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CMS Deputy Administrator and Director of the Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

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

Dear Dr. Seshamani,

The Alliance for Aging Research ("Alliance") appreciates the opportunity to review and comment on the initial guidance regarding the implementation of the Medicare Drug Price Negotiation Program. 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 actively supported several provisions in the Inflation Reduction Act of 2022—expansion of the low-income subsidy program; reducing beneficiary costs for vaccination; an inflationary cap; and most notably, the Medicare Part D provisions restructuring the benefit and adding a much-needed annual cap on out-of-pocket costs. However, since 2019, the Alliance has consistently urged federal policymakers to reject reliance on cost-effectiveness methodologies that discriminate against older adults and persons with a disability – the very populations that Medicare serves. As CMS implements the price negotiation provisions of the IRA, it is vital that the agency avoid

the use of such methodologies and instead focus on use of patient-centered value assessment techniques.

Our concerns regarding implementation without due consideration of potential beneficiary impacts—including significantly decreased access to necessary drugs, therapeutics, and other forms of care—remain, and we have outlined them in our comments below. We thank CMS for the opportunity to provide feedback and suggestions to ensure that any potential negative impacts of the Medicare Drug Price Negotiation Program ("Negotiation Program") on patient access to care are avoided or mitigated.

§50.2 and §60.3.3: Indirect Use of the Quality-Adjusted Life Year and Other Similar Metrics

The older adult and disability communities have communicated at length about the discriminatory impacts of the quality-adjusted life year (QALY) on patient access to care. While the Alliance supported the QALY-related language in the Inflation Reduction Act of 2022, it did not go far enough. The language states, "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, non- disabled, or not terminally ill". Further, this language did not communicate the full extent to which the law forbids CMS from using QALYs in the negotiation process. Previously-established statutory language from the Affordable Care Act (ACA) states:

> "The Patient-Centered Outcomes Research Institute established under section 1181(b)(1) shall not develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability) as a threshold to establish what type of health care is cost effective or recommended. **The Secretary shall not utilize such an adjusted life year**

> **(or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII.**"[1]

The National Council on Disability (NCD), an independent federal agency, has noted that use of the QALY and similar measures would undermine major disability and civil rights laws, including the Americans with Disabilities Act.[2] Additionally, there are similar metrics that operate similarly to the QALY that CMS should avoid using in the Negotiation Program to ensure that the metrics used to assess value support the provision of equitable, fair, and nondiscriminatory healthcare in the Medicare program.

In the draft guidance, the Medicare program has stated that reports that use QALYs will likely be a tool and reference point for price-setting, indicating that complimentary metrics like the estimated value of life years gained (evLYG) and conclusions drawn from incomplete data and discriminatory assumptions are still on the table for consideration. However, when the output of these methodologies is used, it has detrimental impacts on patient access, patient-centered care, and shared decision-making. In the initial guidance, CMS proposed the following:

> "Information submitted … that treats extending the life of individuals in these populations as of lower value, for example certain uses of quality-adjusted life-years (QALYs), will not be used in the negotiation process. In instances where a study uses QALYs in a life-extension context but has clearly separated this use of QALYs from other evidence in the report (e.g., clinical effectiveness, risks, harms, etc.) that is relevant to the factors listed in section 1194(e)(2) of the Act, CMS intends to consider such separate evidence. CMS will ask entities submitting

[1] Social Security Administration. "Limitations on Certain Uses of Comparative Clinical Effectiveness Research." https://www.ssa.gov/OP_Home/ssact/title11/1182.htm
[2] National Council on Disability. "Quality-Adjusted Life Years and the Devaluation of Life with Disability: Part of the Bioethics and Disability Series." 6 Nov 2019. https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf

> information to indicate whether or not their submission contains information from studies that use QALYs in a life-extension context.

We have deep concerns that CMS has expressed interest in utilizing QALYs as long as they are not used in a "life extension context." Though the IRA language speaks to life extension only, this does not abrogate the clear prohibition on the use of QALY and similar metrics in Medicare's coverage and reimbursement decisions codified in the ACA. It is troubling that the draft guidance proposes an intent to include direct or indirect application of discriminatory cost-effectiveness standards, including contracting with these third-party organizations such as the Institute for Clinical and Economic Review (ICER) that have adopted and endorsed the use of these metrics. **Clearly stated, CMS should not utilize information that includes reference to the QALY, even if its use is not specific to life extension.**

