. This is especially important given a recent analysis showing a sharp rise in insurer exits in 2024 after the IRA (relative to the prior six years), leading to 7.5 percent of beneficiaries (nearly three million people) losing their Part D plans and raising serious concerns about continuity of care.[193]

CMS should require plans to allow patients to initiate coverage determinations directly at the pharmacy counter to protect timely access to medically necessary medications. A well-functioning appeals and exceptions process is a vital safeguard for Medicare Part D beneficiaries, particularly as changes under the IRA may increase coverage restrictions. The current process is often complex and burdensome, discouraging patients from pursuing needed care. To reduce the administrative burden that prevents patients from accessing their medication, CMS should ensure that processes that are developed that allow patients to begin the coverage determination process at the point of sale, while minimizing any additional burdens on pharmacists. This will help reduce delays, minimize administrative barriers, and support faster access to prescribed therapies.

CMS should ensure appropriate oversight and guardrails over Medicare Advantage plans to ensure that enrollees do not face undue barriers to Part B selected drugs and their competitors beginning in IPAY 2028.

Beyond the access concerns that PhRMA has conveyed regarding Part D medicines subject to price setting, our concerns extend to potential barriers that Medicare Advantage enrollees could face when attempting to access selected Part B medicines and/or their competitors beginning in IPAY 2028.

Unlike in fee-for-service Medicare, MA plans are allowed to impose step therapy (ST) requirements on Part B medicines. Step therapy is a form of utilization management that requires patients to try and fail on one or more plan-selected medicines before gaining access to a clinician-preferred medicine. CMS issued guidance in 2018 giving MA plans the ability to use ST for Part B medicines for the first time starting in 2019, and codified this policy in regulations issued in 2019 and implemented in 2020.[194] As mentioned in numerous previous comment opportunities, PhRMA is categorically opposed to the use of ST in MA for Part B medicines, and believes that the guidance and regulation allowing MA plans to use ST for Part B medicines violate Social Security Act § 1852(a) because they permit MA plans to impose restrictions that do not exist in Original Medicare.[195]

In the years since MA plans were first allowed to impose ST restrictions, their use of ST for Part B drugs has risen significantly, concurrent with a sustained increase in the share of eligible Medicare beneficiaries electing to enroll in MA plans over traditional fee-for-service Medicare. By 2023, more than half of MA enrollees (54 percent) were enrolled in plans that apply ST to 10 of the most commonly-used medicines for the treatment of rheumatoid arthritis.[196] The increased prevalence of ST requirements for Part B medicines in MA is linked to significant burdens for physicians attempting to prescribe, and patients

[193] Cai C.L., et al. (May 2025). Insurer Exits After the Inflation Reduction Act Part D Redesign. *JAMA.* Available at: https://pubmed.ncbi.nlm.nih.gov/40367936/
[194] 84 Fed. Reg. 23,832 (May 23, 2019).
[195] See PhRMA comments on (CMS-4180-P) Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses (January 2019).
[196] Avalere Health. (May 2024). MA Plans Increase Use of Step Therapy for Part B Drugs. Available at: https://advisory.avalerehealth.com/insights/ma-plans-increase-use-of-step-therapy-for-part-b-drugs

attempting to access, clinically appropriate treatments. In a recent survey of 300 providers across specialties, 94 percent of respondents reported that ST limits access to clinically-preferred Part B treatments—and over 60 percent of providers described the burden of ST for Part B medicines on patient access as "high" or "extremely high."[197]

CMS should take a lesson from the significant cost and access barriers that Part D enrollees are already facing and take proactive and decisive action to ensure that MA enrollees who rely on Part B medicines to treat chronic and complex conditions like cancer are not negatively impacted by plan behavior. Consistent with our recommendations on Part D access safeguards, we believe that CMS should adopt strong oversight and transparency safeguards to ensure that MA enrollee access to Part B selected drugs and their competitors are not disrupted by burdensome ST requirements.

III. Strengthen Formulary Review Standards and Engage Stakeholders

CMS conducts annual reviews to ensure Part D formularies comply with coverage requirements and do not discriminate against specific beneficiary groups. In the IPAY 2028 draft guidance, CMS acknowledges concerns that Part D plan sponsors might broadly restrict access to medicines selected for negotiation after those drugs have been announced, specifically, in the contract year prior to the drug's MFP taking effect, but notes that CMS did not observe such behavior in contract year 2025 for drugs with initial price applicability in 2026.[198] However, an analysis evaluating changes in formulary coverage for the 25 medicines that have been selected for federal price setting found that fewer medicines are available on formulary in 2025 relative to 2024. Payers are increasingly combining administrative forms of UM, exclusions, and tiered patient cost sharing; interactions with collective implications for patient access. For instance, in addition to the decrease in coverage, another analysis found that the average OOP cost for 9 of 10 MFP medicines increased by 32 percent. CMS should undertake comprehensive analysis of the aggregate impact of these mechanisms to assess the overall effects on patient access.

Exacerbating this, the heightened risk of plans further restricting access will increase as government price setting increasingly influences coverage incentives. These access restrictions could take the form of placing more medicines on non-preferred tiers, increasing coinsurance, or excluding certain medications altogether, actions that could significantly undermine patient access to critical treatments.

CMS should monitor and publicly report on formulary trends across all Part D plans, including by therapeutic area and plan type to ensure beneficiaries are not losing access to needed treatment options under IRA. CMS should also monitor and ensure that the average number of medicines covered in each class does not decrease. This monitoring will be particularly important over time and should begin with drug classes with one or more selected drugs. In addition, it is crucial for CMS to clearly articulate the specific steps it will take to prevent further limitations on access to medications, ensuring that beneficiaries are not worse off than they were prior to IRA implementation.

CMS should build a robust and ongoing public engagement structure to strengthen its oversight framework. As noted above, CMS' Part D formulary oversight standards are not transparent and currently do not include a formal, accessible mechanism for systematically collecting and incorporating feedback from patients, caregivers, clinicians, and other stakeholders. CMS could draw on lessons learned from patient-focused listening sessions conducted for selected drugs, using that experience to help start developing a consistent, meaningful, and transparent process for integrating stakeholder perspectives

[197] Avalere Health. (June 2025). White Paper: Provider Survey on Part B Step Therapy in Medicare Advantage. Available at: https://advisory.avalerehealth.com/insights/white-paper-provider-survey-on-part-b-step-therapy-in-medicare-advantage
[198] IPAY 2028 Draft Guidance at § 110.

into formulary review standards and UM policies in Medicare Part D. This approach would help ensure that coverage decisions are grounded in the real-world needs of beneficiaries and do not inadvertently limit access to critical treatments.

Appendix D: Information Collection and Negotiation Process

As in prior years, the Centers for Medicare & Medicaid Services' (CMS, the Agency) draft Initial Price Applicability Year (IPAY) 2028 Guidance fails to establish a clear, consistent methodology for arriving at maximum fair prices (MFPs). Meeting this basic standard is not only required by the statute[199] but is also essential for ensuring accountability of government decision-making. The lack of consistent methodology – reflected in the Guidance and Appendix A of the Draft Guidance (relating to definitions for purposes of collecting data) – creates unpredictability and adds unnecessary burden, exacerbating the MFP program's harmful effects.

To date, CMS has declined to provide any meaningful insight into how it uses manufacturer- or stakeholder-submitted data as part of the "clear and consistent" methodology required by statute. The draft 2028 Guidance unfortunately continues to leave this problem unaddressed. This results in manufacturers facing an opaque process with unclear decision-making standards, exceptionally burdensome data submission requirements, and little recourse but to adhere to the agency's arbitrary demands, even when these demands violate the spirit and letter of the Paperwork Reduction Act (PRA). The lack of transparency throughout the entirety of the price setting process underscores this approach as it remains uncertain whether the Agency even knows what information it needs, which could be a contributing factor for why the Agency continues requesting lengthy and at times irrelevant data from key stakeholders.

Further, some of the potential changes for which CMS seeks input would worsen, rather than mitigating, the harmful effects of the Inflation Reduction Act's (IRA) drug price controls. We are particularly concerned about the Agency soliciting comments on potential new starting points for the initial offer in the IPAY 2028 draft guidance, including "the unit cost of production and distribution of the selected drug" and "other domestic reference prices." These factors – which would further devalue and discourage research and development of new medicines and risk introducing further uncertainty into a process that is already unpredictable – should be rejected by CMS. Additionally, as discussed in detail later in the appendix, PhRMA continues to advocate that CMS should place greater emphasis on the 1194(e)(2) factors relative to 1194(e)(1) factors as manufacturer-specific factors are less relevant for determining MFPs.

CMS' lack of transparency may also discourage participation from patients, caregivers, clinicians, and other key stakeholders. With no transparency into how – or if – CMS is using data or the stories from these stakeholders, there is a risk that key stakeholders will stop replying to the Agency, as they may not feel that the significant investment required to submit data 28 days post selection or forfeit an afternoon for a roundtable or town hall is worth the time or effort. To address this, CMS should clarify how it uses submitted data in the MFP explanations, enabling stakeholders to tailor future submissions to what matters most in the Agency's decision-making.

Consistent with prior comments, PhRMA urges CMS to make basic improvements in the Guidance document's provisions on methodology and process and streamline and modify the upcoming Information Collection Request (ICR) in order to establish a consistent process and methodology,

[199] SSA § 1194(b)(1) ("The Secretary shall develop and use a consistent methodology and process.")

encourage more meaningful stakeholder participation, improve predictability, and reduce unnecessary data submission burdens. Specifically, we recommend the following changes:

- **Information Collection Request / Appendix A of the Draft Guidance:**
  - Streamline and simplify data submission requirements to reduce unnecessary burden and improve CMS decision-making; and
  - Clarify timing of ICR data certification.

- **Manufacturer-Specific Data Elements [1194(e)(1)]:**
  - Eliminate unnecessary regulatory burden and correct methodological inaccuracies;
  - Align data submission requirements with current business practices;
  - Limit submission of R&D costs to a single amount related to a selected drug;
  - Allow manufacturers the option to stipulate that they have recouped research and development (R&D) costs through a simple yes/no checkbox;
  - Do not place greater emphasis on the 1194(e)(1) factors when adjusting the preliminary price;
  - Clarify how data on pending and approved patents will be used to adjust MFP; and
  - Do not collect "forward-looking" forecasts during the data collection process.

- **Evidence About Alternative Treatments [1194(e)(2)]:**
  - Place greater emphasis on the 1194(e)(2) factors vis a vis 1194(e)(1) factors. Within such (e)(2) factors, focus on those directly related to patient benefit and how the selected drug performs in the real world compared to clinically appropriate therapeutic alternatives;
  - Clarify how CMS will weigh different data elements in MFP price-setting;
  - Improve process and standards on selection of therapeutic alternatives;
  - Reject alternative starting points such as the unit cost of production and distribution or domestic reference pricing as a starting point for the initial offer;
  - Support meaningful stakeholder engagement; and
  - Strengthen safeguards against use of quality-adjusted life years (QALYs) and related metrics.

I. Information Collection Request Data Burden and Noncompliance with Paperwork Reduction Act

In advance of IPAY 2026, PhRMA articulated concrete and actionable recommendations focused on key considerations under the Paperwork Reduction Act (PRA) for the implementation and application of the price setting process. Unfortunately, as it did with most comments, the Agency disregarded our recommendations and continued with its burdensome and inefficient process. For IPAY 2027, PhRMA again reiterated our concerns with how CMS' ICR forms are overly burdensome and, as a result, continue to fall far short of the three-prong regulatory test established by the PRA.[200] Yet, the previous administration made only minor changes – along with a modest and underestimated increase in burden estimates - while failing to address the ICR's inefficiencies and PRA noncompliance.

[200] 5 C.F.R. § 1320.5(d)(1)(i)-(iii)

The PRA was enacted in 1995 due to the "enormous growth of our federal bureaucracy" and "its seemingly insatiable appetite for data."[201] However, the previous administration ignored PRA requirements to "minimize and control burdens and maximize the practical utility"[202] of information collections and instead imposed an overly burdensome and complicated process to collect data. This is not only a waste of pharmaceutical manufacturer resources but also is an inefficient use of CMS staff time. There is no evidence[203] that CMS even considered the majority of information provided to the agency to determine the MFPs for IPAY 2026, yet – instead of complying with the PRA and reducing the burden on all data submitters – the previous administration allowed the ICR to balloon from a 47-page form in IPAY 2026 to 73 pages in IPAY 2027.

Further, the 28-day timeline to submit information to the Agency after drug selection is unreasonable and, in many cases, infeasible absent significant preparation in advance of selection. The information requested by CMS is not only vast and far-reaching, but it often requires a lookback of one or more decades along with complex coordination across many business functions under compliance pressure. The intensive process of then quality- and fact-checking the compiled data in order to certify this submission (which can be nearly impossible if possessed solely by a "Secondary Manufacturer") is extremely burdensome and can require substantial time compiling and analyzing data in advance of this compressed 28-day period. The Agency adds to this burden as it is unclear if respondents must continually update their ICR submissions or if they must only modify their submission(s) if it later becomes clear that the information submitted was incorrect based on the information available at the time of submission or if the data changes (e.g., due Medicaid Best Price restatement window). This resubmission process is burdensome and, given the lack of transparency into the MFP setting-process, it remains unclear why CMS requires continued data submission or how the Agency evaluates this data. The renegotiation process makes this even more opaque as CMS states that while manufacturers may voluntarily submit data to be considered for renegotiation, this submission is separate from the "ongoing obligation to update . . . original data submissions."[204] ***PhRMA recommends CMS clarify the certification requirements so that manufacturers must only update submissions if the submitter becomes aware that information was incorrect as of the time of submission.***

Furthermore, there is little evidence to validate why CMS needs the requested information as the Agency has provided no transparency into how, or even if, it used the vast amounts of data collected during the IPAY 2026 and IPAY 2027 price setting process. The IPAY 2026 "explanations" mostly repeated information available in Guidance instead of providing any assurance that CMS truly needed all the information collected. Nor has CMS articulated a data destruction schedule for the vast amounts of proprietary information it has collected or will collect. Not only do these flaws raise questions as to the goals behind the process, but it underscores a lack of consideration for the burden the request imposes or CMS' duties under the PRA.

PhRMA appreciates that CMS is soliciting feedback on the forthcoming ICR for IPAY 2028, and that the Administration is considering streamlining the MFP price-setting factors to reduce burden and improve efficiency. To this end, ***we again urge CMS to consider the requirements and intent of the PRA and,***

[201] *Dole v. United Steelworkers of Am*., 494 U.S. 26, 32 (1990)
[202] 5 C.F.R. § 1320.1
[203] CMS. (December 2024). MFP Explanations. Available at: https://www.cms.gov/priorities/medicare-prescription-drug-affordability/overview/medicare-drug-price-negotiation-program/selected-drugs-and-negotiated-prices
[204] IPAY 2028 Guidance at § 50.1.

consistent with our prior comments to the Agency[205] along with the comments included in this Appendix, streamline and simplify the data submission requirements of the ICR – particularly but not limited to the manufacturer-specific data elements.

II. Manufacturer-Specific Data Elements [(e)(1) Factors]

Section 1194(e)(1) (hereinafter referred to as the (e)(1) or manufacturer-specific factors) of the IRA describes the following manufacturer-specific data that CMS shall consider for purposes of negotiating the MFP of a selected drug: "(A) Research and development costs of the manufacturer for the drug and the extent to which the manufacturer has recouped research and development costs;" "(B) Current unit costs of production and distribution of the drug;" "(C) Prior Federal financial support for novel therapeutic discovery and development with respect to the drug;" "(D) Data on pending and approved patent applications, exclusivities recognized by the Food and Drug Administration, 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;" and "(E) Market data and revenue and sales volume data for the drug in the United States."

For IPAY 2026 and IPAY 2027, the previous Administration interpreted the statute in a manner that led them to require Manufacturer-Specific Data Elements that were flawed and incongruent with current business practices. As stated above, many of the elements requested for collection violated the PRA in terms of both utility and necessity. For example, CMS continues to divide R&D costs into several categories—an approach that goes far beyond how manufacturers typically track or report this data and may conflict with standard document retention practices.[206]

While CMS' effort to streamline R&D data is a small step in the right direction, collapsing multiple subdivisions of R&D costs into two categories while still requiring manufacturers to include basic pre-clinical research for indications of the selected drug and post-IND costs among other costs does not adequately alleviate manufacturer burden associated with data submissions or make submitted data more relevant to determining MFP. CMS has significant opportunities to align data submission requirements with the PRA and current business practices to improve the utility and accuracy of submitted data and reduce the burden that manufacturers face in adhering to the current requirements.

In addition, 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. The ICR offers no way for manufacturers to fully explain the complex and non-linear path of pharmaceutical innovation, which often involves costly setbacks, restarts, and dead ends.

Research and Development Costs

PhRMA appreciates that CMS is soliciting comments on opportunities to streamline the definitions research and development costs and hopes this signals some recognition that the current data requirements

[205] PhRMA. (September 2024). PhRMA Comments on IPAY 2027 Negotiation Data Elements and Negotiation Process ICRs. Available at: https://www.regulations.gov/comment/CMS-2024-0198-0018
[206] Draft IPAY 2028 Guidance at p. 206 (Appendix A)

are unworkable for manufacturers. However, we remain concerned about the subdivision of R&D reporting requirements into more than one category and believe the changes do not go far enough to reduce the burden on manufacturers. Additionally, PhRMA opposes CMS removal of acquisition costs as part of the overall calculation of R&D costs for a particular drug. An acquiring company pays for the value of the R&D already carried out by the selling company. The acquiring company also must weigh whether its money is better spent on the acquisition or investing internally in R&D. Furthermore, if a manufacturer has acquired the selected drug, CMS' position appears to be that the manufacturer may have *no* R&D costs to report. Yet, reporting an R&D cost of zero or minimal amounts would not be representative of the actual costs that went into developing and bringing the product to market. While PhRMA supports consolidating reporting and greater transparency, ***we strongly urge the new Administration to address the burden and methodological inaccuracies that resulted from the past Administration's approach to implementation of the (e)(1) factors.***

In its 2026 and 2027 IPAY Guidance, CMS' reporting requirements for R&D costs have been misaligned with how manufacturers actually track, allocate, and publicly report costs, creating significant compliance challenges under compressed timelines. While CMS' proposed streamlining of reporting requirements for IPAY 2028 is a modest improvement, it does not go far enough to reduce the overall burden of data collection. Manufacturers cannot easily reconstruct highly detailed R&D costs for drugs developed over a decade or more ago, especially given CMS' overly broad definition of QSSD to include products approved under different applications.

Additionally, costs for "abandoned and failed" products with the same "mechanism of action" may be difficult if not impossible for companies to attribute to a drug development program in the ways CMS has specified. This is because of the nature of investment decisions in biopharmaceutical R&D, which include factors that extend well beyond the mechanism of action of the drug candidate. These difficulties are compounded when drug products are developed through the efforts of multiple companies, through early-stage R&D licensing arrangements, or other partnerships. Preclinical investments in platform technologies or tools like artificial intelligence (AI) are shared across programs, making product-level cost allocation, especially for pre-clinical development activities, nearly impossible. CMS' approach demands a level of precision that is impractical, burdensome, and disconnected from how R&D is conducted and documented in practice.

As noted below, CMS should amend the Guidance to allow manufacturers to stipulate, without more, that they have recouped R&D costs through a simple yes/no checkbox. In the alternative, CMS should limit required submission of R&D costs to a single, total amount related to the selected drug, while allowing companies to voluntarily provide supplemental data. In addition, manufacturers should be given the opportunity to provide a supporting narrative.

Research and Development Cost Recoupment

PhRMA continues to be concerned about the validity of CMS' approach to capturing "R&D recoupment" - which does not account for all distribution and supply chain costs required to get products to market, among other concerns - and urges the Agency to acknowledge the concept's flaws and the difficulty of accurately quantifying and complying with it. As PhRMA and others have continually noted, very few

drug candidates that enter clinical trials are ultimately FDA-approved – in fact, just 12 percent.[207] Companies plan R&D across entire portfolios, expecting that only a few successful drugs will generate enough revenue to offset the many costly failures.[208] As a result, CMS' interpretation of the IRA requirement to consider R&D costs at the product level and the extent to which they have been recouped is not only impractical—given how investments are tracked—but also unnecessary under the statutory language. CMS' fundamental misunderstanding of the economics of the biopharmaceutical marketplace exacerbates this flawed provision by continuing to require companies to report in a manner not required by the IRA, such as providing detailed R&D costs and the extent to which they have been recouped, as well as by subdividing such costs into more than one subcategory.

While we appreciate CMS' willingness to consolidate some categories of R&D costs, rather than continuing this highly flawed approach, PhRMA strongly recommends that CMS 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 with the option to provide a supporting narrative. In addition, CMS should place minimal weight on recoupment and specify that it will not be used to reduce an MFP determined on the basis of a drug's therapeutic and clinical attributes. 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 . This approach would also accord with section 1194(e)(1)(A), which merely requires that CMS consider R&D costs and the extent to which they have been recouped. CMS could reason that in cases where a manufacturer stipulates it has recouped R&D costs, the agency would have no need to further include R&D costs in the price-setting analysis (as the costs have been recouped); whereas, in cases where the data show a manufacturer has not recouped R&D costs, such information may inform an upward adjustment to MFP.

Patents and Exclusivities

For IPAY 2028, CMS seeks "comment on…whether CMS should put greater emphasis on certain section 1194(e)(1) factors when adjusting the preliminary price," or "whether CMS should consider and potentially adjust the preliminary price based on" the data described in item D above (data on pending and approved patent applications and exclusivities) "independent of considering other section 1194(e)(1) factors in totality."[209]

First, it is not clear what CMS means by "consider[ing] and potentially adjust[ing] the preliminary price based on" on pending and approved patent applications, exclusivities recognized by the Food and Drug Administration, 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 "independent of considering other section 1194(e)(1) factors in totality." For example, it is not clear whether this statement means that CMS is considering giving this factor more weight than all other factors, and if so, how much weight. Nor is it clear whether CMS would increase or reduce the preliminary price based on the described

[207] DiMasi J.A., Grabowski H.G., Hansen R.W. (February 2016). Innovation in the pharmaceutical industry: New estimates of R&D costs. *J Health Econ*. Available at: https://pubmed.ncbi.nlm.nih.gov/26928437/
[208] Parry B., Moss R. (July 2024). Making more medicines that matter. McKinsey and Company. Available at: https://www.mckinsey.com/industries/life-sciences/our-insights/making-more-medicines-that-matter
[209] IPAY 2028 Draft Guidance, at 137

patents, exclusivities, and marketing applications. ***PhRMA requests that CMS clarify how it intends to consider and weigh the 1194(e)(1) factors and confirm that it will not use these factors to reduce prices.*** Moreover, in describing patents, exclusivities, and approvals that fall under item D above, CMS appears to have changed the term "related" (used to describe patents in the IPAY 2027 Guidance)[210] to "relevant,"[211] and it is not clear whether this change is substantive. CMS should clarify the significance of this change (if any) in the final Guidance.

Second, ***PhRMA urges CMS to consider the data described in item D—i.e., pending and approved patent applications, exclusivities, and pending or approved marketing applications—as markers of a product's innovative nature, the investment that the manufacturer made in developing the product, and the lack of therapeutic alternatives, all of which are factors that weigh in favor of increasing the preliminary price.***

Request for Comment on "Forward-Looking" Market Data

In section 50.1 of the draft Guidance, CMS solicits comment on the collection of additional, forward-looking "market data" for the selected drug. CMS suggests this data could include forecasted net revenue and volume data for the selected drug for future periods and provides examples of a manufacturer's annual forecast of U.S. net revenue, volume by indication, and net pricing for the selected drug itemized by the relevant market channel (e.g., Medicare, Medicaid, commercial or other); and annual gross-to-net ratio trend for the selected drug across all market channels and market share percentages and volume, by indication. CMS states that "these types of data are consistent with the section 1194(e)(1)(E) factor of 'market data and revenue and sales volume data for the drug in the United States.'" "Forward-looking" market data is inappropriate for collection as both a policy and legal matter. As a policy matter, forward-looking data is a forecast that may or may not be realized. Moreover, CMS requires primary manufacturers to certify that the data submission is "complete and accurate," and that notification will occur if information has changed.[212] Forecasts, by definition, constantly evolve based upon new information and changes to the business environment. Thus, it would be impossible to regularly notify CMS when information has "changed." In addition, requiring a delegated official to certify to the "completeness" and "accuracy" of what is merely a forecast places undue, unfair responsibility on such certifiers, who cannot reasonably opine as to whether the predictions will occur. Finally, a forecast does not constitute "data." In interpreting statutes, agencies must use the "ordinary meaning of terms unless context requires a different result."[213] The ordinary meaning of "data" is "factual information (such as measurements or statistics) used as a basis for reasoning, discussion, or calculation."[214] A prediction is not empirical, factual information akin to a "measurement" or a "statistic." In the case of MFPs, CMS' example of the gross-to-net ratio trend is particularly inapt, given that MFP will have a direct impact on net sales. Indeed, CMS may understand that it is stretching the meaning of the statute, as the agency states that its request for forecasted data is merely "consistent" with section 1194(e)(1)(E). This may

[210] IPAY 2027 Final Guidance, at 309
[211] IPAY 2028 Draft Guidance, at 210
[212] Centers for Medicare and Medicaid Services. (November 2024). IPAY 2027 Negotiation Data Elements Form, CMS 10849. Available at: https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202411-0938-010. (Note: PhRMA continues to recommend that CMS revise the certification so that it applies *only* to the information available to the individual at the time of the certification)
[213] *Gonzales v. Carhart*, 550 U.S. 124, 152 (2007)
[214] Merriam-Webster. (n.d.) data. Merriam-Webster.com. Available at: https://www.merriam-webster.com/dictionary/data

indicate that the agency understands the statute does not clearly permit collection of predictions. ***For the above reasons, CMS should not collect "forward-looking" forecasts in its ICR.***

III. Evidence About Alternative Treatments [1194(e)(2)]

Emphasizing 1194(e)(2) Factors Related to Patient Benefit

Section 1194(e)(2) (hereinafter referred to as the (e)(2) factors) of the IRA allows for all stakeholders to submit evidence on the selected drug's performance in the real world. The previous Administration declined to provide any insight or clarity into CMS' methodology including, but not limited to, any information or structure around how the different sections will be weighted. ***As PhRMA and other key stakeholders[215] have previously recommended, CMS should (a) assign a greater weight to (e)(2) factors as compared to the (e)(1) factors; and (b) within such (e)(2) factors, assign greater weight to those that actually reflect the benefit the selected drug brings to patients, caregivers, and society and will help encourage the generation of additional evidence on the comparative health benefits of different treatments. As a corollary, to the extent (e)(1) factors are considered, CMS should place less weight on the (e)(1) factors that would diminish medicines' benefits and could stagnate innovation if overweighted***. Basing prices for medicines on costs incurred by the manufacturer, instead of the value and benefits conferred by the innovation, sends perverse, unintended signals to manufacturers that devalue and disincentivize R&D and pose a significant threat to innovation and progress for future medicines. Manufacturers require a clear understanding as to whether innovation and progress will be valued under CMS' price setting framework. As such, ***CMS should provide greater transparency on the types of evidence it will rely on when evaluating data, such as the extent to which a selected drug represents a therapeutic advance or addresses an unmet medical need, and the effects of the selected drug on specific populations.***

Therapeutic Alternative Selection

Identification of therapeutic alternatives represents a critical element of the MFP process, yet it is also a notoriously difficult element of any process for evaluation of the comparative costs and benefits of different medicines or other health care interventions. To date, CMS Guidance has not provided meaningful clarity on the evidence or process the agency uses to select therapeutic alternatives, a shortcoming that is retained in the IPAY 2028 draft Guidance. This is illustrated by CMS' release of MFP explanations for the IPAY 2026 drugs, which indicate that the agency considered an average of 6.5 therapeutic alternatives across each of the ten selected drugs (ranging from one to ten therapeutics alternatives per selected drug) but provided little specific information about how the agency ultimately selected specific therapeutic alternatives beyond vague statements on use of a "holistic" approach.[216] Selection of clinical comparators can be highly variable, raising questions about whether the decision was

[215] McElwee F., Cole A., Garrison L.P., Towse A. (June 2024). Federal Support Should Not Be A Factor In Determining Pharmaceutical Prices Under The IRA. *Health Affairs Forefront*. Available at: https://www.healthaffairs.org/content/forefront/federal-support-should-not-factor-determining-pharmaceutical-prices-under-ira

[216] National Pharmaceutical Council. (January 2025). "Maximum Fair Price" Explanations for IPAY 2026 Drugs. Available at: https://www.npcnow.org/sites/default/files/2025-01/MFP%20Explanation%20Files%20IPAY%202026%20NPC%20Policy%20Evidence%20Brief%202025_01.pdf

informed by other factors or objectives of the government's decision-making, rather than clinical appropriateness.[217]

As PhRMA has stated previously, therapeutic alternative selection should be based on the most clinically appropriate alternative informed by conversations with and data submissions from experts with real-world experience, including patients, practicing physicians, and pharmaceutical manufacturer(s). However, the agency's extremely compressed timetable for input, combined with vague, poorly defined standards for therapeutic alternative selection, makes it exceptionally difficult for manufacturers and other stakeholders to efficiently provide meaningful input on a selected drug relative to its therapeutic alternatives, and raises the risk that CMS will not identify the most clinically appropriate options. Especially as Part B medicines become eligible for price setting in IPAY 2028, introducing further complexities, CMS must also ensure maximum transparency on the process and mechanics of how they are utilizing therapeutic alternatives to calculate a product's MFP. Without these necessary insights, manufacturers will have no visibility into whether there are gaps or issues in the process, which could ultimately impact pricing. As such, ***CMS should publish the potential therapeutic alternative(s) under consideration for each selected drug when selected drugs are announced and allow data submitters to comment on CMS' proposal as part of their data submission package***. This would significantly reduce stakeholder burden by allowing data submitters to tailor their submissions to CMS and limit the potential scenarios stakeholders currently need to consider when preparing ICR responses.

Consideration of Non-Drug Therapeutic Alternatives

PhRMA appreciates the Agency seeking feedback on whether health care services payable under Part A or B could be considered as therapeutic alternative(s), but we do not believe that would be an appropriate step at this time. CMS has not yet provided clear enough standards or an open enough process to provide assurance that the agency will consistently select appropriate therapeutic alternative even among competing medicines. Expanding therapeutic alternatives to include health care services would increase the risk of CMS selecting clinically inappropriate comparators, while at the same time creating increased burden on data submitters to submit even more information and analysis. There is also a lack of visibility into the Agency's selection of therapeutic alternatives which creates no pathways for stakeholders to provide input on CMS' selection even when they believe CMS' selection may be incorrect. Because of these unaddressed issues, ***it would be premature for the Agency to broaden the consideration of potential therapeutic alternatives to non-drug alternatives.***

Starting Point for Initial Offer

PhRMA is opposed to the use of alternative starting points for initial offers such as those for which CMS solicits comments in the draft guidance. In particular, we are concerned by consideration of a starting point between the price of the therapeutic alternative(s) and the "unit cost of production and distribution," or potential use of "domestic reference prices."[218] As noted above, this approach fails to consider the important clinical and quality of life benefits provided by MFP-selected medicines. As a result, it would devalue treatment advances and discourage continue progress against unmet medical needs, significantly

[217] Hernandez I., et al. (December 2023). Medicare drug price negotiation: The complexities of selecting therapeutic alternatives for estimating comparative effectiveness. *J Manag Care Spec Pharm*. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10909583/

[218] IPAY 2028 Draft Guidance at p. 131, § 60.3.2

exacerbating the damaging effects of the Program. **PhRMA strongly encourages CMS to reject consideration of alternative methodologies for establishing a starting point for negotiation such as domestic reference pricing or unit cost of production and distribution.**

Stakeholder Engagement

While PhRMA appreciates CMS' attempts to improve stakeholder engagement with patients, caregivers, patient advocates, and practicing physicians, the MFP process still falls well short of supporting meaningful patient engagement. For example, CMS frequently releases important information too late in its process, which prevents engagement. In the case of the stakeholder events, CMS failed to release the redacted transcripts from April 2025's events until over a month later in June – after CMS sent impacted manufacturers the Agency's initial offer for IPAY 2027. CMS also held its stakeholder events in the middle of a weekday, on short notice, placing a barrier on patients, caregivers, or practicing clinicians who needed to work or faced another type of conflict. By doing so, CMS severely limited who could participate and as a result, reduced the valuable insight that could impact CMS' evaluation of evidence and its MFP determination. Similarly, allowing these stakeholders only one month to complete the 1194(e)(2) section of the ICR –an interpretation the Agency did not have to adopt under the statute[219] – creates additional barriers for many stakeholders including those who are disabled or underfunded, or otherwise come from a disadvantaged background. CMS also continues to rely on a black box process that may discourage stakeholders from spending their time providing input that they fear the Agency will not take into consideration. For example, the IPAY 2026 MFP explanations primarily repeated existing Guidance instead of providing stakeholders with any insight into CMS' process or if CMS incorporated patient-centered data. ***As PhRMA has previously recommended, we urge CMS to make improvements in the process of soliciting stakeholder input and improve transparency into how this input influences the agency's decision-making. Without fundamental improvements, CMS risks creating the impression of tokenism in which patient and clinician input is sought but not actually considered.***

Quality-Adjusted Life Years

As PhRMA has repeatedly stressed in previous comments, cost-effectiveness metrics such as the Quality-Adjusted Life Year (QALY) should not be used by CMS in setting MFPs in accordance with section 1557 of the Affordable Care Act, section 504 of the Rehabilitation Act, as well as sections 1182(e) and 1194(e) of the Social Security Act. CMS' decision to continue considering analyses that include cost-effectiveness measures, including QALY-alternatives that use the same underlying and discriminatory math,[220] is both misguided and unnecessary. Using cost-effectiveness metrics as the basis for policy decisions risks undervaluing the lives of the elderly, the disabled, and other groups considered to have less than "perfect" health. While we understand that not all stakeholders will understand cost-effectiveness measures, given the breadth of data CMS considers (some of the MFP explanations included almost 300 sources), it is unlikely the Agency will be able to confirm that the studies do not use cost-effectiveness

[219] As PhRMA has previously noted, the statute does not specifically require that manufacturers and other stakeholders submit the information described in section 1194(e) by March 1. Instead, the March 1 deadline applies to non-FAMP data as well as certain other information, but does not cross-reference section 1194(e). SSA § 1194(b)(2)(A) cites to information described in § 1193(a)(4), which includes non-FAMP data as well as certain other information the Secretary absolutely "requires" to carry out price setting, but does not contain a reference to § 1194(e)

[220] National Council on Disability. (November 2022). Alternatives to QALY-Based Cost-Effectiveness Analysis for Determining the Value of Prescription Drugs and Other Health Interventions. Available at: https://www.ncd.gov/report/alternatives-to-qaly-based-cost-effectiveness-analysis-for-determining-the-value-of-prescription-drugs-and-other-health-interventions/

measures in a way that does not discriminate against certain populations. CMS should reconsider its decision to remove the attestation that prevents academics and other third parties from submitting data relying on these fatally flawed metrics. ***Instead, CMS should prioritize data from patients and doctors with prescribing experience, along with clinical effectiveness research that provides insight into a medicine's real-world performance, without undervaluing or discriminating against the lives of the elderly, the disabled, or the terminally ill.***

Appendix E: Renegotiation

I. CMS Cannot Rely Solely on the Existence of Part B Utilization to Justify Renegotiation

The Inflation Reduction Act (IRA) outlines clear requirements governing the identification of renegotiation-eligible drugs and the selection of drugs for renegotiation for years beginning with initial price applicability year (IPAY) 2028. Section 1194(f)(2) of the Social Security Act (SSA) limits "renegotiation-eligible" drugs to drugs that meet strict criteria:

> (1) A change in monopoly status occurs (for IPAY 2028 this is limited from a short-monopoly drug to a long-monopoly drug);
>
> (2) A new indication is added to the drug; or
>
> (3) The Secretary determines there has been a "material change" in any of the factors enumerated in SSA § 1194(e).

In addition, under SSA § 1194(f)(3), for criteria (2) and (3) the Secretary may select only those drugs for which the Secretary "expects renegotiation is likely to result in a significant change" in the maximum fair price (MFP).

The Centers for Medicare and Medicaid Services (CMS) states that it "anticipate[s] that selected drugs from [IPAYs] 2026 and 2027 with Part B utilization are likely to be determined to be "renegotiation-eligible drugs" and "selected for renegotiation" for IPAY 2028.[221] Yet, CMS does not explain: (1) why these drugs would qualify as "renegotiation-eligible drugs" under the statutory criteria; or (2) why they would meet the statutory requirements to be selected for renegotiation even assuming they fell within a category of "renegotiation-eligible drugs." Nor is the relationship between these statutory requirements and the existence of Part B utilization self-evident. ***Accordingly, there is no reason to conclude that a "Part D" selected drug with some Part B utilization necessarily or even probably meets the IRA's renegotiation criteria.***

The only possible basis for a selected drug to qualify as a renegotiation-eligible drug absent a change in monopoly drug status or a new indication is if the Secretary determines there has been a "material change" in any of the factors enumerated in paragraph (1) or (2) of SSA § 1194(e). The mere existence of Part B utilization is not listed in either the manufacturer-specific data elements in section 1194(e)(1) or the factors relating to therapeutic alternatives in section 1194(e)(2). Moreover, there is no reason why the existence of Part B utilization in a drug selected as a "Part D" drug would represent a *material change* in any of these factors. Importantly, we have heard nothing about selected drugs from IPAY 2026 or 2027 that acquired new Part B indications after their selection – and the continued existence of preexisting Part B utilization would not be any kind of change at all, let alone a "material change" in any of the section 1194(e) factors. The only "change" that has occurred is that, starting with IPAY 2028, the IRA's drug selection criteria takes into account Part B spending;[222] but this does not amount to a "material change" in the factors enumerated in section 1194(e) with respect to a selected drug.

[221] IPAY 2028 Draft Guidance § 130.1 at 190.
[222] SSA § 1192(d).

CMS similarly has failed to explain its conclusion that selected drugs from IPAYs 2026 or 2027 with Part B utilization would "likely" be selected for renegotiation. Absent a change in monopoly drug status, CMS may only select renegotiation-eligible drugs for which it "expects renegotiation is likely to result in a significant change" in the MFP.[223] But there is no basis for expecting a significant change in the MFP with respect to a previously selected drug with Part B utilization, as the continued existence of Part B utilization does not alter the factors outlined in section 1194(e), let alone "materially" change any of those factors in a way that would be expected to result in a significant change in MFP. These factors provide "the basis" for CMS to determine the "offers" and "counteroffers" during the renegotiation process, and therefore CMS cannot consider other data or information.[224]

Finally, the possibility of a "significant change" in MFPs from including selected drugs from IPAYs 2026/2027 with Part B utilization in the first renegotiation cycle conflicts with CMS' own statements. CMS recognizes that renegotiation eligibility and selection will begin approximately 15 months after the end of the price setting period for IPAY 2026 selected drugs and immediately after the end of the price setting period for IPAY 2027 selected drugs. Given this short timeframe, CMS states that it "does not expect" that it would be likely that renegotiation would result in a "significant change" to the MFPs for drugs selected for IPAYs 2026 and 2027, "except in unanticipated or unusual circumstances."[225] CMS states that such unusual circumstances could include a new indication being added to the drug shortly after the end of the price setting period, or unit costs increasing significantly due to a shortage of a key ingredient shortly after the end of the price setting period. CMS does not provide any reasoning as to why Part B utilization alone would constitute a "significant change" in the MFP.

CMS' statement that it "anticipate[s]" that IPAY 2026/2027 selected drugs with Part B utilization likely will be selected for renegotiation[226] conflicts with CMS' stated expectation that renegotiation of IPAY 2026/2027 selected drugs will not result in a "significant change" to MFPs absent "unanticipated or unusual circumstances."[227] The continued existence of Part B utilization is not an "unanticipated or unusual circumstance[]." The draft guidance does not attempt to reconcile its contrasting statements about renegotiation of IPAY 2026/2027 selected drugs, nor does it identify any connection between the existence of Part B utilization for a selected drug from IPAY 2026 or 2027 and the statutory requirements for renegotiation eligibility and selection.[228] If Congress meant for Part B utilization alone to be a categorical trigger for renegotiation selection, it could have expressly stated as such when it enumerated the statutory requirements for selection.

II. Outside of Monopoly Status Changes, No IPAY 2026 or IPAY 2027 Selected Drugs Should Be Selected for Renegotiation in IPAY 2028 (Unless Requested by the Selected Drug Manufacturer)

As described above, CMS itself recognizes in the draft program guidance that it is unlikely drugs selected for IPAYs 2026 or 2027 would experience a "significant change" to the product's MFP, given the short

[223] SSA § 1194(f)(3)(C).
[224] SSA § 1194(f)(4)(B) (requiring the renegotiation process to be consistent to the extent practicable with the statutory methodology and process for negotiation, including reliance on the factors enumerated in section 1194(e)).
[225] Draft Guidance § 130.2.1 at 197.
[226] Draft Guidance § 130.1 at 190.
[227] Draft Guidance § 130.2.1 at 197.
[228] See *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211 (2016) (explaining that where an agency has failed to "give adequate reasons for its decisions," "its action is arbitrary and capricious and so cannot carry the force of law").

time between the end of negotiation for these IPAYs and the start of process for IPAY 2028. CMS should thus affirmatively commit to not selecting for renegotiation any IPAY 2026 or 2027 drugs (outside of the statutorily-required change in monopoly status or in the absence of the manufacturer requesting renegotiation). An affirmative commitment would avoid CMS and manufacturers engaging in the resource-intensive, but unnecessary and duplicative, price setting process so close in time to the original negotiation.

