CLL SOCIETY

VIA ELECTRONIC DELIVERY

June 20, 2023

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

RE: CMS-10849
Information Collection Request (ICR) for the Drug Price Negotiation Process under Sections 11001 and 11002 of the Inflation Reduction Act

Dear Administrator Brooks-LaSure:

CLL Society appreciates the opportunity to submit its comments on the Centers for Medicare & Medicaid Services' (CMS') Information Collection Request for the counteroffer process under the Drug Price Negotiation Program (DPNP) provisions of the Inflation Reduction Act of 2022 (IRA).

CLL Society is dedicated to addressing the unmet needs of the chronic lymphocytic leukemia and small lymphocytic lymphoma (CLL/SLL) community through patient education, advocacy, support, and research. We are the largest nonprofit focused exclusively on the unmet needs of patients living with CLL and SLL.

Our patients live with a chronic, rare cancer of the immune system. We strive to fulfill our primary mission of ensuring that patients have access to safe and effective treatment options, which includes informing patients and caregivers about the therapeutic landscape. We also stress the importance of clinical trials to those in our community, build and support patient networks, engage in research, and educate patients and their caregivers.

CLL Society recognizes that the IRA's Medicare Drug Price Negotiation Program (DPNP) has the potential to significantly impact the reimbursement landscape, and consequently, the incentive framework driving (or in many cases deterring) innovation and investment for the foreseeable future. As we have noted in our comments to both CMS' Initial Guidance and its data elements ICR, we remain deeply concerned that any financial relief patients might experience from the DPNP will be far outweighed by its potential to exert a detrimental force on equitable access to existing treatments, and research and development toward new therapeutic options.

This ICR, unfortunately, compounds our concerns with the Initial Guidance and Data Elements ICR in that CMS has failed to acknowledge, much less incorporate, stakeholder comments that might

make the DPNP structurally viable while avoiding unintended consequences for patients living with CLL/SLL and other rare cancers. Our comments below provide a brief background on CLL/SLL and outline our overarching concerns with the framework that is articulated within CMS' Initial Guidance and carried over to the counteroffer process outlined in the ICR. We once again urge CMS to return to the collaborative approach that has historically resulted in well-reasoned processes that minimize unintended harm to beneficiaries.

Background

CLL/SLL is a chronic blood cancer of the white blood cells known as B-lymphocytes where there is a progressive accumulation of too many mature B-lymphocytes. CLL is the most common type of adult leukemia in the United States, with around 21,000 cases diagnosed annually. It is classified as both a type of leukemia and a type of non-Hodgkin's Lymphoma (NHL). SLL is simply a different manifestation of the same disease and is best understood as a stage of CLL where there are not yet a significant number of cancer cells located in the bloodstream. We, therefore, refer to the disease state collectively as CLL.

CLL is extremely heterogeneous, meaning each person's disease course and progression can vary considerably. Some patients have an aggressive form of the disease, experience rapid deterioration, and survive for as little as two years. Others have a less aggressive form of the disease, may never need treatment, and can expect to have a normal life expectancy.

Targeted therapies such as BTK inhibitors and the BCL2 inhibitor known as venetoclax offer substantial efficacy against CLL and have transformed care for our patient community. Patients now have more treatment options compared to just years ago when the standard of care was chemoimmunotherapy. They can take continuous daily oral therapy with a BTK inhibitor (with or without the addition of a monoclonal antibody) until their disease progresses. Alternatively, patients can choose a short-term time-limited treatment approach that combines venetoclax and a monoclonal antibody. The latter approach allows for drug discontinuation until active monitoring reveals that another treatment is needed.

Although most CLL patients can expect a response to initial therapy, nearly all current treatment options are palliative and not curative. Most patients will experience one or more relapses during the course of their disease, and many are forced to either change treatments, take a "drug holiday," or adjust dosing due to drug intolerance. For patients with relapsed or refractory disease (or drug intolerance), treatment decisions are highly individualized based on prior therapies, prior response, the reason for discontinuation of previous therapy, comorbidities, biomarker characteristics, patient preference, and therapeutic goals. Patients can experience serial relapses, and many will be treated with all available agents at some point during the course of their disease.