In light of the ban on QALYs, ICER and the organization's allies[3] are advocating that Medicare use the equal value life years gained metric (evLYG) in the Negotiation Process, characterizing the evLYG as an alternative to the QALY. However, these perspectives fail to acknowledge the major pitfalls of the evLYG. The evLYG was never intended to be used as a standalone metric, it was developed to serve in partnership with the QALY and to be compared when the outcomes of the evLYG analysis differed starkly from the QALY. Because of this, the evLYG maintains the same discriminatory lineage as the QALY. The only difference between the evLYG and the QALY is that the evLYG uses a static health state preference value of .85 as opposed to using values that vary by condition. The calculation is done in the same way for both—by multiplying the amount of time patients are likely to spend in their disease state.[4] As a result, the evLYG

[3] Frank, Richard G; and Nichols, Len M. "Threats to Medicare's new drug negotiation power." USC-Brookings Shaeffer Initiative for Health Policy Blog. 15 Mar 2023. https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2023/03/15/threats-to-medicares-new-drug-negotiation-power/
[4] O'Day, Ken and Mezzio, Dylan. "Demystifying ICER's Equal Value Life Year's Gained Metric." Value & Outcomes Spotlight. Feb 2021. 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

maintains its discriminatory effects. The underlying assumption in both metrics is that older adults have fewer life years to gain than younger individuals from the use of therapeutics. As a result, any condition that disproportionately impacts the aging population will be evaluated as being of lower value than therapeutics whose evLYG is calculated based on a relatively younger population.

Further, the evLYG does not accurately take into account the heterogeneity of patient groups, leaving "quality of life" out of the equation entirely. This choice is marketed as the solution to the improper calculation of quality found in the QALY framework, but leaving this process out entirely does not solve the issue. By not considering the value of quality of life at all, the evLYG measure has no sensitivity given to the alleviation of side effects, symptomatic treatment, or a treatment's method of distribution. All of these factors play a role in a therapeutic's value to patients.

Neither the NCD nor the Disability Rights Education and Defense Fund (DREDF) endorses the evLYG, with the DREDF saying, "Neither [the evLYG or the QALY] accounts for both the full value of life-extension and the value of quality of life improvement." The NCD notes that under the evLYG system, "denial of coverage is still possible, even where a drug would provide significant clinical benefit including life extension."[5] Further, methods for the underlying data collection and analysis of the evLYG are incomplete and immature. At present, groups like ICER 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 evLYG is not representative of a drug's entire intended

[5] National Council on Disability. "Quality-Adjusted Life Years and the Devaluation of Life with Disability: Part of the Bioethics and Disability Series." 6 Nov 2019.
https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf

user base.[6] Further, the evLYG fails to assess treatments that improve quality of life as cost-effective.

Therapeutics evaluated based only on – or for which a price is benchmarked based upon - criteria consistent with traditional cost-effectiveness analysis (CEA) suffer because they can be unfairly and poorly subjected to utilization management practices, lower formulary placement or being left off a formulary all together, resulting in higher co-payments for patients or denial of coverage. Considerations that may be left out by traditional CEA include, "a new therapy's ability to treat a previously inadequately treated illness; its ability to broaden therapeutic options for diseases with great variability in treatment response; the possibility of cure and the importance of hope related to it; the ease of a regimen when alternative therapies are complex, cumbersome, and time consuming; or, its novel mechanism of action that could lead to markedly improved derivative treatments."[7] **We ask that the Medicare program meaningfully consider the heterogeneity of treatment effects, sensitivity assessments, and not rely on reports that tout evidence from traditional CEA models like the QALY or evLYG. It is unacceptable to rely on these models when there are suitable alternatives that do not reference discriminatory methodologies.**

Price Matching with the Department of Veterans Affairs

The Alliance is also concerned that CMS may utilize the prices paid by the Department of Veterans Affairs (VA) to help establish the negotiated price for drugs in Medicare. In 2017, the VA entered into a cooperative agreement with ICER as a component of the formulary development process and to assist in setting benchmarks for price

[6] Institute for Clinical and Economic Review. "2020-2023 Value Assessment Framework." 31 Jan 2020. https://icer.org/wp-content/uploads/2020/11/ICER_2020_2023_VAF_02032022.pdf
[7] Dubois, Robert W. CVS To Restrict Patient Access Using Cost-Effectiveness: Too Much, Too Soon. Health Affairs. 17 Sept 2018. https://www.healthaffairs.org/do/10.1377/forefront.20180913.889578/full/

negotiation.[8] Therefore, referencing the VA's negotiated prices would inappropriately incorporate and adopt the use of the QALY, which would be antithetical to the language in the ACA that prohibits QALY use for the Medicare program. Further, a 2020 report from the Government Accountability Office noted that the two programs have "very different authorities to bargain and negotiate with drug manufacturers and other market participants."[9] As a result of these differences, the VA formulary is significantly narrower than that of Medicare Part D. This narrower formulary is not preferred by Medicare beneficiaries – in fact, a 2021 Morning Consult survey commissioned by the Alliance indicated that only one in five older adults would be willing to trade their current prescription drug coverage for a system resembling the VA's formulary.[10]