III. CMS Should Raise the Threshold of a "Significant Change" in the MFP for Renegotiation Selection

CMS proposes a two-pronged, "holistic inquiry" approach for determining if renegotiation would lead to a "significant change" in the MFP for the purpose of determining renegotiation eligibility for drugs that have a new indication and/or a "material change" in any of the Section 1194(e)(1) or (e)(2) factors. Under the proposed approach, CMS would require that the selected drug meet both of the following two criteria: (1) that renegotiation is likely to result in a 15 percent or greater change in the MFP; and (2) that the expected change in the MFP would have a significant impact on the Medicare program (e.g., program spending, beneficiary cost-sharing).

PhRMA is generally supportive of CMS utilizing specific criteria in its "holistic inquiry" approach for determining renegotiation eligibility. However, we urge the Agency to consider not just whether a "significant change" in the MFP would have financial impacts on the Medicare program and beneficiaries, but also whether that change would lead to greater value to patients. CMS should also work to ensure that there is as much transparency as possible in its determination of renegotiation eligibility—especially for drugs that meet eligibility criteria through a "material change" in the negotiation factors that CMS determines would cause a "significant change" in the MFP. However, most notably, PhRMA believes that CMS should raise the threshold for determining whether an expected change in a drug's MFP would be "significant."

Using CMS' own reasoning it should raise the expected percent change in the MFP threshold from 15 percent to at least 35 percent. CMS notes in the draft program guidance that a 15 percent or greater expected change in the MFP "is consistent with the range of percent reductions in the ceiling price that is statutorily defined for drugs selected for renegotiation due to monopoly status changes." However, it remains unclear how CMS reached 15 percent as a consistent comparator based upon statutorily defined non-federal average manufacturer price (non-FAMP) ceiling changes when a selected drug switches monopoly status.

For drugs selected for initial price applicability years prior to IPAY 2030, the change in non-FAMP ceiling when a selected drug changes monopoly status equals 35 percent, not 15 percent. Section 1194(c)(4)(B)(ii) of the Act explicitly excludes drugs selected for IPAYs 2026 – 2029 from the definition of an "extended-monopoly drug" where the manufacturer has entered into an agreement. CMS acknowledged this, stating: "no selected drug will have a monopoly status change to extended-monopoly for purposes of renegotiation-eligibility" in 2028. Accordingly, the only drugs eligible for renegotiation selection for IPAY 2028 based upon a change in monopoly status will be those that change from short-monopoly to long-monopoly status. Using CMS' own reasoning that a "significant change" in the MFP should be consistent with percent reductions in the statutory non-FAMP ceiling price for different monopoly lengths, CMS should re-define the threshold to equal at least 35 percent. Setting the threshold

to at least 35 percent for expected change in the MFP if a drug were to undergo renegotiation due to either a new indication or material change in the section 1194(e) factors would align with the percentage change in the non-FAMP applicable percentage between short-monopoly (75 percent) and long-monopoly (40 percent) drugs, which would achieve the very consistency CMS cites as its goal in defining a "significant change" in the MFP.

In addition, even if CMS were to include in its analysis the non-FAMP ceiling applicable to extended-monopoly drugs, its proposal for a 15 percent change is arbitrary and does not follow the statute. The applicable percentages included in statute range from 75 percent of non-FAMP for short-monopoly drugs, to 65 percent of non-FAMP for extended-monopoly drugs (10 percentage point, or 13 percent change from short-monopoly), to 40 percent of non-FAMP for long-monopoly drugs (25 percentage point, or 38 percent change from extended monopoly). Put another way, none of the changes in monopoly status are associated with either a 15 percent or 15 percentage point reduction in the applicable percentage of the non-FAMP for determining the statutory ceiling price. As noted above, agencies are required to provide "adequate reasons" for their decisions.[229] CMS has failed to explain how its proposed 15 percent threshold accords with the statutory provisions on the various non-FAMP ceilings of 75, 65 and 40 percent. CMS should adopt the threshold of at least 35 percent starting in 2028, and extend it through 2030, during which the only changes in monopoly status for selected drugs will be from short-monopoly to long-monopoly.

Finally, raising the threshold to at least 35 percent will reduce the time and resource burden for both the Agency and manufacturers of selected drugs, especially if the price setting program continues to grow by CMS newly selecting and/or renegotiating already selected drugs. CMS is required to ensure that its renegotiation process is, "to the extent practicable … consistent with the methodology and process established" for annual price setting under section 1194(b) of the Act.[230] To ensure both manufacturers and CMS can adequately and thoughtfully engage in the offer and counter-offer process, and that the renegotiation process includes the patient and clinical voices essential to understanding each treatment's clinical value, CMS should choose a threshold that does not result in an inordinate number of medicines being chosen for renegotiation. Doing so could also reduce market volatility that may occur if a drug is selected for renegotiation each time a new indication or material change in the 1194(e) factors leads to an expected 15 percent or greater change in the drug's MFP.

IV. CMS Should Reduce Mandatory Data Submission Burden on Manufacturers of Drugs Selected for Renegotiation

CMS details in the IPAY 2028 draft program guidance that it will utilize both voluntary and mandatory data submissions to inform the renegotiation process. CMS notes that while the statute does not require the Agency to collect data from primary manufacturers to determine if there is a new indication or material change in the section 1194(e) factors, it will collect a subset of new (e)(1) data as a voluntary submission from the primary manufacturers whose product does not have a change to monopoly status for the purposes of renegotiation eligibility. Once a drug is selected for renegotiation, CMS will collect new information for all section 1194 (e)(1) data elements. This data submission will be *mandatory* for

[229] *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211 (2016).
[230] SSA § 1194(f)(4)(B).

primary manufacturers to submit via the negotiation data elements ICR (data elements ICR) and will share the same submission deadline as the ICR for the annual price setting process.

PhRMA appreciates the voluntary nature of the data submission to support the determination of eligibility for renegotiation. However, as PhRMA has previously stated[231] and further articulates in Appendix D of our IPAY 2028 draft program guidance comments, CMS' information collection request (ICR) forms are currently egregiously burdensome to stakeholders and continue to fall short of the three-prong regulatory test established by the Paperwork Reduction Act (PRA).[232] Yet, meaningful changes to rectify those concerns and comply with the PRA have not materialized, leaving data submitters spending countless staff hours compiling arbitrary data under intense compliance pressure. To date, it remains unclear how CMS uses the data elements required for ICR responses in the price setting process, or how it intends to use the information during the renegotiation process.

In order to address concerns regarding the overly burdensome data submission required for renegotiation, ***CMS should allow primary manufacturers to submit updates to the original data elements ICR, rather than requiring them to submit an entirely new ICR. To support this process, CMS should allow primary manufacturers to attest to ICR responses that have not significantly changed since the submission of the original data elements ICR. CMS should also be as transparent as possible with manufacturers on how they are using newly submitted information and recalculating the MFP for drugs selected for renegotiation.***

Subjecting manufacturers of selected drugs to repeated negotiation and renegotiation processes is burdensome, inefficient, and out of line with the Administration's focus on reducing needless regulation that hinders innovation and economic growth. A survey of PhRMA members reports that staff labor to populate the data elements ICR exceeds 7,700 hours on average across various business functions, consultants, and outside counsel. These demands will only be amplified if manufacturers are forced to resubmit the entire 73-page ICR for drugs selected for renegotiation. Allowing manufacturers to attest that information has not significantly changed will reduce the overall resource burden on stakeholders and introduce greater efficiency into the renegotiation process.

[231] See PhRMA comments on 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).
[232] 5 C.F.R. § 1320.5(d)(1)(i)-(iii).

June 26, 2025

VIA ELECTRONIC DELIVERY

irarebateandnegotiation@cms.hhs.gov

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Drug Price Negotiation Program (MDPNP)
Draft Guidance for IPAY 2028

Dear Administrator Oz,

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 2028 (the Draft Guidance).

PIRC is a collaborative, multi-stakeholder, patient advocacy coalition focused on improving access to and affordability of existing treatments while preserving incentives to advance future innovations in rare cancers. The coalition seeks to fulfill an important role in exchanging information, identifying, and resolving barriers to access and innovation, and educating both our rare cancer communities and policymakers on the Inflation Reduction Act (IRA) and its impact on rare cancer patients.

PIRC's comments to the Draft Guidance for IPAY 2027 acknowledged that the MDPNP will be an integral factor as investors and manufacturers calculate the feasibility of pursuing a particular drug candidate for a specific indication. Our rare cancer patient communities have expressed an increasing fear that CMS' MDPNP implementation will tip the scales away from innovation in cancers that impact too few patients to ensure a rapid return on investment and reasonable profit potential. As more fully detailed below, we urge CMS to align its MDPNP implementation efforts with the Administration's goals of improving transparency and preserving incentives for innovation.

PIRC's comments provide a brief discussion on rare cancers, including the pre-IRA oncology treatment development paradigm that has historically led to an increasing set of therapeutic options to improve both survival and quality of life for individuals battling cancer. The challenges generic and biosimilar manufacturers face lead to a longer timeline to generic/biosimilar competition that can make MDPNP selection an inevitability regardless of manufacturer behaviors. We highlight aspects of the MDPNP and/or CMS' implementation of the negotiation program that have already disrupted the oncology R&D paradigm to the disproportionate detriment of rare cancer patients, as well as our concerns that MDPNP's expansion to Part B drugs will inject provider complexities that, unless adequately addressed, could impede and delay Medicare beneficiary access to cancer care. PIRC has identified a set of recommendations to help CMS maintain a post-MDPNP access and innovation landscape that does not leave rare cancer patients with fewer new treatment advances and constricted access to existing therapies. PIRC and its rare cancer communities:

- Urge CMS to reconsider its definition of qualifying single source drug for negotiation eligibility purposes.
- Applaud the Administration's recognition that the "pill penalty" skews incentives for innovation away from small molecules and urge CMS to use its statutory drug selection authority to level the playing field until Congress amends the MDPNP.
- Have significant concerns that mechanisms for effectuating the MFP for Part B drugs could have unintended consequences for providers and patients. We recommend that CMS engage a broad set of stakeholders and focus on minimizing provider burden as it considers this aspect of the MDPNP.
- Emphasize that CMS should adhere to the IRA's statutory requirement that Part D plans must retain formulary inclusion for products with an MFP and enforce formulary inclusion requirements for treatments within the six "protected classes."
- Recommend that CMS align its stakeholder engagement approach with the Cancer Support Community's (CSC's) **Principles for Patient-Centered Engagement.**

Background: The MDPNP Does Not Fully Account for Research and Development Approaches in Cancer

CMS selected one oncology drug – Imbruvica, indicated for chronic lymphocytic leukemia (CLL) - for the MDPNP's first year. The set of selected drugs for iPAY 2027 includes four oncology drugs (Xtandi, Pomalyst, Ibrance and Calquence), one of which (Calquence) was a therapeutic alternative to Imbruvica. We expect that as Part B drugs become eligible for selection, the proportion of oncology agents subject to negotiated prices will increase, putting pressures on manufacturers and investors to reconsider whether, how, and when to direct funds toward cancer research and development.

PIRC is especially concerned that the MDPNP has changed the incentive framework for R&D and is tipping the scales against innovation and/or repurposing efforts for rare cancers. oncology R&D

model oncology drug development has traditionally been dynamic, with many drugs gaining multiple indications over time. New cancer therapies frequently launch with a narrow initial indication (often in a rare subtype or for relapsed/refractory subpopulations) and over time expand use to broader populations, adjuvant settings, within combination regimens and in other tumor types. This model has allowed companies to recoup early R&D costs and fund subsequent programs through sequential label expansions. This oncology R&D model has leveraged follow-on indications to treat more patients and increase a drug's value over a longer horizon.

One example of this sequential indication approach is Lynparza (olaparib), a small-molecule PARP inhibitor first approved (in 2014) for a rare, relapsed ovarian cancer subpopulation. Over the subsequent nine years Lynparza gained approvals in breast, pancreatic, and prostate cancers. We do not have to engage in "what if" scenarios to understand the MDPNP's impact. In August 2023, Genentech announced that it might delay an ovarian cancer indication for a small-molecule candidate until it could also submit data to FDA on a larger prostate cancer indication. The company noted that delaying the ovarian cancer launch would allow "nine years of Medicare sales for both ovarian and prostate cancer" at full price, versus losing a few years on the prostate cancer indication.

The MDPNP will disproportionately "penalize" rare cancer drugs due to logistic complexities in bioequivalence studies for oncology generics combined with difficulties sustaining a business case for generics addressing small populations.

In addition to the divergence in R&D approaches for cancers versus non-oncologic conditions, 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 have generics (49% vs. 80%).
- For off-patent drugs, the median time from approval to the first generic approval is longer for oncologic products compared to cardiovascular products (15.4 years versus 12.3 years).
- Several factors impede generic development in oncology, including product dosage form and FDA recommendations requiring patient enrollment for cancer treatment bioequivalence studies.

Availability of generic competition may also be less effective in reducing healthcare costs in cancer than in nonmalignant conditions. This is because newer versions of older cancer drugs offer improvements in progression-free survival and/or overall survival and become replacements for, rather than alternatives to, older treatments. Developing generic versions of older medications, therefore, may not be a viable investment given the challenges to developing these drugs identified above combined with the potential that older medications might become obsolete due to superior outcomes from branded competition. Once a cancer drug is subject to an MFP, the market for a generic alternative becomes even less attractive given the lower price point for the innovator product.

Imbruvica, one of the 10 drugs selected for negotiation during the IPAY 2026 cycle, provides a good example of this pattern. It was the first BTK inhibitor approved for chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL) and represented a sea change in treating this incurable cancer. Throughout the stakeholder engagement events, providers, researchers and patients emphasized that Imbruvica is no longer used as a first-line therapy due to the improved safety and efficacy profiles for second generation BTK inhibitors. Imbruvica is expected to be selected for re-negotiation during the IPAY 2028 cycle due to a change in status to "extended monopoly" and will face another renegotiation once it reaches long-monopoly status. Given the disadvantage it now has due to competition within the BTK inhibitor class, an MFP starting in 2026, and a likely renegotiation during the IPAY 2028 cycle, it is unlikely that Imbruvica will attract interest from generic manufacturers and avoid selection for a second renegotiation as an "extended monopoly" drug with an MFP ceiling of 40% of the relevant benchmark price.

PIRC urges CMS to reconsider its definition of qualifying single source drug (QSSD).

PIRC continues to believe that CMS' approach to identifying a qualifying single source drug (QSSD) based on common moiety (drugs) or common active ingredient (biologics) is not contained or implied by the statutory language directing that the Agency include all doses, formulations, and dosage strengths of a particular drug as a single QSSD.

- The determination of negotiation eligibility turns on the time that has elapsed **since approval of an NDA/BLA**.
- The process of examining therapeutic alternatives to a selected drug in determining an initial offer becomes a muddled proxy for a fair price if multiple NDAs/BLAs in divergent conditions with variable 30-day supplies and diverse sets of therapeutic alternatives are somehow aggregated.

Our patient communities are increasingly concerned that CMS' QSSD definition will make new FDA rare cancer approvals for existing drugs unattractive, and potentially infeasible, from a financial perspective. A recent article[1] authored by scientists at the Center for the Evaluation of Value and Risk in Health at Tufts Medical Center assessed the MDPNP's potential impacts on innovation. One clear consequence was the curtailment of manufacturer efforts to pursue follow-on indications for orphan drugs. The authors noted that their analysis "suggests that the potential foregone follow-on indication approvals for serious illness and unmet needs could be nontrivial. Such potential losses should be considered against the gains to consumers and society that come with lower drug prices."[2]

[1] Chambers JD, Clifford KA, Enright DE, Neumann PJ. Follow-On Indications for Orphan Drugs Related to the Inflation Reduction Act. JAMA Netw Open. 2023 Aug 1;6(8):e2329006. doi: 10.1001/jamanetworkopen.2023.29006. PMID: 37581890; PMCID: PMC10427936.
[2] Id.

As we near the close of the 2nd negotiation cycle, the MDPNP's impact has moved beyond predictions on potential impact into tangible, consequential business decisions disproportionately delaying, or even removing, promising candidates from the rare cancer pipeline. The Genentech/Roche delay in advancing a rare cancerindication outlined above is just one example of howthe MDPNP's economic implications are shaping portfolios and driving research priorities. A drug for an ultra-rare form of cholangiocarcinoma (bile duct cancer) has been put on hold until the manufacturer can seek approval in a broader tumor-agnostic population. Again, a rare cancer indication was shelved in favor of launching first (or simultaneously) in a more financially viable use in a larger population to avoid triggering the clock toward negotiation eligibility.

PIRC understands that the orphan drug exemption was intended to preserve incentives from the Orphan Drug Act. Unfortunately, it applies only if the drug remains a single-designation orphan product with no indications outside that designation. Rare cancer treatments often have FDA approved indications in multiple rare cancers that cannot fit into a single designation, and many have a combination of orphan and non-orphan indications. Between 2003 and 2022 nearly 23% of orphan-designated drugs later gained at least one additional FDA-approved indication, and 61% of those supplemental uses were for other rare diseases. Since enactment of the IRA, the percentage of orphan drugs obtaining a second rare indication has dropped by approximately 48%. Unless CMS refines its QSSD definition or otherwise removes the disincentives to post-approval cancer research, this critical pathway to expanded treatment options may no longer be economically feasible.

PIRC applauds the Administration's recognition that the "pill penalty" skews incentives for innovation away from small molecules and urges CMS to use its statutory drug selection authority to level the playing field until Congress amends the MDPNP.

The MDPNP has, by creating two separate timelines toward negotiation eligibility, set up a differential incentive framework based on whether treatment is a small molecule (MFP can be applied 9 years after approval) or a biologic (not eligible for an MFP until 13 years post-approval). The four additional years afforded biologics are extremely important given that for most drugs, 50% of cumulative sales during the first 13 years occur during years 10-13. Put simply, biologicals have 100% of their first 13 years of sales without a mandatory discount applied to Medicare sales while half of small molecule sales are subject to that discount in Medicare.

PIRC has significant concerns that mechanisms for effectuating the MFP for Part B drugs could have unintended consequences for providers and patients. We recommend that CMS engage a broad set of stakeholders and focus on minimizing provider burden as it considers this aspect of the MDPNP.

Implementing the MFP discounts for Part B drugs will entail new administrative and logistical processes that could burden healthcare providers and, indirectly, patients. Providers administering Part B drugs subject to an MFP will be receiving significantly lower reimbursement and, as the MFP

is renegotiated to lower levels, these cuts could tip the scales for some clinicians and centers and reduce the set of willing providers for negotiated Part B drugs. Rural patients with rare cancers could face access constrictions requiring them to either travel to distant academic medical centers or switch treatment regimens. We also expect that hospitals relying on 340B discounts to maintain their cancer infusion capabilities will find any incremental burden that accompanies a cut in revenue to be unacceptable. We urge CMS to keep this reality top of mind as it considers options for effectuating the MFP for Part B drugs.

CMS has previously outlined mechanisms to ensure manufacturers provide the negotiated price to "dispensing" providers. Both approaches, however, have drawbacks when applied to Part B drugs that could dramatically change how and where rare cancer patients receive infused treatments. These options can be broadly categorized below:

- Prospective Price Reduction Model: Providers would acquire the drug upfront at or below the MFP for their Medicare patients.
    - This alleviates the burden of purchasing drugs at full price and waiting for a rebate
    - Clinics would likely need to maintain separate stock for MFP-eligible Medicare patients
    - Inventory segregation is not only complex logistically but it could require additional storage space and staff
    - These issues are compounded for biologics requiring refrigeration or special handling.

- Retrospective Rebate (Reconciliation) Model: Under this model, providers continue purchasing drugs at normal prices, administer the therapy, and receive reimbursement based on the MFP. The manufacturer would then refund the difference between the purchase price and the MFP.
    - Although this approach avoids multiple inventories, it shifts a financial burden onto providers.
    - If the transaction is processed in the same manner as a Part D refund, a provider could have a 6-8 week wait for each dispensed dose.
    - Small practices and providers with thin cashflow margins will struggle to absorb this financial strain or, alternatively, have to borrow funds to bridge the gap.
    - Providers could also have significant administrative overhead associated with implementing new tracking systems, contracting facilitators or distributors for support, and ensuring compliance with CMS's requirements.

PIRC's patient communities fear that the burdens of MFP effectuation, combined with the reduced revenue due to an MFP well below the ASP, will push some practices out of Medicare participation and lead others to refer Part B drug administration patients to hospitals. For patients, the administrative complexities could lead to inconveniences or delays. For example, clinics maintaining separate inventories might decide to simplify their procedures by reserving doses for

Medicare patients and setting up administration on specific days. Under the retrospective model, provider financial strain could lead to delays reordering costly medications and disrupt patient treatment cycles.

We urge CMS to reach out to provider stakeholders to assess the impact the MFP and its effectuation will have and craft a process or set of processes that preserves, to the extent possible, the status quo for patients relying on Part B drugs for rare cancers and other serious conditions. Stakeholders should include:

- Community oncologist offices
- Independent infusion clinics
- Teaching hospitals
- 340B covered entities.
- Community cancer centers
- Rural oncologists
- Rural hospitals
- Hospitals, infusion centers, and providers in medically underserved areas

PIRC recommends that CMS require Part D and Medicare Advantage plans to include products with an MFP on their formulary, base utilization management tools on evidence, and include all or substantially all products with the protect classes on plan formularies.

Cancer patients face significant challenges in not only finding the best treatment option but being able to afford their prescribed treatments. Individuals with rare cancers typically have a limited set of effective therapeutic options; treatment affordability can be a matter of life and death. The IRA's Part D out-of-pocket cap, combined with enabling Part D enrollees to opt into Medicare's new payment program has reduced the risk that Medicare beneficiaries with rare cancers will be forced to choose between paying for their medications and maintaining access to food and housing.

PIRC understands that the MDPNP is just one part of a broader set of changes to the Part D program. Part D redesign has shifted a greater share of prescription drug costs onto Part D plans. Information on plan behaviors during this initial year of Part D redesign, combined with what can be gathered as the first set of Part D drugs are subject to a negotiated price will help CMS determine whether revised guidance and/or changes to CMS' formulary inclusion policies are warranted. We are, however, concerned that patients could face immediate and potentially harmful access constrictions as these two changes converge.

We have previously drawn CMS' attention to a 2023 double-blind, web-based survey of pharmacy directors, medical directors, and contracting managers/directors. This survey and its analysis provide insight into reactions to the IRA's drug provisions.[3] We remain concerned that most

[3] Ford C, Westrich K, Buelt L, Loo V. Payer reactions to the implementation of the Inflation Reduction Act: forecasting future changes to Medicare Part D plans. Presented at: AMCP Nexus 2023; October 16-October 19, 2023; Orlando.

respondents expect that the IRA's Part D changes will drive their organizations to implement narrower formularies in comparison to pre-IRA formulary design.

In addition, most payers are acutely aware of the increased liability for Part D plans due to the IRA's redesign provision. Payer respondents noted that they expected:

- greater use of utilization management tools
    - 42% anticipated greater utilization management overall.
    - 32% expect greater utilization management for high-cost medications.
    - 10% (n = 5) anticipate no change
- Increased Part D plan premiums
    - 8% anticipate a premium increase greater than 10%.
    - 40% expect an increase from 5% to 10%.
    - 18% anticipate an increase up to 5%.
    - 12% believe Part D plan premiums will remain at their current levels.
    - No payers expect that premiums will be lower than current levels.

CMS recognizes that as negotiated drug prices are implemented, plans will face downstream impacts to their bottom line due to replacement of the traditional rebates (reflected after the point of sale) with the MFP (reflecting discounted cost at the point of sale). The dynamics are uncertain and will vary based on whether there are other available drugs within the same category and class as the selected drug, as well as the PBM's and/or plan's ability to contract with manufacturers for favorable rebates on non-selected drugs.

PIRC remains concerned that by simply "monitoring" plan activities CMS will fail to sufficiently protect Medicare beneficiaries. Without CMS intervention and/or oversight, it is likely that plans will determine which drug(s) are associated with the lowest financial liability and steer patients toward that drug through formulary inclusion/exclusion, tier placement, and/or utilization management tools. The MDPNP will fail in its primary purpose – affordable access – if a selected drug is the only formulary option available despite competing products that may offer improved effectiveness and/or greater tolerability.

As the first anti-cancer treatment for which a negotiated price will be implemented, Imbruvica serves as a good example of how the MDPNP and Part D redesign could impact patient access to prescribed treatments. According to NCCN Guidelines, the most appropriate frontline treatment for CLL and SLL depends on patient-specific factors, including characteristics of the cancer and mutation status, age, and comorbidities. Subsequent lines of therapy are chosen based on the previous treatment as well as the factors outlined above. BTK inhibitors offer considerable improvements in care for patients but can result in drug intolerance requiring interruption, dose reduction, and even treatment discontinuation. Although clinical guidelines and recommendations recognize that newer BTK inhibitors have greater tolerability that would tend to improve outcomes, there is still much to learn about the various BTK inhibitors through real world data generated over time. BTK inhibitors are also increasingly being studied in combination with other treatment

options, and these uses should also be covered by Part D plans when the patient and their clinician determine that it is the best treatment option.

It is, therefore, imperative that Part D plans, including MA-PD plans, include all available treatment options on their formularies, without imposing step therapy protocols, so that clinicians and patients are able to make treatment decisions based on what will enable the patient to achieve a durable response while maintaining their quality of life. There is substantial concern that if Imbruvica is priced in a way that encourages health plans to insist on it as a first step, more patients will be steered away from care consistent with NCCN guidelines. Moreover, failure on one BTK inhibitor likely precludes use of other BTK inhibitors – making step therapy particularly inappropriate and potentially dangerous for patients given the limited lines of treatment available. At the same time, patients need to have access to all viable treatment options and those using Imbruvica successfully for their cancer are unable to take an alternative BTK inhibitor that may be more financially advantageous to a plan due to rebates and other price concessions.

We urge CMS to:

- Require plans to include all drugs subject to an MFP on their formulary as the statute mandates.
- Increase Agency oversight to ensure that plan formularies include all necessary medications, base all utilization management strategies on clinical evidence, and maintain expedited formulary exception processes so vulnerable patients, including those with rare cancers, can get non-formulary treatments while their exception request is pending.
- Provide Part D plans with clear guidelines on coverage, formulary tiers and utilization management (UM) tools.
- Proactively monitor the impact of the Manufacturer Discount Program, the MDPNP, and other D redesign provisions on formulary decisions and UM practices.
- Identify and mitigate any access constrictions, on the plan and sponsor levels as well as program wide.
- Establish a formal mechanism for patients and patient advocacy organizations to communicate their experiences, including any barriers to getting their prescribed medications when they need them, directly with CMS. We urge the Agency to create a dedicated communication channel as well as a set of proactive forums for patients and clinicians.

We are also concerned about the year-over-year erosion of protections for Part D drugs within the six “protected” classes, i.e., immune-suppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics. CMS’ designated these classes of drugs to require that plans include all or substantially all drugs within the class. The rationale --to ensure that formulary designs do not disadvantage and discriminate against vulnerable patients requiring access to specific drugs or combinations of drugs -- is as valid today as it was when the protected classes were created.

We recommend that CMS align its stakeholder engagement approach with the Cancer Support Community's (CSC's) *Principles for Patient-Centered Engagement.*

PIRC has previously emphasized that stakeholder engagement activities related to the MDPNP should be accessible to patients and caregivers and invite dialogue among participants and between participants and CMS staff. We have also urged the Agency to continue engaging patients beyond the negotiation process to ensure that any unintended consequences from the MDPNP are quickly identified and resolved.

Last year, the Cancer Support Community (CSC) collaborated with other stakeholders to establish a set of recommendations for patient-centered engagement within the MDPNP process and to guide and support subsequent policy efforts to ensure patient access to necessary medications. These recommendations include:

- Engage patient advocacy organizations, patients, and caregivers in structured, meaningful ways throughout the MDPNP process.
- Define clinical benefit to prioritize evaluations around endpoints, patient reported outcomes, patient experience data including impact on quality of life, and preferences that matter most to patients living with cancer and other complex conditions. This includes both qualitative and quantitative measures such as clinical endpoints, patient preference data/models, patient reported outcomes, and social impacts.
- Develop critical infrastructure necessary to educate the patient community and facilitate meaningful feedback that prioritizes patient definitions of value, including feedback on the evidence being considered by CMS and whether it reflects patient experiences and preferred outcomes.
- Refer to patient navigators to provide information to patients about the impact of these policies and to receive feedback from patients, with an explicit goal to identify any changes in utilization management practices as a result of IRA implementation.
- Develop a monitoring and evaluation platform and reporting framework surrounding the MDPNP and its impacts on patients to support continuous improvement in ongoing implementation.
- Collect and report specifically on access challenges facing patients as a result of the IRA to allow for continuous improvement of the MDPNP process and lessen the unintended consequences of this process on patients.
- Collect and incorporate meaningful data and real-world evidence that amplifies patient values and input within the MDPNP implementation process, including patient reported outcomes, patient experience data, impact to quality of life, and models that capture the dynamic and varied preferences of patients.

- Prioritize outreach to patients, people with disabilities, and people living in rural communitiesto ensure that the MDPNP supports all patient populations and does not threaten healthcare access.
- Consider the groups and populations that have not already engaged in defining patient-focused clinical benefit and impact of the MDPNP process and determine how best to activate those individuals.

PIRC urges CMS to align its ongoing MDPNP efforts with these principles.

Conclusion

PIRC appreciates the opportunity to contribute the rare cancer patient perspective 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.

A Cure In Sight
Biomarker Collaborative
Cancer Support Community
Cholangiocarcinoma Foundation
Chondrosarcoma Foundation
CLL Society
Cutaneous Lymphoma Foundation
Desmoid Tumor Research Foundation
Exon 20 Group
ICAN, International Cancer Advocacy Network
MET Crusaders
PDL1 Amplifieds

Point32Health
1 Wellness Way
Canton, MA 02021
point32health.org

June 26, 2025

Robert F. Kennedy, Jr., Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Kennedy:

On May 12, the Department of Health and Human Services (HHS) released draft guidance for the third cycle of the Medicare Drug Price Negotiation Program. We support efforts to support affordable healthcare access for the Medicare Advantage population and appreciate the opportunity to provide our insight.

Who We Are

Point32Health is a leading health and well-being organization, delivering an ever-better healthcare experience to everyone in our communities. Building on the quality, nonprofit heritage of our founding organizations, Tufts Health Plan and Harvard Pilgrim Health Care, we leverage our experience and expertise to help people find their version of healthier living through a broad range of health plans and tools that make navigating health and wellbeing easier.

Our programs take a 360-degree view of health for our members -- no matter their age, health, identity, or income. Our Foundation works with communities to support, advocate, and advance healthier lives for everyone and our Institute works to improve population health. We use empathy to understand what's important to those we serve, always making their priorities our own. We work to guide and empower people by bringing together wide-ranging partners and perspectives to create new approaches that make a real difference for both our industry and our 2.2 million members across the United States. We are proud that our Harvard Pilgrim Health Care Commercial Combined HMO, PPO and POS plans in Massachusetts and Maine, our Exchange HMO plans in Massachusetts and Maine, as well as Tufts Health Plan's Medicaid and Exchange HMO plans, have received full Health Equity Accreditation from the National Committee for Quality Assurance (NCQA). We are consistently a highly rated Medicare Advantage plan. For eight years, from Star Year 2016 to Star Year 2023, our Tufts Medicare Preferred HMO plan received a 5-star rating from the Centers for Medicare & Medicaid Services, the highest rating possible.

We are proud that Point32Health was recently recognized for the fourth time and the third year in a row as one of the 50 most community-minded companies in the nation by Points of Light, the world's largest nonprofit dedicated to volunteer service. A national standard for corporate citizenship, the Civic 50 showcases how leading companies are incorporating social impact, civic engagement, and community integration into their practices and values.

Overview of Our Comments

We appreciate CMS's efforts to reduce healthcare costs via the Medicare Drug Price Negotiation Program. In order to ensure this program functions optimally for all Americans, we recommend that CMS:

I. **Reduce Global Discrimination in Drug Pricing:** In the U.S., prescription drugs are two to three times more expensive than in the European marketplace. We greatly appreciate the actions this Administration has taken to reduce this global price discrimination, such as the recently-released Most-Favored Nation Executive Order (EO). It is especially helpful that the EO appears to apply to all types of health coverage, including drugs purchased for commercial health plans covering working Americans as well as those purchased for Medicare beneficiaries. We encourage the Administration to view drug pricing through the lens of "fair trade" – or in this case, unfair trade practices that impact pharmaceutical costs in both government programs (e.g. Medicare) as well as the commercial market and employer-based coverage. Higher drug costs in the U.S. translates into higher input costs for American manufacturers and disadvantages American-made products.

II. **Ensure the American People Receive the Best Negotiated Rate in the Medicare Drug Price Negotiation Program:** While we appreciate that the Medicare Drug Price Negotiation Program is a tool to leverage the full buying power of the United States government, there are nonetheless occasions when individual plans can secure lower negotiated rates for specific drugs. When this occurs, plans should be able to leverage their lower rates, rather than being forced to adopt the higher Medicare Drug Price Negotiation Program price. We urge CMS to grant this flexibility.

III. **Exercise Discretion in Identifying Qualifying Single Source Drugs for Initial Price Applicability Year 2028:** In the draft guidance, CMS describes its methodology for "fixed combination" drugs. Specifically, if a fixed combination drug has two or more active moieties/active ingredients, the distinct combination of active moieties/active ingredients has been considered one active moiety/active ingredient. Therefore, all formulations of this distinct combination offered by the same New Drug Application (NDA)/biologics license application (BLA) holder are aggregated across all dosage forms and strengths of the fixed combination drug. This is not required by statute, and therefore we encourage CMS to use the full discretion afforded by statute.

IV. **Leverage Existing Tools Rather Than Adding Administrative Burden:** CMS seeks comment on how best to monitor Medicare Advantage (MA) plans' use of Part B step therapy practices to ensure compliance with program rules and any data or policy clarifications that may be needed for implementation. In the spirit of this administration's focus on reducing administrative burden and regulatory red tape, we believe CMS should leverage existing MA rules and reporting requirements to monitor program implementation, rather than adding new regulatory requirements.

The healthcare environment presents increasingly complex challenges as we strive to maintain affordability, improve health outcomes, and comply with evolving regulatory expectations. We appreciate this important initiative by the federal government.

We look forward to continued collaboration to advance a stable, affordable, and accessible healthcare system. Please contact Christina.Nyquist@Point32Health.org if we can provide additional assistance.

Sincerely,

Christina Nyquist

Vice President, Federal Affairs

Appendix

I. **Reduce Global Discrimination in Drug Pricing:** U.S. prices for brand drugs were 3.22 times as high as prices in comparison countries, even after adjustments for estimated U.S. rebates. We appreciate the Administration recently issued an Executive Order on Most Favored Nation pricing for pharmaceuticals. Given that pharmaceuticals comprise 24% of premium costs, this is a significant challenge for patients and employers. However, it also is a larger issuer for the economy overall. By paying "below value" prices for pharmaceuticals, western European countries can afford to sell other products to the United States at a discount. In 2019, the latest year for which data are available, private insurers and government health programs spent $963 per capita on prescription drugs while comparable countries spent an average of $466. Looking at this very simplistically -- that means those countries had lower "input" costs of any product they produced of $497 per capita for the Western European employees involved in designing, manufacturing, selling, and distributing that product to the United Sates.

   Recommendation: We appreciate the recent Executive Order promoting Most Favored Nation pricing. It is especially helpful that the EO appears to apply to all types of health coverage, including drugs purchased for commercial health coverage as well as those purchased for Medicare beneficiaries. We encourage the Administration to view drug pricing through the lens of "fair trade" – or in this case, unfair trade practices that impact pharmaceutical costs in both government programs (e.g. Medicare) as well as the commercial market and employer-based coverage.

   While we support innovation in medical care, including the development of new curative pharmaceuticals, it is nonsensical that Americans are the lone wealthy country to disproportionally fund these advancements. Either Western European countries should be held directly responsible for fair trade drug payments, or indirectly by imposing requirements on pharmaceutical companies. However, we urge the Administration to approach this carefully, as direct tariffs on the pharmaceuticals themselves could backfire and send cost-spikes through the healthcare system. Unlike normal consumer goods, pharmaceuticals may not have readily available alternatives and so purchasers lack the flexibility to "walk away."

   We also urge CMS and this administration to consider solutions that positively impact both government programs as well as private sector coverage. Otherwise, well-intentioned improvements in government programs could lead to cost shifting to working Americans with private coverage.

II. **Ensure the American People Receive the Best Negotiated Rate:** While we appreciate that the Medicare Drug Price Negotiation Program is a tool to leverage the full buying power of the United States government, there are nonetheless occasions when individual firms can secure lower negotiated rates for drugs. However, plans are required to adopt the maximum fair price (MFP) negotiated by the federal government as part of the Medicare Drug Price Negotiation Program. As a result, members receive a worse deal than they otherwise would have absent the MFP. This is counter to the aims of the negotiation program and counter to common sense.

Recommendation: To maximize impact to the American people, CMS should grant flexibility to plans that are able to negotiate better rates for specific drugs than the MFP under the negotiation program to leverage those lower rates, rather than being forced to adopt the higher federal negotiated price. We urge CMS to grant this flexibility.

III. **Exercise Discretion in Identifying Qualifying Single Source Drugs for Initial Price Applicability Year 2028:** In the draft guidance, CMS describes its methodology for "fixed combination" drugs. Specifically, if a fixed combination drug has two or more active moieties/active ingredients, the distinct combination of active moieties/active ingredients has been considered one active moiety/active ingredient. Therefore, all formulations of this distinct combination offered by the same NDA/BLA holder are aggregated across all dosage forms and strengths of the fixed combination drug. Given that Part B drugs will first be eligible for inclusion in initial price applicability year 2028, CMS solicits comments on whether it should modify the fixed combination drug policy, including potentially grouping fixed combination drug products with products containing at least one but not all of the active moiety(ies)/active ingredient(s) into the same potential qualifying single source drug under Part B and/or Part D.

Statute mandates that CMS aggregate a drug across dosage forms and strengths, including new formulations, for maximum fair price (MFP) purposes. Nothing in the statute specifies that CMS aggregate by active moiety/ingredients. Just as CMS is not bound by the Food and Drug Administration's (FDA's) NDA and BLA enumeration system to define a drug, CMS is also not bound by the FDA's method of listing active moieties when determining how to aggregate a drug across formulations.

Given this lack of statutory prohibition, we believe CMS should take an expansive approach to defining a single-source drug for MFP purposes. A rigid approach that disaggregates fixed combination drugs into separate combinations unless they have identical active moiety/ingredients – even when some of those active ingredients or moieties are not biologically active (or "clinically meaningful") - provides a roadmap for drug manufacturers to evade the statutory requirements. Not only would this allow unscrupulous manufacturers to evade negotiation by adding a clinically meaningless ingredient or moiety – therefore undercutting the purpose of the drug price negotiation program – it would also penalize good-faith manufacturers who invest in clinically relevant improvements like extended release formulations.

Recommendation: We encourage CMS to use the full discretion afforded to the agency by statute to aggregate all formulations of fixed combination of active moieties/ingredients that have clinically meaningful differences. This would allow a fixed combination drug formulation to be treated as a single source drug despite the existence of active ingredients or active moieties in one or more of the drugs that are not present in the other drug(s).

IV. **Leverage Existing Tools Rather Than Adding Administrative Burden:** CMS seeks comment on how best to monitor MA plans' use of Part B step therapy practices to ensure compliance with program rules and any data or policy clarifications that may be needed for implementation. In the

spirit of this administration's focus on reducing administrative burden and regulatory red tape, we believe CMS should leverage existing MA rules and reporting requirements to monitor program implementation, rather than adding new regulatory requirements.

The MA program already contains robust regulatory oversight requirements. For example, In particular, 42 CFR § 422.136 requires MA plans that implement a step therapy program for Part B-covered drugs to: 1) apply step therapy only to new administrations of Part B drugs, using at least a 365 day lookback period; 2) establish policies and procedures to educate and inform health care providers and enrollees concerning its step therapy policies; and 3) ensure that the step therapy program has been reviewed and approved by the MA organization's pharmacy and therapeutic (P&T) committee. CMS can monitor potential issues relating to an MA plan's use of Part B step therapy practices through the Part C reporting requirements that cover organization determinations and reconsiderations. Furthermore, CMS also has authority to conduct audits related to step therapy.

This issue is particularly salient to Point32Health, as increased regulatory burdens disproportionately impact regional and not for profit organizations as compared to for-profit national organizations. Smaller health plans are less able to absorb administrative costs, resulting in resources being diverted from initiatives to improve patient experience and outcomes. Moreover, these burdensome rules thwart competition as over-regulation of an industry favors the largest competitors and forces smaller operations to exit the market or to never enter at all.

> ***Recommendation:*** Consistent with this administration's efforts to reduce regulatory burdens, CMS should leverage existing tools to monitor plans' use of step therapy practices rather than layer on additional, unnecessary reporting requirements.