The experience with PI3K inhibitors in CLL illustrates the inherent difficulties associated with studying this disease and the heightened risk manufacturers must consider when pursuing new therapeutic candidates. Delays associated with the wait for overall survival data have already dampened research efforts and slowed patient access to potentially life-saving therapies. In addition, while we advocate for crossover in clinical trials to save lives, the strategy inherently compromises the "purity" of survival data. Therefore, CLL is not an ideal disease state from a research perspective. Historically, new treatments have been first approved for other cancers and then later approved for CLL.

DPNP implementation remains a high priority for CLL patients given the impact that it is already having on drug manufacturer and investor research and development decisions. CLL Society has received anecdotal reports of manufacturers retreating from pipeline projects, including those expanding FDA labels for existing treatments. In addition, a survey conducted on behalf of a trade association for the pharmaceutical industry confirmed that these reports may be indicative of a disturbing trend among drug manufacturers. A staggering three-quarters of manufacturer respondents indicated that they are reconsidering research strategies, and 78% said they will likely cancel early-stage pipeline projects due to uncertainties in DPNP implementation. Of particular importance to those with CLL, 95% of survey respondents stated that they expect to develop fewer follow-on indications for existing treatments (See https://catalyst.phrma.org/wtas-inflation-reduction-act-already-impacting-rd-decisions).

CLL Society continues to believe that CMS, with feedback from patients, providers, and industry stakeholders, has a pathway to implement the DPNP without disrupting incentives for innovation in CLL and other small population diseases. Each piece of the DPNP implementation that CMS has released, however, signals that the Agency either does not fully understand the impact of its policies or that it has determined to stay the course with those policies despite the impact. We have attached our written comments to CMS' Initial Guidance and its ICR on DPNP data elements and ask that CMS consider our concerns and recommendations as it moves toward selection of the first set of drugs that will be subject to price negotiation. Our comments on the counteroffer ICR are offered within the context of an overall framework that has yet to be fully outlined and vetted.

CMS' lack of transparency on the full negotiation process, including the initial offer and negotiation program agreement, hinders stakeholder efforts to submit meaningful feedback on the counteroffer ICR.

When CMS initiated its efforts toward implementing the DPNP, it provided stakeholders with assurances that it would solicit, consider, and incorporate stakeholder feedback into the DPNP processes. Although CMS has provided opportunities for stakeholder comment within the context of information collection activities, both the underlying paradigm of defining negotiation-eligible drugs by moiety or active ingredient (rather than New Drug Application [NDA] or Biologics License Application [BLA]) and the Primary/Secondary Manufacturer construct were devised without

affording patient communities an opportunity to comment. In addition, CMS has not followed up on identifying potential approaches to protect incentives for orphan drug research and development. CLL Society remains concerned that the opportunity to comment on the counteroffer ICR will have little real-world impact toward creating a viable DPNP that functions as Congress intended, unless CMS reconsiders the portions of the Initial Guidance released as "final."

With respect to the counteroffer ICR, we also note that:

- The breadth and extent of information CMS intends to present to both the public and the manufacturers with respect to the initial offer and its justification are crucial to determining whether the ICR is sufficient and less burdensome than alternative approaches.
    - CMS should provide stakeholders with an opportunity to comment on both the public and CMS-to-manufacturer information it expects to include in the initial offer and its justification.
    - CMS has not articulated how it will weigh feedback from the patient community on alternative treatment options and any added value associated with a particular drug.

- The ICR does not appear to contemplate a manufacturer response to feedback from other stakeholders. The following questions remain:
    - Will manufacturers be able to review the information submitted by patients and providers?
    - Will CMS provide an explanation on whether and how that information was incorporated into the initial offer?
    - How can manufacturers incorporate relevant information from the patient and provider communities into their counteroffer justification?