Alternative Methodologies for Consideration

There are many other methodologies and perspectives that are useful in determining a maximum fair price (MFP). Several groups are working to define value assessment in ways that do not discriminate and are working to actively identify and quantify endpoints that are meaningful to patients. The Patient Centered Outcomes Research Institute (PCORI) was established through the Affordable Care Act and focuses on comparative clinical effectiveness research. PCORI's approach to value assessment calls for consideration of economic impacts as a part of the larger whole of outcomes that matter to patients and caregivers.[11] Other groups are also working to develop consensus-based principles on the most effective methods for value assessment, including specific efforts to address health equity. The Innovation and Value Initiative (IVI) has identified four areas where value assessment has failed to address equity, including lack of

[8] Institute for Clinical and Economic Review. ICER's Collaboration with the Department of Veterans Affairs. https://icer.org/who-we-are/history-impact/impact-case-study-2/
[9] Government Accountability Office. "Prescription Drugs: Department of Veterans Affairs Paid About Half as Much as Medicare Part D for Selected Drugs in 2017." Dec 2020. https://www.gao.gov/assets/gao-21-111.pdf
[10] Alliance for Aging Research. New Poll Highlights Seniors' Priorities and Concerns in Prescription Drug Pricing Legislation, Misalignment with Congress on Definition of Negotiation. 22 Sept 2021. https://www.agingresearch.org/news/new-poll-highlights-seniors-priorities-and-concerns-in-prescription-drug-pricing-legislation-misalignment-with-congress-on-definition-of-negotiation/
[11] Patient Centered Outcomes Research Institute. "About PCORI." https://www.pcori.org/about/about-pcori

incorporation in study objectives, non-representative patient participation, an absence of analysis of impacts across segments or subpopulations, and missing data on patient preferences from communities of color.[12] To address these identified issues, the IVI is now working to develop best practice protocols to inform value assessors and help mitigate these gaps.

The Medicare program *is not required* to use CEA to set a maximum fair price. There are many alternatives; this includes cost-benefit analysis, in which the dollar value of the health outcomes of a treatment are subtracted from the cost of a treatment, which the NCD notes could be a potential alternative to QALY based CEA.[13] It is imperative that the Medicare program be discerning and ensure that discriminatory methodologies are not being used at any point during the price setting process, that decisions are only made where there is robust clinical evidence, and that patient voices are included in the process. Before an MFP is finalized, calculations must be done to ensure that patient access to care is prioritized and maintained. **Overall, if the new MFP lessens patient access based on methodologies placing a lower value on conditions affecting older adults or individuals with a disability, it is not a fair price at all.**

§60: Involving patients more substantially in the process

In its press release on its recent guidance on the Medicare Drug Price Negotiation Program for Price Applicability Year 2026, CMS publicly committed[14] "to collaborating and engaging with the public" on Medicare negotiation, including involving "patients

[12] Innovation and Value Initiative. "Health Equity Initiative: How Patient Engagement and Innovation of Methods Can Move Us Closer to Achieving Health Equity." 10 Aug 2022. Health-Equity-Initiative-Overview.pdf (thevalueinitiative.org)
[13] National Council on Disability. "Quality-Adjusted Life Years and the Devaluation of Life with Disability: Part of the Bioethics and Disability Series." 6 Nov 2019. https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf
[14] Centers for Medicare and Medicaid Services. HHS Releases Initial Guidance for Historic Medicare Drug Price Negotiation Program for Price Applicability Year 2026. 15 Mar 2023. https://www.cms.gov/newsroom/press-releases/hhs-releases-initial-guidance-historic-medicare-drug-price-negotiation-program-price-applicability

and consumers." Additionally, throughout Section 60 of this guidance, CMS mentions several times that it will consider the "patient experience" in the Negotiation Program's implementation.

We commend CMS for having an open-door policy to patient groups throughout this process and have appreciated the opportunity to share the Alliance's perspective as CMS navigates implementation of the IRA. We hope that the role for the patient voice and perspective will become more formalized as this process continues in order to allow a broad representation of patient groups the opportunity to meaningfully engage. Any decisions made must keep the patient in mind. In order to do so, the patient voice must be heard, understood, and acted upon.

CMS should develop a patient engagement infrastructure that creates an ongoing dialogue about IRA implementation and systemic issues with those most affected by them. This should include:

- Creating a patient ombudsman charged with oversight of implementation;
- Convening public roundtables of disease or treatment-specific experts from the patient and disability communities for each drug selected for MFP negotiation;
- An Administrator-level Patient Advisory Committee for overall feedback on this program and other work of the Agency;
- Publicly posting all comments; and
- Seeking input from diverse communities in order to gain insights and information on the priorities and needs of those subpopulations.