PORTAL
Program On Regulation, Therapeutics, And Law
Division of Pharmacoepidemiology and Pharmacoeconomics
Harvard Medical School | Brigham and Women's Hospital

Date: June 23, 2025

From: John Kim; Aaron S. Kesselheim, MD, JD, MPH; Benjamin N. Rome, MD, MPH; *all from the Program On Regulation, Therapeutics, And Law (PORTAL), Division of Pharmacoepidemiology and Pharmacoeconomics, Department of Medicine, Brigham and Women's Hospital and Harvard Medical School, Boston, MA.*

To: Chris Klomp, CMS Deputy Administrator and Director of the Center for Medicare, Centers for Medicare & Medicaid Services

Re: Comments related to the May 12, 2025 Draft Guidance on the Medicare Drug Price Negotiation Program

Halting Hyaluronidase Hopping: Why CMS Should Prevent Strategic Reformulations from Undermining the Medicare Drug Price Negotiation

On May 12, 2025, the Centers for Medicare and Medicaid Services (CMS) released a draft guidance for implementing the Medicare Drug Price Negotiation Program under the Inflation Reduction Act (IRA) for the initial price applicability year 2028. Among several technical updates is a proposed clarification in Sec 30.1, which could have outsized implications for the program's success.

Under the IRA, CMS is required to aggregate data across dosage forms and strengths of a drug when identifying qualifying single source drugs. To operationalize this process, CMS has adopted the terminology "active moieties" and "active ingredients." As defined by the U.S. Food and Drug Administration (FDA), an "active moiety" is the core physiologically active molecule of a drug, while an "active ingredient" is a broader concept that refers to any substance intended to have pharmacological activity. For fixed combination drugs that contain multiple active ingredients or moieties, CMS previously indicated in guidance that they would be treated separately from a products containing each individual active ingredient or moiety.

In its new 2025 draft guidance, however, CMS solicited feedback for implementing a clarification to this policy. The guidance states in Section 30.1 (page 13): *"CMS acknowledges that*

there may exist fixed combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference."

Thus, CMS proposes that they would group these fixed-dose combination products with other products containing the therapeutically active ingredient. This clarification is essential to safeguarding the IRA's negotiation framework from manufacturer tactics that seek to reset or delay negotiation timelines by exploiting minor reformulations without meaningful clinical impact.

CMS's proposal is timely because a growing number of intravenously infused biologic drugs that could otherwise be eligible for price negotiation in the next few years have been re-marketed with hyaluronidase to allow subcutaneous administration. Although subcutaneous versions of medications can be more convenient and better tolerated than intravenous formulations, the addition of hyaluronidase does not modify the therapeutic activity of the products against the target disease. The FDA defines hyaluronidase as a separate active ingredient in these products, which means that under prior CMS guidance these would have be treated as fixed-dose combination products separate from the original non-hyaluronidase versions for the purposes of determining eligibility for Medicare price negotiation. This would have allowed manufacturers to engage in "hyaluronidase hopping": introducing new versions of drugs co-formulated with hyaluronidase with the effect of delaying price negotiation since the newer hyaluronidase versions would not be subject to negotiation until several years after the original intravenous version.

In a recent study,[1] we found that as of December 2024, at least nine biologics had hyaluronidase versions either approved or in late-stage clinical development. In 2022, Medicare spending on these products totaled $10.3 billion. For example, daratumumab (Darzalex) was first approved in 2015 for multiple myeloma; a subcutaneous coformulation (Darzalex Faspro) was later approved in 2020, and by 2022 Darzalex Faspro accounted for 82.9% of the Medicare Part B spending on daratumumab products.

The financial stakes of CMS's draft guidance are perhaps most acute for pembrolizumab (Keytruda), the world's top-selling drug in 2024, with $29.5 billion in sales. Keytruda was approved in 2014 and will likely be eligible to be selected for Medicare price negotiation in 2026, the first year Part B drugs are eligible for selection. However, a hyaluronidase version of Keytruda is expected to launch in

[1] John Kim, Aaron S Kesselheim, Edward R Scheffer Cliff, Benjamin N Rome, Medicare spending and use of subcutaneous biologic formulations with hyaluronidase, *The Oncologist*, Volume 30, Issue 6, June 2025, oyaf149, https://doi.org/10.1093/oncolo/oyaf149

the US by October 2025.[2] Considered as a separate product, this new version would not become eligible for price negotiation until at least 2036. If many Medicare patients switch from using the intravenous to the subcutaneous hyaluronidase version of Keytruda, this could effectively undermine the savings Medicare might expect from negotiating a lower price for Keytruda. However, under the new guidance, CMS could combine the intravenous and subcutaneous versions of Keytruda for the purposes of price negotiation.

To ensure that manufacturers of drugs like Keytruda cannot "hyaluronidase hop" to delay the effects of price negotiation, CMS should specify a clear operational distinction between active ingredients/moieties that provide therapeutic benefit and those that function solely to facilitate delivery. Thus, we propose that CMS should define "therapeutically active" ingredient as independently conferring benefit for the treatment of the indicated disease state. Therapeutically active should not include ingredients such as excipients and enzymes that alter absorption or tissue permeability, such as hyaluronidase, which actively depolymerizes hyaluronan to enhance the dispersion of co-administered agents in subcutaneous tissue. Hyaluronidase and its recombinant variants (e.g., rHuPH20, berahyaluronidase alfa), while biologically active, function solely to facilitate subcutaneous delivery of other therapeutically active ingredients.

If a therapeutically inactive ingredient is included in a fixed combination drug, this product should be combined for the purpose of drug price negotiation with other products that contain the therapeutically active ingredient(s). CMS should clarify in the final guidance that the presence of a therapeutically inactive ingredient or moiety in a fixed combination drug does not warrant classification as a distinct drug for the purposes of selection.

This definition would affect more than just hyaluronidase co-formulated products, because there are several other examples of therapeutically inactive ingredients that are part of fixed combination products. In the Parkinson's disease treatment carbidopa-levodopa, levodopa—a precursor to dopamine—is therapeutically active, while carbidopa reduces the peripheral metabolism of levodopa and thus enhances its bioavailability in the brain. Buprenorphine, an effective treatment for opioid use disorder, is often co-formulated with naloxone, an opioid antagonist that has essentially no absorption when the product is used orally or sublingually as directed; instead, naloxone serves as a deterrent and prevents overdose if the product is injected or inhaled**.** Several HIV antiviral treatments include ritonavir

[2] https://www.reuters.com/business/healthcare-pharmaceuticals/merck-plans-us-launch-subcutaneous-version-keytruda-october-1-2025-03-27/

or cobicistat, which boost the pharmacokinetic effects of other antivirals by inhibiting cytochrome P450-34A. In each of these cases (carbidopa, naloxone, and ritonavir or cobicistat), the therapeutically inactive ingredients are not used alone to treat the disease.

One argument against CMS combining drugs along with their counterparts co-formulated with therapeutically inactive components for the purposes of qualifying for negotiation is that this could disincentivize the development of new formulations that enhance delivery, efficacy, or safety. However, brand-name manufactures already have substantial financial motivation to pursue such innovations to increase sales of their products, In some cases, manufacturers are able to patent the co-formulated versions, which can delay generic or biosimilar competition. Additionally, any added benefits of the fixed combination version over the original version or any other therapeutic alternatives can be considered by CMS as part of the negotiation process. By negotiating products that include therapeutically inactive ingredients alongside products that contain only therapeutically active ingredients, CMS can preserve incentives for meaningful innovation while preventing opportunities for manufacturers to strategically undermine the negotiation process.

One additional change that CMS should incorporate in its new guidance is necessary to ensure that manufacturers are unable to delay or defer price negotiation by introducing new formulations, including fixed combination drugs that include therapeutically inactive ingredients. The IRA specifies that drugs with generic or biosimilar competition are ineligible for price negotiation. Under current operating procedure, CMS determines whether "*a generic drug or biosimilar biological product has been approved or licensed for any of the strengths or dosage forms for the potentially qualifying single source drugs"* (30.1). Thus, if there are multiple dosage forms available but only 1 has generic competition, the entire product is excluded from negotiation, even if the newer version(s) alone would qualify.

This could prevent CMS from negotiating in cases when there is generic or biosimilar competition for an older version of a drug even while the new version without competition has substantial Medicare spending.[3] For example, in the case of the antipsychotic paliperidone, the existence of generic competition for the oral formulation would have prevented negotiation of later-introduced long-acting intramuscular formulations that incurred billions of dollars in Medicare spending.

[3] Matthew Vogel, Benjamin N. Rome, Aaron S. Kesselheim, et al. Medicare Negotiation's Drug Reformulation Problem. Ann Intern Med.2024;177:817-819. doi:10.7326/M24-0138

In the case of hyaluronidase or other similar products, manufacturers could avoid price negotiation on blockbuster products by using their marketing resources to convert most patients to the new fixed-dose co-formulations and allowing biosimilar competitors to enter the market for the older, less-used formulations. For example, Darzalex Faspro accounts for the overwhelming majority of Medicare spending on daratumumab products, but this version would be exempt from negotiation if the older, less-used intravenous version faces biosimilar competition.

To close this loophole, CMS should aggregate spending only across formulations that do not face generic or biosimilar competition when evaluating eligibility for price negotiation. If the remaining formulations without a generic or biosimilar account for aggregated Medicare spending exceeding $200 million, they should remain eligible for negotiation. Additionally, if bona fide generic or biosimilar competition begins for a drug that has already been selected and negotiated, CMS should evaluate whether the competition affects all included dosage forms and formulations. If one or more formulations lack generic or biosimilar competition, CMS should retain those versions as selected drugs.

Because of the major financial implications of hyaluronidase hopping for patients and the US health care system, we support CMS's assertion that fixed combination drugs that contain therapeutically inactive ingredients can be combined with other formulations of the active ingredient for the purposes of price negotiation. Doing so will ensure that modified formulations are negotiated alongside the original versions of drugs, fulfilling Congress' intent in the IRA. In addition, CMS should modify its approach to excluding drugs based on generic or biosimilar competition so that competition for one formulation does not prevent negotiation for other formulations. Implementation of both changes will ensure that drugs are not inappropriately excluded from reasonable price negotiation by the Medicare program.

Prism Squared's response to CMS' request for comments

Prism^2 would like to thank CMS for the opportunity to comment on the proposed implementation of CMS' Medicare Drug Price Negotiation Program (MFP) and Draft Guidance dated May 12, 2025 "Providing Access to the MFP in 2026, 2027, and 2028 CMS."

In the Draft Guidance, CMS seeks comments on "potential private market solutions that could offer an alternative to the MTF and the extent to which interested parties perceive a need for ongoing MTF support over time." It is our intent to describe, at a high level, the benefits of utilizing a real-time, rules-based platform for prescription payment reform across Medicare, Medicaid, commercial and self-funded plans that is fully transparent, provides full disclosure to patients of all benefits provided toward the prescription costs, and the entire process is fully auditable.

In our collective effort to make medications more affordable, multiple sources of prescription discounts and benefits have become available to patients. As a multiplicity of financial assistance sources have become available, our current system of notification and providing access has become complicated, inefficient, and conflict-prone, often leading to overlaps, duplications, and omissions when none of those issues should exist. These additional sources of benefit are available, but the chronology is not flexible due to policy and regulatory restrictions that prevent the application of certain sources of financial benefit prior to the claim being presented to CMS for payment consideration. If these restrictions were removed and other discounts or rebates could be applied prior to the claim being presented to CMS, the remaining amount to be considered for payment by CMS would be greatly reduced; saving the program significant money in addition to reducing administrative effort and expense. Without addressing issues such as:

- 340b vs MFP de-duplication
- Dataset validation
- Patient and claim eligibility

- Dispensing entity eligibility
- Prescribing authority and eligibility

and other claim eligibility and integrity issues in real-time, the MFP program is likely to face many challenges, some of which have already been identified and remain unresolved. What is needed is an overall re-architecture of the claims processing and payment methodologies while utilizing existing standards, frameworks, and capabilities.

Below are our comments, suggestions, and explanations of issues, solutions, and proposed actions that, in our view, will stabilize and promote the success of CMS' MFP program in coordination with the 340B program.

Section 40.4.2.1 Primary Manufacturer Participation in the MTF DM, page 68, paragraph 4

While primary manufacturers are bound by law to participate in the MTF DM, that data module has weaknesses that could be overcome if utilizing capabilities for the MTF that are standard in the prescription processing and payment industry. For example, items 1 and 2 describe that if the claim either does not have any DDPS edits or has edits, but they are unrelated to the MFP eligibility, the MTF DM will transmit the claim-level data to the manufacturer and start the 14-day prompt payment window. However, if the claim has DDPS edits that are required for the MTF PM, the MTF DM will not transmit the claim-level data to the manufacturer until either they are resolved, or 90 days have passed. After the 90-day resolution window, the MTF DM will notify the dispensing entity that the claim has not been paid.

In the normal course of processing and adjudicating a prescription claim request, data elements required to successfully process a benefit claim are specified by a "payer sheet". The "payer sheet" defines what data elements the pharmacy system must submit electronically for a claim to be considered for successful adjudication and what the payer will return to the pharmacy system as a response so the pharmacy can successfully administrate the response for the claim. The examples given on page 68, paragraph 3 of "missing service provider ID" or "missing or invalid date of service", are standard data elements that are required for successful adjudication of prescription benefit claims.

We recommend CMS to utilize a real-time adjudication process such that each PDP or MAPD benefit claim was also adjudicated to a Medicare Drug Price Negotiation Program benefit, all of the PDE data elements that are listed in Table 2 on pages 64-66 could all be verified as present in real time. That process would completely avoid the opportunity for those data elements not to be present, thereby negating the utilization of a potential 90-day delay while the plan verifies the missing data element. If a required data element was not present on the claim, the claim would fail, and no benefit/rebate/discount would be due.

Additionally, the dispensing entity would receive an electronic notification in real time describing how to amend the claim for successful consideration of benefits eligibility.

Section 40.4.2.1 Primary Manufacturer Participation in the MTF DM, page 68, paragraph 2

Here it is stated: "*Beginning January 1, 2025, the "Submission Clarification Code" value of "20" and the "Submission Type Code" value of "AA" was added to the PDE record to indicate a 340B claim. · A dispensing entity may* ***voluntarily*** (emphasis added) *apply these indicators to a Part D claim to indicate the claim is being billed for a 340B drug.*

CMS goes on to say that it will not guarantee the validity of the dispensing entity's submission of these data elements or that the claim is or is not eligible for 340B discounts.

One of the issues identified by manufacturers, some of whom have even taken legal action against HRSA, is that if they have already provided 340B discounts up front to Covered Entities, they are not expected (by law) to provide further rebates or discounts, including for the MFP. The currently available process for the manufacturer to identify claims as 340B claims and avoid paying further rebates (for example Medicaid), is not extremely accurate and takes significant time to complete. That is one reason why some have attempted to pursue financial rebates for 340B instead of the legacy upfront discounts.

While the rebate approach would help the manufacturer to avoid duplication of discounts/rebates, the Covered Entities state that the higher price up front coupled with delays in payment of rebates while the manufacturer qualifies rebate claims would present significant financial hardship on their provision of health services to the people they serve.

While CMS and HRSA define how the 340B and MFP discounts and rebates will be effectuated in the future, whether 340B is implemented through an up-front discount or a post-dispense rebate, an ideal solution would be flexible enough to support either method yet intelligent enough to determine which path provided the most benefit to CMS and consumers and choose that path to proceed. Once the path of adjudication is completed, payment for either the 340B or the MFP rebate will occur within 7 days of dispense. While having the 340B program managed under the same supervision as the Medicare Drug Negotiation Program would be helpful, it should not be mandatory to facilitate the synchronization of both programs

Section 40.4.3 MTF Payment Facilitation

The MFP requires Primary Manufacturers to issue MFP refund payments directly to dispensing entities. Prior to this program, manufacturers did not issue payments to these entities and as stated, the methodology to do so did not exist. Due to that, "CMS received significant feedback from interested parties urging the establishment of a payment facilitation mechanism that would create standardization, predictability, and reduced

burden for all parties." Due to the apparent necessity of creating a means for these payment flows to occur; CMS has engaged a contractor to build and make available an MPF Payment Module that manufacturers can utilize to facilitate these payment flows.

However, these capabilities have, in fact, already existed and have been thoroughly used prior to the Medicare Drug Price Negotiation Program. Brand manufacturers have utilized prescription coupons for decades and the functionality utilized there does just that. A financial benefit for a patient is generated from a manufacturer and it is executed through a third party to generate amounts owed to individual dispensing entities. Payment is then received from the manufacturers by the third party and payment is made to the dispensing entities by the third party on behalf of the manufacturer.

However, what is missing is automation of the benefit. In the coupon example, those are not utilized in every case and reliability of availability of benefit to every qualified recipient is not guaranteed.

We recommend CMS require an automated process that would provide the MFP benefit only to eligible transactions, at the pharmacy, in real time utilizing existing processing and payment mechanisms. The path to successful implementation is cleaner, faster, more accurate, and proven. This process needs to occur, and the discount needs to be applied, prior to the claim being submitted to CMS. While this path may require policy changes to alter the chronology of claims, the result streamlines the administrative effort and cost in addition to reducing up-front cost to CMS for claims payment.

If CMS were to utilize a standard benefits adjudication platform with defined benefits eligibility criteria, many, if not all, of these issues would be resolved. However, we recognize that adjudication to multiple entities under the **current** business practices would require the pharmacy to submit two separate claims; one for the PDP or MAPD benefit and the second for the MFP benefit. However, if CMS were to allow it a methodology could be utilized that would make multiple adjudications possible from a single benefit request in an automated process. While this may be new territory for CMS, technology similar to this has existed in the public arena since 2005.

Section 40.4 *Providing Access to the MFP in 2026, 2027, and 2028, page 54,* paragraph 7

In the request for comment in the referenced section and paragraph, CMS suggests that "the private sector could develop alternative solutions for sharing verified data or for routing refund payments from manufacturers to dispensing entities." We would like to inform CMS of our patented process that, if implemented, would do that in addition to supporting other current challenges presented to the Medicare Drug Price Negotiation Program. The process would also provide a pathway for complete transparency to the end consumer by providing an all-inclusive description of all financial benefits provided toward

the cost of their prescription and by whom they were provided. We call this re-design of the current system **Prism^2.**

Prism^2 is designed to deliver:

- Real-time processing and adjudication of multiple claims for multiple benefits, rebates, or discounts from a single claim submission
- Rebate de-duplication (MFP vs 340b vs commercial)
- Transparent, encrypted payment flows
- Automated legal compliance
- Cost savings for plans (including CMS), manufacturers, and patients
- Integration into current claim and payment workflows in the pharmacy, including prompt pay requirements

Why it matters:

- **For Patients:** Lower out-of-pocket costs and **full disclosure of benefit streams**
- **For Pharmacies:** Fair, faster payments that fit into current business flows, less work in the pharmacy.
- **For Plans/Payers (ex. CMS):** Accurate spend tracking, faster rebate payment, rebate auditability to plan and member level, lower cost of benefits, full disclosure of all benefits provided to the member's prescription cost
- **For Regulators:** Compliance automation, auditability, duplication avoidance, and speed of payment and data processes
- **For Manufacturers:** Prevents duplicate rebate liability, lower costs, informing the patient of all benefits provided by the manufacturer toward the cost of each prescription

Attached to these comments are figures 1 and 4 from US Patent #11,475,986, a description of the flow for figure 4, and a sample mock-up of a patient Explanation of Benefits that would be provided in both paper and electronic form. There are multiple iterations of the capabilities described in the patent and this is just one example. The steps represented in Figure 4 do not mean that a benefit is available, rather, it represents that the possibility is there and, therefore, that path must be considered. Processing up to 5 endpoints has been estimated to take place in 5 seconds or less.

We encourage CMS to consider all these solutions, including policy changes that would allow other sources of benefit to be applied in real time to claims prior to CMS shouldering the load for the remaining value of the claim.

Finally, we would like to thank CMS again for the opportunity to provide insight from the public sector about a proposed solution to address issues that CMS' Medicare Drug Price Negotiation Program is expected to experience once live.

Sincerely,

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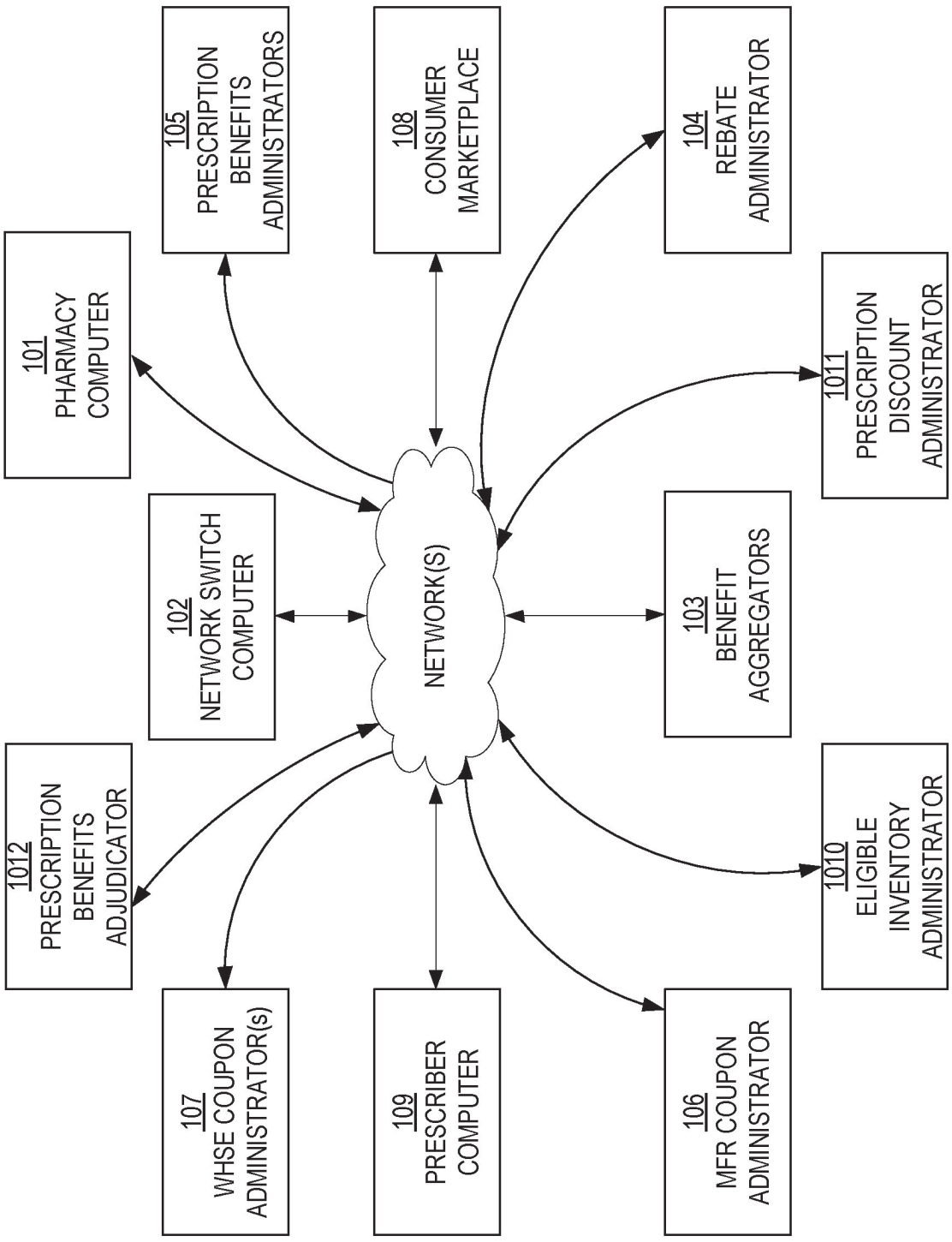
101 PHARMACY COMPUTER
105 PRESCRIPTION BENEFITS ADMINISTRATORS
108 CONSUMER MARKETPLACE
104 REBATE ADMINISTRATOR
1011 PRESCRIPTION DISCOUNT ADMINISTRATOR
102 NETWORK SWITCH COMPUTER
NETWORK(S)
103 BENEFIT AGGREGATORS
1012 PRESCRIPTION BENEFITS ADJUDICATOR
1010 ELIGIBLE INVENTORY ADMINISTRATOR
107 WHSE COUPON ADMINISTRATOR(s)
109 PRESCRIBER COMPUTER
106 MFR COUPON ADMINISTRATOR

FIG. 1

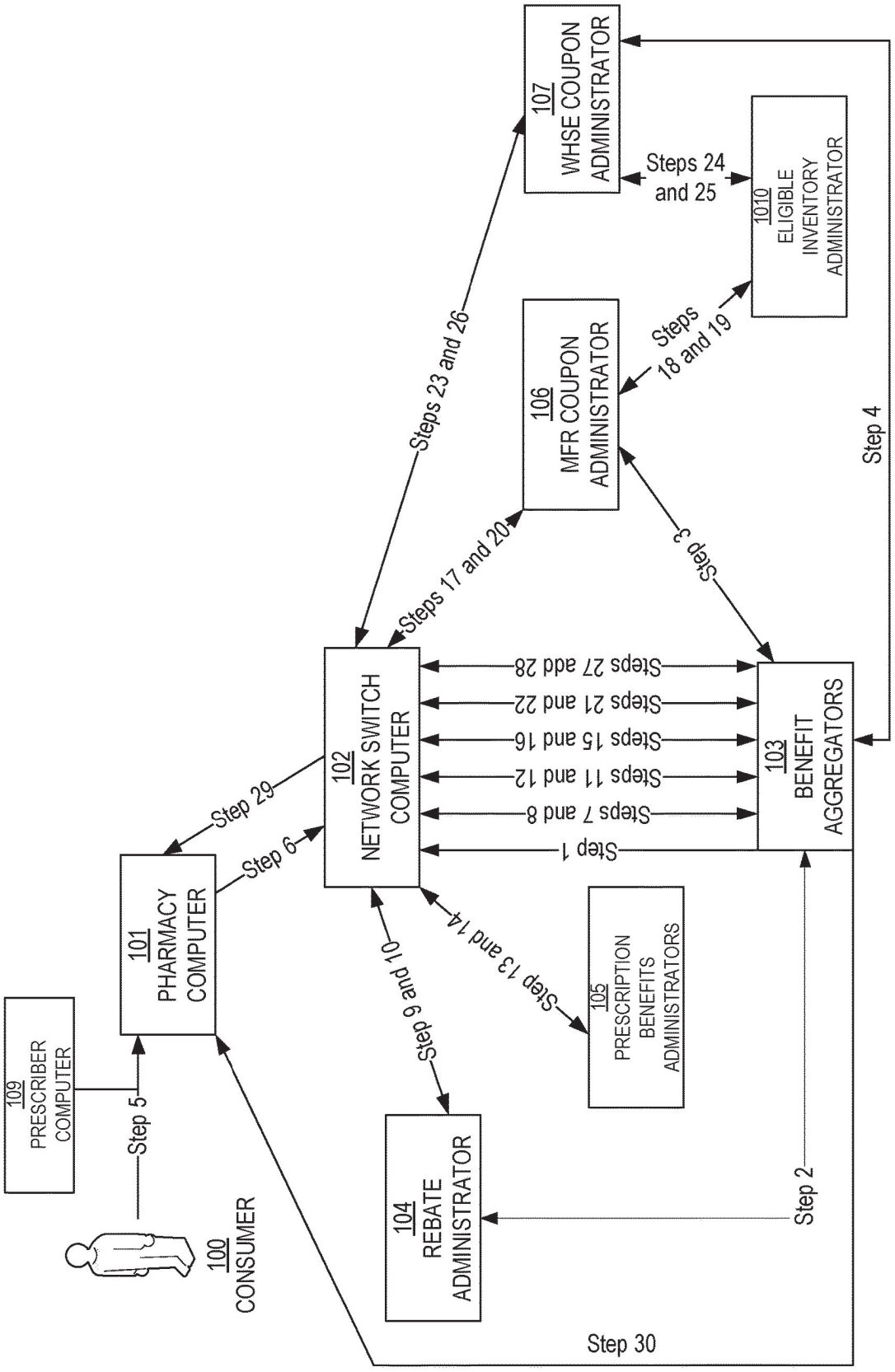
100 CONSUMER
109 PRESCRIBER COMPUTER
101 PHARMACY COMPUTER
102 NETWORK SWITCH COMPUTER
103 BENEFIT AGGREGATORS
104 REBATE ADMINISTRATOR
105 PRESCRIPTION BENEFITS ADMINISTRATORS
106 MFR COUPON ADMINISTRATOR
107 WHSE COUPON ADMINISTRATOR
1010 ELIGIBLE INVENTORY ADMINISTRATOR
Step 1
Steps 7 and 8
Steps 11 and 12
Steps 15 and 16
Steps 21 and 22
Steps 27 add 28
Step 2
Step 3
Step 4
Step 5
Step 6
Step 29
Step 30
Step 9 and 10
Step 13 and 14
Steps 17 and 20
Steps 18 and 19
Steps 23 and 26
Steps 24 and 25

FIG. 4A

Description for Figure 4

1. 103 sends claim targeting information to 102

2. Claim processing information and benefit design information is exchanged

a. 103 provides to 104

b. 104 provides to 103

3. Claim processing information and benefit design information is exchanged

a. 103 provides to 106

b. 106 provides to 103

4. Claim processing information and benefit design information is exchanged

a. 103 provides to 107

b. 107 provides to 103

5. 100 or 109 presents prescription order or inquiry to 101

6. 101 sends prescription benefits claim request to 102

7. 102 identifies claim request as meeting requirements provided from 103 in step 1 and redirects claim request to 103

8. 103 determines all possible benefits claims subject to claim request, sets claim order sequence, populates first claim request and submits to 102 to be forwarded to 104

9. 102 forwards claim one to 104 for benefits consideration

10. 104 considers claim for benefits eligibility, approves or denies the request and sends response to 102

11. 102 identifies the response as originating from 103 and forwards response to 103

12. 103 accepts response, records it, extracts data from it, populates second claim request and submits to 102 to be forwarded to 105

13. 102 forwards claim two to 105

14. 105 considers claim for benefits eligibility, approves or denies the request and sends response to 102

FIG. 4B

Description for Figure 4 (Continued)

15. 102 identifies the response as originating from 103 and forwards response to 103

16. 103 accepts response, records it, extracts data from it, populates third claim request and submits to 102 to be forwarded to 106

17. 106 considers claim for benefits eligibility and sends eligible inventory inquiry to 1010

18. 1010 considers the quantity requested in claim three against the eligible inventory of the specific product requested in claim three on record

19. 1010 denies or confirms the presence of sufficient inventory available to the requesting pharmacy to fulfill the request and sends response to 106

20. 105 considers claim for benefits eligibility, approves or denies the request and sends response to 102

21. 102 identifies the response as originating from 103 and forwards response to 103

22. 103 accepts response, records it, extracts data from it, populates fourth claim request and submits to 102 to be forwarded to 107

23. 107 considers claim for benefits eligibility and sends eligible inventory inquiry to 1010

24. 1010 considers the quantity requested in claim four against the eligible inventory of the specific product requested in claim three on record

25. 1010 denies or confirms the presence of sufficient inventory available to the requesting pharmacy to fulfill the request and sends response to 107

26. 107 considers claim for benefits eligibility, approves or denies the request and sends response to 102

27. 102 identifies the response as originating from 103 and forwards response to 103

28. 102 recognizes that no further claims related to claim one need to be generated or submitted to benefits administrators on behalf of the pharmacy, aggregates the responses from all of the benefits administrators creates an aggregated claim response to claim one and forwards to 102 to be returned to 101

29. 102 returns aggregated claim to 101

30. 103 creates a data file containing each of the individual claims that are included in the aggregated response for claim one and sends the file to 101 for documentation and reconciliation purposes.

NOTE: Steps one through twenty-nine take place in a real time environment taking fifteen seconds or less to complete them in total. Step thirty does not take place in real time, rather it could be immediately following the real time transaction or in a scheduled delivery at a later time.

FIG. 4C

EXPLANATION OF BENEFITS

CUSTOMER SERVICE NUMBER: 1-800-123-4567

STATEMENT DATE: XXXXXX
DOCUMENT NUMBER: XXXXXXXXXX

MEMBER NAME:
ADDRESS:
CITY, STATE, ZIP:

THIS IS NOT A BILL

SUBSCRIBER NUMBER: XXXXXXXXXX ID: XXXXXXX GROUP: ABCDE GROUP NUMBER: XXXXX

PATIENT NAME: XXXXXX	PROVIDER:	CLAIM NUMBER: XXXXXXXXXX
DATE RECEIVED: XXXXXXXXXX	PAYEE:	DATE PAID: XXXXXXXXXX

CLAIM DETAIL					WHAT YOUR PROVIDER CAN CHARGE YOU			TOTAL CLAIM COST			YOUR RESPONSIBILITY		
Prescription Number	Date of Service	Pharmacy Name	Sequenced Benefit Provider #	Claim Status	Provider Charges	Allowed Charges	Benefits Provider Name	Paid by Benfits Provider	What You Owe	Remark Code	Co-Pay	Deductible (or Out of Pocket)	Coinsurance
123456789	3/20/22-3/20/22	Ima Pharmacy	1	Submitted	$ 1,000.00	$ 1,000.00							
123456789	3/20/22-3/20/23	Ima Pharmacy	1a	Approved	$ 1,000.00	$ 1,000.00	<Pharma Mfr Name>	$ 400.00	$ 600.00	Medicare Negotiated Price Rebate			
123456789	3/20/22-3/20/24	Ima Pharmacy	1b	Approved	$ 600.00	$ 600.00	<PBM Name>	$ 480.00	$ 120.00	Medicare Benefit		$ 120.00	$ 120.00
			Total Charges Alowed			$ 1,000.00							

Benefits Paid by <Pharma Name>	$ 400.00
Benefits Paid by <Rx Benefit Name>	$ 480.00
Total Benefits Paid	$ 880.00

NOTES:

- This is a sample EOB for a Medicare claim.
- This EOB will be created and sent to the consumer
- Note that this is a mock up. The information contained here is all available in the system and the system will create EOB's. There will be additional information added to the landscape.
- EOB's are viewed as essential due to the commitment to transparency for the consumer.

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Chris Komp, 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, Maryland 21244-1850
Docket Number CMS-4210-N, Document Number 2025-08607
IRARebateandNegotiation@cms.hhs.gov

•

June 26, 2025

Re: Medicare Drug Price Negotiation Guidance Program - Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027 and 2028

Dear Deputy Administrator Klomp,

Sanofi is a research and development-driven, AI-powered healthcare biopharma company committed to improving lives through innovative medicines and vaccines. Sanofi brings together world-class research and development in the pursuit of leading health care solutions that serve major therapeutic areas including vaccines, diabetes, chronic disease, multiple sclerosis, cardiovascular disease, oncology, rare diseases, immunology, and hemophilia. We are committed to taking the lead on breakthrough science and striving to go further and faster for patients with innovative and effective treatments that change people's lives.

We appreciate CMS's commitment to learn from, collaborate with, and engage with affected entities like pharmaceutical manufacturers in the policy-making process, and appreciate the opportunity to comment on CMS's May 12, 2025 draft guidance for the 2028 initial price applicability year and manufacturer effectuation of the maximum fair price in 2026, 2027, and 2028 (the "Draft Guidance"). In addition, we appreciate CMS's stated goals to have the negotiation process continue to foster innovation as well as provide greater value to beneficiaries and taxpayers.

Below is a summary of Sanofi's comments to the Draft Guidance:

I. Making America healthy again means continued support for innovation.
II. Manufacturer innovation with respect to multi-indication drugs, which provide a significant value to patients and the healthcare system, should be recognized and rewarded.
III. Seasonal flu vaccines reimbursed under Medicare Part B cannot be subject to Medicare Drug Price Negotiation Program (the "Program") because they are not qualifying single source drugs. Moreover, as a matter of policy, price setting influenza vaccines offers no clear benefit to Medicare or its beneficiaries and could potentially lead to higher governmental costs and broad disruption of the flu vaccine market.
IV. Maximum Fair Price (MFP) effectuation in Part B should fully address the unique challenges of provider-administered drugs in future guidance.

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V. To support post approval research, orphan drugs that receive a subsequent non-orphan indication should have their eligibility for negotiation begin on the date of the approval for the non-orphan indication.

VI. Sanofi supports CMS's decision to provide transparency of the 50 Top Negotiation Eligible Drugs Ranked by Expenditure and asks CMS to consider expenditure ranking imbalances as it relates to Part B flu vaccines.

In addition, as members of both the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Innovation Organization (BIO), we support the overall positions of their respective comment letters. We have highlighted below, **in section VII**, the specific areas of particular importance to Sanofi that are addressed in those comments**.** In addition, as a member of the Coalition to Stop Flu, we support the comments submitted by that organization.

I. Making America Healthy Again Through Supporting Innovation

Sanofi is strengthening our pipeline with potentially transformative therapies that could shift paradigms in treatment and prevention. For example, potential treatments aimed to address disease progression and prevention in autoimmune and chronic diseases. Stopping disease progression results in fewer hospitalizations, fewer late-stage diagnosis, and ultimately more healthy Americans. We know that investing in therapies that slow disease prevention extends lives and reduces the long-term costs to our healthcare system. We encourage CMS to ensure that its policies and approaches under the Program encourage innovation aimed to make Americans healthier by slowing chronic disease progression.

II. Rewarding Manufacturer Innovation for Multiple Indication Drugs

Developing life changing and lifesaving medicines is a long and resource-intensive process that often results in multiple failures before yielding success. The overall probability of success for a drug or vaccine to make it to market is currently estimated at only 13.8 percent.[1] On average, development for drugs necessitates investing more than $2 billion to progress a drug from discovery to launch.[2] As pharmaceutical innovation represents cumulative progress, manufacturers such as Sanofi also invest in post-approval research to broaden the therapeutic applications of approved drugs to new indications and to new patient populations. This is especially true for "first-in-class" drugs (i.e., therapies that confront diseases in which no effective treatment exist or that approach conditions in fundamentally new ways). Post-approval research for these "first-in-class" drugs serves to advance innovation as far as possible to fulfill unmet needs and deliver therapeutic advances. However, this post-approval research requires extensive research investments, including Phase III clinical trials, to support additional indications across additional patient populations.[3]

Studies, however, continue to show how the Program is negatively affecting manufacturer decisions related to post-approval research. For example, following the passage of the Inflation

[1] Chi Heem Wong, Kien Wei Siah, Andrew W Lo, *Biostatistics*, Vol. 20, Iss. 2, April 2019, 273-286 (Jan. 31, 2018), https://doi.org/10.1093/biostatistics/kxx069

[2] *See* Deloitte, Be brave, be bold, Measuring the return from pharmaceutical innovation, 15th edition, March 2025.

[3] *See* Sandra Barbosu, The Value of Follow-On Biopharma Innovation for Health Outcomes and Economic Growth, Information Technology & Innovation Foundation, March 2025.

Reduction Act (IRA), the average monthly number of manufacturer-sponsored post-approval trials decreased by 38.4 percent.[4] The decline was notable for both small-molecule drugs, which saw about a 47 percent reduction, as well as for biologics, which saw a 33 percent reduction.[5] At the time of the study, the rate of new government-funded trials, however, remained unchanged, which suggests that this drop in post-approval research is due the new policy environment that drug manufacturers now face following the IRA's enactment.

For certain therapeutic areas in which post-approval research is common, like oncology, this reduction in post-approval research will translate to less treatment options for patients living with cancer. One study found that approximately 57 percent of all indications and 68 percent of manufacturer clinical trials in oncology were for conducted post-approval.[6] Vulnerable populations such as children with cancer are most at risk since most pediatric clinical trials and indications are post-approval – of the 6 percent of pediatric clinical trials for cancer drugs, 78 percent are conducted post-approval.[7]

Patient access to biologics, which activate cells or proteins in an individual's immune system to create specific responses to targeted diseases, is also at risk. In a study of approved biologics during a six-year timeframe, 72 percent had at least one indication approved after the initial approval, and 41 percent received three or more additional approvals.[8] These post-approval indications represent treatments for new disease targets (53 percent), new treatment populations (22 percent), and other important advances including new age groups (13 percent).[9] The study also found that new uses were often awarded several years after initial approval, with over half (59 percent) of new uses approved seven or more years later.[10] For small-molecule drugs, which are often easier for patients to take, more than half of the indications (52 percent) were post-approval.[11] Of these post-approval indications, 32 percent expanded a medicine's use to new age groups and 25 percent were for new disease targets; the remaining indications represented new combination therapies, earlier disease preventions, new standalone therapies, and new genetic targets.[12]

The new framework established by prior Guidance and how CMS has been implementing the IRA, puts future post-approval discoveries at risk of never being discovered at all. For Sanofi, this risk of limiting post-approval discoveries is substantial. In 2024 alone, we ushered in scientific breakthroughs by expanding indications for five approved medicines including one medicine as the first and only add-on maintenance treatment for children with inadequately controlled chronic rhinosinusitis with nasal polyps, another medicine for adults with inadequately

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[4] Zheng, H., Patterson, J.A. & Campbell, J.D. The Inflation Reduction Act and Drug Development: Potential Early Signals of Impact on Post-Approval Clinical Trials. *Ther Innov Regul Sci* (2025). https://doi.org/10.1007/s43441-025-00774-2.