- The 1500-word limit on manufacturer submissions may be overly restrictive. We suggest that CMS work with manufacturers during the first year of DPNP implementation, and if necessary, later identify a limit that enables the submission of relevant information without overburdening CMS staff.

We would also ask that CMS provide greater transparency on the overall negotiation process so that stakeholders can contribute meaningful feedback on the counteroffer process and the sufficiency of CMS' ICR.

CLL Society is concerned that CMS has not resolved conflicts between its perspective on Primary Manufacturers and the real-world contractual arrangements that may constrain entities from submitting information and/or committing to a maximum fair price (MFP).

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CLL Society has previously asked that CMS reconsider its determination to identify a qualifying single source drug based on common active moiety (drugs) or common active ingredient (biologics) (see attached). We reiterate our request that CMS treat products as the same qualifying single-source drug only when they share an NDA or BLA. This interpretation is within the plain language of the statute. Adhering to the plain language of the statute would not only reduce the burden to manufacturers seeking to comply with CMS' DPNP requirements, but it would also increase the nexus between the information collected and the true treatment value, including unmet needs addressed, and available alternative therapies.

We similarly reiterate our concern that CMS' implementation of a Primary/Secondary Manufacturer construct creates substantial sets of burdens that are not required under the statute. CMS' ICR asserts that the statute requires Primary Manufacturers **and only** Primary Manufacturers must submit all information related to the negotiation process, and agree to, reject, or propose a counteroffer in response to CMS' initial offer. Innovations in treating CLL and other rare cancers are often achieved through the efforts of small research-oriented entities that develop products through FDA submission and approval but rely on larger manufacturers for commercialization activities. Funds from licensing agreements or other arrangements are often invested in clinical studies toward new indications or the development of additional pipeline candidates. We expect the arrangements between a research and development entity and its commercialization partner(s) to take a variety of forms.

We strongly urge CMS to gain a clear understanding of whether (and how) existing agreements might interface with the IRA DPNP process, and potentially impede a CMS-identified Primary Manufacturer from full compliance. Additional questions remain, including the following:

- If a BLA holder is not responsible for commercialization activities, could contractual provisions prohibit that entity from accessing or disclosing information? Could contractual provisions also prohibit that entity from entering into pricing agreements with Medicare and/or other payers?

- Would a BLA holder without authority to negotiate drug pricing have liability for any excise taxes or other penalties that may arise from failure to submit information, propose a counteroffer, or agree on an MFP?

- What impact does the Primary/Secondary Manufacturer construct have on the value of drug products that are currently under development, and for which a commercialization and/or investment partner is needed?

- Would a BLA holder without the authority to agree to an MFP (or to cease sales related to federal payers) have any recourse for avoiding financial repercussions other than to withdraw its NDA/BLA for the product subject to negotiation?

CLL Society believes that having more robust stakeholder engagement would enable CMS to avoid situations in which a Primary Manufacturer would potentially face CMS-imposed penalties for contractual terms set prior to enactment of the IRA and its DPNP provisions. While we are unaware of whether NDA/BLA holders of the drugs that will be selected for the initial DPNP year will face any of the issues identified above, it is likely that CMS will encounter these issues (and, perhaps, others that we have not identified) in future years. CMS' estimates of the burden associated with the ICR do not appear to account for these scenarios.

Conclusion

CLL Society once again appreciates the opportunity to contribute the CLL patient perspective as CMS implements the DPNP. We remain hopeful that the Agency will take our comments and recommendations into account as it implements the DPNP, and we welcome the opportunity to discuss our comments and/or the experience of those living with CLL more generally.

If you have any questions, please feel free to contact Saira Sultan, CLL Society's Director of Government Affairs and Public Policy at ssultan@cllsociety.org.

Sincerely,

Brian Koffman, MDCM, MSEd
Co-Founder, Chief Medical Officer, & Executive Vice President
CLL Society