Further, we ask that CMS announce a plan to ensure that the impacts of negotiation on patients will be studied following implementation and that comments will be solicited from stakeholders, including the patient community, on this topic. This study should include quantitative metrics to assess patient access to care before and after negotiation, and look to meaningfully engage the patient community in the process of developing

solutions to any beneficiary experience problems that may occur. This study should include quantitative metrics to assess patient access to care before and after negotiation and look to meaningfully engage the patient community in the process of developing solutions to any beneficiary experience problems that may occur.

§60.3.3: Definition of unmet medical needs

In the initial guidance, meeting "unmet clinical need" is defined as "treating a disease or condition in cases where very limited or no other treatment options exist." This definition is not nearly as expansive as the FDA's definition for unmet clinical need. FDA defines unmet need as a "condition whose treatment or diagnosis is not addressed adequately by available therapy." FDA notes that a new treatment generally would be considered to address an unmet medical need if it, for example, "has an improved effect on a serious outcome(s) of the condition compared with available therapy," "has an effect on a serious outcome of the condition in patients who are unable to tolerate or failed to respond to available therapy," or "provides safety and efficacy comparable to those of available therapy but has a documented benefit, such as improved compliance, that is expected to lead to an improvement in serious outcomes."[15]

Under the Negotiation Program, CMS is required to consider "the extent to which the selected drug and therapeutic alternatives to the drug address unmet clinical needs". The CMS definition of unmet need is far too narrow to adequately consider conditions that require complex treatments and for which there are different possibilities for positive clinical outcomes. A more robust definition will ensure that CMS is not undervaluing the patient perspective. There are many reasons patients may believe that the needs of their community are not met by current treatments and therapeutics. This can include but is not limited to treatments having major side effects, not being totally

[15] U.S. Food and Drug Administration. Guidance for Industry Expedited Programs for Serious Conditions – Drugs and Biologics. June 2014. https://www.fda.gov/files/drugs/published/Expedited-Programs-for-Serious-Conditions-Drugs-and-Biologics.pdf

effective, or adversely interacting with other medications/comorbidities for the patient. To protect patients, this definition must be expanded to align more closely with the needs of the Medicare population. Unmet need cannot mean only that no other treatment options exist. Instead, it must look at the nuanced factors that go into managing, treating, and curing a given condition. **CMS should expand their definition of unmet clinical needs to align with that of the FDA.**

§110: Utilization management and Requirements for Coverage

As noted in the initial guidance, drugs selected for negotiation must be included on Medicare plan formularies. However, the guidance did not provide information regarding the potential use of utilization management (UM) tools, even if selected drugs are required to be included on formularies.

The Negotiation Process will allow the Medicare program to negotiate and accrue per unit savings on the eligible drugs and biologics that accrue the highest annual expenditures. UM tools are most commonly applied to direct beneficiaries through tiered formulary placement or step therapy. However, Medicare's establishment of the MFP by definition indicates that the program is paying a "fair price" for the therapeutic benefit derived from a drug or biologic. In isolation, the utilization-based need for UM techniques should be severely lessened.

At the same time, the IRA included a broader redesign of the Part D program which increases plan liability for drug costs once a beneficiary has reached the annual out-of-pocket limit ($2,000 in 2025, indexed to growth in Part D expenditures in subsequent years). This change in liability is likely to broadly incentivize increased use of UM tools. This would be problematic, as UM efforts like prior authorization, step therapy, and cost sharing lead to increased patient and administrative burden, worse long-term outcomes, stress, costly out-of-pocket expenses, and an inability for a patient to work with their care provider to determine the best course of treatment. This would be problematic, as

UM efforts like step therapy and cost sharing through placement on non-preferred formulary tiers leads to increased patient and administrative burden, worse long-term outcomes, costly out-of-pocket expenses, and an inability for a patient to work with their care provider to determine the best course of treatment.

The Alliance encourages CMS to provide guidance directing MA-PD and PDP plans to limit or avoid use of UM for drugs selected for negotiation. It is currently unclear if and how negotiation may impact patient access. However, incentives to increase use of UM may confound the access impacts of negotiation with impacts of Part D redesign. By prohibiting plans from using step therapy or placing drugs selected for negotiation on non-preferred or specialty formulary tiers, CMS can better observe changes in access as a result of these policies. Further, beneficiaries should be able to broadly access drugs for which the cost as established through the MFN is reflective of therapeutic benefit.

Contact Information

The Alliance thanks CMS for the opportunity to comment on this issue. If you have any questions or would like to follow up on the items discussed in our comments, please contact Adina Lasser, Public Policy Manager, at alasser@agingresearch.org. We look forward to continuing our work with you on this issue.

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