[5] Id.

[6] Henry Grabowski, Josepah A. DiMasi, and Genia Long. Postapproval Innovation for Oncology Drugs and the Inflation Reduction Act. *Health Affairs* (Oct. 2024). https://doi.org/10.1377/hlthaff.2024.00202

[7] Id.

[8] Partnership for Health Analytic Research, Implications of the Inflation Reduction Act Price Setting Provisions on Post-approval New Uses for Biologics (prepared for the Pharmaceutical Research and Manufacturers of America), March 2025.

[9] Id.

[10] Id.

[11] Partnership for Health Analytic Research, Implications of the Inflation Reduction Act Price Setting Provisions on Post-approval Indications for Small Molecule Medicines (prepared for the Pharmaceutical Research and Manufacturers of America), June 2023.

[12] Id.

controlled chronic obstructive pulmonary disease, and a treatment for adults with newly diagnosed multiple myeloma. However, our continued ability to make these investments is dependent on the regulatory landscape. Sanofi is therefore encouraged that CMS recognizes that "public feedback on all aspects of the negotiation process and manufacturer effectuation of the MFP is critical to achieving the goals of greater value for beneficiaries and taxpayers and continuing to foster innovation."[13] We are also appreciative of CMS's willingness to engage with manufacturers to inform future policy.

As such, Sanofi encourages CMS to consider changing its current approach to multiple indication drugs to support ongoing innovation and to better reflect the value of multi-indication drugs. Specifically, we urge CMS to consider the following approaches:

- **Establish MFP at the statutory ceiling price for Multi-Indication Drugs** – To ensure that the negotiation process rewards manufacturers' innovation, CMS can establish the MFP at the statutory ceiling price for selected drugs with demonstrated, ongoing post-approval research for new indications. This approach can minimize the impact of the negotiation process on future innovation by ensuring a predictable framework, which of itself can be an incentive for innovation. CMS can easily expand the data it requests from manufacturers expressly to include indications currently under investigation. Moreover, to determine whether a multi-indication drug is eligible for the statutory ceiling price under this framework, CMS can incorporate various factors including the number of approved indications (for example, five or more additional indications since launch) or whether a single new indication represents a pioneering and new approach to therapy. Individual indications can also be assessed for whether the indication meets unaddressed patient needs.
- **Delay Selection for Drugs with Approved or Active Development Pipelines for Additional Indications** – To incentivize the continuation of post-approval research, CMS can also seek to delay the price setting process if a manufacturer demonstrates that it is actively developing another indication for a post-approval drug. For approved indications, CMS can seek to establish a delay period when manufacturers receive FDA approval for a set number of indications after a predetermined timeframe post initial launch. Providing such a delay can help to encourage post-approval research and the value that it brings to patients.

As a company committed to chasing the miracles of science, we encourage CMS to recognize the substantial value that post-approval research brings to the healthcare system and to patients by extending the therapeutic utility of a single drug across diverse clinical contexts. Sanofi strongly encourages CMS to exercise its authority with the above listed approaches to multiple indication drugs as these approaches would still ensure a process that aims to "achieve the lowest maximum fair price" while rewarding manufacturer's innovation.[14]

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[13] Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191-1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028, Section 10, pg. 1.

[14] Social Security Act (SSA) § 1194(b)(1); Medicare Drug Price Negotiation Program: Final 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 in 2026 and 2027, pg. 14.

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III. Seasonal flu vaccines reimbursed under Medicare Part B cannot be subject to the Medicare Drug Price Negotiation Program

The Social Security Act, as amended by the IRA, specifies that only qualified single source drugs (QSSDs) are eligible for negotiation. To be considered a QSSD, at least 11 years must have lapsed between FDA licensure of a biological product and the selected drug publication date for the biological product to be subject to negotiation.[15] In Section 30.1 of the Draft Guidance, CMS proposes to identify whether a biological product is a potential QSSD based on its active ingredients / active moieties. Specifically, Section 30.1 says: "[F]or purposes of the Negotiation Program, CMS will identify a potential qualifying single source drug using . . . all dosage forms and strengths of the biological product ***with the same active ingredient*** . . . ." (emphasis added). Furthermore, if a drug is a fixed combination drug with two or more active ingredients / active moieties, the distinct combination of active moiety / active ingredient will be considered as one active ingredient / active moiety for the purpose of identifying potential QSSDs.

As outlined below, under the statute, and consistent with the Draft Guidance, CMS can and should determine that multivalent seasonal influenza vaccines cannot be considered QSSDs eligible for negotiation. Because the active ingredients for flu vaccines – the antigens of the seasonal strains – change virtually every year, each new FDA approval creates a new QSSD, which will never be on the market for 11 years. Further, even under CMS' guidance aggregating all products with the same active ingredient into a single QSSD, these different active ingredients cannot be aggregated within the same QSSD. Therefore, a given seasonal flu vaccine will never remain on the market for 11 years.

A. The Active Ingredients for Flu Vaccines Change Nearly Every Year, such that Flu Vaccines Never Qualify as QSSDs.

Under CMS guidance regarding QSSDs, flu vaccines do not qualify as QSSDs because they are developed with new active ingredients – the antigens of the circulating seasonal influenza strains – virtually every year. By way of background, the flu virus analysis begins on a global scale, involving an intricate, labor-intensive process by many stakeholders who come together to help ensure flu seasonal preparedness and response. The World Health Organization (WHO) suggests strains based on global surveillance data, and the CDC's Influenza Division collects and reports information on flu activity in the United States each week.[16] Generally, based on this information, the FDA Vaccines and Related Biological Products Advisory Committee (VRBPAC) selects which of the circulating flu strains have the highest likelihood to cause illness in the United States for the next flu season.[17] Each year, manufacturers use these FDA-identified strains in formulating their vaccines to provide the strongest protection against seasonal flu.[18]

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[15] Inflation Reduction Act of 2022, sec. 1192(e).

[16] See World Health Organization, Global Influenza Programme, https://www.who.int/teams/globalinfluenza-programme/surveillance-and-monitoring/influenza-surveillance-outputs; Centers for Disease Control and Prevention, Influenza Division, https://www.cdc.gov/ncird/flu.html. 10 Food and Drug Administration, Seasonal Information for Influenza Virus Vaccine, https://www.fda.gov/vaccines-blood-biologics/lot-release/seasonal-information-influenza-virus-

[17] Food and Drug Administration, Seasonal Information for Influenza Virus Vaccine, https://www.fda.gov/vaccines-blood-biologics/lot-release/seasonal-information-influenza-virus-vaccine#:~:text=Each%20year%2C%20the%20FDA%2C%20World,most%20illness%20in%20the%20upcoming.

[18] *See* J. Weir and M. Gruber. An overview of the regulation of influenza vaccines in the United States, Influenza Other Respir Viruses. 10(5): 354-360. Sept. 2016.

The FDA has repeatedly and consistently identified these selected antigens, developed to protect against the seasonal flu strains, as the "active ingredients" of such reformulated flu vaccines. More specifically, the active ingredients are the specific antigens of the circulating influenza strains – which change virtually every year. In its regulations,[19] the FDA defines "active ingredient" by focusing on the component of the drug that is responsible for the drug's effectiveness:

> "Active ingredient means any component that is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body of man or other animals. The term includes those components that may undergo chemical change in the manufacture of the drug product and be present in the drug product in a modified form intended to furnish the specified activity or effect."[20]

As noted above, seasonal flu vaccines are reformulated each year per FDA guidance to include the circulating strains of influenza most likely to cause illness during the upcoming flu season. The FDA explains that this reformulation is necessary because the vaccine triggers an antibody response to the specific viral strain and "the immune response elicited by previous vaccination may not be protective against new variants."[21] Because the antibody response is specific to the seasonal strain of influenza, the antigen of the corresponding seasonal strain is the component that is "intended to furnish pharmacological activity" and thus would constitute the "active ingredient." It follows, therefore, that when the antigen in a flu vaccine is updated to target a different flu strain, the vaccine's *active ingredient* is changed.

This understanding is also supported by FDA's approach to determining the sameness of biological product active ingredients in other contexts (e.g., orphan drug and reference product exclusivity context). For those purposes, FDA considers two biological products to be different products from each other if they differ with respect to their "principal structural molecular features."[22] A vaccine formulated with a different antigen directed at a different flu strain undoubtedly has different "principal molecular structural features" than the prior year's vaccine and therefore has a different active ingredient (and is a different biological product) from the prior vaccine.

The Draft Guidance specifically notes that "CMS will identify the active ingredient or active moiety of the drug using public sources such as RxNorm, OpenFDA, FDALabel, and FDA's Active Ingredient-Active Moiety Relationship/Basis of Strength file." CMS also notes that it may consult with the FDA when clarification is needed.[23]

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[19] Although this definition is found in FDA's new drug application ("NDA") regulations, it is our inferred understanding that it also reflects the agency's thinking on active ingredients for biologics products.

[20] See 21 C.F.R. § 210.3 (b)(7)

[21] *See* FDA Guidance, "Clinical Data Needed to Support the Licensure of Seasonal Inactivated Influenza Vaccines," at 3 (May 2007), *available at*: https://www.fda.gov/regulatory-information/search-fda-guidance-documents/clinical-data-needed-support-licensure-seasonal-inactivated-influenza-vaccines (last accessed June 2, 2025).

[22] See 21 C.F.R. § 316.3 (b)(14); FDA, *Draft Guidance for Industry, Reference Product Exclusivity for Biological Products Filed Under Section 351(a) of the PHS Act* (August 2014).

[23] Draft Guidance, p. 12.

FDA sources[24] that CMS proposes to use to identify the active ingredient, among others, routinely identify the antigens of seasonal influenza strains as the active ingredients of seasonal flu vaccines:

- **Prescribing Information**: The Prescribing Information (PI) for influenza vaccines across the market (e.g., Fluzone, Fluzone High-Dose, Flublok, Fluad, Flucelvax) include a description of the new viral strains included in that year's formulation and are required to be updated and approved by the FDA each time the vaccine is reformulated.[25] Section 11 of the PI for approved vaccines, which provides the product's description, refers to the specific viral strains for that year's formulation as the active ingredients for the particular vaccine.

- **FDA GSRS**: In its Global Substance Registration System (GSRS), the FDA generates unique ingredient identifiers (UNIIs) for substances included in FDA-regulated products and provides information related to each substance, including whether the substance is an active ingredient. Here, the FDA identifies the seasonal influenza strain antigens as the active ingredients for influenza vaccines.[26]

- **FDA SPL Resources**: In multiple instances within its Structured Product Labeling (SPL) resources, the FDA indicates that the active ingredient for the influenza vaccine is the antigen of the seasonal strain. For example, within the "Physician Labeling Rule Content of Labeling & Application Number Validation" file, the "Active Ingredient UNIIs" listed for Flublok and Fluzone correspond to the antigens of the seasonal strains.[27]

  Further, the "Active Ingredient-Active Moiety Relationship/Basis of Strength" file provides a list of active ingredients and their corresponding active moieties.[28] The antigen of the seasonal strain of an influenza vaccine is identified as the active ingredient. Notably, the file includes multiple strains within the same subtype/lineage. In other words, the SPL drug listing files explicitly list out the "active ingredient(s)" included in a flu vaccine, and the names of the ingredients on the list change every year when a flu vaccine is

[24] In addition to these sources, both the former Director of CBER and the former Acting Director of FDA's Office of Vaccine Research Review characterized the seasonal strain as the active ingredient in influenza vaccines in statements before Congress. For example, in a statement regarding influenza vaccine supply needs made before the House of Representatives Committee on Energy and Commerce in 2005, Jesse Goodman, the Director of CBER, said "influenza vaccine is unique because its active ingredient – the virus strains used to develop the vaccine – change almost every year." Goodman, J., *Statement on Influenza Vaccine Supply Needs*. Testimony before the Committee on Energy and Commerce, U.S. House of Representatives. U.S. Food and Drug Administration (May 4, 2005).

[25] *See, e.g.*, Flublok. Prescribing Information. Protein Sciences Corporation ("For the 2024-2025 influenza season it is formulated to contain 135 mcg HA per 0.5 mL dose, with 45 mcg HA of each of the following 3 influenza virus strains: A/West Virginia/30/2022 (A/Wisconsin/67/2022 pdm09-like virus) (H1N1), A/Massachusetts/18/ 2022 (H3N2) and B/Austria/1359417/2021."); Fluzone High-Dose. Prescribing Information. Sanofi Pasteur Inc.; Fluzone. Prescribing information. Sanofi Pasteur Inc.; FLUAD. Package insert. Seqirus, Inc.; Flucelvax. Package insert. Seqirus, Inc.

[26] U.S. Food and Drug Administration, FDA's Global Substance Registration System, https://www.fda.gov/industry/fda-data-standards-advisory-board/fdas-global-substance-registration-system.

[27] U.S. Food and Drug Administration, Structured Product Labeling Resources, https://www.fda.gov/industry/fda-data-standards-advisory-board/structured-product-labeling-resources.

[28] U.S. Food and Drug Administration, Structured Product Labeling Resources, https://www.fda.gov/industry/fda-data-standards-advisory-board/structured-product-labeling-resources.

reformulated. This confirms that FDA considers a flu vaccine as formulated with a different seasonal strain antigen to have a different "active ingredient."

- **FDA List of Active Moieties:** Pursuant to the FDA's physician labeling regulations, the FDA has published a list of active moieties that are part of an established pharmacologic class, including active moieties for influenza A and influenza B virus vaccines.[29] Like the FDA's SPL resources, the list of active moieties includes the antigen or HA antigen of the seasonal strains of each influenza virus, rather than the broader influenza subtype/lineage.

Notably, the Centers for Disease Control and Prevention (CDC),[30] too, has consistently treated the antigens of seasonal influenza strains as the active ingredients in seasonal influenza vaccines:

- **CDC "Pink Book"**: In The Epidemiology and Prevention of Vaccine-Preventable Diseases, also known as the "Pink Book," the CDC's Advisory Committee on Immunization Practices (ACIP) provides health professionals with the "CDC's most comprehensive information on routinely used vaccines and the diseases they prevent."[31] Therein, the CDC describes antigens to be the "active ingredient" in vaccines.[32]

- **CDC "Explaining How Vaccines Work":** In a resource updated in August 2024, entitled "Explaining How Vaccines Work," the CDC explicitly states that "[t]he active ingredient in all vaccines is an antigen, the name for any substance that causes the immune system to begin producing antibodies."[33]

Because the antigen of the seasonal flu strain is the active ingredient in a flu vaccine, and because flu vaccines are reformulated with *different* seasonal strain antigens on nearly an annual basis, flu vaccines with the same active ingredient would never be on the market long enough to qualify as QSSDs. Because flu vaccines are not QSSDs, they are not eligible for selection in the Program.

B. Multivalent Flu Vaccines Also Qualify as Fixed Combination Drugs.

In addition, because Sanofi's multivalent flu vaccines are comprised of a combination of different active ingredients – the selected seasonal strain antigens – they should be subject to the policy for fixed combination drugs under CMS's Draft Guidance. Under that policy, when a multivalent

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[29] U.S. Food and Drug Administration, FDA EPC Text Phrases for Indications and Usage Heading in Highlights, https://www.fda.gov/media/177252/download?attachment.

[30] The CDC's view of vaccine active ingredients should be highly probative, as the IRA separately establishes that vaccines recommended by ACIP will be covered by Medicare Part D absent cost-sharing. In this manner, Congress, within the IRA, interlinked ACIP (and therefore the CDC) recommendations with Medicare coverage and reimbursement rules.

[31] The Centers for Disease Control and Prevention, The Epidemiology and Prevention of Vaccine-Preventable Diseases (the "Pink Book"), Table of Contents, https://www.cdc.gov/pinkbook/hcp/table-of-contents/index.html.

[32] *See, e.g.,* The Centers for Disease Control and Prevention, The Epidemiology and Prevention of Vaccine-Preventable Diseases (the "Pink Book"), Appendix B, Vaccine Excipient Summary.

[33] The Centers for Disease Control and Prevention, Explaining How Vaccines Work (updated August 10, 2024), *available at*: https://www.cdc.gov/vaccines/basics/explaining-how-vaccines-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fhcp%2Fconversations%2Funderstanding-vacc-work.html (last accessed June 2, 2025) (emphasis added).

vaccine is updated and any one of the antigens (i.e., active ingredients) is changed, the vaccine becomes a different QSSD. As with other flu vaccines, these fixed combination flu vaccine formulations with all of the same antigens are not on the market long enough to meet the 11-year licensure threshold necessary to be considered QSSDs under the Program, and thus are not eligible for selection.

C. There are Compelling Policy Reasons for Excluding Flu Vaccines from the Negotiation Program.

In addition to the foregoing, policy reasons further support the conclusion that influenza vaccines should be excluded from the Program. Preventative flu vaccines are already low-cost per unit, undergo a government-led health economic analysis before being recommended,[34] are available to beneficiaries with zero out-of-pocket costs, and result in substantial overall savings to the Medicare program.

Selecting flu vaccines for the Program would not result in savings to the Medicare program. Medicare likely saves substantially more than it spends on flu vaccines by preventing serious complications and the associated healthcare costs.[35] In recognition of the cost-effective role of flu vaccination in preventing illness in Medicare, Congress continues to reimburse Medicare Part B flu vaccines based on 95% of average wholesale price (AWP) rather than based on average sales price (ASP). While the IRA amended the payment amount for selected drugs that are otherwise reimbursed at 106% of ASP to 106% of the maximum fair price, the statute did not amend the payment methodology for Part B vaccines.[36] Thus, even if selected under the Program, CMS reimbursement for flu vaccines would remain unchanged and Medicare would achieve no savings.

Furthermore, while one stated benefit of the Negotiation Program is to reduce out-of-pocket costs for Medicare beneficiaries, there is no beneficiary cost-sharing for flu vaccines. Under existing law, flu vaccines receive first-dollar coverage under Medicare Part B, meaning

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[34] Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP), ACIP: Guidance for Health Economics Studies, https://www.cdc.gov/vaccines/acip/committee/economic-studies.html, last reviewed Oct. 23, 2019 (last accessed June 17, 2025).

[35] For instance, one study sponsored by Sanofi found that the use of Fluzone® High-Dose (versus standard dose influenza vaccines) in the United States avoided 6.9% of hospital admissions or 102.7 per 1,000 all-cause hospital admissions possibly related to influenza. *See* C. DiazGranados, et al. Prevention of serious events in adults 65 years of age or older: A comparison between high-dose and standard-dose inactivated influenza vaccines. Vaccine. 33:(2015): 4988-4993. Extrapolating data from the same study found that during the 2022-2023 influenza season, 22.8 million seniors who received Fluzone High-Dose avoided approximately 160,000 hospitalizations, which resulted in a health care system savings of nearly $1.2 billion, net of vaccination costs. Centers for Medicare and Medicaid Services, Vaccine Pricing, https://www.cms.gov/medicare/payment/all-fee-service-providers/medicare-part-b-drug-average-sales-price/vaccine-pricing (last accessed March 12, 2024); HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. https://datatools.ahrq.gov/hcupnet (last accessed April 6, 2023). Using CMS seasonal flu vaccine pricing data and after accounting for the total cost of Fluzone High Dose at $1,594M, CMS and the healthcare system saved approximately $1,195M on hospitalizations. Using the data on HCUPnet, we calculate the cost of hospitalization to be $17,369, resulting in a savings to CMS and the healthcare system of approximately $1,195 M on hospitalizations.

[36] *See* Inflation Reduction Act of 2022, sec. 1198(b)(1)(A), amending Section 1847A(b)(1)(B) of the Social Security Act.

beneficiaries pay nothing out of pocket. Thus, establishing maximum fair prices for flu vaccines would do nothing to reduce out-of-pocket costs for beneficiaries.

Finally, flu vaccines are an important tenet of public health and, unlike medicines that treat cohorts of specific diseases, flu vaccines are broadly recommended for seniors over age 65 as they are at a higher risk of getting serious flu related complications.[37] Public policies and system incentives should support the goal of high flu vaccine utilization to avoid dangerous and costly complications and hospitalizations. The Program process runs counter to that goal. High volume, low-cost flu vaccines may be inadvertently penalized since such products are more likely to be selected even if they are actually lowering costs for the Medicare program. This selection methodology lessens the incentives to invest in production of flu vaccines for the Medicare population as doing so merely increases the risk of negotiation for the primary manufacturer. The vaccine production process to deliver millions of new product doses each year is time sensitive and complex, and the possibility of selection under the Program adds to the complexity by adding uncertainly and risk.

In sum, selecting flu vaccines for the Program produces no real benefit to Medicare or beneficiaries as they are already low cost, cost-effective, and available to beneficiaries with zero out-of-pocket costs. To the contrary, selecting flu vaccines has the potential to waste CMS resources and be counterproductive, disrupt access, create market distortions, and put at risk future manufacturing investment decisions.

IV. Effectuation of MFP for Medicare Part B

As discussed above, Sanofi does not believe flu vaccines reimbursed under Medicare Part B are eligible for selection under the Program. However, should CMS nonetheless seek to so include flu vaccines in the Program, it is important for CMS to consider the unique reimbursement considerations for these vaccines and appropriately address them in its guidance regarding MFP effectuation in section 40.4. Sanofi respectfully urges CMS to engage with Sanofi in a more robust dialogue on Part B effectuation to address the unique challenges for Part B flu vaccines and other Part B medicines. Subsequently, Sanofi recommends CMS reissue draft guidance on MFP effectuation.

V. Support for Continued Innovation for Orphan Drugs

CMS has stated in its IPAY 2028 guidance that public feedback is critical to achieving the goals of greater value for beneficiaries and taxpayers and continuing to foster innovation[38]. One concrete way to foster innovation is to incentivize manufacturers to continue to conduct post-approval research on multi-indication drugs, including orphan drugs. With respect to orphan drugs, the current CMS policy disincentivizes innovation and the intent of the orphan drug exclusion by tying the eligibility for selection to the original orphan indication approval rather than a subsequent approval for a non-orphan indication. This type of policy approach harms patients since the result of post-approval research may mean new uses and therapies. We encourage CMS to change their policy approach and begin the clock for determining a QSSD

[37] Centers for Disease Control and Prevention, Summary: 'Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP) – United States, 2023-24'.

[38] Sec. 10, p. 1.

from when a subsequent non-orphan indication is approved. This policy change will incentivize continued innovation in post-approval research for orphan drugs.

VI. Transparency of the 50 Top Negotiation Eligible Drugs Ranked By Expenditures

Sanofi supports CMS's decision to publish not only the list of 15 selected drugs for the third round of the Program, but also the list of the up to 50 top negotiation-eligible drugs ranked by combined total expenditures under Part B and D (and, if any, the list of drugs selected for renegotiation) by February 1, 2026. We applaud this decision and encourage CMS to continue this type of transparency regarding what drugs may be eligible for the Program in the future.

As stated previously, Sanofi does not believe Medicare Part B preventative flu vaccines should be eligible for negotiation. Should CMS nonetheless be inclined to include them in its selection of drugs ranked by expenditures, we urge CMS to consider the unique reimbursement methodology for flu vaccines as opposed to other Part B products. We urge CMS to consider this factor when evaluating flu vaccines in the context of Total Expenditures. Sanofi would be eager to discuss ideas to address this with CMS in the near future.

VII. Support for PhRMA and BIO Comments

As members of PhRMA and BIO, we support their overall positions contained in their respective comments. Of particular importance to Sanofi are as follows:

Simplifying the Biosimilar Pause

We encourage CMS to simplify the current process to request a Biosimilar Pause and allow for such an initial or subsequent pause request when (i) a manufacturer can demonstrate that any filed agreements do not bar a manufacturer from marketing or (ii) investor disclosures indicate marketing will be ready before the end of the relevant period. In addition, for purposes of the Biosimilar Pause and other provisions of the IRA, CMS should remove the "bona fide marketing" standard as this does not exist in the underlying statute.

The Requirement for Renegotiation Due to New Indication

In response to CMS's request for feedback on CMS's approach to renegotiation, we reiterate PhRMA's comments. In addition, we encourage CMS to incorporate the above policy approaches to multi-indication drugs to ensure a policy environment that encourages post-approval innovation.

Maximum Fair Price Effectuation in Part D

We encourage CMS to rethink their current approach to Part D effectuation as the current approach risks patient access. We support PhRMA's suggestion to model Part D effectuation off of the Coverage Gap Discount Program – passing through pre-funded MFP amounts to pharmacies on behalf of manufacturers with manufacturers invoiced at a later date. We believe this approach will protect patient access as pharmacies will have the financial security to stock and administer drugs subject to MFP.

Excluding MFP from the Calculation of ASP

We reiterate PhRMA's comments on excluding MFP from the ASP calculation and reiterate the needs to provide this clarification to provide stability to provider payments. Inclusion of MFP in

ASP will not only erode provider reimbursement but also create perverse incentives in the market.

Ensuring Access and Coverage
We also recommend that CMS adopt stronger oversight and safeguards to ensure that Part D plans are not limiting access to important medications for the more than 50 million seniors and individuals with disabilities that rely on Medicare Part D. We encourage CMS to implement the proposed policies in our trade association comments including improving transparency and data collection, enhancing safeguards for patient access, and strengthening formulary review reporting.

Thank you for the opportunity to provide feedback to CMS's 2028 Draft IPAY Guidance. Sanofi appreciates your consideration of our comment letter. Please feel free to reach out to Liz Cirri at Liz.Cirri@Sanofi.com or Emily Ahrens Emily.Ahrens@Sanofi.com if you have any questions about our comments or if there is any further information that we can provide.

Sincerely,

/s/

Liz Cirri
Head of U.S. Reimbursement and Public Policy

SENIOR CARE PHARMACY COALITION

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June 25, 2025

VIA ELECTRONIC SUBMISSION (IRARebateandNegotiation@cms.hhs.gov)

The Honorable Chris Klomp
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

Re: Medicare Drug Price Negotiation Program Draft Guidance

Dear Deputy Administrator Klomp:

On behalf of the Senior Care Pharmacy Coalition (SCPC), we write to comment on the draft Guidance entitled: "Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028." We appreciate the opportunity to comment on the draft Guidance, particularly to address several considerations for CMS as the agency implements the Manufacturer Transaction Facilitator (MTF) for Part B drugs dispensed by pharmacies in 2028, when several Part B drugs are expected to be subject to Medicare drug price negotiation.

SCPC is the only Washington-based organization exclusively representing the interests of long-term care (LTC) pharmacies. SCPC's membership includes 75% of all independent, closed-door LTC pharmacies. Our members serve one million residents daily in LTC facilities across the country. Given the distinct characteristics of the LTC patient population and the enhanced clinical and other responsibilities of LTC pharmacies, we offer unique perspectives on CMS' initiatives and proposals, particularly how Medicare Prescription Drug Benefit (Part D) policies and requirements impact Part D enrollees with institutional level of care needs and the LTC pharmacies that serve them.

SCPC notes with interest the references to the expansion of the MTF for Part B drugs in 2028. We appreciate that the agency is not yet ready to propose specific implementation information for the expansion of the MTF program pending initial implementation for Part D drugs starting January 1, 2026. However, we wish to provide CMS with several suggestions related to the 2028 Part B expansion, set out below.

- **CMS must ensure that pharmacies are included in Ensure Pharmacies are Included in Part B Implementation.** While most Part B providers are physicians and hospitals, many pharmacies, including LTC pharmacies, dispense Part B drugs and must be included

in the Part B MTF implementation. We urge CMS to consult pharmacies – particularly LTC pharmacies - as the agency adapts the MTF to Part B drugs to assure that Medicare beneficiaries maintain access to part B drugs dispensed by pharmacies. The implementation process CMS established should work for all Part D providers.

- **CMS must ensure that Part B implementation includes "835 data".** CMS certainly appreciates that "dispensing entities" must be able to track manufacturer payments to specific dispensing events through the MTF. Under Part D, CMS which relies on the X12 Health Care Claim Payment/Advice or the "835" transaction to allow pharmacies to connect manufacturer payments to specific claims/dispensing events. The agency relies on the "Prescription Dispensing Event" (PDE) to initiate the data exchange and payment processes. For Part B, however, CMS Medicare Administrative Contractors (MACs) do not use the X12 system or process 835 records, and there are no PDEs involved in Part B Claims. While CMS is likely considering using the "Form 1500" claim submission (paper or electronic) to be the record triggering the MTF payment process for manufacturers, the Form 1500 does not contain the requisite information that would allow pharmacies to connect a manufacturer payment back to the dispensing event. MACs have the capacity to provide 835 transaction reports to pharmacies, and we urge CMS to require that they do so for pharmacy-dispensed MFP Part B drugs, so that the manufacturers can use that file and return the same file with payment information to the pharmacies.

- **Enrollment.** As CMS develops the Part B protocols for the MTF process, we appreciate that enrolling providers will be a significant task. Many, if not all, pharmacies dispensing Part B drugs will have already been enrolled in the MTF DM (and likely the MTF PM) starting in 2026. We urge CMS to rely on existing pharmacy registrations rather than require that pharmacies re-enroll in the MTF for Part B drugs.

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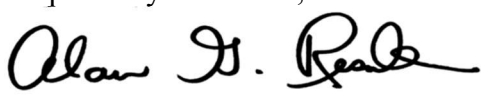
Thank you for your consideration. If you have questions or wish to discuss our comments, please feel free to contact me at arosenbloom@seniorcarepharmacies.org or (717) 503-0516.

Respectfully submitted,



Alan G. Rosenbloom President & CEO
Senior Care Pharmacy Coalition

March 5, 2025

Stephanie Carlton
Chief of Staff and Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Meeting Request to Reconsider the **IRA Implementation that Increases Drug Costs** for Healthcare Providers, Hospitals, and Pharmacies

Dear Acting Administrator Carlton,

On behalf of our 60,000 pharmacist, student pharmacist, and pharmacy technician members, we urge the Centers for Medicare & Medicaid Services (CMS) to take immediate action to ensure that implementation of the Inflation Reduction Act (IRA) negotiated drug pricing framework does not threaten patients by undermining the financial stability of hospitals, pharmacies, and other community providers. We urgently request an opportunity to meet with you to discuss our concerns regarding the IRA framework rolled out by the previous administration and offer suggestions to effectively bring down drug prices.

The **proposed IRA framework would actually increase prices** for providers and pharmacies, and increase bureaucratic red tape, without benefiting patients. The IRA was supposed to lower drug prices. Instead, the program raises drug purchasing costs by:

- Forcing providers to **purchase medications at an inflated price** (wholesale acquisition cost);
- Requiring providers to finance the **higher carrying cost of inventory** purchased at inflated prices until rebates are received from the manufacturer;
- Creating a system where **rebates may be significantly delayed or denied at the manufacturers' discretion**; and
- Saddling providers with **inflated administrative costs to comply with rebate programs** that vary from manufacturer to manufacturer and drug to drug.

Providers are forced to purchase medications at inflated prices

CMS's proposed approach places drug manufacturers in full control of whether patients, providers, and pharmacies can purchase products at the lower discounted price negotiated by the government, or if they must buy these medications at higher prices and then wait for the manufacturer to provide a retrospective rebate. If, as expected, most manufacturers' IRA plans will require providers to purchase medications at higher up-front prices, hospitals will face increased financial strain from drugs purchased under this program.

Hospitals must incur financing costs on the inventory purchased at elevated prices

A retrospective discount program for IRA pricing will require hospitals to come up with significant cash to purchase drugs at these higher prices. As a result, many hospitals will need to access financing through the bond market or a loan. Hospitals will be required to pay interest on such financing from the time of purchase until the rebates are received from manufacturers. This financing cost will further erode the operating margin of already cash-strapped safety-net hospitals.

As one hospital explained based on an analysis of converting just two common drugs to a rebate model, even if all claims for the two drugs were validated and nothing denied, a 30-day delay to get rebates would require a $2 million in working capital just to fund purchasing two of the IRA negotiated drugs at upfront

WAC pricing. If this model were to apply to all IRA and 340B drugs, hospitals would face millions in additional financing costs – in some cases, the cost would be enough to wipe out a hospital's margins, threatening their financial viability.

Rebates will be significantly delayed or unpaid for some portion of drugs

Retrospective rebates will significantly delay access to negotiated prices. As a result, providers will not only need to purchase drugs at significantly increased prices (wholesale acquisition cost versus the negotiated price). They will also need to wait to receive the rebates, with no guarantee that a rebate will actually be paid.

Providers will need to anticipate that some portion of rebates will be disputed and never paid, or at best significantly delayed, by manufacturers. Every time a rebate remains unpaid or is significantly delayed it lowers the operating margin of safety-net hospitals. This threat to provider's financial health would be easily addressed by requiring manufacturers to provide prices upfront, rather than as a rebate, because providers would realize the reduced cost of a drug immediately, rather than facing higher purchasing costs without any guarantee that a rebate will be received in the future.

There are significantly greater administrative costs for a rebate program compared to up-front discounts

Rebate models also impose significant administrative complexity, which raises the costs for providers, reducing money that would otherwise be spent on patient care. Because the IRA guidance puts drug companies in the driver's seat when structuring IRA negotiated rebate models, including product-specific models, each manufacturer will likely have their own model. Multiple inconsistent models further increase expenses and add to confusion relating to tracking rebate data submitted to manufacturers, validating/auditing whether rebates were received and pursuing payment for denied rebates. These concerns are compounded by the fact that CMS has indicated that hospitals and dispensers will not have access to the models until September 2025, leaving very little time for input and/or necessary revisions. With drug companies driving the process, it seems unlikely that models will adequately address the practical needs of other stakeholders.

We urge you to take immediate action to prevent the current proposed IRA drug negotiation framework from taking effect and to adopt an upfront discount model to ensure patients, providers, and our healthcare system benefit from lower drug prices. We look forward to working with you to improve the health of all Americans. Please do not hesitate to treat us as a resource should you have questions or need assistance on this or any other issue.

Sincerely,

American Society of Health-System Pharmacists
Alabama Society of Health Systems Pharmacists
Arizona Pharmacy Association
Arkansas Association of Health-System Pharmacists
Avera Health
Ballad Health
BayCare Health System
Bayhealth Medical Center
California Society of Health-System Pharmacists
Colegio de Farmaceuticos de Puerto Rico
Cone Health
Connecticut Society of Health System Pharmacists
Ephraim McDowell Regional Medical Center
Fairview Health Services
Florida Society of Health-System Pharmacists
Georgia Society of Health-System Pharmacists
Harris County Hospital District dba Harris Health
Idaho Society of Health-System Pharmacy
Illinois Council of Health-System Pharmacists
Indiana Pharmacy Association
Intermountain Health
Kansas Council of Health System Pharmacy
Kentucky Society of Health-System Pharmacists

Maine Society of Health-System Pharmacists
Massachusetts Society of Health-System Pharmacists (MSHP)
Methodist Health System
Michigan Society of Health-System Pharmacists
Minnesota Society of Health-System Pharmacists
Mississippi Society of Health-System Pharmacists
Missouri Society of Health-System Pharmacists
Nebraska Pharmacists Association
Nevada Society of Health-System Pharmacists
New Jersey Society of Health-System Pharmacy
New York State Council of Health-System Pharmacists
New Hampshire Society of Health-System Pharmacists
North Dakota Society of Health-System Pharmacist
Northeast Georgia Health System
Ohio Society of Health-System Pharmacists
Oklahoma System of Health-System Pharmacists
Oregon Society of Health-System Pharmacists
Pennsylvania Society of Health-System Pharmacists (PSHP)
Pharmacy Society of Wisconsin
Renown Health
Rhode Island Society of Health-System Pharmacists
Riverside Health
South Dakota Society of Health-System Pharmacists
Sharp HealthCare
South Carolina Society of Health-System Pharmacy
SSM Health
The Ohio State University Wexner Medical Center
University of Chicago Medical Center
University of Iowa Health Care
University of Pittsburgh Medical Center (UPMC) Health System
Utah Society of Health-System Pharmacists
UVA Health
Vermont Society of Health-System Pharmacists
Virginia Society of Health-System Pharmacists
Vizient, Inc.
West Virginia Society of Health-System Pharmacists
Wyoming Society of Health-System Pharmacy

I am submitting the following comments about CMS' draft guidance for the third cycle of the Medicare Drug Price Negotiation Program.

70. Removal from the Selected Drug List Before or During Negotiation, or After an MFP is in Effect

In all cases, after CMS determines the statutory criteria in section 1192(c) of the Act for generic competition are met for a selected drug, CMS will publish such information on the CMS website.

COMMENT

Will there be public notice that a product is not longer subject to the negotiation process, or just a posting to the CMS website that will require plans to continually monitor?

110. Part D Formulary Inclusion of Selected Drugs

CMS will use its formulary review process to assess: (1) any instances where Part D sponsors place selected drugs on non-preferred tiers; (2) any instances where a selected drug is placed on a higher cost-sharing tier than non-selected brand drugs in the same class; (3) any instances where Part D sponsors require utilization of an alternative brand drug prior to a selected drug (i.e., step therapy); or (4) any instances where Part D sponsors impose more restrictive utilization management (e.g., step therapy and/or prior authorization) for a selected drug compared to a non-selected brand drug in the same class.

COMMENT

Will the formulary review process assessment require selected drugs be placed in preferred tiers or utilization management that requires a step through other drugs?

Thank you for your consideration.

Curtis Skane
Regulatory Compliance **|** SS&C Health

1055 Broadway, Kansas City, MO 64105
curtis.scane@sscinc.com **|** health.ssctech.com

From: Denise Clayton <dclayton@ssrhealth.com>
Sent: Thursday, June 26, 2025 10:12 AM
To: CMS IRA Rebate and Negotiation <IRARebateandNegotiation@cms.hhs.gov>
Cc: Richard Evans <revans@ssrhealth.com>; Scott Hinds <shinds@ssrhealth.com>
Subject: Medicare Drug Price Negotiation Program Draft Guidance.

Good Morning,

Thank you for taking comments pertaining to the May 12, 2025, Draft Guidance on the Medicare Drug Price Negotiation Program. Below are our comments and questions related to that document.

Best,

Denise Clayton, PhD

Health Economist, SSR Health

1. Do Total Expenditures under Part D include amounts paid when Medicare is not the primary payer?

2. Do Total Expenditures under Part B include amounts paid when Medicare is not the primary payer?

3. Footnote 5 under section 30 of the May 2025 Guidance indicates "CMS will determine Total Expenditures by using Part B claims data to calculate total allowed charges (meaning the amount that is inclusive of the beneficiary coinsurance and Medicare payment for the covered Part B item or service)." Do Total Expenditures for Part B drugs include beneficiary deductible payments in addition to the Medicare payment and beneficiary coinsurance?

4. For the purpose of calculating Total Expenditures under Part B, how will CMS determine if the drug or biological product is bundled or packaged into the payment for another service in order to exclude those expenditures?

5. If a line-level claim in the carrier fee-for-service file has a HCPCS code for a specified drug (e.g., J0129 for ORENCIA®), is it assumed that the payment associated with that line of the claim is not bundled or packaged into the payment for another service?

6. In footnote 26 of the May 2025 Guidance, the text indicates 'For alignment, CMS provides in sections 30.1.2, 30.2, 30.2.1, 60.2.1, 60.3.2, and 60.5 of this draft guidance that, for initial price applicability year 2028, PDE records with a compound code indicating the PDE record is for a compounded drug will be excluded from the

PDE data used to calculate the low-spend Medicare drug exclusion (section 30.1.2), the ranking of negotiation-eligible drugs (section 30.2), the Small Biotech Exception Total Expenditure calculations (section 30.2.1), the ceiling for the MFP (section 60.2.1), the Net Part D Plan Payment and Beneficiary Liability of a therapeutic alternative(s) (section 60.3.2), and the application of the MFP across dosage forms and strengths (section 60.5). A PDE record for a selected drug billed as a compound refers to a PDE record with a compound code field equal to "2=Compound." CMS will only use PDE records with a compound code field equal to "1=Not a Compound." '

Will PDE records with a value of "0=Not specified (missing values are also possible)," which make up roughly 15% of the records in the PDE file for 2023, be excluded from the Total Expenditure calculation?

7. In the May 2025 Guidance, CMS "acknowledges that there may exist fixed combination drugs for which one of the active ingredients or active moieties contained is not biologically active against the disease state(s) the drug is indicated for and thus does not result in a clinically meaningful difference." The guidance provides an example in which an "active moiety / ingredient X is not therapeutically active against the disease state" but improves the bioavailability of an active moiety / ingredient Y that presumably is effective against the disease.

We seek clarification on how to assess the 'clinically meaningful' standard regarding products with more than one active moiety. We interpret this standard based on the presence or absence of therapeutic effect, against the labelled indication, at the labeled dosage level. Such an interpretation divides potential fixed combination products into three groups. For a fixed combination containing active moieties X and Y:

- Active moiety X has known 'stand-alone' therapeutic utility, though not for the labelled indication(s) of Y. Instead, its co-formulation with active moiety Y serves to improve the effectiveness or tolerability of active moiety Y when used for the labelled indication(s). An example would be the co-formulation of hyaluronidase (X) with daratumumab (Y) in DARZALEX FASPRO®. We infer from CMS' comments in the May 12 guidance that products matching this description do not fit the definition of a fixed combination for the purpose of eligibility for IRA selection, and thus DARZALEX® and DARZALEX FASPRO® would be considered a single negotiable entity under the IRA, but would ask CMS to clarify
- Active moiety X has known 'stand-alone' therapeutic utility for the labelled indication(s), but is dosed at a level that is sub-therapeutic for the labelled

indication(s). The NDA or BLA sponsor makes no claim of therapeutic effect for X, and co-formulates X with Y only to improve the effectiveness and/or tolerability of Y. An example would be the co-formulation of ritonavir (X) with lopinavir (Y) in KALETRA®. We would ask CMS to clarify whether products matching this description would be eligible for IRA selection separately, or together (e.g., would KALETRA® be independently eligible for IRA selection from NORVIR®, generic availability aside)?

- Active moiety X has known 'stand-alone' therapeutic utility for the labelled indication(s), and is dosed at a level sufficient to produce a therapeutic effect. The NDA / BLA sponsor could have any purpose for co-formulating active moiety X and active moiety Y that is consistent with current law and regulation. We infer from the May 12 guidance that products matching this description do fit the definition of a fixed combination for the purpose of eligibility for IRA selection, but would ask CMS to clarify

8. We also ask for clarification on the distinction between co-formulation vs. co-packaging. More specifically, would a drug with two active moieties meeting all other requirements for being considered as a fixed combination still be viewed by CMS as a fixed combination for the purpose of IRA selection if the two active moieties are not co-formulated, but present in separate dosage forms that are sold in a single package? An example would be the co-packaging of KISQALI® and FEMARA® under NDC 00078-0909. Would the KISQALI® and FEMARA® co-pack be considered a separate co-formulation, or would the total expenditures for the co-pack be part of total expenditures of KISQALI®?

June 26, 2025

Chris Klomp
Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically to: IRARebateandNegotiation@cms.hhs.gov

RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Director Klomp:

Takeda Pharmaceuticals America, Inc. (Takeda) appreciates the opportunity to provide comments on the draft guidance relating to implementation of the Medicare Drug Price Negotiation Program (MDPNP) under the Inflation Reduction Act (IRA) for Initial Price Applicability Year (IPAY) 2028 and effectuation of Maximum Fair Prices (MFPs) for IPAYs 2026, 2027, and 2028 (the Draft Guidance).

Takeda is a global, values-based, R&D-driven biopharmaceutical company focused on creating better health for people and a brighter future for the world. We aim to discover and deliver life-transforming treatments in our core therapeutic and business areas, including gastrointestinal and inflammation, rare diseases, plasma-derived therapies, oncology, neuroscience and vaccines.

Takeda appreciates the great complexity of the issues introduced by the expansion of the MDPNP to include Part B drugs and, most significantly, recommends that CMS reduce the complexity of this effort by following the IRA's statutory directive to treat products covered under both Medicare Part B and Part D as separate products – one with respect to each Part. These comments complement the feedback provided by Takeda in a meeting with CMS staff in April 2025, and we look forward to ongoing engagement with the agency on these issues.

I. Overview of Takeda Comments

In summary, Takeda provides the following comments:

- CMS should not treat drugs covered by both Part B and Part D to be the same products for the purposes of identifying Qualifying Single Source Drugs (QSSDs), negotiation-eligible drugs, and selected drugs, and should instead follow the statutory directives to identify selected drugs separately as Part B and Part D products.
- CMS should also negotiate and apply an MFP for a Part B selected drug only with respect to Part B, and should negotiate and apply an MFP for a Part D selected drug only with respect to Part D, following the IRA's statutory language and removing a significant amount of confusion and complexity that would be created by attempting to develop and apply a single MFP to both Part B and Part D.
- For Part B effectuation, CMS should adopt a per unit approach, where a single ceiling price and MFP are calculated per unit of a drug, rather than trying to develop a 30 Day Equivalent Supply (DES), because the 30 DES approach is particularly unsuited to Part B drugs. If CMS maintains its approach to developing one MFP across Part B and Part D for a product covered under both Parts and does not develop a per unit price for Part B selected drugs, Takeda recommends that the agency refine its approach to determining 30 DES for Part B drugs.
- CMS must provide significantly more detail regarding potential plans for effectuation of MFPs for Part B products for stakeholders to provide meaningful comments.
- In considering potential changes to the negotiation process, CMS should:
    - Continue its current approach of having one methodology for developing a starting point for its initial offer, providing greater clarity and predictability for stakeholders.
    - Maintain its existing policy of flexibly weighting factors regarding therapeutic alternatives described in Section 1194(e)(2) of the Social Security Act.

II. General Comments on Draft Guidance and Comment Process

As a general matter, the comment period provided for the draft guidance, 45 days, is an insufficient amount of time to provide meaningful comments and engage substantively with CMS given the significant range of new complexities in incorporating Part B drugs into the MDPNP. These new issues include but are not limited to the methodology for selecting drugs under Part B (including the decision to combine spending under Part B and Part D in defining QSSDs); developing an MFP for Part B drugs, including methods for estimating a 30-day equivalent supply for Part B drugs, which are dispensed and administered in far more variable ways than Part D drugs (a complex process even without CMS' attempt to create a unified MFP

across Parts B and D); and effectuation of an MFP in Part B, especially with regard to providers and suppliers.

While CMS will continue to develop policies regarding Part B MFP effectuation in next year's guidance, continuing its practice of refining effectuation policies for each IPAY in the year leading up to the first year those prices are implemented, this practice itself creates challenges for stakeholders, because effectuation policies are not finalized until just a few months before actual effectuation begins, making it far more difficult for stakeholders to plan and support smooth and effective MFP implementation. In addition, next year, both the agency and stakeholders will also be occupied with the development of rulemaking for IPAY 2029 and beyond, as the statute directs.[1]

To address these concerns, CMS should provide more meaningful opportunities for comment on IPAY 2028-specific issues this year. The agency can take advantage of the flexibility offered by the statute's direction to use program instruction to release an updated draft guidance with further clarity on application of negotiation to Part B drugs, particularly with regard to Part B effectuation, to allow an opportunity for more in-depth feedback and engagement with the agency. If the agency decides against issuing an additional draft guidance, it should consider offering other opportunities for comment on effectuation for Part B—for instance, the agency could release a request for information later this year, around the release of the final IPAY 2028 negotiation guidance, providing more information on plans the agency is contemplating regarding Part B effectuation.

III. Definition of Qualifying Single Source Drugs and Identification of Negotiation-Eligible Drugs (Guidance Sections 30.1, 30.2, 30.3)

a. CMS Should Not Aggregate Drugs Across Part B and Part D in Defining a Qualifying Single Source Drug.

A central element of the statutory design of the MDPNP is the definition of what constitutes a qualifying single source drug, or QSSD. It is only by identification as a QSSD that a product becomes a negotiation-eligible drug,[2] and it is only by selection from the list of negotiation-eligible drugs[3] that a product is subject to negotiation and an eventual MFP. The statute clearly defines a "qualifying single source drug" as "a covered Part D drug … *or* a drug or biological product for which payment may be made under part B of Title XVIII" (emphasis added).[4] This statutory text explicitly describes a QSSD as a Part D product *or* a Part B product—not both. Of

[1] Sec. 11001(c), Inflation Reduction Act (Pub. L. 117-169).
[2] Social Security Act (SSA) Section 1192(d).
[3] SSA Section 1192(c).
[4] SSA Section 1192(e)(1).

course, a single product may be both a covered Part D drug *and* a product for which payment may be made under Part B, but the statute's use of the disjunctive "or" makes it clear that the concept of a QSSD is created with respect to coverage under Part B *or* Part D. In other words, where a product is covered by both Part B and Part D, it constitutes two QSSDs—a Part B QSSD and a Part D QSSD.

b. CMS Should Not Aggregate Drugs Across Part B and Part D in Defining a Negotiation-Eligible Drug and Identifying Selected Drugs.

This distinction between Part B and Part D drugs is carried throughout the statute's description of the drug selection process and of the MFP development process (see further discussion below regarding MFP development and effectuation).

Under Section 1192(d)(1), a "negotiation-eligible drug" is selected from the set of QSSDs, and a negotiation-eligible drug is a QSSD that is identified in "either of" two paragraphs (not, for instance, as the statute could have been written, "either or both of" two paragraphs). One of those two paragraphs (subparagraph (A) of subsection (d)(1)) provides a methodology for identifying 50 "Part D high spend drugs,"[5] and one provides a methodology for identifying 50 "Part B high spend drugs"[6] (subparagraph (B) of subsection (d)(1)).

Takeda recognizes that CMS plans to develop and publish these two lists, for Part B and Part D drugs, and supports this decision. Indeed, CMS correctly interprets the statute by stating that "CMS will consider these 50 Part D high spend drugs and 50 Part B high spend drugs" identified through this separate Part B and Part D rankings "to be the negotiation-eligible drugs for initial price applicability year 2028."

It then follows from the statutory framework that the agency should then select the top 15 negotiation-eligible drugs from these two lists, ranked by spending under Part B or Part D as applicable. Instead, CMS's guidance departs from the statute by stating that the agency "will rank the list of negotiation-eligible drugs identified … by combined Total Expenditures under both Part B and Part D in descending order."[7] The statute directs the Secretary to "rank negotiation-eligible drugs described in subsection (d)(1) according to total expenditures for such drugs under parts B and D," but does not refer to a concept of "combined Total Expenditures" at all. The concept of "Total Expenditures for a negotiation-eligible drug across Part B and Part D" does not fit within the context of the statute more generally, since the statute elsewhere explicitly

[5] SSA Sec. 1192(d)(1)(A).
[6] SSA Sec. 1192(d)(1)(B).
[7] Draft Guidance, p. 27.

defines a "negotiation-eligible drug" as being identified by virtue of coverage under Part B *or* Part D.[8]

Notably, while the statute does not refer to the creation of a "Total Expenditures" concept or combining expenditures across Part B and Part D at any point, the statute does refer to aggregation of spending in a different respect. In Section 1192(d)(3)(B), the statute states that, in developing the lists of top 50 Part B products and top 50 Part D products by spend required by Section 1192(d)(1)(A) and (B), "the Secretary shall use data that is aggregated across dosage forms and strengths of the drug"[9]—but not directing the aggregation of spending across Parts. In that subsection, further, the statutory text refers to the Secretary "determining whether a qualifying single source drug satisfies any of the criteria described in paragraph (1) *or* (2)" (referring to Part B and Part D spend), again reinforcing that the statute does not contemplate a QSSD as being selected on the basis of "Total Expenditures" in both Part B and Part D, but rather expenditures under *either* Part B *or* Part D.

Separate treatment of Part B QSSDs and Part D QSSDs for the purposes of negotiation eligibility also aligns with the guidance's implementation of the "small biotech" exception (SBE), including CMS' interpretation of similar statutory language. The text defining this exception, at Section 1192(d)(2) defines QSSDs by reference to "Part B drugs" and "Part D drugs," rather than contemplating the possibility of a QSSD being both a Part B drug and Part D drug. Following this statutory direction, in Section 30.2.1 the draft guidance evaluates eligibility for the "small biotech" exception separately for Part B or Part D. As CMS explains, the statute "requires that CMS evaluate whether a qualifying single source drug qualifies for the SBE based on Total Expenditures under Part B *or* Part D"[10] (emphasis added), and similar "or" language is used with respect to identifying a qualifying single source drug in the first place.

Following the statute by regarding a QSSD, a negotiation-eligible drug, and a selected drug only with respect to its coverage under Part B or Part D would align with the statute's directives and other elements of the statute. It would also allow CMS to simplify the selection process and the criteria used for identifying selected drugs, helping to fulfill the directive in Executive Order 14372 to "improve the transparency of the Medicare Drug Price Negotiation Program."

[8] SSA Sec. 1192(d)(1).
[9] In some cases, drug formulations may determine coverage under Part B or Part D—for instance, an intravenously infused formulation of a drug is payable under Part B while a pen formulation of a drug is self-administered and a covered Part D drug—but in many cases different dosages and forms of a drug are covered by only Part B or Part D (e.g., a product that is available in both tablet and capsule form).
[10] Draft Guidance, p. 21.

IV. MFP Effectuation (Guidance Section 40.4)

a. CMS Must Provide Significantly Greater Clarity on Plans for Part B Effectuation As Soon As Possible.

As CMS is well aware, effectuating MFP for Part B drugs will involve numerous new challenges for manufacturers and Part B providers and suppliers, challenges that are different from those posed by effectuation for Part D drugs. These include, but are not limited to, the complex nature of Part B's "buy and bill" structure for providers and the need to develop a single MFP for Part B products that may involve diverse or irregular dosing schedules. Even after two rounds of draft and final guidance for Part D drugs in IPAY 2026 and 2027, stakeholders remain concerned about the lack of detail and clarity regarding MFP effectuation. We believe these challenges will be even greater with regard to Part B drugs in IPAY 2028. Challenges with the rollout of Part B MFPs pose significant risks to both patients and providers, with the real possibility of interruptions in patient access to Part B selected drugs and providers experiencing uncertainty and confusion in obtaining and paying for these products. Effectuating MFP in Part B is one of the most complex policy rollouts the Medicare program has undertaken in the past two decades, and the success of the MDPNP depends to a large extent on ensuring that patients and providers have consistent, uninterrupted access to selected drugs.

These effectuation concerns would be, to some extent, simplified and alleviated, if, as discussed in Sections III and V.a of this letter, CMS follows the statutory text and considers Part B and Part D products to be different products for the purposes of selection, negotiation, and effectuation. Such a choice would reduce the need for processes to apply across both Part B and Part D for any drug selected under Part B or Part D. As Table 1 below shows, among the Top 75 Part B drugs, Medicare spending on drugs not usually self-administered (e.g., intravenous infusions, intravitreal injections) is concentrated in Part B with 82.7% of spending on such drugs under this Part. Likewise, among the Top 200 Part D drugs, Medicare spending on drugs usually self-administered is concentrated in Part D with 99.6% of spending under this Part. An approach that considers Part B and Part D products to be different products would reduce the burden required and uncertainty involved in Part B implementation during IPAY 2028. Manufacturers with Part D products that are only occasionally covered under Part B would not need to engage in the significant amount of compliance required to provide access to those products at MFP in Part B, and manufacturers with Part B products that are only occasionally covered under Part D would not need to undertake such efforts with respect to Part D. Similarly, Part B providers would not need to consider whether a product rarely used in Part B may be subject to MFP because it was selected based on its more common use in Part D,[11] and dispensing entities would not need to

[11] For example, where a self-administered drug (e.g., sub-cutaneous drug) covered under Part D has a rarely used IV version covered under Part B.

consider whether a product rarely used in Part D may be subject to MFP based on its more common use in Part B.

Table 1. Takeda Analysis of Top 75 Part B and Top 200 Part D drugs. CY 2023 Drug Spending Dashboards

Drug Form(s)	Number of Drugs	Percent of Total Spending (Part B)	Percent of Total Spending (Part D)
Not usually self-administered only	66	82.7%	17.3%
Not usually self-administered AND usually self-administered	22	24.9%	75.1%
Usually self-administered only	164	0.4%	99.6%

Given the extremely limited detail provided on potential Part B effectuation, CMS should provide as many opportunities as possible for input and engagement with stakeholders, including providers, on Part B effectuation beyond this draft guidance. This could take the form of a revised draft guidance specific to IPAY 2028 Part B effectuation later this year, a request for information specific to IPAY 2028 Part B effectuation attached to the release of the revised final guidance later this year, or other formats that CMS can pursue under the flexible nature of program instruction and guidance. Regardless of the format used, Takeda appreciates the opportunity to continue to engage with CMS on this topic.

b. CMS Should Implement a Proposal for Standard Default Refund Amounts but Must Consider a Different Methodology for Part B.

In general, Takeda is supportive of CMS' overall proposal to provide for manufacturers to make retrospective refunds to effectuate the MFP for dispensing entities and Part B providers, as well as the creation of a standard default refund amount (SDRA). However, CMS' specific proposal for IPAY 2026 and 2027, to permit the use of an SDRA for Part D that is equal to Wholesale Acquisition Cost (WAC) minus MFP, has significant limitations in Part B. These limitations are compounded by anticipated challenges in identifying customer acquisition costs from CMS-provided data elements. Access to a Part B SDRA that ensures provider MFP access and calculates accurately manufacturer liability is essential without the ability to identify customer acquisition costs. The Part B SDRA becomes even more critical if CMS does not exercise its existing authority to exclude the MFP from Average Sales Price (ASP) reporting requirements.

In Part D, as CMS recognized, WAC is an accurate proxy for drug acquisition costs. While dispensing entity acquisition costs for Part D drugs may vary from WAC, the variance is not likely to be great. The clustering of drug acquisition costs around WAC allows an SDRA calculated as WAC minus MFP to provide access to the MFP for most dispensers while ensuring that manufacturer liability is accurately represented.

In Part B, drug acquisition costs do not cluster neatly around WAC, making the Part D SDRA formula inappropriate under this Part. Part B drugs are generally acquired by providers at prices tied to ASP. Part B providers may acquire drugs at, above or below ASP. Since Medicare payment for Part B drugs is also based on ASP, providers with acquisition costs at or below ASP are likely to experience a small (relative to overall drug costs) financial gain, and providers with acquisition costs above ASP may experience a relatively small loss.

Counterintuitively, hospital outpatient providers typically have higher Part B drug acquisition costs. These providers are frequently 340B covered entities or accept Part B drug acquisition costs that exceed ASP because commercial rates more than offset Medicare losses. An analysis published in JAMA Internal Medicine illustrates this phenomenon. Among 11 hospitals complying with price transparency requirements, researchers found that average commercial payer-specific negotiated prices for the 10 most highly used physician-administered drugs ranged from 169 percent to 344 percent of Medicare fee-for-service (FFS) rates.[12] Commercial reimbursement benchmarking reports from Milliman corroborate these findings.[13]

Furthermore, for many Part B drugs, hospital outpatient providers are the primary billers (Table 2). For three of the five Part B drugs with the highest Medicare Part B spending in 2023, Medicare FFS hospital outpatient and carrier claims data show that more than 50% of Medicare drug units are billed by hospital outpatient providers. For another drug, more than 40 percent of such units are billed by these providers.

Table 2: Hospital Outpatient Department (HOPD) Share for Top 5 Medicare Part B Drugs, 2023

HCPCS Code	HCPCS Code Description (Brand)	Unique Benes	Benes with HOPD Claims	% Benes with HOPD Claims	Total Units	HOPD Units	% HOPD Units
J9271	Injection, pembrolizumab, 1 mg (Keytruda)	76,233	49,207	64.5%	105,388,209	67,393,852	63.9%
J0178	Injection, aflibercept, 1 mg (Eylea)	346,344	19,615	5.7%	3,721,088	205,599	5.5%
J0897	Injection, denosumab, 1 mg (Prolia)	732,775	291,494	39.8%	100,276,324	43,646,667	43.5%
J9144	Injection, daratumumab, 10 mg and hyaluronidase-fihj	24,212	15,471	63.8%	45,368,637	28,895,402	63.7%

[12] Feldman WB, Rome BN, Brown BL, Kesselheim AS. Payer-Specific Negotiated Prices for Prescription Drugs at Top-Performing US Hospitals. JAMA Intern Med. 2022 Jan 1;182(1):83-86. doi: 10.1001/jamainternmed.2021.6445. PMID: 34747978; PMCID: PMC8576628.

[13] Marshall, S., Zhou, D., Anderson, C., & Mills, C. (2024, June 19). *Commercial reimbursement benchmarking: Commercial payment rates for medical services as percentage of Medicare fee-for-service rates*. Milliman. Retrieved June 19, 2025, from https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-medicare-ffs-rates

HCPCS Code	HCPCS Code Description (Brand)	Unique Benes	Benes with HOPD Claims	% Benes with HOPD Claims	Total Units	HOPD Units	% HOPD Units
J9299	Injection, nivolumab, 1 mg (Opdivo)	29,369	18,591	63.3%	67,787,905	42,165,116	62.2%

CMS should consider these dynamics when deciding on a Part B SDRA formula. Table 3 and Table 4 below illustrate the impact of different methods for calculating a Part B refund amount. Table 3 presents a hypothetical example where provider payment is based on ASP or the MFP, with a refund amount based on acquisition cost. Provider 1 buys a drug below ASP, while Provider 2 and Provider 3 buy at and above ASP, respectively. With Medicare payment based on ASP, Provider 1 gains $3.20, Provider 2 gains $1.20, and Provider 3 loses $0.80. With an MFP set at $12 and a refund amount based on acquisition cost, all three providers gain $0.72. Although all three providers gain from this approach, Provider 1 and Provider 2 have reduced gains compared to the current payment system, whereas Provider 3 benefits significantly. In this scenario, total manufacturer liability is $24.

Table 3. Hypothetical Example: Provider Payment Based on ASP/MFP, Refund Amount Based on Acquisition Cost

Provider	Cost per unit	WAC	ASP	ASP +6%	Gain/ Loss	MFP	MFP +6%	Refund (Cost-MFP)	Sum: MFP +6%, Refund	Gain/ Loss Relative to Cost	Percent Change Gain/ Loss
Prov 1	$18	$23	$20	$21.20	$3.20	$12	$12.72	$6	$18.72	$0.72	-77.5%
Prov 2	$20	$23	$20	$21.20	$1.20	$12	$12.72	$8	$20.72	$0.72	-40.0%
Prov 3	$22	$23	$20	$21.20	$(0.80)	$12	$12.72	$10	$22.72	$0.72	190.0%

In
Table 4, consider the same example, however, the refund amount is calculated as WAC minus MFP. This modification benefits all three providers compared to a refund amount calculated based on acquisition cost. Manufacturer liability increases to $33, which is nearly 40 percent more than required by statute.

Table 4. Hypothetical Example: Provider Payment Based on ASP/MFP, Refund Amount Based on WAC

Provider	Cost per unit	WAC	ASP	ASP +6%	Gain/ Loss	MFP	MFP +6%	Refund (WAC-MFP)	Sum: MFP +6%, Refund	Gain/ Loss Relative to Cost	Percent Change Gain/ Loss
Prov 1	$18	$23	$20	$21.20	$3.20	$12	$12.72	$11	$23.72	$5.72	78.75%
Prov 2	$20	$23	$20	$21.20	$1.20	$12	$12.72	$11	$23.72	$3.72	210.0%
Prov 3	$22	$23	$20	$21.20	$(0.80)	$12	$12.72	$11	$23.72	$1.72	315.0%

These illustrative examples highlight how the formula used to calculate the Part B refund amount affects not only manufacturer refund amounts but also provider economics. They also indicate the necessity of a different formula for the Part B SDRA. We are diligently working to develop more suitable formulas and look forward to engaging CMS further on this topic. Lastly, here, as with other MFP effectuation issues, the need for different SDRA formulations for Part B and Part D drugs underscores the practical logic of providing for separate MFP effectuation based on Part B or Part D, rather than attempting to develop a single MFP applicable across both Parts.

c. CMS Should Proceed with Implementation of the MTF Data and Payment Modules Expanding Claim-Level Data Elements to Account for Differences between Part B and Part D.

Takeda supports CMS' plans to use the MTF Data Module (DM) to exchange data between manufacturers, dispensing entities, and Part B providers, and appreciates the detail that CMS has provided regarding the operation of the DM with respect to Part D products so far. However, the introduction of Part B effectuation in IPAY 2028 will introduce numerous new challenges not discussed in the Draft Guidance, reinforcing the need for more clarity around CMS' plans for Part B effectuation, as well as the logic of separating Part B and Part D effectuation.

A critical component of MFP effectuation in both Part B and Part D is the provision of claims data to verify a selected drug has been administered or dispensed to a Medicare beneficiary. This data, however, not only serves to verify eligibility, but also to allow the manufacturer to identify the customer and their acquisition cost so that an accurate refund amount can be calculated. Under Part D, claims data is reported to CMS by Part D plan sponsors in the form of Prescription Drug Event (PDE) data. Data is collected and reported in a standardized way making the process of extracting this data and providing it to manufacturers relatively straightforward.

Under Part B, accessing and synthesizing claims data for timely and accurate reporting to manufacturers is expected to be more complex. First, in Part B, claims data is held by Medicare Administrative Contractors (MACs) operating the FFS program as well as Medicare Advantage (MA) plans. CMS has ready access to FFS claims data from providers and is expected to be readily able to provide this data to the MTF DM. However, CMS currently has much more limited access to MA claims through MA Encounter Data submitted by these plans. CMS does receive MA Encounter Data, but this data is generally reported with a significant timing lag. If this significant lag continues, it will be impossible to provide prompt payment of MFP refunds to providers serving MA patients. As such, we strongly recommend that CMS require MA plans to submit claims data to the MTF DM on a more frequent basis for purposes of MFP effectuation.

Part B claims data is also more complex as providers billing Part B drugs use different claim forms. Institutional providers such as hospitals bill outpatient services utilizing the CMS-

1450/UB-04 whereas individual healthcare providers and suppliers such as physicians, therapists, and durable medical equipment suppliers utilize the CMS-1500. Data captured by these different claim types is often similar but captured in different fields or in slightly different ways.

Takeda anticipates that manufacturers would likely need access to roughly 20 unique claims data elements for Part B drug claims to be able to verify eligibility and identify customers and acquisition cost. In Medicare FFS claims and MA Encounter data, however, these 20 unique elements are described by more than 40 fields (Table 5). This long list reflects differences across claim types as well as how different billing providers may use those same claim types differently. It also reflects differences between data available in FFS claims versus MA encounter data.

Table 5. Claims Data Elements Expected to be Necessary for Eligibility Verification or Customer Identification

Claims Data Element	OP FFS	Carrier FFS	DME FFS	OP Enc	Carrier Enc	DME Enc
Claim Type Code	x	x	x	x	x	x
Claim Through Date	x	x	x	x	x	x
Medicare Part C Contract Number				x	x	x
Medicare Part C Plan Benefit Package (PBP) Number				x	x	x
Carrier/FI or MAC Number	x	x				
FI or MAC Claim Action Code	x					
Provider Number	x					
Full CMS Certification Number	x					
Carrier/DMERC Claim Referring/Ordering Physician NPI Number		x	x			
Carrier Claim Billing NPI Number		x				
Organization NPI Number	x			x	x	x
Claim Service Location NPI	x					
Claim Place of Service Code					x	x
Claim Rendering Physician NPI Number				x	x	x
Claim Through Date	x			x	x	x
Line Rendering/Performing Physician NPI		x			x	x
Line CMS Provider Specialty Code		x	x		x	x
Carrier Line Performing Group NPI Number		x	x			
Carrier Line Provider Type Code		x	x			
Line Service Count		x	x		x	x
Line Place of Service Code		x	x		x	x
Line First Expense Date		x	x		x	x
Line Last Expense Date		x	x		x	x
HCFA Common Procedure Coding System (HCPCS) Code	x	x	x	x	x	x
HCPCS Initial Modifier Code	x	x	x	x	x	x
HCPCS Second Modifier Code	x	x	x	x	x	x
HCPCS Third Modifier Code	x		x	x	x	x

Claims Data Element	OP FFS	Carrier FFS	DME FFS	OP Enc	Carrier Enc	DME Enc
HCPCS Fourth Modifier Code	x		x	x	x	x
Line National Drug Code (NDC)		x	x		x	x
Line RX Number						x
Line Latest Claim Indicator				x	x	x
Revenue Center From Date	x			x		
Revenue Center Thru Date				x		
Revenue Center Unit Count				x		
Revenue Center IDE, NDC, or UPC Number	x			x		
Revenue Center National Drug Code (NDC) Quantity	x			x		
Revenue Center NDC Quantity Qualifier Code	x			x		
Revenue Center Rendering Physician NPI	x			x		
Revenue Center Adjustment Group Code	x					
Revenue Center Adjustment Reason Code	x					
Revenue Center Remittance Advice Remark Code	x					
Line Adjustment Group Code		x				
Line Adjustment Reason Code		x				
Line Remittance Advice Remark Code		x				

With respect to our request for HCPCS modifier codes, given the statutory prohibition in the Act for duplicate 340B and MFP discounts, we encourage CMS, at a minimum, to identify claims where a "TB" modifier has been used in one of the available modifier fields. Furthermore, this information should be shared with manufacturers as it is necessary to assist manufacturers in ensuring deduplication.

In addition to the data captured by these fields, Takeda urges CMS to also provide manufacturers with the billing provider name, street address, city, state and zip code associated with each claims billing National Provider Identifier (NPI) provider. While this data is not reliably reported on claims data, CMS has access to this data through the National Plan and Provider Enumeration System (NPPES) NPI registry that the agency maintains and should be able to provide it. Billing provider name and address are essential to identifying acquisition costs and determining an accurate and appropriate refund amount.

With respect to the MTF payment module and CMS's interest in exploring whether private market solutions might replace the agency's solution,[14] we believe the current solicitation is premature. Furthermore, any future private market solution should serve as an alternative to rather than a replacement for the MTF PM. We recommend that CMS wait until after IPAY 2028 concludes before seeking feedback on private market alternatives for MFP effectuation.

[14] Draft Guidance, p. 54.

d. Given the Statutory Prohibition for Duplicate 340B and MFP Discounts, CMS Should Ensure a Clear Determination of 340B Status for each FFS and Medicare Advantage Claim. (40.4.5)

In the FFS program, for drugs payable under Part B, CMS mandates the use of the "TB" modifier to identify 340B eligible units. Takeda shares concerns with other stakeholders that all Part B drugs subject to a 340B agreement may not be appropriately captured. We request that CMS establish a new modifier that providers would be required to use when reported Part B drug units are not 340B eligible. This modifier would function similarly to the "JZ" modifier, used by providers to affirm zero discarded units. Implementing this requested new modifier will ensure a clear determination of 340B status for each FFS claim.

Furthermore, we urge CMS to mandate the use of both the "TB" modifier and the requested new modifier by providers seeking reimbursement under MA. Currently, the "TB" 340B claims modifier is not required on provider claims to MA plans. CMS should require MA plans to ensure 340B covered entities in their networks utilize the "TB" modifier effective with calendar year 2028. Under existing 340B replenishment models, chargeback requests are not at the individual claim level. Consequently, manufacturers have minimal insight into whether 340B replenishment requests include Medicare administrations. Without a claims modifier for identifying individual 340B claims, manufacturers will be unable to avoid 340B/MFP duplicate discounts in MA. To ensure a clear determination of 340B status for each MA claim, we also urge CMS to require MA plans to use the requested new modifier as well.

V. MFP Negotiation

a. Following the Statute's Establishment of Part B or Part D QSSDs, MFP Negotiation and Effectuation Should Occur with Respect to Part B or Part D Products.

As discussed in Section III of this letter, the statute directs that CMS identify a QSSD based on a drug's status as either a Part B or Part D drug, but not both. Negotiation of an MFP under Section 1194 and manufacturers' obligations to provide a product at MFP under agreements described in Section 1193 apply only with respect to a selected drug, and a selected drug may only be a product that is a negotiation-eligible drug under Section 1192(b), which in turn must be a QSSD under Section 1192(d)—which is defined by reference with Part B *or* Part D expenditures.

As described above, a faithful and consistent interpretation of the statute requires the identification of a QSSD as either a Part B QSSD or a Part D QSSD, determining which Part B and Part D QSSDs are negotiation-eligible, selecting 15 QSSDs from the list of negotiation-

eligible products, and then negotiating and implementing an MFP with respect to those QSSDs, under either Part B or Part D as applicable. Of course, a single product may be both a Part B product and a Part D drug, and in such a case, it constitutes two QSSDs and negotiation eligibility, selection, and effectuation for the Part B and the Part D QSSDs would proceed separately.

This distinction between Part B and Part D negotiation and effectuation of MFP arises not just from the statute's underlying distinction between identifying a QSSD as either a Part B or Part D drug, however. A crucial element of the negotiation process—the main binding constraint on the negotiation of an MFP, once a QSSD has been identified—is the calculation of a "ceiling price" as described in Section 1194(c)(1)(B). Importantly, the statute provides one methodology for calculating a ceiling price to guide negotiation for a drug covered under Part B,[15] and another methodology for calculating a ceiling price to guide negotiation for a drug covered under Part D.[16] In the Draft Guidance, without authority from the statute, CMS creates the concept of a "subparagraph (B) amount," requiring complex efforts to combine the quite different payment data used to calculate ceiling prices for Part B and for Part B drugs.

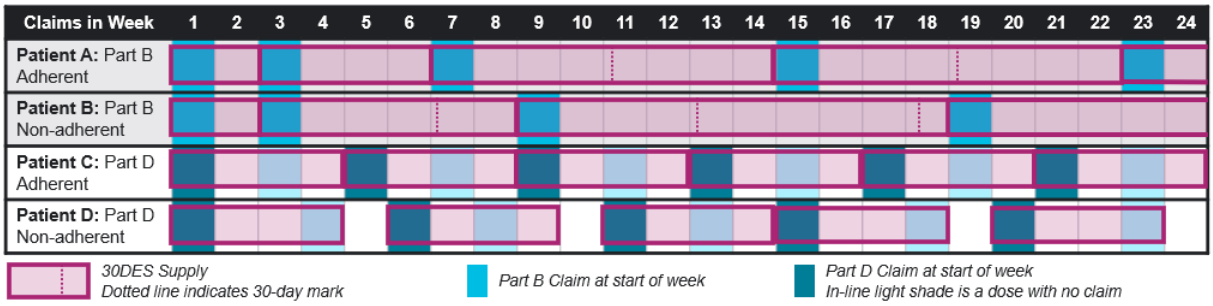
Negotiating and effectuating an MFP under either Part B or Part D separately avoids a number of the practical complications of a common MFP across Part B and Part D that CMS identifies in its guidance. Adopting the separated Part B and Part D approach would avoid CMS' extra-textual effort to calculate a combined ceiling price across Part B and Part D, which introduces complex considerations and additional burden for both manufacturers and the government. For instance, the complex calculations proposed in Section 60.2.2.3, "Determination of Payment Amount for Selected Drugs Payable Under Part B and Covered Under Part D," could be deleted entirely, removing complexity for both the agency (which must perform these calculations) and manufacturers (which will be required to provide input data for such calculations and review them for accuracy).

Takeda has significant concerns with CMS' proposed method for calculating a single ceiling price and MFP for drugs covered under Part B (while noting that these concerns further support the argument for separating Part B and Part D MFPs). Using Part B claims data to calculate the "days between service" as a proxy for days supply is inappropriate. For drugs dispensed by a pharmacy, the prescriber determines the days supply, which is unaffected by patient adherence. In contrast, for Part B drugs administered incident to a physician service, the days between service may or may not accurately reflect the physician's recommended dosing schedule or the equivalent of the prescribed "days supply." A patient who follows their physician's recommended dosing schedule will have "days between service" that corresponds with the prescribed "days supply," whereas a non-adherent patient will not. Figure 1 below illustrates this

[15] SSA Sec. 1194(c)(1)(B)(i).
[16] SSA Sec. 1194(c)(1)(B)(ii).

point. In this figure, Patient A and Patient B take the same Part B drug. For both patients, the recommended dosing schedule is drug at week 0, week 2, week 6 and, thereafter, every eight weeks. Patient A receives their Part B drug according to the recommended dosing schedule and has "days between service" that correspond with the prescribed "days supply." In contrast, Patient B does not receive their Part B drug according to the recommended dosing schedule and has "days between service" that exceed the prescribed "days supply." As shown below, the result for Patient B, is 30-day equivalent supply numbers for dose two and dose three that are greater than expected. Patient C and Patient D examine the effects of patient behavior on 30-day equivalent supply calculations in Part D. These patients both take the same Part D drug, which has a recommended dosing schedule of every two weeks. Patient C takes the drug as prescribed, whereas Patient D does not. Although Patient D does not follow the recommended dosing schedule, the number of 30-day equivalent supplies is not impacted. Furthermore, it is impossible to ascertain from claims data alone whether the "days between service" for a Part B drug corresponds to the physician's recommended dosing schedule or the prescribed "days supply."

Figure 1. Illustrative Example Demonstrating Impact of Patient Adherence on Days Equivalent Supply (DES)



The concept of a 30-day equivalent supply is not suitable for Part B drugs, which often require more frequent recurring administrations and variable dosing based on factors such as a patient's body weight, indication, treatment phase, or response. For instance, treatments for autoimmune and inflammatory diseases might necessitate more frequent administrations at the beginning of the treatment course compared to less frequent administrations once the condition has stabilized or reached a maintenance phase. In Type I diabetes, patients with varying body weights need different amounts of insulin over a 30-day period. Insulin dosing also varies depending on whether it is used to treat Type I or Type II diabetes. The 30-day equivalent supply approach is also not suitable for medications taken infrequently (e.g., vaccines) as utilization of such drugs often occurs once per year or once per lifetime. Utilizing a 30-day equivalent approach, as CMS has been using for covered Part D selected drugs, and is proposing for covered Part B selected drugs, does not account for these important differences in dosing and can result in outcomes that are illogical and do not accurately reflect the value of the drug.

Because of the particular challenges posed by calculating a 30 DES for Part B drugs, we urge CMS to move to a per unit approach for Part B MFP negotiation and effectuation, where a single

ceiling price and MFP are calculated per unit of a drug. We believe a per unit approach would be the best methodology for Part B drugs as a price per unit easily accommodates dosing that change in strength or frequency. A per unit approach will simplify the calculation of a single ceiling price and MFP across dosage forms and strengths when the same drug is delivered in different forms. As a more general matter, the need for a substantially different approach to these calculations for Part B (by contrast to the existing Part D-specific 30 DES regulatory framework CMS has relied on for Part D effectuation) highlights the benefits of following the statutory structure of separate Part B and Part D selected drug.

In the event that CMS does implement its proposed approach to developing a 30-day equivalent supply for both Part B and Part D drugs and the combined Part B and D MFP concept, Takeda recommends the following changes for both Part B and Part D covered drugs.

In Section 60.2.1.1, CMS explains its proposed methodology for calculating the 30-day equivalent supply for Part B products, stating that it will apply a "similar methodology to the methodology as described at 42 C.F.R. § 423.104(d)(2)(iv)(A)(2)" used for Part D records. In cases where the days between service exceeds 34, this methodology involves dividing the days between service by 30. The agency should divide all amounts of days between service by 30, not just those where days between service is greater than 34. The concept of dividing by 30 only where the days between service is greater than 34 may be sensible under the Part D program for determining whether a drug should be placed on a specialty tier. However, it can result in underestimating costs for products when attempting to determine their cost per 30-day equivalent supply, a concern especially great for Part B products where dosing schedules can have dramatically more variability than in Part D. For instance, injectables that are often administered every 2 or 4 weeks will have fewer than 34 days between dates of service but would not, under CMS' proposed methodology, be divided by 30 days in order to calculate 30 DES. Not dividing these by 30 undervalues these services.

CMS should also consider methods to exclude any outlier Part B claims in which the days between service exceeds the maximum days between service contemplated in the dosing schedules in the product's FDA-approved label (or those dosing schedules plus some small margin). For instance, if the label indicates that dosing should be every 8 weeks, then CMS might exclude from the 30-day equivalent supply calculation any Part B claim with days between service exceeding 56 days, or, providing some margin for clinical variation, exceeding 60 days. Any such claims with days between service beyond the FDA-approved dosing schedule would reflect either clinically exceptional practices or a data error, neither of which should feed into CMS' 30-day equivalent supply calculations.

Finally, Takeda recognizes that the 30-day equivalent approach is utilized by CMS not only to calculate a ceiling price and MFP, but also to standardize the cost of the selected drug and the

cost of its therapeutic alternatives for comparison and for determining the starting point for its initial offer. We generally support CMS standardizing costs for this purpose. However, our concerns regarding the current methods remain and we urge CMS to work with the manufacturer of each selected drug to tailor its methods to account for unique circumstances. For example, for treatments for autoimmune and inflammatory diseases, CMS might limit its analysis to patients who have reached the maintenance phase.

b. CMS Should Maintain a Single Methodology for Developing a Starting Point for Its Initial Offer.

In Section 60.3.2, CMS raises the possibility of adopting new, alternative approaches for determining the starting point for developing its initial offer in the negotiation process.[17] One example contemplated would be choosing a starting point between Part B ASP/WAC or net Part D payments for therapeutic alternatives (as applicable), and unit costs of production and distribution of the selected drug, and CMS also requests comment on whether "other domestic reference prices" may be used in place of Part B and Part D payment levels.[18]

Such proposals would depart from a methodology that CMS has already applied for two cycles of negotiation and introduce new uncertainty into the process. It would also undermine CMS' stated efforts, in line with Executive Order 14273 to "improve the transparency of the Medicare Drug Price Negotiation Program." Takeda encourages CMS to maintain its current methodology for calculating a starting point for its initial offer and to consider how it may be able to improve transparency in how it applies and communicates calculations under this existing approach to advance the goals of the Executive Order.

c. CMS Should Maintain Its Current Approach for the Development of an Initial Offer.

In Section 60.3.3, the agency solicits comment on whether it should "put greater emphasis on certain section 1194(e)(2) factors when adjusting the starting point to determine the preliminary price" and, from the perspective of stakeholders, "which section 1194(e)(2) factors are most compelling in informing the section 1194(e)(2) adjustment and what approaches could be used to consistently apply those factors across selected drugs." The IRA statute is silent on how the agency may weight these factors, and the final guidances for the IPAY 2026 and 2027 negotiation process do not formulate an agency policy for how it weights these factors. Takeda recommends that CMS maintain flexibility in how it weights 1194(e)(2) factors, recognizing that the statute does not direct the agency to prioritize particular factors from those listed and that the

[17] Draft Guidance, p. 131.
[18] *Id.*

application of the factors may need to vary significantly across different selected drugs. Takeda further recommends that the weight of these factors be based on the disease area being addressed, the relative unmet needs of the patient population, and the impact on outcomes that are most important to key stakeholders, patients and healthcare providers. Such flexibility is needed to ensure the unique needs of each patient population, including sub-populations with varying disease severity, treatment experience and treatment goals, are adequately considered.

In general, however, it would be helpful for CMS to propose and finalize more predictable methodologies to use in assessing the 1194(e)(2) factors, especially with regard to the selection of therapeutic alternatives. For instance, CMS could commit to beginning selection of therapeutic alternatives within an indication with products recommended or preferred by evidence-based clinical practice guidelines and products newly launched that offer unique treatment profiles but may not have yet established themselves in the market. CMS could depart from such guidelines in exceptional circumstances for which it would provide a justification in its initial offer. Such clarity would be helpful to stakeholders (both manufacturers and other stakeholders providing comment on selected drugs) and would advance EO 14372's directive to make negotiations more transparent.

VI. Conclusion

Takeda thanks CMS for the opportunity to provide these comments on the Draft Guidance and looks forward to providing more input to the agency as it continues to plan for IPAY 2028 and the significant challenges facing the agency, manufacturers, and other stakeholders in implementing the MDPNP for Part B.

If Takeda can provide additional detail on issues raised in this comment letter, please do not hesitate to contact me at Lorena.Ferrara@takeda.com.

Sincerely,

Lorena Ferrara
Senior Director, Public Policy & Reimbursement
U.S. Public Affairs
Takeda Pharmaceuticals America, Inc.

teva | Legal Group

June 26, 2025

By Electronic Mail
IRARebateandNegotiation@cms.hhs.gov

Administrator Mehmet Oz, MD, MBA
c/o Chris Klomp, CMS Deputy Administrator and Director for the Center of Medicare
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Manufacturer Comments on IPAY 2028 Draft Guidance

Dear Administrator Oz and Deputy Administrator Klomp:

Teva Branded Pharmaceutical Products R&D, Inc. ("Teva") appreciates the opportunity to comment on the Draft Guidance on the Medicare Drug Price Negotiation Program released on May 12, 2025 ("Draft Guidance").

Teva is a global pharmaceutical company, committed to helping patients around the world to access affordable medicines and benefit from innovations to improve their health. Teva operates worldwide, with a significant presence in the United States, Europe, and many other markets around the world. We are a global leader in generics and a leading specialty pharmaceuticals company developing and manufacturing innovative treatments for disorders of the central nervous system, including neurological and neurodegenerative disease, migraine, and movement disorders, as well as products in oncology and respiratory.

Two such medicines are AUSTEDO® (deutetrabenazine) tablets and AUSTEDO XR (deutetrabenazine) extended-release tablets which are indicated for tardive dyskinesia and Huntington's disease, a rare disorder. Both products were selected for the second round of the CMS Drug Price Negotiation Process earlier this year for an MFP effectuation of January 1, 2027. According to the Draft Guidance, they could be selected for renegotiation in the same month its MFP goes into effect, January 2027. This would allow for selection by CMS without a crucial piece of information; the impact of the 2027 MFP.

Section 1194(f)(2) of the Act sets out that CMS may select a drug for renegotiation if "the Secretary determines there has been a material change to any section 1194(e)(1) or (e)(2) factor." Without data reflecting the financial impact of the MFP on IPAY 2027

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drugs, CMS's ability to make a materiality determination will be severely impaired and prevent it from conducting a "holistic inquiry," particularly with respect to 1194(e)(1) adjustments.

Teva respectfully requests that CMS revise its Draft Guidance to delay selection eligibility for renegotiation listing by two years following a drug's IPAY. For example, AUSTEDO and AUSTEDO XR should not be reselected for renegotiation based upon materiality considerations until 2029 at the earliest to allow for the full impact of the MFP to be assessed.

Teva appreciates CMS's consideration of these comments. Please do not hesitate to contact me at (862) 246-5273 or marc.eida@tevapharm.com with any questions.

Sincerely,

_____

Marc Eida
General Counsel
U.S. Innovative Medicines and Biosimilars

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THBI
TEXAS HEALTHCARE & BIOSCIENCE INSTITUTE

THE TEXAS POLICY VOICE FOR HEALTHCARE AND BIOSCIENCE

June 26, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz,

On behalf of the Texas Healthcare and Bioscience Institute (THBI), I am writing to express strong opposition to the Centers for Medicare & Medicaid Services' (CMS) proposed interpretation of a Qualifying Single Source Drug (QSSD) as outlined in the Medicare Drug Price Negotiation Program Draft Guidance for the Initial Price Applicability Year 2028. THBI is the statewide organization representing the life science industry in Texas, who, in partnership with our regional BIO partners, represents over 9,200 establishments and over 129,245 employees involved in the research, development, and manufacturing of pharmaceuticals, medical devices, biomedical technologies, nationally recognized research institutions, and the economic development partners who support them.

While the Inflation Reduction Act (IRA) aims to improve affordability for patients, CMS's current proposal to define QSSDs based on shared active ingredients or active moieties—regardless of clinical distinctions or approval pathways—oversteps the bounds of the statute and threatens the very innovation patients depend on.

The proposal's broad interpretation undermines decades of medical innovation by disincentivizing the development of clinically distinct therapies. By treating products with different formulations, delivery mechanisms, or indications as interchangeable based on a common active moiety, CMS risks erasing the value of post-approval R&D aimed at improving patient adherence, safety, and quality of life. These advances—such as subcutaneous formulations that reduce infusion time—have meaningful impact, especially for patients managing chronic illnesses or cancer.

If finalized as drafted, this policy will significantly reduce incentives to develop nuanced treatments that respond to evolving patient needs, particularly for rare diseases and oncology populations that require highly tailored care approaches.

The IRA statute clearly ties QSSD identification to distinct New Drug Applications (NDAs) or Biologics License Applications (BLAs)—reflecting the FDA's well-established regulatory framework. By disregarding this structure, CMS is not only acting outside the scope of the IRA but also introducing uncertainty that could disrupt investment in targeted therapies.

Patient-centered care is foundational to modern medicine. The current proposal, however, fails to consider how access to distinct formulations and delivery methods directly supports adherence, improves outcomes, and respects patient choice. These differences are not trivial; they reflect years of ongoing research into real-world barriers to care and patient-reported outcomes.

CMS must adopt a more responsive and transparent approach that meaningfully incorporates patient and provider perspectives when defining drug distinctiveness and assessing therapeutic value.

We respectfully urge CMS to:

- Withdraw its interpretation of QSSD based on active moiety/ingredient.
- Align its policy with the IRA statute by identifying QSSDs according to distinct NDAs or BLAs.
- Establish a formal process to engage with patients, caregivers, and clinicians in determining the clinical and practical value of therapeutic innovations.

This course correction is critical not only to comply with legislative intent, but also to ensure patients continue to benefit from innovation that improves health outcomes and quality of life.

Thank you in advance for your time and consideration.

Sincerely,

Danielle Lobsinger Bush
Director of Policy
Texas Healthcare and Bioscience Institute

Courtney Lawrence
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June 26, 2025
VIA EMAIL SUBMISSION TO IRARebateandNegotiation@cms.hhs.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: Medicare Drug Price Negotiation Program Guidance
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Drug Price Negotiation Program Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

To Whom It May Concern:

The Cigna Group welcomes the opportunity to respond to the draft guidance on the Medicare Drug Price Negotiation for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) for 2026, 2027, and 2028.

The Cigna Group is a global health company committed to improving health and vitality. Our Cigna Healthcare and Evernorth Health Services divisions are providers of medical, pharmacy, dental, behavioral health, and related products and services, with over 182 million customer and patient relationships in the more than 30 countries and jurisdictions in which we operate. In the United States, Cigna Healthcare provides medical coverage to approximately 16 million Americans in the commercial group health plan market, predominantly in the self-insured segment. For 2025, we are providing individual market coverage in 337 counties across 11 states, both on- and off-Exchange, currently insuring over 440,000 individual market customers.

Our health services business, Evernorth Health Services, includes a broad range of coordinated and point solution health services and capabilities, in pharmacy benefits, home delivery pharmacy, specialty pharmacy, distribution, and care delivery and management solutions, which are provided to health plans, employers, government organizations, and health care providers. Across all segments we serve, The Cigna Group is focused on working to deliver health care that is affordable, predictable, and simple – so people can live healthier, more vibrant lives.

With that context in mind, The Cigna Group offers the following recommendations:

First, CMS should incorporate discounts such as rebates obtained by plans when selecting eligible Part D drugs for negotiation versus using gross expenditures, to align more closely with IPAY 2028 Part B drug selection.

Second, CMS should ensure new processes like Direct Member Reimbursement (DMR), and the removal of selected drugs from negotiation utilize existing pathways to the extent possible, to reduce administrative burden and ensure timely delivery of information to Part D plans.

We provide more detailed section-by-section comments below.

* * *

Section 30 – Identification of Selected Drugs for Initial Price Applicability Year 2028

CMS reiterates that the agency will rank negotiation-eligible drugs for initial price applicability year 2028 according to the total combined expenditures for such drugs under Part B and Part D for the 12-month period prescribed by the IRA. For 2028, CMS will select up to 15 negotiation-eligible drugs with the highest total expenditures under Part B and Part D and publish the list no later than February 1, 2026. Part B drugs will be ranked based on Part B claims data to calculate the total allowed charges, while for Part D CMS will continue to use gross covered prescription drug costs (GCPDC) using prescription drug event (PDE) data.

Cigna Comments:

Cigna remains concerned that CMS's approach to identifying eligible Part D drugs for negotiation under IPAY 2028 does not account for existing price concessions, such as manufacturer rebates and discounts, in the expenditure calculation. By relying solely on gross expenditures to rank negotiation-eligible drugs, CMS risks prioritizing products where their negotiated savings will be reduced rather than focusing on drugs where significant reductions in spending could be realized because limited or no discounts exist today. This is also in contrast to the approach to Part B drug selection, which uses claims data that represents net market pricing, taking into account all discounts and price concessions. Cigna recommends that CMS align the selection approach for Part D drugs to incorporate net cost measures or discount-adjusted spending to more effectively target drugs that will produce significant savings through negotiation.

Section 40 – Requirements for Manufacturers of Selected Drugs

40.4 Providing Access to the MFP in 2026, 2027, and 2028

For IPAY 2028, CMS will sign Medicare Drug Price Negotiation Program Agreements with the willing Primary Manufacturers of selected drugs and details that such agreements set forth requirements of the primary manufacturers for participation in the Negotiation Program, which includes ensuring that dispensing entities that dispense drugs and Part B providers that furnish or administer drugs to MFP-eligible individuals have access to the MFP for the selected drug. Specific to making MFP available, CMS details that currently, it is not including detailed policy on providing access to the MFP for selected drugs payable under Part B and intends to align the policies and operations for

providing access to the MFP for selected drugs payable under Part B with those for selected drugs covered under Part D, to the extent feasible.

CMS also details that while it expects that Primary Manufacturers and dispensing entities will use the MTF platform (including the voluntary MTF Payment Module (PM)) to support access to the MFP for selected drugs starting January 1, 2026, it is possible that the private sector could develop alternative solutions for sharing verified data or for routing refund payments from manufacturers to dispensing entities. Therefore, CMS is soliciting comments on potential private market solutions that could offer an alternative to the MTF and the extent to which interested parties perceive a need for ongoing MTF support over time.

Cigna Comments:

Outside of a handful of oral products, Part B drugs primarily include infused therapies, biologics, and other physician-administered treatments commonly used by individuals with cancer, autoimmune conditions, and rare diseases. There are distinct differences between these provider-administered products and Part D drugs that should be taken into consideration as CMS develops the processes for negotiation and effectuation of MFP. Medicare Part D drugs are typically dispensed through pharmacies and adjudicated by plans and pharmacy benefit managers (PBMs) with defined payment processes. In contrast, Part B drugs are generally administered in clinical settings and reimbursed using a buy-and-bill model, where providers purchase the drug up front and are later reimbursed at Average Sales Price (ASP) plus 6%. Applying the MFP to these therapies requires a rethinking of how provider workflow and reimbursement, beneficiary cost-sharing, and claims processing will operate.

CMS should evaluate how changes in provider reimbursement may trigger downstream billing shifts that impact payers and other stakeholders. Also, provider buy-and-bill workflows differ significantly from pharmacy dispensing and adjudication, and such billing practices are not always consistent, or timely. CMS should consider developing standards for provider Part B billing of selected drugs to reduce impact on plans, while also leveraging existing mechanisms for providers to receive reimbursement for acquisition above MFP.

In terms of the MTF process, Cigna believes that while private market solutions may eventually offer viable alternatives, ongoing agency support for the MTF platform will be essential to ensure consistent access to the MFP across stakeholders. Given the potential cost and complexity of developing independent systems, Cigna urges CMS to maintain and invest in the MTF infrastructure to avoid unnecessary administrative burden and ensure a reliable, centralized process during the initial years of implementation.

40.4.2.2 Dispensing Entity Enrollment in the MTF DM

CMS noted that in response to the IPAY 2027 draft guidance, it received feedback from dispensing entities expressing concern that the operations of the MTF and the timeline for the 14-day prompt MFP payment window would create delays in cashflow compared to the existing requirements for Part D prompt payment by plan sponsors. Commenters particularly noted that small pharmacies that rely primarily on prescription revenue to maintain business operations would face material cashflow pressures due to the shift from payment by the Part D plan sponsor to a combination of Part D plan sponsor payment plus a potentially lagged MFP refund. Based on comments received, CMS is concerned that this challenge will be most acute in the transition period when MFPs for selected drugs first become effective in January 2026 and at the start of each subsequent initial price applicability year when MFPs for new selected drugs first become effective. CMS does not anticipate this challenge to continue with respect to a

selected drug once MFP refunds for that selected drug are flowing and dispensing entities become accustomed to the 14-day prompt MFP payment window.

Cigna Comments:

Cigna appreciates CMS's recognition of the potential cash flow challenges dispensing entities may face, particularly smaller pharmacies, during the transition to MFP implementation. We urge CMS to remain sensitive to the financial burden that even short-term delays in MFP refunds can impose on pharmacies that rely heavily on timely reimbursement to maintain operations. Cigna remains actively engaged on this issue and supports measures that promote operational stability for dispensing entities, including thoughtful implementation timelines and reliable payment processes.

Section 60 – Negotiations Process

Section 60.6 - Publication of the MFP

Pursuant to law, CMS will publish by November 30, 2026, the MFP for each selected drug for initial price applicability year 2028. CMS will publish the following on the CMS website: the selected drug, the initial price applicability year, the MFP file, and the explanation for the MFP.

Cigna Comments:

Cigna would like to underscore the importance of CMS publishing MFPs by the November 30, 2026, deadline to ensure that Part D plans have adequate time to operationalize the formulary inclusion requirement and MFP requirements and incorporate them into dispensing entity negotiations and bid development for 2028.

Section 70 – Removal from the Selected Drug List Before or During Negotiation, or After an MFP is in Effect

CMS states that a selected drug will be removed from the negotiation process if the FDA approves and the manufacturer begins marketing either (1) a generic version under section 505(j) of the FD&C Act or (2) a biosimilar version under section 351(k) of the PHS Act, provided that the generic or biosimilar identifies the selected drug as its reference product. CMS emphasizes that actual marketing of the approved product is required for removal. After removal, CMS will monitor the marketing practices of the approved generics or biosimilars to ensure continued compliance. CMS states that once the statutory criteria for generic competition are met for a selected drug, CMS will publish such information on the CMS website.

Cigna Comments:

Cigna requests that CMS clarify the process by which stakeholders will be notified when a drug is removed from the selected drug list, as the draft guidance does not clearly establish how or when these notifications will occur. Timely and proactive communication is essential, particularly given the operational challenges that would arise from repricing claims initially processed at the MFP. We recommend that CMS adopt a consistent and public notification mechanism, such as a Health Plan Management System (HPMS) memo accompanied by updated file postings, with adequate advance notice to allow Part D plan sponsors and pharmacies time to adjust. Additionally, Cigna urges CMS to consider revising regulations to explicitly allow plan sponsors to immediately remove a drug from

formularies once it is no longer selected, including eliminating successor product limitations where appropriate, to ensure plan sponsor flexibility.

Section 80 - MFP-Eligible Individuals in 2026, 2027, and 2028

80.1 Direct Member Reimbursements and Access to the MFP for Selected Drugs in 2026, 2027, and 2028

CMS states that for 2026 through 2028, Medicare Part D plan sponsors will be responsible for ensuring MFP-eligible individuals who submit a covered direct member reimbursement (DMR) request for a selected drug, i.e., when the drug is paid for out-of-pocket and later reimbursed—receive the benefit of the Maximum Fair Price (MFP). CMS outlines that for in-network DMRs, plan sponsors must reimburse at least the difference between the cash price paid and the negotiated price (capped at the MFP plus dispensing fees), while for out-of-network DMRs, the reimbursement must be based on the MFP plus dispensing fees. CMS also clarifies that in these cases, dispensing entities are not required to facilitate MFP refunds, as the individual's cash payment is considered sufficient to meet MFP access requirements.

Cigna Comments:

Cigna is concerned that CMS's proposed approach to handling DMR requests for selected drugs under the Medicare Drug Price Negotiation Program introduces a reimbursement methodology that diverges from the standard process used in the Part D benefit. Establishing a separate set of requirements and expectations for DMR claims specific to MFP-selected drugs risks creating confusion for beneficiaries and increases operational complexity for plan sponsors. Cigna recommends that CMS align the DMR process for selected drugs with the existing framework used for all other Part D drugs to ensure consistency, streamline administration, and minimize beneficiary misunderstanding. We also encourage CMS to consider the potential for unintended consequences, such as increased out-of-network pharmacy use, and to ensure any process changes do not disrupt existing plan safeguards or utilization management practices.

Section 90. Manufacturer Compliance and Oversight

90.2.1 Manufacturer Plans for Effectuating MFP

CMS mandates that Primary Manufacturers submit their plan for MFP availability, including deduplication of 340B covered units for the selected drug, to CMS in writing. Primary Manufacturers' plans must also include description(s) of the types of documentation and data they would collect, maintain, and deliver to CMS, if requested, for the purposes of auditing and compliance with the requirement to make the MFP available.

Cigna Comments:

We urge CMS to ensure that Primary Manufacturers share thorough documentation to support nonpayment of refund amounts based on deduplication of 340B covered units. In the absence of claim-level documentation and identification, we are concerned that Primary Manufacturers may indiscriminately decide not to pay retrospective refunds on selected drugs.

Cigna supports CMS's guidance that such documentation should also be maintained by Primary Manufacturers and be made available to CMS for auditing and compliance enforcement purposes.

Section 110. Part D Formulary Inclusion of Selected Drugs

For contract year 2028, CMS will continue the formulary inclusion policies described in CMS' revised guidance for initial price applicability year 2026 and final guidance for initial price applicability year 2027 and manufacturer effectuation of the MFP in 2026 and 2027. Currently, CMS does not have sufficient information to determine whether changes to these formulary inclusion policies are warranted. CMS expresses concern 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 that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs.

Cigna Comments:

Cigna recommends that CMS preserve formulary flexibility for Part D sponsors, including the ability to manage utilization, determine tier placement, and set appropriate cost-sharing for selected drugs. This flexibility is essential to maintaining clinically appropriate, cost-effective formularies that serve diverse beneficiary needs. Cigna also urges CMS to allow for the immediate substitution of a selected drug with a newly approved generic or interchangeable biological product at any point during the calendar year, regardless of when the product came to market.

Conclusion

Thank you for your consideration of these comments as we work together to improve prescription drug affordability for Medicare beneficiaries. Cigna would welcome the opportunity to discuss these issues with you in more detail at your convenience.

Respectfully,

Courtney Lawrence

NATIONAL ALLIANCE FOR CAREGIVING
Making Caregiving More Sustainable, Dignified, and Equitable

June 26, 2025

Mehmet Oz, MD, MBA Administrator
Centers for Medicare & Medicaid Services Department of Health and Human Services 7500 Security Boulevard
Baltimore, MD 21244

RE: Draft Guidance for the Medicare Drug Price Negotiation Program: Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Administrator Oz -

The National Alliance for Caregiving (NAC) welcomes the opportunity to provide input on the Centers for Medicare & Medicaid Services' (CMS) draft guidance for the Medicare Drug Price Negotiation Program for Initial Price Applicability Year (IPAY) 2028. As this landmark program advances into its third negotiation cycle under the Inflation Reduction Act (IRA), we recognize the critical importance of ensuring that implementation strategies address the needs of both Medicare beneficiaries and their family caregivers. We applaud CMS for its commitment to enhancing medication affordability and respectfully submit these recommendations to strengthen implementation through a caregiver-informed lens.

As the nation's only nonprofit organization dedicated to supporting family caregivers across all ages, conditions, and life stages, NAC has championed caregiver needs for over 25 years. Our mission centers on advancing the health and wellness of our nation’s family caregivers through research, policy, and narrative change. Through our extensive research, including the landmark Caregiving in the U.S. studies, we represent the voices and experiences of the more than fifty-three million Americans who provide unpaid care to adult family members and friends. Our membership spans caregiving organizations, healthcare providers, technology companies, and other stakeholders committed to supporting family caregivers.

NAC commends CMS’s ongoing enhancement of the Medicare Drug Price Negotiation Program, especially its broadened coverage and increased focus on operational clarity. These advances create meaningful opportunities to reduce financial burdens for individuals managing chronic conditions and disabilities, as well as their family caregivers who often coordinate care and manage healthcare expenses. Our feedback centers on critical policy elements within the guidance, emphasizing areas where enhanced stakeholder input—particularly from the caregiving community—could strengthen program outcomes. Throughout our comments, we highlight the essential role family caregivers play in medication management, healthcare

navigation, and financial coordination, underscoring the need for caregiver-inclusive implementation strategies.

The recommendations outlined in this comment align with and advance the goals established in the 2022 National Strategy to Support Family Caregivers (National Strategy), which calls for healthcare systems to recognize and support the essential role of family caregivers in care delivery. The National Strategy was developed jointly by the advisory councils created by the RAISE Family Caregiving Act and the Supporting Grandparents Raising Grandchildren Act, signed into law by President Trump in 2018, with extensive input from the public, including family caregivers and the people they support.

As CMS implements the Medicare Drug Price Negotiation Program, there is a critical opportunity to operationalize the National Strategy's vision by ensuring that drug pricing decisions and program implementation systematically consider caregiver perspectives and family-centered outcomes. This alignment would demonstrate federal commitment to supporting family caregivers across all aspects of healthcare policy, from direct service delivery to the fundamental economic structures that determine medication access and affordability.

Defining Family Caregiver

For the purposes of this comment, NAC refers to family caregivers as defined in Section 2 of the RAISE Family Caregivers Act: "The term ''family caregiver'' means an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation."[1]

Who are Family Caregivers?

According to our research project with AARP, Caregiving in the U.S., family caregivers represent a substantial portion of American society, with more than one in five Americans (21.3 percent) providing care for older adults, people with serious illnesses, or individuals with disabilities, including children. These unpaid caregivers play a critical role in navigating complex care for people with serious illness, as nearly half (45%) are caring for someone with two or more conditions—a significant jump from 37% in 2015. The complexity of their caregiving responsibilities is evident in the medical tasks they perform, with three in five caregivers (58%) performing medical and nursing tasks such as wound care and managing medications. Additionally, more family caregivers (26%) have difficulty coordinating care up from 19% in 2015, highlighting the increasing challenges they face in managing the intricate healthcare needs of their loved ones with serious illnesses.[2]

[1] U.S. Congress. Recognize, Assist, Include, Support, and Engage Family Caregivers Act of 2017. Public Law 115-119. January 22, 2018. https://acl.gov/sites/default/files/about-acl/2018-10/PLAW-115publ119%20-%20RAISE.pdf.
[2] National Alliance for Caregiving and AARP. Caregiving in the United States 2020. Washington, DC: AARP. May 2020. https://doi.org/10.26419/ppi.00103.001

Family Caregiver Participation in Patient Listening Sessions

NAC strongly supports CMS's commitment to conducting patient-focused listening sessions as part of the Medicare Drug Price Negotiation Program. These sessions represent a vital channel for capturing the real-world experiences of both patients and their family caregivers regarding selected medications. For the caregiving community, these forums offer an essential opportunity to share insights that extend beyond clinical data to encompass the broader family impact of medication costs, access challenges, and treatment management.

Family caregivers bring a unique and comprehensive perspective to medication evaluation that is often missing from manufacturer submissions and clinical trials. Family caregivers frequently coordinate multiple aspects of care—from managing medication schedules and side effects to navigating insurance systems and coordinating with healthcare providers. They witness firsthand how medication costs affect family finances, how treatment burden impacts entire households, and how access barriers create cascading effects on family wellbeing. This perspective is crucial for determining whether a drug's pricing truly reflects its value not just to the patient, but to the family system that supports treatment success.

To ensure that listening sessions capture meaningful caregiver insights and foster inclusive participation, NAC recommends the following enhancements—in addition to patient engagement strategies outlined by NAC partners like the National Health Council—which are focused on caregiver accessibility, representation, and meaningful engagement:

1. **CMS should explicitly invite and accommodate family caregiver participation with adequate advance planning time.** A minimum 30-day notice period would allow patients and their family caregivers to arrange coverage for their caregiving responsibilities, coordinate with their care recipients, and prepare substantive input. Many caregivers manage complex care schedules and require extended lead time to participate without compromising the care they provide.

2. **CMS should offer thematic guidance and clearly defined expectations for each session.** Publishing advance notice of themes— such as "family financial impact," "caregiver burden and medication management," "coordination challenges across providers," and "impact on family employment and income" will help participants prepare more tailored and relevant input. These prompts should also include examples of narratives or data that are particularly useful in informing negotiation-related decisions.[3] Further, CMS should add clarity on the level of detail for these themes that would be most relevant in listening sessions and in any written submissions. For example, CMS should clearly state whether it is helpful to have information on financial impacts across diseases, or treatments, or stages of disease. Without clear direction on the most meaningful evidence from the caregiving community, organizations may expend scarce resources – including the time and trust of their members – on research or activities that

[3] U.S. Food and Drug Administration, FDA Patient-Focused Drug Development Guidance Series, March 21, 2025.

may not benefit patients if CMS does not consider the information.

3. **CMS should offer multiple participation modalities that accommodate patient and caregivers' unique constraints.** In addition to live testimony, options should include written submissions, recorded video testimonials, and structured phone interviews. Many caregivers and patients cannot leave their care recipients for extended periods and need flexible participation options that work around caregiving schedules and responsibilities.

4. **CMS should ensure accessibility supports address both patient and caregiver needs.** Default accommodations should include not only interpretation and assistive services, but also virtual participation options for caregivers who cannot physically attend sessions. Recognition that caregivers may be participating while managing ongoing care responsibilities should inform session design and timing. Further, sign language interpretation, closed captioning, multilingual translation, and accommodations for cognitive or sensory impairments should be standard features, not contingent upon special requests. Establishing these supports by default reflects CMS's commitment to broad patient participation and minimizes the administrative burden on patients already navigating serious health challenges.[4]

Beyond participation logistics, CMS must enhance transparency regarding how patient and caregiver input influences pricing decisions. Currently, there is limited visibility into whether and how these perspectives are integrated into the negotiation process. Without clear demonstration of how these insights are meaningfully incorporated, CMS risks undermining future stakeholder engagement. In the patient and caregiving community, resources are already stretched very thin. If participants cannot see that their efforts are leading to information that genuinely influences decision-making, this could significantly disincentivize future participation. The ultimate consequence would be a negotiation process that lacks authentic patient and caregiver perspectives, potentially resulting in pricing decisions that fail to address the real unmet needs across diseases and patient populations.

NAC urges CMS to publish comprehensive post-session summaries that specifically highlight patient and caregiver contributions, including:

- **Caregiver and patient-reported themes** organized by impact area (e.g., family financial burden, care coordination challenges, employment effects);
- **Summaries of patient and family-level impacts** shared during sessions, including effects on household finances, family functioning, and caregiver health;
- **Documentation of how caregiver insights informed price negotiations,** particularly regarding real-world treatment burden and family-centered value assessments;
- **Explanation of patient and caregiver-reported concerns that were noted but not incorporated,** with clear rationale for these decisions.

[4] Centers for Medicare & Medicaid Services. CMS Framework for Healthy Communities. U.S. Department of Health and Human Services. February 28, 2025. https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework.

- **Summary of key data gaps and recommendations for future research and engagement to ensure the stakeholder engagement process can improve iteratively.**

This level of transparency would demonstrate CMS's recognition that medication value extends beyond individual patient outcomes to encompass family and caregiver wellbeing—a critical factor in treatment adherence and long-term success.

Additionally, CMS should create a dedicated caregiver archive within its public listening session repository, making caregiver testimonies and insights accessible to researchers, policymakers, and other caregiver organizations. This resource would help build the evidence base around family-centered medication value assessment and inform future policy development.

Finally, NAC strongly encourages CMS to formally partner with patient and caregiver organizations, including those representing diverse communities and specific condition-focused groups. These organizations can help identify and recruit patients and caregivers whose voices might otherwise go unheard, ensuring that the full spectrum of caregiving experiences informs Medicare drug pricing decisions.

Family caregiver participation in listening sessions and through written public comments represents a fundamental opportunity to ground drug pricing decisions in the reality of how medications function within family systems. By strengthening caregiver inclusion, ensuring meaningful access for all family caregivers, and demonstrating transparent integration of caregiver insights into policy decisions, CMS can honor the comprehensive nature of healthcare delivery and improve outcomes for both Medicare beneficiaries and their families nationwide.

Implementation of MFPs for Part B Drugs: Challenges and Safeguards

NAC recognizes the significant expansion of the Medicare Drug Price Negotiation Program to include drugs reimbursed under Medicare Part B as a critical advancement for patients with serious conditions such as cancer, autoimmune diseases, and rare disorders. This extension brings into scope infused therapies, biologics, and other physician-administered treatments that are essential for many Medicare beneficiaries and their families. However, the operational complexities of implementing Maximum Fair Prices (MFPs) for Part B drugs require careful attention to the unique role family caregivers play in coordinating these treatments and managing associated billing responsibilities.

Provider Communication and Caregiver Education Needs

NAC urges CMS to establish clear, structured communication protocols that specifically address the needs of family caregivers who coordinate Part B drug treatments. While large health systems may have dedicated billing departments to manage MFP implementation, smaller practices, and rural providers—where many caregivers seek care for their family members—often lack the resources for comprehensive patient education about billing changes.

Billing Error Identification and Resolution

Family caregivers need straightforward guidance on how to identify when MFP pricing has not been correctly applied to Part B drug administration. Unlike pharmacy transactions where pricing errors may be immediately apparent, Part B billing often occurs retroactively, making it difficult for patients and caregivers to recognize discrepancies. CMS should establish clear benchmarks and provide patients and caregivers with tools to verify that MFP pricing was properly implemented.

Considerations for Future Drug Selection and Renegotiation

NAC welcomes CMS's establishment of a formal framework for renegotiating MFPs as drugs' clinical and economic value evolves over time. The ability to adjust negotiated prices in response to new FDA-approved indications, biosimilar entry, shifts in real-world utilization, or emerging clinical evidence reflects a thoughtful approach to ensuring that pricing remains aligned with therapeutic value and patient needs. However, the current renegotiation framework must be enhanced to systematically capture the family caregiver perspective, which provides essential insights into how treatment changes affect daily life and long-term care management.

Family caregivers possess a unique and comprehensive view of medication effectiveness that extends beyond clinical trial endpoints to encompass real-world treatment burden, adherence challenges, and family-wide impacts. When drugs undergo renegotiation, caregivers can provide critical insights about medication adherence patterns, side effect management, and the practical challenges of treatment implementation that may not be reflected in manufacturer submissions or clinical data. Their perspective is particularly valuable for understanding how pricing changes or treatment modifications affect family financial stability and care coordination.

Incorporating Caregiver Burden and Family Impact Assessments

CMS should expand its renegotiation criteria to explicitly include assessments of caregiver burden and family financial effects when evaluating whether a drug's value has changed sufficiently to warrant price adjustment. The current framework references "material changes" in clinical benefit or unmet need, but these determinations should encompass the broader family impact of treatment, including caregiver time, family employment effects, and household financial strain. Further, CMS should develop and publish illustrative examples—drawn from clinical, economic, and operational contexts—to clarify the types of changes that would meet the threshold for triggering renegotiation.

NAC recommends that CMS develop structured methods for collecting caregiver input during renegotiation proceedings. This should include formal opportunities for caregivers to provide testimony about changes in treatment burden, evolving care coordination requirements, or shifting family financial impacts that have occurred since the original price negotiation. Such input is particularly crucial for medications used to treat progressive conditions where caregiver responsibilities may intensify over time, or for treatments where new indications may alter the caregiving experience significantly.

Transparency and Stakeholder Engagement

NAC urges CMS to establish structured opportunities for patient and caregiver engagement that are separate from but complementary to manufacturer negotiations. This should include public comment periods specifically designed to capture these experiences, listening sessions focused on family impact, and clear communication about how patient and caregiver input influenced renegotiation decisions.

Furthermore, CMS should publish summaries of renegotiation outcomes that specifically address how patient and family and caregiver considerations were integrated into pricing decisions. This transparency will help build trust in the renegotiation process and demonstrate CMS's commitment to family-centered value assessment.

The inclusion of patient and caregiver perspectives in the renegotiation process is essential for ensuring that pricing decisions reflect the full scope of a medication's value and impact. By systematically incorporating caregiver insights, CMS can make more informed decisions that support not only individual patient outcomes but also the family systems that are crucial to treatment success.

Conclusion

The IPAY 2028 draft guidance represents a significant milestone in the evolution of the Medicare Drug Price Negotiation Program. NAC recognizes CMS's important work to broaden the program's scope to include physician-administered drugs under Part B, establish clearer enforcement and compliance frameworks, and create formal pathways for renegotiating previously selected medications. We particularly appreciate the agency's continued commitment to integrating patient experiences and real-world evidence into the negotiation process.

While these developments are encouraging, NAC urges CMS to take additional steps to systematically embed both patient and family caregiver perspectives throughout all aspects of program implementation. The success of this initiative will ultimately be measured not only by the fiscal savings it generates, but by its ability to deliver meaningful improvements in medication access, care coordination, and family wellbeing. This requires operational protocols that acknowledge caregivers' vital role in medication management, transparent communication strategies that reach and inform family caregivers, and access safeguards that protect the care coordination systems families depend upon.

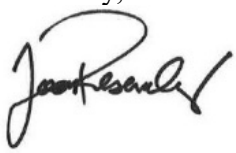
Family caregivers are integral to the success of medication therapies, serving as care coordinators, medication managers, and advocates for Medicare beneficiaries. Their perspectives and experiences must be woven into the fabric of program implementation to ensure that drug pricing decisions reflect the full scope of treatment value and impact. From listening sessions that capture caregiver insights to billing processes that accommodate caregiver involvement,

every aspect of the program should recognize and support the essential role family caregivers play in healthcare delivery.

NAC remains firmly committed to partnering with CMS in the successful implementation of this historic program and stands ready to collaborate in ensuring that both Medicare beneficiaries and their family caregivers are central to every decision the program encompasses. We believe that by embracing a truly family-centered approach, the Medicare Drug Price Negotiation Program can achieve its goals while strengthening the care systems that millions of American families depend upon.

Thank you for the opportunity to provide input on this critical guidance. Please do not hesitate to contact Jason Resendez, President & CEO, National Alliance for Caregiving at Jason.resendez@caregiving.org if you or your staff would like to discuss these recommendations in greater detail or explore ways to enhance caregiver integration throughout program implementation.

Sincerely,



Jason Resendez
President and CEO
National Alliance for Caregiving

Inspired by patients.
Driven by science.

Submitted via email (IRARebateandNegotiation@cms.hhs.gov)

Mr. Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

June 26, 2025

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028

Dear Mr. Klomp:

UCB, Inc. (UCB) is a global biopharmaceutical company focused on innovating new medicines to treat chronic, severe diseases in neurology and immunology. We are more than 9,000 people globally, inspired by patients and driven by science. Our foundational commitment to crafting sustainable solutions and delivering medicines that aim to improve lives is at the core of all that we do, as we live our purpose each day. Since 1928, we have brought together the expertise, talent, tools and scientific ingenuity needed to pursue what's right for people living with severe disease and society. UCB is committed to ensuring that all patients have affordable access to the right medicine at the right time, regardless of age, ethnicity, geography, or economic circumstance. Patients are at the heart of everything we do at UCB, from where we invest our research dollars to how we engage with other stakeholders to bring new therapies to market. Every day, we work to ensure that patients have the best individual experience while promoting access to high-quality, coordinated, affordable care and equitable access to medicines for all patients.

UCB appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the draft guidance on the Medicare Drug Price Negotiation Program (Program) under sections 11001 and 11002 of the Inflation Reduction Act (IRA) for Initial Price Applicability Year (IPAY) 2028 and the effectuation of the Maximum Fair Price (MFP) in IPAYs 2026, 2027 and 2028 (Draft Guidance).[1] As discussed further below, UCB has concerns that certain proposals in the Draft Guidance could hinder biopharmaceutical innovation and that some of CMS's guidance is inconsistent with the IRA statute and lacks transparency. It is crucial that CMS administer the Program in a way that ensures

[1] Memorandum from Chris Klomp, CMS Deputy Administrator and Director of the Center for Medicare to Interested Parties (May 12, 2025), https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf.

the integrity and operational feasibility of the MFP and appropriately considers the complexities in adding Part B drugs to the Program.

Specifically, UCB makes the following recommendations, which are described further herein:

I. Additional safeguards and CMS guidance are necessary to effectuate the MFP in accordance with the statute, particularly for Part B drugs. Specifically:
   A. CMS must implement controls to prevent duplication of 340B discounts and the MFP. Existing private sector solutions, such as 340B rebate models, provide an efficient and accurate mechanism for preventing such duplicate discounts, and UCB urges CMS and the Health Resources and Services Administration (HRSA) not to oppose such solutions.
   B. CMS should clarify that the MFP is excluded from Average Sales Price (ASP) calculations.
   C. CMS should clarify that manufacturers may incorporate an add-on payment into the standardized default refund amount (SDRA) for Part B drugs to help mitigate potential lower reimbursement of a drug with an MFP.

II. CMS should not use the unit cost of production and distribution as a starting point for the initial offer for selected drugs with multiple therapeutic alternatives, as this metric would artificially lower the starting point and disincentivize innovation.

III. It would be inconsistent with the statute to require manufacturers to provide speculative "forward-looking" market data, and inappropriate for CMS to consider such data in setting the MFP of a selected drug.

I. Additional Safeguards and Guidance are Necessary for the Effectuation of the MFP for Part B Drugs.

UCB has concerns that the processes set forth in the Draft Guidance do not sufficiently account for the distinctive challenges of adding Part B drugs to the Program. Medicare Part B and Part D drugs are often fundamentally different types of products and are reimbursed in a different manner. UCB urges CMS to take care that its addition of Part B drugs to the Program considers the unique attributes of Part B drugs, including how such drugs are billed and reimbursed. UCB provides specific recommendations for the MFP effectuation processes for Part B drugs below.

A. CMS Must Implement Controls to Prevent Duplication of 340B Discounts and the MFP.

Under the IRA, when a selected drug is administered to a Medicare patient of a 340B covered entity, the manufacturer is required to provide access to the lower of: (1) the drug's MFP or (2) the

drug's 340B ceiling price.[2] The statute thus explicitly prohibits duplication between the MFP and the 340B ceiling price.[3] In the Draft Guidance, however, CMS states that it will not, at this time, assume responsibility for nonduplication of discounts between the 340B ceiling price and MFP.[4] UCB is concerned that CMS' failure to develop a solution to comply with the statutorily required nonduplication provisions of the IRA will result in significant inefficiencies in MFP effectuation and will lead to increased disputes over the applicable price for a particular unit of a selected drug. Disputes over duplicate discounts could delay payments to covered entities and pharmacies, as well as financially and administratively burden the federal government by leading to more frequent engagement of the government in dispute resolution processes.

As a potential solution to these challenges, some drug manufacturers have proposed 340B "Rebate Models" that provide the 340B ceiling price to covered entities through a rebate.[5] Under a Rebate Model, a manufacturer would offer a 340B rebate to a covered entity after the manufacturer receives limited claims-level data requested from the covered entity that verifies that a claim is eligible for the 340B ceiling price. The Rebate Model would provide manufacturers of a selected drug with the data necessary to efficiently identify 340B claims, so that they could make available the lower of the MFP or the 340B ceiling price (as applicable), within fourteen days of receipt of the original claims-level data elements, as set forth in the Draft Guidance.[6] Although the 340B statute allows manufacturers to effectuate 340B ceiling prices through rebates,[7] to date, HRSA has taken the position that certain Rebate Models that have been announced by manufacturers are inconsistent with the 340B statute and has, for example, provided that the Rebate Models, if implemented, would subject manufacturers to "potential consequences" such as "termination of [the manufacturer's] Pharmaceutical Pricing Agreement."[8] HRSA additionally said that if one manufacturer moved forward with implementation of its Rebate Model, "HRSA will initiate a referral to the HHS Office of Inspector General."[9] HRSA has

[2] Social Security Act (SSA) § 1193(d).
[3] *Id.*
[4] Draft Guidance § 40.4.5.
[5] *See, e.g.*, Johnson & Johnson, Why Transparency is Critical for Patients (Nov. 12, 2024), https://www.jnj.com/media-center/press-releases/why-transparency-is-critical-for-patients (noting Johnson & Johnson's 340B rebate model to allow the company to verify 340B claims are actually purchased and dispensed by a 340B entity); Bristol Myers Squibb, Statement on 340B Rebate Model Litigation (Nov. 26, 2024), https://www.bms.com/340b-rebate-model-litigation.html (providing that the company's proposed rebate model would help ensure 340B program compliance, enable more transparent data sharing, and reduce duplicate discounting).
[6] Draft Guidance § 40.4; § 40.4.5.
[7] 42 U.S.C. § 256b(a)(1) (directing the Secretary to "enter into an agreement with each manufacturer of covered outpatient drugs under which the amount required to be paid (taking into account *any rebate or discount*, as provided by the Secretary) to the manufacturer for covered outpatients drugs . . . does not exceed" the ceiling price.").
[8] *See* HRSA Letter to Johnson & Johnson (Sept. 17, 2024), https://www.hrsa.gov/sites/default/files/hrsa/opa/sept-17-2024-hrsa-letter-johnson-johnson.pdf; *see also* HRSA Letter to Sanofi (Dec. 13, 2024), https://www.hrsa.gov/sites/default/files/hrsa/opa/dec-13-2024-hrsa-letter-sanofi.pdf.
[9] *See* HRSA Letter to Johnson & Johnson (Sept. 27, 2024), https://www.hrsa.gov/sites/default/files/hrsa/opa/sept-27-24-hrsa-letter-johnson-johnson.pdf

provided that it will release guidance on 340B Rebate Models to stakeholders, but to date, such guidance has not been published.[10]

Recently, the Administration has announced organizational changes through which CMS will assume responsibility over the 340B program.[11] UCB is hopeful that these changes will encourage CMS to take a more active role in implementing policies and procedures to prevent duplicate discounting between the 340B program and other statutorily mandated discounts. Regardless of which agency is responsible for administering the 340B program, however, UCB urges the Department of Health and Human Services (HHS) not to impose barriers on private sector solutions to MFP effectuation such as Rebate Models. If CMS refuses to assume responsibility for nonduplication of discounts between the 340B ceiling price and the MFP, but at the same time prohibits Rebate Models, UCB believes there will be a significant likelihood of the occurrence of statutorily prohibited duplicate discounting. This will be burdensome for all stakeholders, including manufacturers, covered entities, pharmacies, and the federal government.

UCB additionally requests that CMS leverage the "JG" and "TB" billing modifiers for 340B claims, which CMS uses to identify 340B rebates excluded from the IRA Part B inflation rebate calculation,[12] to mitigate the risk of duplicate discounts. CMS should expand the 340B claims modifier requirement to extend to all MFP-eligible claims, rather than just fee-for-service claims as currently set forth in the Part B inflation rebate regulations.[13] UCB also recommends that CMS implement measures of enforcement to ensure that covered entities and contract pharmacies include 340B modifiers on insurance claims. The use of such modifiers should be mandatory to help identify duplicate discounts in a timely manner.

B. The MFP Should be Excluded from Average Sales Price.

UCB requests clarification from CMS that the MFP will be excluded from the calculation of a selected drug's average sales price (ASP). The IRA statute provides that the manufacturer of a Part B selected drug must provide access to the MFP to "hospitals, physicians, and other providers of services and suppliers" when it administers or otherwise furnishes the drug to Medicare beneficiaries.[14] In such a case, the manufacturer must either ensure prospectively that the provider or supplier acquires the drug at no more than MFP or provide a retrospective rebate that reduces the provider or supplier's net acquisition cost for the unit furnished to a Medicare beneficiary to no more than the MFP.[15] For Medicare Part B fee-for-service utilization subject to the MFP, the provider's reimbursement amount (before sequestration) is MFP plus 6%, rather than ASP plus 6%.[16] As described below, CMS has the legal

[10] *See* Notice, Kalderos v. United States, et. al., 1:21-cv-02608-DLF (D.D.C. May 2, 2025).
[11] HHS, Fiscal Year 2026 Budget in Brief at 27, available at https://www.hhs.gov/sites/default/files/fy-2026-budget-in-brief.pdf.
[12] 42 C.F.R. § 427.303(b).
[13] *Id.*
[14] SSA § 1193(a)(1)(B).
[15] Draft Guidance § 40.4.
[16] SSA § 1847A(b)(1)(B).

authority to exclude the MFP from ASP reporting requirements, and UCB urges CMS to confirm the MFP's exclusion from ASP to help avoid market disruptions and provide stability in provider payments.

As a threshold matter, UCB notes that the MFP is not listed as one of the categories of transactions that must be included in ASP.[17] The Medicare statute also provides the Secretary authority to establish ASP "units" for manufacturers to report and methods for "counting units" included in ASP for years after 2004.[18] CMS has previously relied on this authority to exclude units sold to vendors through the Part B Competitive Acquisition Program (CAP) from the calculation of ASP. Under the CAP program, a provider could acquire certain Part B drugs either under the traditional buy-and-bill model, or alternatively from CAP vendors under contract with CMS. In a 2005 interim final rule, CMS revised the definition of "unit" to provide that during the CAP program's first three years "the method of counting units excludes units of CAP drugs … administered to a beneficiary by a participating CAP physician."[19]

To exclude MFP units of drug from ASP calculations, CMS could invoke this same "counting units" authority. This would help avoid the impact of reduced reimbursement rates on providers, and therefore patient access, which, as discussed further below, could have particularly substantial adverse impacts on smaller community physician practices and their patients. UCB thus urges CMS to amend the definition of a "unit" in 42 C.F.R. § 414.802 to specify that for selected drugs, "units" also excludes units priced at MFP (or for which the manufacturer provided a rebate to reduce the provider's price to the MFP).

Moreover, there are crucial policy reasons to exclude the MFP from ASP calculations. The inclusion of MFP in ASP calculations would have substantial negative impacts on providers and patients. Historically, many private payors have used ASP as the basis of their reimbursement methodology for physician-administered drugs.[20] While Medicare Advantage (MA) plans are not required to follow Part B reimbursement policies, MA plans have a history of using ASP as the basis of the payment formula for physician-administered drugs.[21] In addition, many commercial payors use ASP to reimburse for drugs.[22] A 2016 Government Accountability Office report comparing payors' reimbursement methodologies for physician-administered drugs, for example, found that two large private payors used Medicare's rate of 106% of ASP as a benchmark for negotiation.[23]

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[17] SSA § 1847A(c)(3).
[18] SSA § 1847A(b)(2)(B); after 2004, "[t]he Secretary may establish the unit for a manufacturer to report and methods for counting units as the Secretary determines appropriate to implement this section."
[19] 70 Fed. Reg. 70,478, 70,481 (Nov. 21, 2005) (amending 42 C.F.R. § 414.802).
[20] *See, e.g.*, Dep't of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation, Issue Brief: Medicare Part B Reimbursement of Prescription Drugs, 3 (June 2014) (explaining that following the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, "most private payers adopted the Medicare Part B drug payment system.").
[21] *See, e.g.*, Sarah Alwardt et al., *IRA Question of the Week: How Will Negotiation Affect Reimbursement?*, Avalere (Mar. 23, 2023), https://avalere.com/insights/ira-question-of-the-week-how-will-negotiation-affect-reimbursement.
[22] *See, e.g.*, Sarah Alwardt et al., *IRA Question of the Week: How Will Negotiation Affect Reimbursement?*, Avalere (Mar. 23, 2023), https://avalere.com/insights/ira-question-of-the-week-how-will-negotiation-affect-reimbursement.
[23] U.S. Gov't Accountability Office, Physician-Administered Drugs: Comparison of Payer Payment Methodologies (Aug. 1, 2016), https://www.gao.gov/assets/gao-16-780r.pdf.

Because such a significant portion of reimbursement under commercial and Medicare Advantage plans is structured based on ASP, a decrease in a drug's ASP would have adverse economic effects on providers, lowering their reimbursement rates. These lower reimbursement rates could disproportionately impact community physician practices rather than larger hospitals, because drug reimbursement arrangements in the physician office setting are more likely to be based on ASP, rather than a "percent of charges" methodology that tends to insulate hospitals from changes in ASP.[24] Many of these independent community physician practices rely on sufficient reimbursement to stay afloat and manage their overhead costs, meaning that a reduction in reimbursement could negatively impact patients' access to care.

C. CMS Should Clarify that Manufacturers May Incorporate an Add-On Payment into the Standardized Default Refund Amount (SDRA) for Part B Drugs that Will Mitigate Lower Provider Reimbursement.

UCB appreciates that the Draft Guidance would establish a "standardized default refund amount" (SDRA) for effectuating the MFP.[25] An SDRA helps provide clarity for both manufacturers and providers as to how the MFP refund process will operate. UCB has concerns, however, that under CMS' current guidance, providers will face a significant reduction in reimbursement for Part B selected drugs, which could result in significant cash flow issues for those providers and threaten patient access to their required medications. We encourage CMS to clarify that manufacturers may incorporate an add-on payment into the SDRA for Part B drugs, to address the fact that providers will likely receive lower add-on payments of drugs subject to an MFP. UCB believes this flexibility aligns with CMS's intention to maintain consistency between Part D and Part B MFP effectuation where possible, given that the agency has stated its intention to allow a "Primary Manufacturer flexibility to determine its preferred methodology for calculating its [Part D] MFP refund payments."

If providers receive lower reimbursement for selected drugs, those providers will be disincentivized from prescribing those products that are appropriate for the particular patient. The Draft Guidance provides that the SDRA for all selected drugs is equal to the product wholesale acquisition cost (WAC) minus the MFP, multiplied by the quantity of the units of drug dispensed.[26] CMS should clarify in its final guidance that manufacturers may incorporate an add-on payment when calculating the SDRA for Part B drugs to mitigate the patient access challenges created by under-reimbursement. For example, manufacturers would have the option to provide an SDRA equal to the ASP plus 6%, minus MFP plus 6%, multiplied by the quantity of the units of drug dispensed. This add-on payment would help put selected and non-selected drugs in an equal position from a reimbursement perspective.

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[24] Sarah Alwardt et al., *IRA Question of the Week: How Will Negotiation Affect Reimbursement?*, Avalere (Mar. 23, 2023), https://avalere.com/insights/ira-question-of-the-week-how-will-negotiation-affect-reimbursement.
[25] Draft Guidance § 40.4.1.
[26] *Id.*

UCB cares deeply about patient access and is concerned that without such mitigation, providers may be disincentivized from prescribing selected drugs that are appropriate for the patient. The purpose and text of the IRA, such as the provision requiring selected drugs to be included on Part D formularies,[27] show that Congress was equally concerned about patient access to selected drugs. CMS should thus make clear that manufacturers may support such access through an add-on payment in the SDRA. In addition, CMS should clarify that the entire SDRA (inclusive of any add-on payment) is excluded from ASP, for the reasons set forth in Section I.B above.

II. The Unit Cost of Production and Distribution is an Inappropriate Starting Point for Selected Drugs with Multiple Therapeutic Alternatives.

UCB appreciates CMS's consideration of possible alternative approaches to determining a negotiation "starting point" for a selected drug with one or more therapeutic alternatives.[28] The Draft Guidance provides that one potential approach is "considering a starting point between (a) the Part B ASPs/WACs, the Net Part D Plan Payment and Beneficiary Liability, or the combined Part B and Part D amount discussed above for therapeutic alternatives and (b) unit cost of production and distribution of the selected drug."[29] UCB strongly opposes the consideration of unit cost of production and distribution of the selected drug as a starting point for drugs with multiple therapeutic alternatives, as this approach is likely to significantly undervalue the selected drug. Focusing on unit cost of production and distribution fails to take into account the costs of drug development and overhead costs and can result in a measure of pricing and reimbursement that is not based on the value the medicine delivers. As a result, focusing on unit cost of production and distribution could have the consequence of ultimately disincentivizing drug development and limiting patient access to innovative therapies. Using this metric as a starting point for the MFP initial offer would not accurately capture the investments the manufacturer has made in the selected drug and would not allow innovators to recoup their research and development costs (which often is reinvested into further drug development).[30] UCB reinvests nearly 25-30% of our revenue into research and development globally each year.[31] Moreover, basing pricing on the unit cost of production and distribution drives biopharmaceutical innovators toward the most profitable areas rather than encouraging innovation that focuses on value to patients and health systems. In addition, UCB has concerns that the focus on unit cost of production and distribution for MFP-setting purposes would disincentivize efficiency in pharmaceutical production and distribution.

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[27] SSA § 1860D-4(b)(3)(I)(i) (providing that, in general, beginning in 2026, "the PDP sponsor offering a prescription drug plan shall include each covered part D drug that is a selected drug under section 1192 for which a maximum fair price…is in effect with respect to the year.").
[27] Draft Guidance § 60.3.2.
[28] Draft Guidance § 60.3.2.
[29] *Id.*
[30] *See, e.g.*, Deloitte, Measuring the Return from Pharmaceutical Innovation (Mar. 2025), https://www.deloitte.com/us/en/Industries/life-sciences-health-care/articles/measuring-return-from-pharmaceutical-innovation.html (reporting two years of growth in returns on pharmaceutical research and development for the top twenty biopharma companies, including a 5.9% return on innovation for 2024).
[31] UCB Integrated Annual Report 2024, https://djmyn0vvwsj0h.cloudfront.net/UCB_IAR_2024_ENG_4f4ead3812.pdf

Rather than focusing on the unit cost of production and distribution as a starting point for drugs with multiple therapeutic alternatives, UCB urges CMS to use the statutory ceiling price as a starting point for the MFP initial offer, as this approach would appropriately consider the value of the selected drug and would better maintain incentives for continued innovation.

III. CMS Should Not Require Manufacturers to Provide Speculative Forward-Looking Market Data and Should Not Use this Data as the Basis for MFPs.

The Draft Guidance provides that CMS is considering collecting additional forward-looking "market data" for a selected drug as part of its data collection from manufacturers for the purposes of negotiating the MFP.[32] The IRA does not permit CMS to compel manufacturers to report forward-looking market data (which is inherently speculative), and it would be inappropriate for CMS to rely on such speculation of future market conditions that may never occur when it imposes MFPs.

The statute enumerates a specific list of information that a manufacturer must submit as part of the MFP-setting process.[33] The IRA authorizes CMS to collect from manufacturers of selected drugs "[m]arket data and revenue and sales volume data for the drug in the United States."[34] This does not permit the agency to collect speculations about future market conditions (which are conditions that are typically outside of a particular manufacturer's control). The plain meaning of "market data" includes objective and verifiable data and would not include manufacturer projections about future revenues or sales volumes. Merriam-Webster, for example, defines "data" as "factual information (such as measurements or statistics) used as a basis for reasoning, discussion, or calculation."[35] Speculative information is not factual information. In addition, the legislative history of the IRA makes clear that Congress chose not to include forward-looking market data in the manufacturer-specific factors CMS would consider as part of the MFP-setting process. Predecessor legislation to the IRA shows that Congress considered incorporating "projected future revenues" into the market data that would be submitted by a manufacturer under section 1194(e)(1).[36] However, this language was not included in the enumerated factors in the IRA, demonstrating that Congress made the choice to exclude such speculative data.

Congress' ultimate decision not to collect forward-looking market information makes sense given that such information is, by its nature, subject to change, and in many circumstances such information changes due to circumstances beyond a manufacturer's control (for example, through competitor activities or regulatory changes). No manufacturer can predict the future and considering such information thus injects inherent uncertainty and inaccuracy into the MFP determination process. For these reasons, compelling manufacturers to provide such information is not consistent with the statute

[32] Draft Guidance § 50.1.
[33] SSA § 1194(e)(1).
[34] SSA § 1194(e)(1)(E) (emphasis added).
[35] "Data", Merriam-Webster, https://www.merriam-webster.com/dictionary/data.
[36] *See, e.g.*, Elijah E. Cummings Lower Drug Costs Now Act, H.R. 3, 117th Cong. § 1194(d)(1)(B) (2021).

and such speculative information is inappropriate for CMS to consider in setting the MFP of a selected drug.

* * *

UCB appreciates the opportunity to provide input on the Draft Guidance. We respectfully urge CMS to meaningfully consider the feedback submitted herein to help ensure continued drug innovation and that patient interests are upheld during IRA implementation. If you have any questions, please feel free to contact Kasia Kujawski, U.S. Public Policy Lead, at kasia.kujawski@ucb.com.

Sincerely,

Patty Fritz
Vice-President, U.S. Corporate Affairs
UCB, Inc.

Office of Strategic Health Initiatives

Rural Health Research and Policy Center

June 25, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
IRA Rebate and Negotiation

Sent Via: https://www.regulations.gov/commenton/CMS-2025-0054-0001

RE: Request for Comments – Medicare Drug Price Negotiation Program Draft Guidance. [FR Doc. 2025-08607 Filed 5-12-25; 4:15 pm]

Dear Mr. Holland,

Thank you for the opportunity to provide input on the CMS' draft guidance for the third cycle of the Medicare Drug Price Negotiation Program, the first cycle of renegotiation, and manufacturer effectuation of the maximum fair price for 2026, 2027, and 2028 for the implementation of the Inflation Reduction Act (IRA). We hope that our input will provide information addressing the draft guidance which describes how CMS intends to implement the Negotiation Program for Initial Price Applicability Year (IPAY) 2028 (January 1, 2028, to December 31, 2028), including renegotiation, and specifies the requirements for manufacturer effectuation of the MFPs for 2026, 2027, and 2028.

The University of Hawai'i (UH) Rural Health Research and Policy Center (RHRPC) was established in 2022 and seeks to translate community health needs into actionable, evidence-based policy solutions. With a focus on improving the quality, affordability, and accessibility of healthcare in Hawai'i, RHRPC provides policy analysis and strategy to support community members' efforts to enact structural changes through policy. Our work to date has focused on the adequacy of Medicare Geographic Practice Cost Index (GPCI) and Health Professional Shortage Area (HPSA) methodologies as well as transportation access in rural communities across our state. While not providing direct care, we are intimately involved with community providers, patients, and residents – especially those in rural communities.

Feedback & Recommendation on Part 1 of the Medicare Drug Price Negotiation Act Draft Guidance

- We recommend adding more drugs to the list of those eligible for negotiation as currently only the high spending drugs are selected each year. There are many drugs that are not in the top 10 or 15; however, they are still very expensive for patients.

- We recommend that the time before negotiation eligibility be shortened. The "Pill Penalty" already explained that drugs become eligible after 9 years (pills) or 13 years (biologics). However, we recommend reducing the waiting period to 7 or 10 years. A change of this nature would help to reduce drug prices sooner while still allowing manufacturers to recover their costs from research and development efforts.
- We recommend that support for small biotech innovation be retained beyond the current cut-off date of 2029. Small biotech companies could have innovations for rare diseases and specialty drugs that will increase affordability and access, providing benefits to the patient and reducing morbidity and mortality.

Feedback & Recommendation on Part 2 of the Medicare Drug Price Negotiation Act Draft Guidance

- **Section on "Bona fide marketing = marketing efforts that are genuine legitimate, and without and deceptive or fraudulent intent"**
    - What data should CMS use to decide if a drug is really being marketed?
        - Our recommendation is that CMS should rely on multiple reliable data sources, such as IQVIA. Trusted healthcare datasets, such as IQVIA, provide comprehensive sales data solutions such as market trends, competition, and product performance. Other data sources could be pharmacy dispensing records or FDA Orange Book marketing status (checking for safety and effectiveness and including a drug's marketing status). By doing so, CMS could make sure that decisions are based upon real-world activity.
    - For drugs that are not priced using common methods, what other ways could CMS use to set a fair price?
        - Our recommendation is to consider alternative pricing standards. For example, CMS could consider using the Federal Supply Schedule (FSS), which is a long-term, government-wide contract that allows commercial companies to do business with the government by providing access to millions of commercial products and services at fair and reasonable prices. Another example is the Medicaid Best Price or prices from international markets.
    - How to choose the first offer in negotiations? CMS must start with an opening price. What is the best way to determine that number? Should CMS look at how useful the drug is, how many patients use it, or its cost? What evidence should matter most?
        - Our recommendation is that CMS should use a value-based framework that considers clinical benefit, cost-effectiveness, how many patients use the drug, and whether alternative treatments exist.
    - What evidence should matter most. When deciding the final price, which facts should count more?

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        - Our recommendation that the most important evidence should be a combination of clinical outcomes, unmet medical need, availability of generics or biosimilars, and real-world effectiveness, as well as patient impact and affordability.

- **Section on "Considerations for Burden Reduction"**
    - If CMS wants to re-negotiate prices later, would that be too much work? How could it be done more easily?
        - We recommend that renegotiation should only happen when there are significant changes (for example, if the drug gets approved for a new use, has safety issues, or its patent runs out). In those cases, CMS should use a fast and easy process to reduce the burden for drug companies.

- **Considerations for MFP effectiveness and the MTF**
    - Making refund payments easier for drug companies: When companies must provide refunds to match the lower negotiated price, how can the refund process be made smoother and simpler, especially for drugs covered under Part B (i.e., those drugs usually given in doctor's offices)?
        - Our recommendation is for CMS to provide drug companies with a clear and easy-to-use tool to report refunds, along with deadlines which must be followed. For Part B drugs, working closely with Medicare billing contractors and using real time tracking can help to ensure payments are not delayed.
    - Improving data and money flow between CMS and Plans (the Medicare Transaction Facilitator System, MTF): How can the MTF system be improved to work well for all drugs, even those paid under different parts of Medicare?
        - Our recommendation is to change the MTF system to be 'real-time' so that drug companies and health plans can keep track of price changes, payments, and rules. We also recommend that CMS ensure the MTF system consistently across Medicare parts – for example, ensure that the system works the same way for both Part D and Part B drugs.
    - Making sure people in Medicare advantage plans get the discount too. Some people are in private Medicare plans. How can CMS make sure they get the same price discounts?
        - Our recommendation is for CMS to require Medicare Advantage plans to provide patients with the lower Maximum Fair Price (MFP) price. Using the same benefit rules and clear feedback reports, across all Medicare Plans, will provide consistency and aid in ensuring plans follow the rules.

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- **Considerations for Manufacturer Oversight and Compliance**
    - Better rules for oversight, especially for part B Drugs. What changes should be made to make sure companies follow the rules, especially for drugs given in clinics or hospitals?
        - We recommend that CMS implement clear rules just for Part B drugs. For example, CMS could request that companies send in refund plans in a timely manner and keep clear records. It is also important for CMS and the drug companies to work closely with the billing systems used in doctor's offices.
    - Handling disputes and complaints better: If there is a problem or disagreement, how can the process for filing complaints or resolving issues be clearer and faster?
        - We recommend that CMS establish an online portal for submitting and tracking complaints. Timelines should be clearly defined, for example 30 days for a response. In addition, it is essential to establish an independent review process for disputes that cannot be resolved quickly. The independent review process would provide the ability for a neutral person to review and decide dispute resolution.

RHRPC greatly appreciates the opportunity to provide input, ensuring our commitment to ensuring affordable access to care and medicines for all patients, especially those who reside in remote, rural communities. For questions or more information, please reach out to Michelle Kim, Pharm.D. at msk@hawaii.edu or Diana M V Shaw, PhD, MPH, MBA, FACMPE, Rural Health Policy Advisor, at dmshaw@hawaii.edu.

Sincerely,

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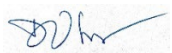

Diana M V Shaw, PhD, MPH, MBA, FACMPE
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Resources

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June 26, 2025

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244–1859

Submitted via e-mail: IRARebateandNegotiation@cms.hhs.gov

Re: Medicare Drug Price Negotiation Program Draft Guidance

Dear Sir/Madam:

UnitedHealthcare (UHC) is responding to the May 12, 2025 memo titled *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028* and the *Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program Draft Guidance* comment request notice published in the Federal Register on May 15, 2025 (90 FR 20674).

UHC offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. UHC is the health benefits business of UnitedHealth Group, a health care and well-being company working to help build a modern, high-performing health system through improved access, affordability, outcomes and experiences. We are committed to a future where every person has access to high-quality, affordable health care and a modern, high-performing health system that reduces disparities, improves outcomes, and lessens the burden of disease.

30.3.1.3 High Likelihood

CMS proposes to review Biosimilar Delay Requests to determine whether there is a high likelihood that the biosimilar will be licensed and marketed before the High Likelihood Deadline. Specifically, CMS is soliciting comments regarding what additional or alternative information/ evidence they should consider in assessing whether a biological product should be excluded from price negotiations due to the anticipated entry of a biosimilar. For example, this may include information surrounding ongoing patent litigation or public-facing statements from the biosimilar manufacturer asserting that demonstrates that an ongoing patent dispute will be resolved or not prevent marketing of the biosimilar by the High Likelihood Deadline.

- UHC supports CMS adopting a flexible, evidence-based framework that considers information including industry-recognized milestones that occur in ongoing patent litigation and public-facing statements on market readiness to ensure that the appropriate drugs are selected for price negotiation. This will help ensure that Medicare Part D plan sponsors are

not in a position where they have to cover a brand negotiated drug on their formulary when there are other lower-cost biosimilars that are on the market.

130.2.1 Holistic Selection Approach for Renegotiation

CMS is soliciting comments on the renegotiation selection approach, including adoption of a holistic inquiry of two criteria, for identifying drugs eligible for renegotiation of their Maximum Fair Prices (MFPs).

- UHC supports CMS's evidence-based, holistic inquiry based on the totality of the information available and circumstances of the renegotiation-eligible drug. To the extent CMS moves forward with this approach, UHC recommends that CMS provide additional guidance on the selection process and how it will assess "significant impact" to the Medicare Program if it adopts the inquiry of the two criteria as described. Specifically, UHC would like to understand what factors CMS would consider in assessing if a drug meets the 15% or greater price-change threshold. Further, UHC is interested in how CMS will assess new clinical effectiveness data to assess favorable/positive and unfavorable outcomes/results.

130.4.3 Renegotiation Process

CMS is considering whether conforming to the procedures, structure, and timing of the negotiation process is practicable for the renegotiation process and is soliciting comments on whether there are specific aspects of the negotiation process that may not be practicable for the renegotiation process.

- UHC recommends that CMS maintain the current negotiation timelines to ensure stability and predictability across the negotiation cycles. Changing any aspects of the timing of the negotiation process will impact plans' ability to implement the Maximum Fair Price drugs, particularly as it relates to formulary coverage and administration.

Thank you for your thoughtful consideration of our comments. Should you have any questions, please do not hesitate to contact me.

Sincerely,

Jennifer Martin
Director, Regulatory Affairs
jennifer_j_martin@uhc.com
763-283-4469

U.S. Chamber of Commerce

1615 H Street, NW
Washington, DC 20062-2000
uschamber.com

June 24, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Oz:

The U.S. Chamber of Commerce ("Chamber") appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' ("CMS's") Draft Guidance implementing Initial Price Applicability Year 2028 ("IPAY 2028") of the Medicare Drug Price Negotiation Program created by the Biden Administration under the Inflation Reduction Act ("IRA"). While we commend the Trump Administration for its efforts to ensure American patients have access to life-saving medicines, we have significant concerns regarding the potential negative impacts of the Draft Guidance on patient access, biopharmaceutical innovation, and the broader healthcare ecosystem.[1] As we explain below, the draft guidance is problematic, in large measure, because it carries forward interpretive and policy decisions made by the Biden Administration that do not comport with the law and do not reflect President Trump's policy direction.

As a threshold matter, we believe that CMS continues to make decisions regarding the IRA's price controls in a black box that lacks needed transparency. We understand the Draft Guidance to reaffirm that CMS will not disclose information about how it will set medicine prices until months after these decisions are made. This lack of transparency undermines CMS's stated commitment to "learning from, collaborating with, and engaging with the public" by keeping key stakeholders in the dark about how it will set prices until it is too late to provide effective input.

This is particularly true in the context of CMS's attempts to engage patients and providers. The Draft Guidance fails to offer insight into how collected data are used and leaves the door open for parties to submit discriminatory cost-effectiveness measures, including those based on the Quality-Adjusted Life Year (QALY). These measures carry the risk of undervaluing the lives of seniors, the disabled, and the

[1] As CMS is aware, the Chamber and other parties have challenged the IRA's price-control program in federal court as unconstitutional on several grounds. The Chamber respectfully submits that even if the IRA program were lawful (which it is not), both sound policy and legal considerations would require CMS to improve the approach set forth in the Draft Guidance, as explained in this letter.

chronically ill. We note that the IRA provides that in using evidence concerning comparative effectiveness, CMS "shall not use evidence from comparative clinical effectiveness research in a manner 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."

For both reasons, and separate from the Chamber's additional concerns detailed below, we strongly recommend that CMS adopt a more transparent, collaborative approach, providing timely and detailed information, subject to all necessary precautions to protect trade secrets and confidential business information, about the price-setting process to all stakeholders, but most especially America's innovative life-science companies and chronically ill patients.

Turning to the Chamber's additional policy-specific concerns with the draft guidance, we set forth three key concerns here.[2] First, we understand that the draft guidance would maintain the previous Administration's improper and legally invalid decision to adopt an overly broad definition of a qualifying single source drug (QSSD). The IRA defines a QSSD as one approved under its own new drug application (NDA) or biologics license application (BLA). However, CMS's policy disincentivizes innovation by treating products with the same active ingredient or moiety as the same QSSD, even if they are approved under different applications. This approach is inconsistent with the statutory language and deviates from the established Food and Drug Administration's approval framework for NDAs and BLAs, undermining incentives to develop new indications, forms of administration, or combination products that could demonstrate safety and efficacy in additional diseases or provide real-world utility and accessibility enhancements. This means there is effectively no age limit for CMS to subject a medicine to price-setting, even if it has just launched, has a different trade name, or represents a significant advancement for patients.

For example, new products that utilize innovations like subcutaneous (SC) administration can save patients 2.7–3 hours per visit[3], cut active healthcare provider

[2] These concerns do not represent the entirety of the problems inherent in the program or in its past or proposed implementation. Some of the concerns also apply to the previous Administration's CMS guidance, which we urge this Administration to revisit with a fresh approach that better reflects a policy of supporting innovation and economic growth. For more information about flaws in the previous Administration's guidance implementing the program, please see, for example, our letter to CMS of July 2, 2024, commenting on the Draft Guidance implementing IPAY 2027 of the program, at https://www.uschamber.com/intellectual-property/u-s-chamber-submits-comments-on-medicare-drug-price-negotiation-program.

[3] Soefje SA, et al. Clinical Administration Characteristics of Subcutaneous and Intravenous Administration of Daratumumab in Patients With Multiple Myeloma at Mayo Clinic Infusion Centers. JCO Oncol Pract. 2023 Apr;19.

time by nearly 50%[4], and lower the risk of infusion-related reactions.[5] These advancements address critical unmet needs and are meaningful by improving access, reducing treatment burden, and enhancing the overall patient experience—particularly in community, rural, and resource-limited settings. Accordingly, we urge CMS to reverse this policy and stay consistent with the statute by identifying QSSDs by distinct NDA or BLA.

Second, we are concerned that CMS has failed to adopt changes to the Orphan Drug Exclusion that would better protect development by maintaining orphan incentives. Moreover, CMS has stopped seeking input on what actions it can take to best support orphan drug development in the implementation of the price-setting program. We strongly urge CMS to seriously evaluate the impact of its interpretation on orphan drug development incentives and reopen this policy for consideration.

Finally, we are concerned with how the draft guidance could impact generic and biosimilar competition. While most brand medicines with an approved and marketed competitor at the time of selection are exempt from price setting, the timing for selection in the law predates the typical timeline for generic and biosimilar competition. Exacerbating this issue, the Draft Guidance would maintain another unsound decision made by the previous Administration by providing that CMS will evaluate whether a competitor is engaged in "bona fide marketing"—an arbitrary standard that is not consistent with the statute. Relying on this ill-defined concept means that marketed generics or biosimilars would be forced to compete against medicines with government-set prices, significantly reducing the incentive to bring them to market. We recommend that CMS amend its approach to ensure that the reference drug's Maximum Fair Price (MFP) becomes inapplicable immediately upon generic market entry.

We also recommend that CMS not pursue the potential alternative approach, described on page 131 of the draft guidance, for developing a starting point for an initial offer for a selected drug that would rely in major part on the unit cost of production and distribution of the drug. Such an approach would disincentivize innovation, compromise future patient access, and promote the inefficient development of medicines. Accurately estimating unit costs is prohibitively challenging at the product level, and undue reliance on this consideration in price-setting would penalize life sciences companies for pursuing efficiencies, ultimately resulting in fewer advances in treatment options and less progress in areas of unmet need.

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[4] https://www.merck.com/news/mercks-investigational-subcutaneous-pembrolizumab-with-berahyaluronidase-alfa-demonstrates-noninferior-pharmacokinetics-compared-to-intravenous-iv-keytruda-pembrolizumab-in-pivotal/

[5] Usmani SZ, Nahi H, Mateos MV, et al. Final analysis of the phase III non-inferiority COLUMBA study of subcutaneous versus intravenous daratumumab in patients with relapsed or refractory multiple myeloma. Haematologica. 2022;107(10):2293–2302

In conclusion, the Chamber believes that CMS's Draft Guidance would make an already harmful law worse, in significant part because it maintains decisions made by the Biden Administration that are either unlawful, inconsistent with President Trump's policy direction, or both. Throughout the Draft Guidance, CMS has failed to consider the risks to patient access and future innovation. The Guidance should therefore be revised to conform more faithfully with the mandate of section 3(a) of President Trump's Executive Order 14273 (Apr. 15, 2025), which provides that CMS's guidance "shall … minimize any negative impacts of the maximum fair price on pharmaceutical innovation within the United States." Ultimately, CMS has disregarded concerns brought forth by stakeholders and put American patients' access to medicines further at risk. We strongly urge CMS to adopt a more thoughtful and inclusive approach that prioritizes patient access, innovation, and the long-term sustainability of the biopharmaceutical industry.

Thank you for your time and attention. We look forward to collaborating with CMS to develop market-oriented solutions that enhance affordability and access without compromising the innovation that drives life-saving breakthroughs.

Sincerely,

Marty Durbin
Senior Vice President, Policy
President, Global Energy Institute
U.S. Chamber of Commerce

June 26, 2025

VIA ELECTRONIC SUBMISSION THROUGH IRARebateandNegotiation@cms.hhs.gov

Chris Klomp, MBA
Deputy Administrator and Director
Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028

Dear Deputy Administrator Klomp,

On behalf of The US Oncology Network (The Network), thank you for the opportunity to offer feedback on the *Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price in 2026, 2027, and 2028.*

The Network is the nation's largest network of independent, community-based oncology physicians. Uniting more than 1,900 like-minded physicians, The Network treats nearly 1.8 million cancer patients a year nationwide at over 700 sites of care in 30 states. These physicians share a common vision of expanding patient access to high quality, state-of-the-art care close to home and at lower costs for both patients and our entire healthcare system. Our mission is to help patients fight cancer as effectively and efficiently as possible.

While The Network remains deeply concerned about the potential unintended consequences that the Inflation Reduction Act (IRA) may have on the viability of physician practices and timely access to innovative therapies for patients, we commend the Administration for its efforts to engage stakeholders and increase transparency around the Negotiation Program. These efforts represent a crucial step toward building trust and accountability in the implementation process. We encourage CMS to continue emphasizing transparency not only within this program but across all agency initiatives. We are hopeful that this openness will foster a more collaborative environment and lead to thoughtful, data-driven adjustments to the program that address the concerns raised by the provider community—particularly those related to access, practice sustainability, and innovation in patient care. Our comments address two themes raised in the guidance:

- Protecting providers from financial risk and operational burden; and
- Ensuring accurate utilization data in Medicare Advantage

Protecting Providers from Financial Risk and Operational Burden

Generally, the inclusion of Part B drugs in the Negotiation Program injects significant uncertainty and operational risks for physician practices—particularly in oncology, where the use of physician-administered drugs is a frequent and essential course of therapy. The Network is deeply concerned that reimbursement under the Maximum Fair Price (MFP) model, could force providers to absorb the difference between MFP and acquisition

costs. This would place an unsustainable financial burden on practices, especially smaller, community-based providers, and could jeopardize their ability to continue offering timely, high-quality cancer care. **The Network urges CMS to ensure that providers are not forced to shoulder the upfront costs of high-priced therapies—an unsustainable burden that could accelerate practice closures, drive further consolidation, and ultimately restrict patient access to timely, community-based care.** In addition to the financial concerns around inclusion of Part B drugs in the program, oncology practices are concerned about the operational changes that must take place to implement the program.

Currently, CMS reimburses physicians for the cost of Part B drugs at the manufacturer's average sales price (ASP) plus 6%, which is effectively reduced to 4.3% due to sequestration. This add-on payment is intended to help offset a range of overhead costs associated with acquiring, storing, and administering these drugs. These overhead costs are substantial and unavoidable. They include specialized storage requirements—such as refrigeration or temperature-controlled environments—inventory management systems, staff time for drug preparation and administration, compliance with hazardous drug handling protocols, and the financial risk of drug wastage or non-reimbursement. Oncology drugs, in particular, often require complex handling and administration protocols, adding to the operational burden on practices.

Under the Inflation Reduction Act (IRA), reimbursement for negotiated drugs will shift to the maximum fair price (MFP) plus 6%. This change will result in reduced reimbursement to providers, even though the associated overhead costs and financial risks remain unchanged. This discrepancy could further strain the financial viability of community-based oncology practices, potentially limiting patient access to timely and high-quality cancer care.

A recent analysis found that providers across both Medicare and the commercial market could lose at least $25 billion in add-on payments for the first 10 Part B drugs expected to be negotiated. Among these, three oncology/hematology products are projected to experience a 39% to 64% reduction in Medicare fee-for-service (FFS) add-on payments—highlighting the disproportionate impact on cancer care providers.

Oncology practices typically incur substantial upfront costs when acquiring, storing, and handling physician-administered oncology drugs. If reduced reimbursement rates under the Negotiation Program fail to adequately cover these core acquisition and operational expenses, practices will face heightened financial strain—further increasing the risk of consolidation with large health systems, practice closures, or reduced patient access to life-saving therapies.

Congress has considered several policy solutions to alleviate financial pressures on physician practices and safeguard patient access to innovative therapies and ongoing research. In the previous Congress, Senator John Barrasso (R-WY) and Representative Michael Burgess, M.D. (R-TX) introduced the Protecting Patient Access to Cancer and Complex Therapies Act. This legislation aimed to shield physician reimbursement for Part B drugs from the negative financial impacts of the Medicare Drug Price Negotiation Program. Under the proposal, physician practices would continue to receive reimbursement at the current ASP+6% rate, while drug manufacturers would provide a direct rebate to the federal government for the difference between that rate and MFP. Patients would benefit from lower out-of-pocket costs, as their coinsurance would be based on the reduced MFP.

The Network supports this approach as it would preserve the financial viability of physician practices while still achieving cost savings for Medicare through manufacturer rebates, without placing providers in the middle of

the pricing gap. Notably, this straightforward solution could potentially be implemented administratively, offering a practical path forward that balances fiscal responsibility with patient access and provider sustainability.

Furthermore, in limited cases, previous adverse pricing issues have led manufacturers to withdraw products from the market altogether, posing a serious threat to patient access. **The Network remains deeply concerned over any potential disruption to the supply chain and strongly cautions CMS to reconsider policies that will not jeopardize patient access to essential, life-saving drugs.** We would welcome the opportunity to continue engaging with CMS to share provider perspectives and discuss the real-world impacts that these policies may have on patient care and practice sustainability.

Ensuring Accurate Utilization Data: The Role of Medicare Advantage

CMS is soliciting comments on the potential use of additional data sources to support the review of utilization for drugs payable under Part B and/or covered under Part D. Specifically, CMS is considering incorporating, when available, Average Sales Price (ASP) data, Medicaid State Drug Utilization Data (SDUD), and data from nationally representative, commercially available databases. CMS also requests input on whether other data sources may provide timely and reliable utilization data for these drugs.

The Network encourages CMS to consider several additional factors. With more than half of Medicare beneficiaries now enrolled in Medicare Advantage (MA) plans, it is essential to understand how CMS intends to account for this growing population. While the draft guidance references the use of "Part B claims data" to identify high-cost drugs, it is unclear whether this includes data from MA plans. CMS has been collecting Medicare advantage prescription drug (MA-PD) claims data for several years and has recently indicated in rulemaking that it may begin relying on MA data more directly, rather than continuing to depend solely on fee-for-service (FFS) claims. Without the inclusion of robust and representative MA data, the proposed methodology risks producing an incomplete and potentially skewed picture of drug utilization.

Moreover, private oncology practices, which often operate with limited margins, may be disproportionately affected if policy decisions are made using incomplete data that underrepresents the complexity and cost of cancer care in the MA setting. Ensuring that MA claims data is fully integrated into CMS's analysis is critical to maintaining equitable access to high-quality oncology care across all Medicare populations.

Conclusion

While we understand and appreciate efforts to reduce patients' out-of-pocket prescription drug costs, we are concerned that physician practices, particularly community-based oncology practices, will be caught in the middle of the IRA's drug negotiation process, which could ultimately undermine and threaten patient access to care. The Network appreciates the opportunity to share these thoughts and concerns. Please feel free to use us as a resource moving forward. Please reach out to Ben Jones, Vice President of Government Relations at Ben.Jones@usoncology.com with any questions.

Sincerely,

Les Busby, M.D.
Chief Medical Officer
The US Oncology Network

June 26, 2025

Chris Klomp
CMS Deputy Administrator
Director, Center for Medicare
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Comments Regarding the Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program Draft Guidance (Docket No. CMS-2025-0054)

Dear Director Klomp,

The Alliance of U.S. Startups & Inventors for Jobs (USIJ) respectfully submits these comments on the Centers for Medicare & Medicaid Services' draft guidance for the third cycle of Medicare drug price negotiations.

USIJ is deeply concerned that CMS is considering treating separately patented, FDA-approved reformulated drugs as indistinguishable from their predecessors for pricing purposes. This is not a minor technical matter -- it would operate as a backdoor price control, effectively overriding valid patent rights and weakening the protections that make follow-on innovation economically feasible. If CMS moves forward with this approach, it will discourage investment in exactly the kinds of improvements patients depend on: new formulations, better delivery methods, and expanded indications for existing therapies.

USIJ is a group of inventors, startup companies, venture capitalists, incubators, and research institutions who have come together in the interest of safeguarding our nation's innovation ecosystem. Our members have helped pioneer technologies in fields ranging from medical devices and biotechnology to clean energy and cloud computing. These breakthroughs were made possible because the U.S. patent system provides a clear and reliable framework to protect and commercialize new ideas.

But that framework only works if we respect it. By contemplating whether to group reformulated drugs with older versions based on whether a given component is "therapeutically active," CMS risks ignoring how real-world innovation works -- and how it is evaluated by both the U.S. Patent and Trademark Office and the FDA. These agencies routinely recognize reformulated products as distinct. If CMS blurs that distinction for pricing purposes, a newly approved therapy could face price controls on day one, despite holding its own valid patents and full FDA approval.

The signal this would send is deeply worrying. Why would any company invest in a subcutaneous version of an infused biologic, explore new dosing regimens, or study new uses for an existing compound if the resulting innovation will be lumped into a pricing category with a decade-old product? The answer is simple: they won't. And as a result, patients will lose access to precisely the kinds of incremental advances that improve safety, effectiveness, convenience, and reach.

Innovation depends on clarity. Startups, universities, and investors rely on the expectation that improvements will be judged on their own merits and protected accordingly. Undermining that expectation -- especially through regulatory guidance rather than legislation -- injects risk and uncertainty across the development pipeline for all advanced technologies.

The Inflation Reduction Act does not authorize this policy. Congress carefully structured the statute to contain targeted tools for cost control while minimizing harm to innovation. Nothing in the law empowers CMS to collapse distinct, separately patented drugs into a single pricing category. This reinterpretation exceeds the agency's statutory authority and undercuts the Constitution's commitment to securing exclusive rights for inventors.

This proposal is especially troubling given the broader policy climate, where inventors already face mounting threats to their intellectual property rights, including repetitive administrative patent challenges and proposed legislative constraints. CMS's contemplated reinterpretation of what qualifies as a distinct, single source drug adds another layer of risk.

The implications of this decision extend far beyond Medicare -- and even beyond the life sciences. If one agency can disregard valid patents when they conflict with cost-containment goals, inventors across high-tech sectors will reasonably question whether other parts of government might follow suit. That would erode global confidence in the U.S. innovation system and accelerate the shift of investment, talent, and discovery to more predictable policy environments.

USIJ urges CMS to reconsider this potential policy and publicly commit that FDA-approved, separately patented reformulations will be treated as distinct qualifying single source drugs for purposes of the Medicare Drug Price Negotiation Program. That position aligns with how the USPTO and FDA recognize and evaluate innovation. It would preserve the incentives that fuel continued medical progress and send a clear signal that the United States remains the best place in the world to build, fund, and scale breakthrough technologies.

Thank you for considering these comments.

Sincerely,

Chris Israel
Executive Director
Alliance of U.S. Startups and Inventors for Jobs

June 26, 2025

Chris Klomp
CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1859

RE: Comments on Draft Guidance on the Medicare Drug Price Negotiation Program issued May 12, 2025

Dear Deputy Administrator Klomp,

Thank you for the opportunity to submit these comments in response to CMS' latest Draft Guidance on the Medicare Drug Price Negotiation Program. I applaud CMS' dedication to on-time implementation of the negotiation program while balancing stakeholder input.

In this letter, I make recommendations on two topics: calculating spending for negotiation-eligible drugs under Part B and considering active ingredients without therapeutic effect in identifying a qualifying single source drugs (QSSD).

1. **Calculating spending for negotiation-eligible drugs under Part B**

CMS should include estimated Medicare Advantage plan spending to identify negotiation-eligible high-spending drugs under Part B.

The Inflation Reduction Act (IRA) directs CMS to identify high-spending drugs under Part B for negotiation. The guidance proposes to use Part B fee-for-service claims data to determine spending on such drugs. However, Part B claims data do not fully capture expenditures for drugs covered under Part B, as more than half of Medicare beneficiaries receive their Part B benefits through Medicare Advantage (MA) plans. Using only Part B fee-for-service data would systematically underestimate spending on these products and result in lost savings. It would also encourage manufacturers to develop products for Part B over Part D.

CMS should not interpret the IRA's references to Part B as an exclusion of MA. In fact, MA benefits themselves are defined by Part B. Social Security Act Section 1852(a) establishes that MA plans are responsible for providing to members "*benefits under the original Medicare fee-for-service program*" and that this means "*those items and services […] for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B…*"

To incorporate MA spending, CMS will have to overcome a technical challenge: The agency only has access to encounter data, which do not include details on drugs administered. Nevertheless, drug utilization and spending in this group of beneficiaries could be estimated by one (or a combination) of several approaches. One would be to project MA spending based on observed fee-for-service spending. This could be done by identifying MA encounters with ICD-10 diagnosis codes associated with treatment using specific drugs and estimating utilization. CMS could further refine its approach by adjusting for characteristics of beneficiaries observed to use these drugs in fee-for-service data. Another alternative would be to request that MA plans themselves submit data on the drugs administered and paid for as part of delivering Part B benefits to their beneficiaries.

2. **Considering active ingredients without therapeutic effect in identifying a QSSD**

CMS should consider whether a formulation of a QSSD containing another active ingredient adds to its therapeutic effect.

The definition of a QSSD is central to the success of the negotiation program. Savings to patients and Medicare depend on ensuring that makers of a drug with a negotiated price cannot replace it with a close substitute in the form of another formulation with a higher price.

To date, CMS has identified such formulations by treating distinct combinations of active ingredients as their own QSSD, but not distinguishing between different formulations of the same active ingredients with different inactive ingredients. Because active ingredients are intended to "furnish pharmacological activity" or have a diagnostic or therapeutic effect, fixed combinations of different active ingredients are less likely to be close substitutes for one another than the same active ingredients with different combinations of inactive ingredients.

But active ingredient is not a perfect proxy for identifying close substitutes. This is particularly true for infused biologics covered under Part B that have been or are being reformulated with hyaluronidase to create subcutaneous versions of the same product. These drugs, including Opdivo and Keytruda, often require higher doses than can be administered subcutaneously; hyaluronidase enables the injection to more easily penetrate tissues at the site of injection and thus allows the higher dose. While the FDA considers hyaluronidase to be an active ingredient, it has no standalone therapeutic effect. The subcutaneous version of the drug is a close substitute to the infused.

To improve its ability to identify when such products should be part of the same QSSD, CMS should consider including in a QSSD any formulations with an added (or subtracted) active ingredient that do not substantially contribute to the therapeutic effect of the QSSD. This determination could be based on whether the clinical trials supporting FDA approval of the formulation are designed to demonstrate non-inferiority to the QSSD.

Thank you for the opportunity to comment on this guidance. Please do not hesitate to contact me if I can provide further information on answer any questions about my suggestions.

Sincerely,

Anna Kaltenboeck
President, Verdant Research

June 26, 2025

VIA ELECTRONIC SUBMISSION — Submitted via email to: IRARebateandNegotiation@cms.hhs.gov

Chris Klomp
Deputy Administrator
Centers for Medicare & Medicaid Services
Director
Center for Medicare
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028

Dear Director Klomp,

ViiV Healthcare Company ("ViiV") appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services ("CMS," or the "Agency") IPAY 2028 Draft Guidance, Implementation of Sections 1191-1198 of the Social Security Act for the Initial Price Applicability Year (IPAY) 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028 (Draft Guidance).[1] As CMS undertakes the process of finalizing this guidance, ViiV appreciates CMS's willingness to solicit comments and offer listening sessions to understand stakeholder impacts and concerns related to implementation.

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus ("HIV") treatment and prevention to support the needs of people with HIV and those who could benefit from prevention of HIV. From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

An estimated 1.2 million people in the United States are living with HIV, with at least 13 percent unaware of their HIV status.[2] HIV is a unique area of health as both an infectious disease and chronic condition that when effectively managed cannot be transmitted to others, a concept known as "undetectable = untransmittable," ("u=u").[3] HIV began as an epidemic that disproportionately affected younger people, but with the development of new antiretroviral ("ARV") treatments that enable long-term management of the disease, the age distribution of people with HIV has shifted higher. Today, over 50 percent of people with

[1] Center for Medicare. Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028. May 12, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf. Accessed June 21, 2025.
[2] HIV.gov. U.S. Statistics. February 21, 2025. https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics. Accessed June 21, 2025.
[3] National Institutes of Health (NIH). HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention. May 21, 2019. https://www.niaid.nih.gov/diseases-conditions/treatment-prevention. Accessed June 20, 2025

HIV are now aged 55 or older, with the average age expected to continue rising.[4,5] In addition to treatment, ARVs can also be used as pre-exposure prophylaxis (PrEP) to prevent acquisition of HIV. Today there are an estimated 2.2 million people in the United States who could benefit from PrEP.[6]

The health of people affected by HIV depends on access and innovation. CMS has recognized the need for access by identifying ARVs as one of six protected classes that must be covered by all Medicare prescription drug plans. CMS also recognizes the importance of innovation, most recently issuing a National Coverage Determination (NCD) for prevention of HIV. New ARV treatments and prevention tools are critical for staying abreast of an evolving virus. Only three major manufacturers continue to invest in HIV research and development, and ViiV is concerned that ARV price setting could have long-term detrimental impacts on innovation and achieving the nation's goal of *Ending the HIV Epidemic* ("EHE").

ViiV encourages CMS to account for how HIV is a unique and evolving area of health care and how policies in this guidance could inadvertently impact access and innovation toward future prevention tools, treatments, and, ultimately, a cure. In light of these considerations and the Trump Administration's concentrated efforts under EHE, ViiV offers the following targeted recommendations:

I. HIV medications should be excluded from Medicare negotiation to ensure innovation continues for HIV in support of ongoing efforts to End the HIV Epidemic.

II. If HIV drugs remain in scope for Medicare negotiation, CMS should highly weigh product value, including preventive value and HIV resistance characteristics in developing initial price offers.

- ***a. HIV Resistance and Challenges of Limited Therapeutic Options***
- ***b. Preventive Value***

III. For therapeutic alternative selection for HIV treatments, CMS should limit selection to antiretrovirals, account for dosing requirements, and account for last-line ARVs with no therapeutic alternatives.

IV. CMS should create a more privacy-focused, systematic and continuous patient engagement process or comment opportunity.

I. HIV medications should be excluded from Medicare negotiation to ensure innovation continues for HIV in support of ongoing efforts to End the HIV Epidemic.

As a public health issue, HIV is unique and advancements in treatment and prevention have the potential to eradicate the disease, but only if new options continue to be made available. CMS already treats HIV medications differently than other drug products in Medicare Part D. HIV is recognized as a one of only six "classes of clinical concern" or "protected classes" by Medicare due to the difficulty in managing the disease. Because HIV is difficult to manage and can build resistance to medications, the class should be excluded from IRA's MFP negotiation.

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[4] AIDSVu. Location Profile: United States. 2022. https://map.aidsvu.org/profiles/nation/usa/overview#0-2-Demographics. Accessed June 20, 2025.
[5] Althoff KN, Stewart CN, Humes E. The shifting age distribution of people with HIV using antiretroviral therapy in the United States. AIDS. 2022 Mar 1;36(3):459-471. Accessible at https://pubmed.ncbi.nlm.nih.gov/34750289/.
[6] Kourtis AP, Wiener J, Weiming Z, Minttu MR, Saloman J, Huang AY, Lyles C, Patel RR, Hoover KW, Fanfair RN, Mermin J. Estimating the population need for preexposure prophylaxis for HIV in the United States. Annals of Epidemiology. 2025 Jun 106: 48-54. Accessible at https://doi.org/10.1016/j.annepidem.2025.04.017.

The Medicare Part D protected classes rule requires all (or substantially all) prescription drugs to be covered in six protected therapeutic classes including HIV.[7] CMS adopted the Part D policy to "mitigate the risks and complications associated with an interruption of therapy for these vulnerable populations."[8] This protected class policy aligns with the recommendations of health experts, policymakers and HIV-specialized providers, who recommend unrestricted formularies in HIV treatment. The U.S. Department of Health and Human Services' "Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV" emphasize the need for individualized treatment regimens to enhance adherence and ensure long-term treatment success.[9] The same policy rationale should extend to ensure HIV treatment and prevention are protected in terms of setting MFP.

HIV treatment and prevention options are public health tools that deserve unique considerations not similarly contemplated for other classes of biologics or drugs. Specifically, HIV treatment is beneficial to the patient, suppressing the virus, reducing complications and promoting the wellness of persons with HIV. In addition, once a person with HIV achieves viral suppression, HIV treatment also reduces the risk of sexual transmission of HIV to others.[10] This "treatment as prevention" benefits population health. However, as mentioned previously, only 57 percent of diagnosed individuals had achieved viral suppression as of 2022, according to the CDC.[11]

The federal government has recognized public health benefits of treating HIV in its creation of the "Ending the HIV Epidemic Initiative: A Plan for America" (EHE),[12] a bold national effort that aims to leverage scientific advances in HIV to end the HIV epidemic in the United States. The EHE focuses efforts across many federal health agencies, offices, and programs, including the US Department of Health and Human Services (DHHS) Office of the Assistant Secretary for Health, the Centers for Disease Control and Prevention (CDC), the Ryan White HIV/AIDS Program (RWHAP), the Health Center Program, the National Institutes of Health (NIH), the Indian Health Service, and the Substance Abuse and Mental Health Services Administration (SAMHSA).[13] These federal agencies are working with state and local governments, health departments, and communities to develop jurisdictional plans to expand the use of the highest-impact HIV prevention strategies, including PrEP utilization.[14]

This level of federal commitment to end a single disease is notable. ViiV urges CMS to consider how best to align the nation's efforts to eradicate HIV with the goals of the IRA and its implementation, and respectfully ask that HIV products are excluded from negotiations.

II. If HIV drugs remain in scope for Medicare negotiation, CMS should highly weigh product value, including HIV resistance characteristics and preventive value in developing initial price offers.

While ViiV continues to urge CMS to exclude HIV ARVs from drug price negotiation given the singular challenges of the disease and its treatments, if the agency declines to exclude them, it should apply a

[7] Centers for Medicare and Medicaid Policy. Medicare Advantage and Part D Drug Pricing Final Rule. May 16, 2019. https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-part-d-drug-pricing-final-rule-cms-4180-f. Accessed June 20, 2025.
[8] CMS.gov. Medicare Prescription Drug Benefit Manual. Chapter 6 – Part D Drugs and Formulary Requirements. January 15, 2016. https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/part-d-benefits-manual-chapter-6.pdf. Accessed June 20, 2025.
[9] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. September 12, 2024. https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/adult-adolescent-arv/guidelines-adult-adolescent-arv.pdf. Accessed June 20, 2025.
[10] HIV.gov. Viral Suppression and Undetectable Viral Load. June 7, 2022. https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/viral-suppression#:~:text=In%20addition%20to%20preventing%20sexual%20transmission%20of%20HIV%2C,transmission%20risk%20for%20people%20who%20inject%20drugs.%20. Accessed June 20, 2025.
[11] HIV.gov. HIV care continuum. February 26, 2025. https://www.hiv.gov/federal-response/other-topics/hiv-aids-care-continuum. Accessed June 20, 2025.
[12] HIV.gov. EHE Overview. March 20, 2025. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview. Accessed June 20, 2025.
[13] HIV.gov. HHS Agencies Involved in Ending the HIV Epidemic. March 2, 2022. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/federal-action/agencies. Accessed June 20, 2025.
[14] HIV.gov. HHS Agencies Involved in Ending the HIV Epidemic. March 2, 2022. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/federal-action/agencies. Accessed June 20, 2025.

comprehensive framework of product value ("Evidence About Alternative Treatments") and definition of unmet need than what is currently finalized ("treating a disease or condition where very limited treatment options exist").

In developing initial price offers, ViiV encourages CMS to weigh negotiation factors for product value) more heavily than factors focused on cost recovery ("Manufacturer-Submitted Data"). The current framework fails to account for the clinical realities of HIV treatment, where maintaining therapeutic options is crucial to preventing viral resistance. This narrow definition risks undervaluing ARVs that require individualized regimens and adherence support to achieve long-term efficacy. When assessing product value, ViiV strongly encourages CMS to consider data that demonstrates how access to medication—and often multiple ARVs at once—can mitigate costs through prevention for an individual beneficiary's care, conditions averted, and community health.

a. HIV Resistance and Challenges of Limited Therapeutic Options

HIV's rapid mutation rate produces billions of variants daily, making resistance a constant threat. If a person with HIV becomes resistant to a current regimen, therapeutic options are drastically reduced, and future treatment becomes far more complex and costly. Effective ARV must stop viral replication, which hinges on adherence to customized regimens tailored to factors like treatment history, co-morbidities, and drug interactions. Clinical guidelines, including those from HHS[15] and CDC,[16] emphasize the importance of individualized treatment and prevention strategies to support adherence and prevent resistance.

Undervaluing these factors in developing an initial offer creates a false perception that HIV treatments are interchangeable, overlooking the unparalleled value of therapies that enable adherence and resistance prevention—avoiding significantly more costly chronically managed cases. Expanding the definition of unmet need to account for adherence and preventing resistance reflects the true clinical and economic value of HIV therapies, ensuring sustainable access for patients while reducing future costs associated with resistance-driven treatment failures.

b. Prevention

Greater prevention of HIV benefits Medicare. People with HIV represent a large patient population that is aging into Medicare, and prevention keeps this population from expanding. As of 2021, 40 percent of people with HIV and 10 percent of new HIV diagnoses were among people aged 55 or older in the United States.[17] The health care system saves an estimated $939,946 (2022 USD) for every case of HIV prevented.[18,19,20]

HIV ARVs reduce individual health care costs and prevent HIV transmission. When taken as prescribed, ARVs prevent disease progression, reduce health care utilization, and enable people with HIV to live full,

[15] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. September 12, 2024. https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/adult-adolescent-arv/guidelines-adult-adolescent-arv.pdf. Accessed June 20, 2025.
[16] Centers for Disease Control and Prevention. Guidelines and Recommendations. May 6, 2025. https://www.cdc.gov/hivnexus/hcp/guidelines/index.html. Accessed June 20, 2025.
[17] Centers for Disease Control and Prevention (CDC). HIV Surveillance Report, 2020; vol. 33. May 2022. Accessible at: https://stacks.cdc.gov/view/cdc/121127. Accessed June 20, 2025.
[18] Brogan AJ, Davis AE, Mellott CE, Fraysse J, Metzner AA, Oglesby AK. Cost-effectiveness of cabotegravir long-acting for HIV pre-exposure prophylaxis in the United States. Pharmacoeconomics. 2024 Apr;42(4):447-461. Accessible at: https://pubmed.ncbi.nlm.nih.gov/38267806/.
[19] Cohen JP, Beaubrun A, Ding Y, Wade RL, Hines DM. Estimation of the incremental cumulative cost of HIV compared with a nonHIV population. Pharmacoepia Open. 2020;4(4):687–96. Accessible at: https://pubmed.ncbi.nlm.nih.gov/32219732/.
[20] US Bureau of Labor Statistics. Consumer price index for Medical Care. 2022. https://data.bls.gov/cgi-bin/surveymost?cu. Accessed June 20, 2025.

healthy lives.[21,22] ARVs also benefit public health by reducing HIV in the blood to levels undetectable by lab tests which prevents transmission of HIV to others. This is commonly referred to as Treatment as Prevention (TasP),[23] or Undetectable = Untransmissible (U=U).[24]

In addition to TasP, ARVs are also a primary prevention tool when used as PrEP, which protects individuals without HIV from acquiring the virus. In 2023, the U.S. Preventive Services Task Force (USPSTF) assigned a Grade A Recommendation for PrEP as a highly effective preventive intervention.[25] PrEP has been shown to reduce the risk of acquiring HIV from sex by 99 percent and from injection drug use by 74 percent.[26] CMS has also recognized PrEP as an effective preventive service in a National Coverage Determination finalized in late September 2024.[27]

For these reasons, CMS should consider the preventive value of ARVs as both treatment and PrEP for direct and indirect healthcare costs averted when developing initial price offers.

III. For therapeutic alternative selection for HIV treatments, CMS should limit selection to antiretrovirals, account for dosing requirements, and account for last-line ARVs with no therapeutic alternatives.

ViiV recommends CMS restrict its therapeutic alternative selection for HIV products to ARVs. ViiV is concerned that the IPAY 2028 draft guidance would allow CMS to compare MFP-selected HIV treatments to therapeutic alternatives that are inappropriate for benchmark price comparisons when considering outcomes and value.

In the draft IPAY 2028 guidance, CMS states that it will continue to identify potential therapeutic alternatives by using "drug classification systems commonly used in the public and commercial sector for formulary development [and] CMS-recognized Part D compendia."[28] In many public and commercial compendia, HIV ARV treatments are categorized as antivirals alongside products for different indications that would be inappropriate comparisons for developing initial offers.

If CMS uses the US Pharmacopeia (USP) Medicare Model Guidelines (MMG), for example, within the MMG, HIV ARV treatments are categorized as antivirals alongside anti-hepatitis C agents, antiherpetic agents, antiviral coronavirus agents, and anti-influenza agents.[29] Comparing HIV treatments to these other product areas is inappropriate as there are clear differences in outcomes and value for patients.

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[21] HIV.gov. Viral Suppression and Undetectable Viral Load. February 1, 2023. https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/viral-suppression. Accessed June 20, 2025.

[22] Cohen CJ, Meyers J, Davis KL. Association between daily antiretroviral pill burden and treatment adherence, hospitalisation risk, and other healthcare utilisation and costs in a US medicaid population with HIV. BMJ Open. 2013 Aug 1;3(8):e003028. Accessible at https://pubmed.ncbi.nlm.nih.gov/23906955/.

[23] Centers for Disease Control and Prevention (CDC). HIV Treatment as Prevention. October 24, 2024. https://www.cdc.gov/hivpartners/php/hiv-treatment/?CDC_AAref_Val=https://www.cdc.gov/hiv/risk/art/index.html. Accessed June 20, 2025.

[24] National Institutes of Health (NIH). HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention. May 21, 2019. https://www.niaid.nih.gov/diseases-conditions/treatment-prevention. Accessed June 20, 2025

[25] HIV.gov. Pre-Exposure Prophylaxis. February 7, 2025. https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/viral-suppression. Accessed June 20, 2025.

[26] HIV.gov. Viral Suppression and Undetectable Viral Load. February 7, 2025. https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/viral-suppression. Accessed June 20, 2025.

[27] Centers for Medicare & Medicaid Services. National Coverage Determination: Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention. September 30, 2024. https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=310. Accessed June 20, 2025.

[28] Center for Medicare. Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028. May 12, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf. Accessed June 21, 2025.

[29] US Pharmacopeia. USP Medicare Model Guidelines v9.0. September 29, 2023. https://www.usp.org/health-quality-safety/usp-medicare-model-guidelines. Accessed June 21, 2025.

ViiV is especially concerned that in its proposed guidance, CMS will continue its policy of identifying therapeutic alternatives beyond a drug's class. When compared to IPAY 2026, the more expansive methodology finalized in the IPAY 2027 guidance and proposed again in the IPAY 2028 draft guidance suggests that CMS is downgrading reliance on clinical appropriateness by considering products outside of a drug's class.[30,31]

ViiV remains opposed to this proposed change and strongly recommends that CMS restrict HIV treatment therapeutic alternative selection to ARVs. Benchmarking the price of a selected MFP HIV treatment to non-ARV therapeutic alternatives within the broader antiviral class, or beyond, would be inappropriate when considering patient outcomes and value.

ViiV also recommends that CMS limit therapeutic alternative selections to products that have the same dosing requirements (e.g., once daily)—a key differentiator and often deciding factor in an HIV treatment regimen that will promote adherence. CMS should consider the ramifications of comparing products that are not fully equivalent—such as once daily oral ARVs and long-acting injectable ARVs—and how that practice could stifle innovation.

Finally, ViiV recommends that CMS use a patient-focused approach when identifying therapeutic alternatives and determining a product's comparative value. When people with HIV develop resistance to ARVs, they may be prescribed a non-first-line ARV treatment with no therapeutic alternative. This should be reflected in that product's comparative value.

IV. CMS should create a more privacy-focused, systematic and continuous patient engagement process or comment opportunity.

Privacy Focused

ViiV thanks CMS for hosting ongoing patient-focused listening sessions and its proposal to improve the design of the sessions, including through alternative formats. ViiV recommends that CMS provide an option to participate privately or create an alternate opportunity for comment that allows for privacy. If left unchanged, the public forum format used for IPAY 2026 and that is being used for IPAY 2027 could discourage people affected by HIV from participating due to concerns about disclosing their HIV status or their likelihood of acquiring HIV (for those who may benefit from PrEP). Despite advances that demonstrate Undetectable = Untransmissible (U=U),[32] HIV remains a highly stigmatized condition. Furthermore, populations disproportionately affected by HIV are also often stigmatized for their sexual orientation, race/ethnicity, drug use, and other factors.[33]

ViiV supports a change in the format of the listening sessions to promote more meaningful and insightful feedback from people affected by stigmatized conditions, such as HIV. ViiV recommends that CMS allow opportunities for public comment by patients via writing and an option to provide comment anonymously.

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[30] Center for Medicare. 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. https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf. Accessed June 21, 2025.

[31] Center for Medicare. Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2028 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026, 2027, and 2028. May 12, 2025. https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf. Accessed June 21, 2025.

[32] National Institutes of Health (NIH). HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention. May 21, 2019. https://www.niaid.nih.gov/diseases-conditions/treatment-prevention. Accessed June 20, 2025.

[33] Greenwood GL, Wilson A, Bansal GP, Barnhart C, Barr E, Berzon R, Boyce CA, Elwood W, Gamble-George J, Glenshaw M, Henry R, Iida H, Jenkins RA, Lee S, Malekzadeh A, Morris K, Perrin P, Rice E, Sufian M, Weatherspoon D, Whitaker M, Williams M, Zwerski S, Gaist P. HIV-Related Stigma Research as a Priority at the National Institutes of Health. AIDS Behav. 2022 Jan; 26(Suppl 1):5-26. Accessible at: https://pmc.ncbi.nlm.nih.gov/articles/PMC8060687/. Accessed June 26, 2025.

Systematic and Continuous Engagement

ViiV aligns with recommendations from the Partnership to Improve Patient Care (PIPC) encouraging CMS to deepen its patient engagement beyond written comment periods and ad hoc listening sessions toward a more systematic and continuous process.

ViiV encourages CMS to use and build upon the patient-engagement frameworks developed by the Patient Centered Outcomes and Research Institute (PCORI),[34] the PATIENTS Program at the University of Maryland,[35] the Innovation and Value Initiative and AcademyHealth,[36] and the Milken Institute.[37]
To make its patient engagement meaningful, CMS should incorporate patient input and data into the selection of therapeutic alternatives and the development of initial price offers—and to be transparent in how it develops pricing when setting MFP.

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ViiV Healthcare appreciates CMS's consideration of these comments. Please feel free to contact Carie Harter at (770) 710-9620 or carie.a.harter@ViiVhealthcare.com should you have any questions.

Sincerely,

Carie Harter
Head, Government Relations
ViiV Healthcare

[34] Patient-Centered Outcomes Research Institute. Engagement in Research: Foundational Expectations for Partnerships. February 2024. https://www.pcori.org/sites/default/files/PCORI-Engagement-in-Research-Foundational-Expectations-for-Partnerships.pdf. Accessed June 21, 2025.
[35] The PATIENTS Program at the University of Maryland School of Pharmacy. PATIENTS Professors Town Hall: Recommendations for the CMS Drug Price Negotiation Program Final Report. July 12, 2023. https://www.pharmacy.umaryland.edu/media/SOP/wwwpharmacyumarylandedu/programs/PATIENTS/pdf/Patient-driven-recommendations-for-the-Medicare-Drug-Price-Negotiation-Program.pdf. Accessed June 21, 2025.
[36] Innovation and Value Initiative and AcademyHealth. A Research Framework to Understand the Full Range of Economic Impacts on Patients and Caregivers. May 2023, https://thevalueinitiative.org/wp-content/uploads/2023/06/05-2023-Economic-Impacts-Framework-Report_FINAL.pdf. Accessed June 21, 2025.
[37] Awo Osei-Anto H, Puerini R. The Current Landscape of the Science of Patient Input. The Milken Institute. November 28, 2022. https://milkeninstitute.org/report/science-patient-input-current-landscape. Accessed June 21, 2025.

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June 26, 2025

Submitted electronically to IRARebateandNegotiation@cms.hhs.gov

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Drug Price Negotiation Program Draft Guidance

Dear Administrator Oz,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) draft guidance for the third cycle of the Medicare Drug Price Negotiation Program (MDPNP), the first cycle of renegotiation, and the Primary Manufacturer effectuation of the Maximum Fair Price (MFP) for 2026, 2027 and 2028 for the implementation of the Inflation Reduction Act (IRA) (hereinafter "draft guidance"). Consistent with prior comments, Vizient is concerned that various elements of the MDPNP, particularly the retrospective refund, will be disruptive to providers and the patients they serve.

Background

Vizient, Inc., the nation's largest provider-driven healthcare performance improvement company, serves more than 65% of the nation's acute care providers, including 97% of the nation's academic medical centers, and more than 35% of the non-acute market. The Vizient contract portfolio represents $140 billion in annual purchasing volume enabling the delivery of cost-effective, high-value care. With its acquisition of Kaufman Hall in 2024, Vizient expanded its advisory services to help providers achieve financial, strategic, clinical and operational excellence. Headquartered in Irving, Texas, Vizient has offices throughout the United States. Learn more at www.vizientinc.com.

Recommendations

Vizient is responding to elements of the Draft Guidance which would pose challenges to providers. We continue to urge CMS to better address provider concerns, particularly related to additional financial strain and administrative burdens associated with variable Primary Manufacturer effectuation plans (e.g., retrospective rebate models) and challenges with the complaint and dispute resolution processes. Vizient offers suggestions for the agency's consideration, including that the agency work closely with providers to better ensure the MDPNP does not cause harm and disrupt care.

Section 40 – Requirements for Manufacturers of Selected Drugs

40.4 Providing Access to the MFP in 2026, 2027, and 2028

In the Draft Guidance, CMS indicates that it is not yet including detailed policy on providing access to the MFP for selected drugs payable under Part B. However, CMS also notes that the agency aims to align the Part B policies and operations for providing access to the MFP with

those for Part D. Vizient appreciates that CMS identifies different topics related to Part B in the Draft Guidance for feedback (e.g., how effectuation of the MFP refund payments for drugs payable under Part B may differ from what is outlined for Part D) and agrees that additional information is needed before CMS provides detailed policy on access to the MFP under Part B. Vizient recommends that CMS, in developing Part D policies, simultaneously consider the feasibility of alignment with Part B by engaging directly with providers. Further, we encourage CMS to clarify the circumstances, particularly in the context of effectuating access to the MFP, in which it currently anticipates Part B policy and operations will differ from Part D.

Also, in the Draft Guidance, CMS seeks feedback regarding different functions of the Medicare Transaction Facilitator (MTF) and whether these functions can be replaced by private solutions. As CMS is aware, the MDPNP has yet to be implemented and IPAY 2028 will pose new challenges as more types of providers and products will be included in the program. While Vizient appreciates the agency's interest in gaining feedback, we are concerned that these decisions will be made prematurely and without provider input. As such, Vizient cautions CMS from narrowing the role of the MTF.

Vizient appreciates that CMS will provide effectuation plans to dispensing entities via the MTF and to other stakeholders upon request, as this will add significant transparency. We urge CMS to keep this flexibility as the Draft Guidance is finalized. Vizient also urges CMS to provide additional transparency by sharing information about access to the MFP. For example, reporting aggregated information stratified by product regarding the volume of MFP denials, reasons for denial, frequency with which the prompt pay requirements were not met and expenses associated with denials would help add to this transparency. Vizient also encourages CMS to work with providers to define and identify other data elements related to the complaint and dispute process.

40.4.1 Retrospective Refund Amount to Effectuate the MFP and the Standardized Default Refund Amount

In the Draft Guidance, CMS indicates that regardless of whether the MFP is passed through the MTF Payment Module (PM) or payment is made outside of the PM, neither Primary Manufacturers nor their third-party vendors shall charge dispensing entities any transaction or other fees for the pass-through of the MFP refund to the dispensing entity. As CMS is aware, providers are already under significant financial strain and imposing greater upfront costs on providers while they wait for refunds exacerbates these strains. Although Vizient appreciates the agency's clarification to prevent additional fees, Vizient continues to urge CMS to ensure prospective access to the MFP to support providers, rather than a retrospective refund. Alternatively, if retrospective refunds are permitted, CMS should strengthen prompt payment requirements so that the MFP is effectuated as soon as possible by the Primary Manufacturer, including when the Primary Manufacturer or their third-party vendor lacks certainty about the appropriateness of MFP pricing.

Regarding the potential pass-through of fees, Vizient believes additional clarifications and protections would be helpful for providers. For example, CMS could provide information about how it intends to monitor whether additional fees are passed through to providers or how CMS plans to identify such fees. CMS could also make clear that Primary Manufacturers cannot limit access to medications by requiring providers to contract with third parties, particularly those who charge fees to providers or require additional information from providers. Vizient encourages CMS to regularly collaborate with providers to respond to these and other questions, as they emerge.

In addition, CMS may not be aware that providers can face other types of burdens should payment be provided outside of the PM, even if additional fees are prohibited. For example, third-party solutions that are not interoperable with existing systems or require use of new portals shift burden onto providers and should be avoided. Vizient encourages CMS to ensure that Primary Manufacturers and their third-party vendors do not create additional burden or fragmentation from the provider perspective.

Lastly, the Draft Guidance does not detail providers' recourse opportunities or the scope of the agency's oversight in the context of Primary Manufacturers' third-party vendors. Should Primary Manufacturers' arrangements with third parties be the source of disruption for providers (e.g., withholding of the MFP, inaccurate payments), CMS should provide policy to ensure such issues are promptly resolved and that dispensers are not burdened in having to communicate with multiple vendors or through different platforms, which adds burden. Should recurring issues emerge with certain vendors or practices, Vizient suggests CMS consider how these issues can be most promptly resolved and prevented, including by adding transparency regarding problematic practices.

40.4.2 Medicare Transaction Facilitator Data Facilitation

CMS requests comments on what role, if any, the MTF and/or Primary Manufacturers could play in notifying dispensing entities of claims that are not resolved within the timeframes noted in the Draft Guidance. Vizient believes it is critical that dispensing entities are immediately notified if a claim is not resolved and should receive clear status updates regarding claim resolution. Such communications should be clear and opportunities for standardization should be explored. In addition, to add transparency, providers should have easy access to the documentation and other resources Primary Manufacturers use when determining a claim's eligibility for a refund.

40.4.5 Nonduplication with 340B Ceiling Price

In the Draft Guidance, CMS indicates that a Primary Manufacturer may not provide access to the MFP if the claim is 340B-eligible and the MFP is greater than the 340B ceiling price. Also, CMS clarifies in the Draft Guidance that the Primary Manufacturer would be required to provide documentation demonstrating the claim was 340B-eligible and the 340B ceiling price was lower than the MFP request from CMS. Based on this information, providers may not have access to the documentation the Primary Manufacturer provides to CMS, but such documentation may be useful to providers should potential complaints or disputes emerge. Vizient suggests CMS require Primary Manufacturers to share this information with providers.

In addition, Vizient believes the Draft Guidance provides excessive latitude for Primary Manufacturers with respect to ensuring there is nonduplication with the 340B ceiling price, while also allowing Primary Manufacturers to defer refunds based on these concerns. Should retrospective refunds be permitted in the 340B program and the MDPNP, Vizient is concerned that providers will be in a position where a Primary Manufacturer does not provide either the 340B price or MFP. In these circumstances, provider access to appropriate pricing could hinge on burdensome complaint and dispute resolution processes and refund payments to providers would be excessively delayed, if paid at all. Vizient urges CMS to provide additional oversight of Primary Manufacturer decisions and financial support to providers as complaints and disputes are being resolved. Further, Vizient recommends modifying the Draft Guidance such that the Primary Manufacturer would be required to provide documentation demonstrating the claim was identified as 340B-eligible and the 340B ceiling price was lower than the MFP. In addition, as noted in more detail below regarding the complaint and dispute resolution processes, to prevent excessive financial harm to providers (i.e., non-payment or excessive delays of refunds), we recommend that the MFP refunds be given to the provider promptly, unless the Primary

Manufacturer is certain payment is improper (e.g., Primary Manufacturer is certain the 340B ceiling price was provided). Finally, we recommend CMS provide clear guidance for the MFP/340B complaint and dispute processes that can be handled at the claim level.

80. MFP-Eligible Individuals in 2026, 2027, and 2028

In the Draft Guidance, CMS indicates that beginning in 2028 for drugs selected or renegotiated for initial price applicability in year 2028, MFP-eligible individuals will include those enrolled under Part B, including those enrolled in a Medicare Advantage (MA) plan under Part C. While Vizient appreciates that CMS seeks feedback regarding the implications of including MA beneficiaries in the MDPNP, Vizient is concerned that broadening the scope of MFP-eligible individuals could add significant, unnecessary complications during a period where providers will also have to adjust to the MDPNP. Additionally, should MA plans align reimbursement rates with those provided under the MDPNP, Vizient believes it is imperative that providers have access to the MFP to avoid being significantly under-reimbursed.

Vizient is also concerned that other payers may aim to align reimbursement rates to providers with those provided under MDPNP, but provider access to the MFP will not be required in these circumstances. Should this occur, providers may incur significant financial losses due to inadequate reimbursement and related operational issues. While beyond the scope of the MDPNP, Vizient recommends CMS more broadly provide policy to prevent other types of payers from reducing provider reimbursement to align with rates resulting from the MDPNP, since providers will likely not have access to MFP for those products outside of the MDPNP and the related infrastructure (e.g., CMS oversight, MTF PM and DM) to support the program.

Lastly, Vizient reiterates our concerns that Primary Manufacturers may excessively withhold payments by improperly identifying non-MFP-eligible individuals. As a result, providers could face excessive delays for refunds, assuming they are able to utilize the complaint and dispute resolution processes. Vizient recommends that access to the MFP, including refunds, be given promptly to providers, unless the Primary Manufacturer is certain an individual is not MFP-eligible.

90.2.2. Centralized Intake System for Complaints and Disputes Related to MFP Availability and MTF Functionality

In the Draft Guidance, CMS details the complaint and dispute process, which will have two "tracks". The first track is a dispute functionality within the MTF regarding a technical aspect of the MTF process[1] and the second track is a complaint process that will include any issues that do not qualify as disputes (e.g., MFP not being made available; concerns regarding credit/debit ledger system). As CMS is aware, hospitals have limited resources and face challenges in devoting resources to raising and resolving complaints and disputes, especially given the resources spent on learning and implementing variable effectuation plans, and monitoring refund payments. Providers will likely be in an untenable position of having to decide whether to devote even more resources to dispute and complaint processes with uncertain outcomes. To prevent harm to providers, Vizient urges CMS to ensure that the MFP is prospectively provided to reduce burden and simplify the MDPNP. Again, should retrospective payment be permitted, refunds should be provided unless the Primary Manufacturer is certain that doing so is

[1] As provided in the Draft Guidance, "Under the Negotiation Program, CMS considers a dispute to be a specific, identifiable challenge to a technical aspect of the MTF system and process (e.g., claims included as potentially requiring an MFP refund)."

inappropriate and shares information demonstrating their position, as this heightened level of certainty may also limit the frequency of track 2 complaints. Vizient also recommends CMS provide additional technical assistance to providers throughout the complaint and dispute processes.

Lastly, Vizient strongly encourages CMS to share information regarding the complaint and dispute processes to add transparency. For example, information regarding complaint and dispute volumes, types of disputes, dispute duration and dispute outcomes (e.g., was the dispute rectified in favor of the provider) on an aggregated basis stratified by product will help increase transparency and inform future policies. Vizient encourages CMS to work with providers to define and identify other data elements to share related to the complaint and dispute processes.

Conclusion

Vizient appreciates CMS's efforts to gain additional feedback regarding the MDPNP. Vizient provides solutions and services that improve the delivery of high-value care for more than 65% of the nation's healthcare providers. In closing, on behalf of Vizient, I would like to thank CMS for providing the opportunity to respond to this Draft Guidance. Please feel free to contact me, or Jenna Stern at Jenna.Stern@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these recommendations.

Respectfully submitted,

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